Technical Report # 40

Baseline Survey Report: In-Service Training, Health and Population Sector Program (HPSP), Bangladesh

August 2003

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Contents

Tables, Figures, Boxes and Appendices

Tables

Figures

Boxes

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This nation-wide survey assesses and documents the baseline capacity status of In-Service Training under the Health and Population Sector Program (HPSP) at both the institutional and individual levels. In-Service Training, the Technical Training Unit (TTU), conducted this survey with technical assistance from PRIME-HPSP under the direction of the Line Director (LD).

Personnel from Lead Training Organizations — GUS, NIPORT, and PSTC — and from JICA also greatly assisted this effort by participating in data collection and processing. The TTU provided funding for data collection activities.

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Acronyms

ADCC	Assistant Director Clinical Contraception
AHI	Assistant Health Inspector
AOP	Annual Operational Plan
AV	Audio-Visual
BCC	Behavior Change Communication
CC	Community Clinic
CS	Civil Surgeon
DCS	Deputy Civil Surgeon
DDFP	Deputy Director Family Planning
DGHS	Directorate General of Health Services
DTCC	District Training Coordination Committee
DUTT	District/Upazila Training Team
EPI	Expanded Program of Immunization
ESP	Essential Service Package
FP	Family Planning
FPI	Family Planning Inspector
GOB	Government of Bangladesh
GUS	Gano Unnayan Sangstha
HA	Health Assistant
HPSP	Health and Population Sector Program
ICMH	Institute of Child and Mother Health
IMR	Infant Mortality Rate
IST	In-Service Training
JICA	Japan International Cooperative Agency
LD	Line Director
LD-IST	Line Director, In-Service Training
LTO	Lead Training Organization
M&E	Monitoring and Evaluation
MIS	Management Information System
MO	Medical Officer
MO MCH	Medical Officer Maternity and Child Health

MOCC	Medical Officer Clinical Contraception
MOCS	Medical Officer Civil Surgeon
MOHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
NIPORT	National Institute of Population Research and Training
PM	Program Manager
PSTC	Population Services and Training Center
P/TNA	Performance/Training Needs Assessment
QoC	Quality of Care
RH	Reproductive Health
RMO	Resident Medical Officer
RTC	Regional Training Center
SC	Satellite Clinic
SDP	Service Delivery Point
TMIS	Training Management Information System
TOT	Training of Trainers
TTT	Training Technology Transfer
TTU	Technical Training Unit
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UHFPO	Upazila Health and Family Planning Officer
USAID	United States Agency for International Development

Executive Summary

Introduction

The Government of Bangladesh (GOB) launched the Health and Population Sector Program (HPSP) in 1998 to improve the health of women, children, and other vulnerable segments of society. To achieve this goal, the GOB has begun to reorganize and integrate vertical health services to deliver an Essential Service Package (ESP) at Upazila level and below. Some 13,500 community clinics (CCs) are being constructed to serve as one-stop ESP service delivery points (SDPs). A health program of this magnitude requires enormous human resources. Therefore, a TTU was established, under the Line Director for In-Service Training (LD-IST), to plan, manage, and coordinate the training of health care personnel. To support the LD-IST, a number of Lead Training Organizations (LTOs), from both the public and the non-governmental organizations (NGOs) sectors, are helping develop curricula, conduct Training of Trainers (TOT), as well as support decentralized training at the district and Upazila levels. Altogether, the LD-IST is mandated to provide training to about 100,000 workers in the Health and Population Sector.

To guide this effort, the Ministry of Health and Family Welfare (MOHFW) approved a National In-Service Training (IST) Strategy and Action Plan for the ESP 1999-2003. This strategy calls for an IST Monitoring and Evaluation (M&E) Plan and for a Baseline Survey to establish the early status of selected indicators. The TTU, with the technical assistance of PRIME, a cooperating agency of United States Agency for International Development (USAID), developed and implemented the M&E Plan and the present Baseline Survey.

The broad objectives of this survey are:

- To assess the capacity of the TTU, and the LTOs, to plan, manage, monitor, and evaluate training related activities at the central level;
- To assess the capacity of District Training Coordination Committee (DTCC) and District/Upazila Training Team (DUTT) members to manage training related activities at the district and Upazila levels;
- To assess the existing supervisory mechanisms for the service providers;
- To assess provider performance at the SDPs; and,
- To assess client reactions toward providers and SDPs.

Methods and Materials

Achieving the baseline survey objectives required data collection at two levels:

- ***At the institutional level***: This level includes the TTU, five LTOs, 12 DTCCs, and 36 DUTTs. A multistage random selection procedure selected DTCCs and DUTTs. Ten TTU members, ten LTO trainers (two from each of five LTOs), 23 DTCC members, and 70 DUTT members provided data through interviews using semi-structured questionnaires, which were prepared separately for each institutional level.
- ***At the SDP level***: A multistage random sampling strategy selected 36 Upazilas of 12 districts under three divisions. One hundred fifty-six SDPs within these Upazilas were

then selected based on the status of CC construction. Interviewers collected data from 153 immediate supervisors (one Assistant Health Inspector (AHI) or Family Planning Inspector (FPI) from each SDP), 333 field service providers (one Health Assistant (HA) and one Family Welfare Assistant (FWA) from each SDP) using a semi-structured questionnaire. A performance assessment checklist was used to observe directly 288 field service providers (one HA and one FWA from each SDP). In addition, 289 clients answered an interview questionnaire to assess their perception of ESP services at the SDPs.

Results

TTU

At the time of the survey, the TTU was operating with six professional staff and several vacant positions. Four of these professionals have experience as physicians, one is a lecturer, and one is an audio-visual (AV) engineer. Other TTU staff has technical, secretarial, or support backgrounds.

Sixty percent of the respondents stated they had written job descriptions. Fifty percent of the TTU members reported that they had carried out many additional activities not included in their job descriptions. Sixty percent of the TTU members said they had read the National In-Service Training Strategy and the In-service Training Guidelines, while 40% had read the draft National In-service Training Standards. None of the respondents had seen the training and monitoring plan or knew the exact ESP training targets to be achieved. However, most of the respondents were aware that targets for training had not been met. Half of the TTU personnel felt frustrated that all trainees got certificates, even if a trainee was obviously deficient. They suggested that a standard of performance should be met before a trainee could receive a certificate of completion.

Thirty percent of TTU respondents said that they had enough supplies and materials. Seventy percent of the TTU members said there was no organizational policy for continuing education. Sixty percent of the TTU members felt they lacked the skills and knowledge to do their jobs adequately. The remaining 40% felt they had adequate skills, but were interested in continuing education and training in order to improve their job performance. When asked to make specific suggestions, respondents provided a list of needs, including: instruction in modern training techniques and the English language, along with continuing training in needs assessment, financial management, preparing AV aids, computer use, etc.

LTOs

Seventy percent of the trainers had held their current positions for more than three years. Eighty percent of the trainers had written job descriptions but 70% said they performed tasks not included in their job descriptions. Most of the trainers (80%) did not know the exact target number and 70% did not know how many workers had already been trained. The trainers (80%) said they had a reporting system for monitoring or evaluating training. Only 40% of trainers stated they had ever seen or read the National In-Service Training Strategy and the draft National In-Service Training Standards; while 90% of them had read the ESP Training Guidelines.

Fifty percent of the trainers reported that they had followed-up their trainees in the field. Sixty percent of trainers used checklists to evaluate trainees' performance. Most trainers felt hesitant and uncomfortable sharing poor performance results with trainees, but many said they had given individual guidance to "weak" trainees. They also reported informing supervisors if trainees were deficient in certain areas, or if trainees needed refresher courses.

With regard to the working environment, 50% of the trainers reported that they had received training supplies as needed. The remaining 50% received needed supplies each month or "infrequently," which they said made it difficult to appear professional when providing training. Eighty percent of the trainers reported that their organization had no written policy for continuing education. Ninety percent of the LTO personnel felt that they had adequate skills and knowledge, while 60% stated they needed additional skills and knowledge to do their jobs well.

DTCC

The majority of the DTCC members (74%) had been in their position between six months to three years. Eighty-seven percent of the respondents said that they had a job description. Eighty-seven percent of them had had a TOT course and 30% had received TOT on Basic ESP Training. Only 9% of the respondents had been trained in monitoring and supervision.

Ninety-six percent of the respondents reported that they participated in training related activities. The major areas of involvement were planning, organizing, and conducting training. There was little involvement in designing curriculum, preparing resources or documentation. Seventy-four percent of the respondents said that they had planned training jointly with others, although only 4% of the DUTT members reported participating in planning. Seventy-four percent of the respondents reported using their own venue for training, while 26% of them rented private venues. Ninety-six percent of the respondents said they had encountered some problems in conducting training.

Regarding performance feedback and organizational support, 52% of the respondents had received follow-up help while they were conducting training. Sixty-seven percent of these were followed up by their trainers and 42% were followed up with the use of a checklist. Eighty-three percent of those followed up received feedback on their performance. Fifty-seven percent said that they monitored training activities at the district and Upazila levels, but only 8% used TTU supplied checklists. Fifty-two percent of the respondents reported that they had followed up trainees at worksites and 67% of them used checklists. Thirty-three percent of the respondents reported that they provided feedback through monthly meetings held at the Upazila Health Complex (UHC), while 38% provided feedback verbally on the spot and only 29% provided feedback via written notes. In terms of using the results of monitoring and follow-up, 61% of the respondents mentioned that they had used the results for planning, problem identification, and designing interventions.

Seventy percent of the respondents stated that they kept records of training and 69% of them kept files. In addition, 74% of the respondents sent training records to different stakeholders. Of these respondents, 48% sent training records to the respective LDs and Program Managers (PMs), 33% to TTU and 19% to others. Only 22% of the respondents reported that they knew about the Training Management Information System (TMIS) and 91% did not know the person responsible for sending information to the TMIS.

District/Upazila Training Team (DUTT)

The majority of the respondents (66%) had held their current position for six months to three years. Ninety-three percent of the respondents reported that they had a job description. Only 24% of the DUTT members mentioned training as one of their main jobs. A majority of the respondents had received some ESP training, either through the Five-day Orientation (63%) or through the TOT on the Basic ESP course (61%). Only a few (10%) of the respondents had ever received training in monitoring and supervision. Almost all of the respondents felt the need for some additional training; and a majority expressed the need for training in administration and financial management (63%) and in specialized skills (58%). Eighty-one percent of the respondents reported that they were involved in training activities, and 64% of them felt that training activities interfered with their main jobs. The training activities in which respondents were most frequently involved were planning (54%), organizing (61%), managing (56%), and conducting training (66%). They participated infrequently in curriculum development (16%) and training documentation (13%).

The majority of the respondents (81%) reported that they did not have a training calendar to organize training and that they did not use any training guidelines for planning (66%). In addition, only 13% of the respondents mentioned the involvement of DTCC members in joint planning. Regarding the disbursement of training funds, 47% of the respondents had received funds to organize training. Of these; a majority (58%) faced some problems with the funding, and 42% reported that funds did not arrive on time. Eighty-six percent of the respondents stated that they had organized training in their own building and the rest of them rented space or utilized other public or private facilities. Respondents reported that they had encountered problems during training. Their suggestions on how to overcome these problems included: arranging accommodation for trainees (43%), supplying logistics in a timely manner (36%), providing sufficient teaching aids (36%), ensuring the timely flow of funds (27%), employing skilled trainers (24%), improving monitoring and follow-up (17%), and getting communications in advance (10%).

Regarding performance feedback and organizational support, 34% of the respondents stated that they received follow-up during training. Only 33% of the trainers of these respondents had used checklists. Seventy-five percent received feedback on their performance. Most respondents had not yet received key documents from the TTU, needed to guide and support their training, such as the ESP training strategy (70%), standards (84%) and guidelines (67%). Of those who had received the Basic ESP Training Guidelines, only 30% had used the checklists for follow-up of trainers and providers.

In respect to supervision and follow-up, 53% of the respondents mentioned that they had followed up the performance of providers at worksites. Of these respondents, 43% used checklists. Only 23% of the respondents reported that the trainers prepared the follow-up plan according to Basic ESP Training Guidelines. In terms of frequency of follow-up visits, 37% of the respondents said they checked providers every month as a matter of routine. With regard to training monitoring, 36% of the respondents reported that they were involved in the M&E of training at the provider worksite level. Only 12% of them used the TTU-provided checklists.

Seventy-three percent of the respondents reported that they kept records of training, and a majority of them (67%) kept records in files. On the other hand, 39% of the respondents

reported that they did not send training records anywhere. Regarding TMIS, only 24% of the respondents knew about it and none knew that the Upazila Family Planning Officer (UFPO) was responsible for sending information to the TMIS.

Immediate supervisors (AHI/FPI) of providers

All AHIs and FPIs interviewed for this survey mentioned that they were the immediate supervisors of service providers (HAs and FWAs) working in CC and satellite clinic (SC), or SDPs. Very few of the respondents had ever received training in management (26%) or supervision (30%). Moreover, the majority of these respondents (77% in management and 65% in supervision) had received this training more than three years ago.

Performance of providers (HA and FWA)

Forty-three percent of the respondents reported that they had a new job description but very few of them (16%) could show it to the interviewers. Out of 333 respondents, only 25 (8%) had received their 21-day Basic ESP Training. Of these, 68% felt that they could use the knowledge and skills gained from the course. Seventy-six percent of these trained respondents felt that the course would be more useful if it were strengthened in certain subject areas, such as health (63%), family planning (FP) (16%), and ESP services (11%). Only 18% of these trained respondents had been followed up at the worksite by their trainers.

The majority of the respondents (65%) reported that they had enough supplies to treat patients. The results showed differences in the availability of supplies between CCs and SCs. Seventy-six percent of the CCs lacked supplies and equipment but only 32% of the SCs did. The Facility Assessment of the clinics, which was conducted as part of the survey, had similar findings. Thirty-nine percent of the respondents at CCs and 55% of the respondents at SCs reported that they had never run out of drugs. Forty-eight percent of the respondents stated that they had reference materials at the clinic, which they could consult to treat their patients. Providers were observed and scored in their performance of ten routine skills. Average performance scores of all providers was 10.4%, with a statistically significant difference ($p<0.01$) between providers at CCs (6.4%) and SCs (14.7%).

Clients

Eighty-four percent of the clients interviewed were female. The mean age of the respondents was 28.7 years, with most (70%) in the age group of 21-40 years. The majority (87%) of the clients reported that it took them 1-30 minutes to come to the clinics. Most of the clients came to the clinics for reproductive health (RH) services (36%), immunization (26%), and limited curative care (45%). The majority of the clients at the SCs came for RH care (42%) and immunization services (39%); while the majority of the clients at the CCs needed limited curative care (58%).

Ninety-three percent of the respondents reported that they felt comfortable asking the providers questions. Sixty-seven percent of the respondents reported that the providers had discussed problems with them. When asked about the adequacy of supplies for their prescribed treatment, the majority (72%) of the patients interviewed reported that the clinics had the needed supplies. However, the respondents' opinion with regard to supplies varied by type of clinic. Sixty-four percent of the respondents at the CCs and 81% of the respondents at the SCs reported that the clinics had supplies to treat patients. This indicates

that the CCs, which provided a wider range of services, were more likely to lack needed supplies. Fifty-four percent of the respondents reported that they had seen the providers wash their hands; and this finding was similar in frequency irrespective of the type of clinic (CC or SC), despite the fact that CCs (unlike SCs) are supplied with tube-well water on the premises. The majority (81%) of respondents said that they would return to the clinics for a follow-up visit or for other services, as instructed by the provider. Sixty-five percent of the respondents reported that they had received some advice from their providers, such as whether to schedule a return visit to the clinic, referrals to other providers or clinics, health education and treatment instruction, etc.

Conclusions

As a training coordination unit, the TTU should have clear job expectations, which should be reflected in job descriptions for all staff members. All professional staff should be fully conversant and familiar with the key program documents, i.e., IST strategy, standards, guidelines, and monitoring and follow-up systems. They should be able to help the LTOs to follow these standards and guidelines. They should always be up-to-date on the status of their training targets and achievements.

All the LTOs were well staffed with experienced trainers, but there were deficiencies in their working environments. LTO trainers should also demonstrate familiarity and compliance with the training strategy, standards, and the monitoring and follow-up system. IST should emphasize strengthening the LTOs' training capacity and assuring smooth coordination with the LTOs, including the timely flow of funds.

Most of DTCC and DUTT members were involved in training related activities but were not yet familiar with the national training strategy, standards and guidelines. As a result, follow-up of trainees at worksites rarely occurred, despite its prominence as an important and integral task required under Basic ESP Training Guidelines.

Only a few (8%) service providers had received their Basic ESP Training at the time of survey. These trained providers suggested improvements in some clinical skill-based areas of the 21-day Basic ESP Curriculum. They also made suggestions for the improvement of worksites so that they could better utilize their knowledge and skills. At the time of the survey, most of the CCs lacked essential equipment and supplies.

The providers were observed serving all levels of clients, between the ages of two months to 75 years. The majority of their clients were female, aged 21-40 years. At CCs, most of the clients needed limited curative care. At SCs, which at the time of the survey were more adequately supplied and equipped than CCs, comparatively more clients needed immunization and RH services.

Introduction

Background

With a population of almost 130 million, Bangladesh continues to grow at a rate of 1.5% annually.[1] The country has undergone considerable development in many sectors during the last few years, but health indicators continue to be among the most dismal in the world. The Infant Mortality Rate (IMR) is 57/1000 live births and under-5 mortality is 116/1,000.[1] Maternal mortality stands at three per 1,000 live births. Life expectancy is 59.8 years for females and 60 years for males.[1] The Total Fertility Rate (TFR) is 3.3.[2] Seventy percent of the mothers suffer from nutritional deficiency.[3] Seventy-five percent of pregnant women do not receive antenatal care or assistance from a trained attendant at the time of birth, and less than 40% of the population has access to basic health care.[3] The health system is characterized by underutilization of health services, particularly at the community level, overcrowding of health services at the district and central levels, and the inequitable distribution of funds between urban and rural areas. Moreover, users perceive the quality of care (QoC) to be poor.[3]

The MOHFW of the People's Republic of Bangladesh has made a commitment to improve the quality of health care for its people. The HPSP, implemented in 1998, is designed to reorganize vertical health services into an integrated ESP that offers quality health care services at the community level.[3] The goal of the program is to improve health, especially of poor women and children, and to increase the utilization of health services at the local level. The program is now building 13,500 CCs, each of which will serve about 6,000 people. The CCs will offer RH, Child Health, Communicable Disease Control, and Limited Curative Care services.[3] To reach this important goal, Bangladesh must train large numbers of health and family welfare personnel. High quality training is vital to ensure that the people of Bangladesh receive better health care.

IST under HPSP

The Technical Training Unit (TTU) of the IST Sector under HPSP has been mandated to train nearly 100,000 health and family welfare personnel in the ESP area to assure high quality care at the Upazila level and below. To ensure quality training, the TTU has developed a "National In-Service Training Strategy and Action Plan for ESP, 1999-2003." This plan has six strategic objectives: [4]

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1 Bangladesh Bureau of Statistics (BBS). 2000. Statistical pocket book of Bangladesh 1999. Dhaka: BBS.

2 Mitra S N, Al-Sabir A, Cross A R and Jamil K. 1997. Bangladesh Demographic and Health Survey (BDHS), 1996-97. Calverton, Maryland and Dhaka, Bangladesh: NIPORT, Mitra and Associates, and Macro International Inc.

3 Program Implementation Plan (PIP), Part-1, April 1998. Health and Population Sector Program 1998-2003. MOHFW, Dhaka, Bangladesh.

4 National In-Service Training Strategy and Action Plan for ESP, 1999-2003. Line Director IST, MOHFW, 1999. Dhaka.

1. To strengthen central-level capacity to plan, implement, and follow-up ESP training;
2. To standardize the process of planning, implementing, and following up IST;
3. To strengthen the capacity of LTOs to serve as leaders in the training of Upazila-level trainers;
4. To strengthen Upazila-level capacity to plan, implement, manage, supervise, and evaluate training activities;
5. To conduct and follow-up the training of personnel at the Upazila level and below in order to improve service quality and to increase coverage of the population; and,
6. To develop the TMIS while enhancing evaluation capabilities at the central and Upazila levels in order to record and assess the effects and impact of decentralized training on the availability and quality of ESP services.

Evaluation plan

The TTU will evaluate the IST Program using a pre-post test evaluation design. In addition, there will be Annual Program Reviews (APR) and continuous reporting by the TMIS. With funding by the USAID, PRIME-HPSP has helped the TTU to develop its M&E plan and TMIS.

A baseline assessment has been conducted to establish the early status of selected indicators under the TTU's M&E plan. The broad objectives of the survey are:

1. To assess the capacity of the TTU and LTOs to plan, manage, monitor, and evaluate ESP IST related activities at the central level;
2. To assess the capacity of DTCC members and DUTT members to manage training related activities in districts and Upazilas;
3. To assess existing supervisory mechanisms for the service providers;
4. To assess provider performance at the SDPs; and,
5. To assess client reactions to providers and SDPs.

Methodology

Study design

The baseline survey required data collection at two levels:

1. At the institutional level, to assess the capacity of the TTU, LTOs, districts and Upazilas; and,
2. At the SDP level, to assess QoC, including provider performance, factors affecting it, and satisfaction of clients and the community as a whole.

Sample strategy

A needs assessment was initiated for the purpose of gathering data on the performance and training needs of the TTU at the Directorate General of Health Services (DGHS) in Mohakhali, Dhaka. The performance improvement approach was used as a model for the needs assessment in order to develop qualitative and quantitative indicators of the TTU's performance. Each member of the TTU, including professionals, managers, trainers and office support staff, was able to express his or her views, needs, and suggestions during individual interviews.

To assist the TTU, five LTOs were contracted at the national level to conduct different types of training activities under the IST strategy. A similar needs assessment was conducted at the following LTOs.

1. National Institute of Population Research and Training (NIPORT)
2. Institute of Child and Mother Health (ICMH)
3. Training Technology Transfer (TTT)
4. Population Services and Training Center (PSTC)
5. Gano Unnayan Sangstha (GUS)

NIPORT and ICMH are government organizations, while TTT, PSTC, and GUS are NGOs.

A multistage sampling strategy was adopted for the baseline survey at the district, Upazila, and SDPs, ensuring a maximum sampling error at the 95% confidence level.

- **First stage** – Three (50%) out of the six divisions were selected. Two divisions (Chittagong Division and Rajshahi Division) were selected purposefully and one division (Khulna Division) was selected randomly from the remaining four divisions. Chittagong division, which is hilly, less accessible, and has a greater tribal population, is a low performing area. Rajshahi division, which is on a plain and easily accessible, is a high performing area.
- **Second stage** – 12 districts were randomly selected (20% of the districts in each sampled division). Of these 36 Upazilas (two to four Upazilas from each district based on population) were randomly selected.
- **Third stage** – 156 CCs or SCs were selected as SDPs from 12 districts (13 SDPs per district).

Tools, sample populations and data collection methods

Tool to review current status of performance issues in the TTU (semi-structured)

Ten out of 11 members of the TTU were interviewed at their respective offices during February and March 2001. Questions were formulated to cover performance improvement factors, including:

1. Clear Job Expectations;
2. Immediate Performance Feedback;
3. Adequate Physical Environment and Tools;
4. Motivation;
5. Organizational Support;
6. Appropriate Knowledge and Skills.

The TTU is responsible for the development, coordination, and management of the ESP IST program, and many of its members do not conduct actual training. Therefore, it was not possible to observe them during ESP training. However, appropriate members assessed their own training skills. The results of these self-assessments are contained in this report. See Appendix D.1.

Tool to review performance issues in the LTOs (semi-structured)

Ten trainers – two from each LTO – were interviewed at their respective institutes during February and March 2001. In addition, Directors of Training were asked questions and their responses were compared with those of the trainers. Questions covered the six performance improvement factors listed above. See Appendix D.2.

District level Performance/Training Needs Assessment (P/TNA) and baseline capacity assessment tool (semi-structured)

Twenty-three DTCC members – approximately one from the Civil Surgeon (CS) Office and one from the Deputy Director Family Planning (DDFP) Office in each of the 12 districts – were interviewed to assess their capacity in training related activities at district level. See Appendix D.3.

Upazila level P/TNA and baseline capacity assessment tool (semi-structured)

Seventy DUTT members from 36 Upazilas – about two from each Upazila – were interviewed to assess their capacity in training related activities at Upazila level. See Appendix D.4.

Competence assessment tool of immediate supervisors of field service providers (semi-structured)

One hundred and fifty three immediate supervisors – one AHI or one FPI from each SDP – were interviewed at CCs and SCs to assess their competence in supervising providers at their worksites. See Appendix D.5.

Service provider's competence assessment tool (semi-structured)

In all, 333 field service providers – one HA and one FWA from each SDP – were interviewed to assess their competence in delivering ESP at their SDPs. See Appendix D.6.

Provider's performance observation checklist at worksite

Delivery of service by 288 providers – one HA and one FWA from each SDP – was directly observed, using a performance checklist to assess actual performance whenever possible. See Appendix D.7.

Exit interview tool for clients at SDP (semi-structured)

To assess client perceptions of ESP services at SDPs, two clients – one served by an HA and one served by an FWA – were interviewed immediately after they received services from the providers. In all, 289 clients were interviewed. See Appendix D.8.

Facility (equipment, furniture and logistic supplies) assessment checklist for SDPs

A checklist was used to assess the availability of equipment, furniture, and logistic supplies at 141 SDPs in one Upazila, the Sitakund of Chittagong District. The survey team could not visit SDPs because providers and their supervisors were attending a routine monthly staff meeting at the Upazila. See Appendix D.9.

Orientation of surveyors and data collection

A one-day workshop was organized to orient the interviewers from the TTU, 5 LTOs, and the Japan International Cooperative Agency (JICA). The interviewers, 23 of whom were nationals and two of whom were expatriates, were familiarized with tools and interview techniques and terms of reference of team leader and members. The workshop also stressed the importance of obtaining each interviewee's consent and assuring his or her confidentiality. Team leaders and members were briefed in detail on the terms of reference during data collection. A central team of ten to 15 members completed data collection in six stages (by division) from February to May 2001. A tour program for data collection was developed and disseminated to the sampled districts and Upazilas at least one week before each field visit. The survey teams were primarily composed of PRIME-HPSP and LTO staff. The PRIME-HPSP National Consultant for Training Evaluation, acted as the Baseline Survey Team Leader.

Data collection at institutional level

At the TTU, LTO, district, and Upazila levels, information was collected from key informants using an interview schedule to assess the capacity of various institutions. PRIME staff collected information from the TTU, LTOs, and DTCC members, while PRIME and LTO staff collected information at the Upazila levels.

Data collection at the SDP level

PRIME and LTO staff collected CC/SC level information from immediate supervisors, providers, and clients. DTCC members, DUTT members, and supervisors accompanied and assisted central team members for data collection from SDPs.

Data Processing and Analysis

The team leader developed a detailed workplan and timeline for data processing, i.e., data cleaning, editing, coding responses, computing, and analysis. Three interested and experienced staff members involved in data collection were assigned to data processing activities during the month of June 2001. All tools were sorted and marked by serial

numbers. Data code plans were developed for each tool. Following the coding plan, structured responses were initially coded. For open questions, responses were listed and then categorized for coding. Database formats were developed in Microsoft (MS) Excel and SPSS 11.5 for each data collection tool. Data were entered in MS Excel to generate individual data work sheets, which were then rechecked with a 15% tool chosen with a systematic random sample selection procedure.

In late June 2001, with assistance of the PRIME Regional Evaluation Manager, the data analysis plan was developed. Data were then transferred from MS Excel to a SPSS database and analyzed accordingly.

Results

TTU

Introduction

After inception of the HPSP, the TTU was established as the operational unit for the management, coordination, and implementation of the IST Strategy and Action Plan. The TTU is responsible for developing policies, guidelines, performance indicators, and curricula in accordance with service delivery priorities and guidelines. The TTU is also responsible for developing training standards and tools to measure trainer, provider, and system-wide performance against agreed-upon criteria. The TTU thus contributes to the goal of decentralizing the IST program, by building capacity at the central (LTOs), district (DTCC), and Upazila (DUTT) levels.

Clear job expectations

Eighty percent of the TTU members had been in their positions since the TTU was formed in mid-1998. At the time of the survey, there were six professional staff positions, including one PMs, two Deputy Program Managers (DPMs), two Training Specialists and one AV Officer. Several additional positions were vacant. All of the professionals were males, between 30 and 57 years old. Four had backgrounds as physicians, one member was a lecturer, and the remaining had technical, secretarial, or support backgrounds. There were two women on the TTU staff; one was a secretary and the other was a data enterer.

Table 1 shows that 60% of the respondents stated they had written job descriptions. Those without job descriptions said they knew what to do in their jobs most of the time because someone had told them what their responsibilities were. There was confusion, mainly among the secretarial staff, about job responsibilities. Fifty percent of the TTU members reported doing activities not mentioned in their job descriptions. Of these, approximately 50% felt that those activities interfered with their ability to carry out their primary responsibilities. The majority said their responsibilities included all IST, not limited to the ESP program.

Regarding the targets to be achieved, no respondent knew the exact number to be trained in ESP related areas. One half of respondents thought they knew a general figure, but could not relate this at the time of interview. Nor could they tell interviewers how many had already been trained (Table 1).

Table 1: TTU response on job descriptions and ESP training (n=10)

Subject	Yes	No
	n	n
Has clear job description.	6	4
Is involved in activities other than those in job description.	5	5
Is involved in training other than ESP.	10	0
Knows target to be achieved.	0	10
Knows achievement by target.	0	10

Respondents stated they had read the National In-Service Training Strategy (60%), the ESP Training Guidelines (60%), and the draft National In-Service Training Standards (40%). When asked about monitoring and follow-up of trainees after training courses, all respondents said there was no M&E plan. Nor did they mention any system that would reflect whether this had been carried out. With respect to funding, most respondents reported that money was received from the government, but agreed that getting the funds could be difficult. There was some concern that sending funds directly to the LTOs made the process even more difficult. Respondents mentioned that the process of obtaining funding was lengthy and only 20% of funding was available at the beginning of the training activity. Trainers proposed the following list of suggestions to improve fund flow:

- Allocate all funds at the beginning of training.
- Simplify the flow of funds
- Send funds to LD-IST on approval of Annual Operational Plan (AOP)

Most of the respondents were aware that the targets for training had not been met. They mentioned several reasons for not meeting the targets. There seemed to be some confusion about how reporting was done. Some respondents thought reporting on ESP training was done quarterly, while others thought reporting was done after each course or after several courses. Respondents suggested ways to improve the reporting system, which they felt would enable them to increase their output. These suggestions are illustrated in the following box.

Box 1: Perceived problems in achieving targets and suggestions for improvement

Problems encountered meeting target	Causes of problems	Suggestions for improvement of reporting system
▪ Difficulties following up training due to lack of funds ▪ Lack of delegation by supervisors and Line Director ▪ Not enough training materials ▪ Background in an area other than teaching and training ▪ Facing many problems, but trying to do best job possible	▪ Lack of training schedules ▪ Late selection of LTOs ▪ No guidelines for training ▪ Fund release problems ▪ Not enough manpower ▪ Problems with call-up notices ▪ Time constraints ▪ No training done during the first year of the HPSP	▪ Establish TMIS ▪ Report monthly ▪ Simplify the reporting forms ▪ Get reports in timely manner ▪ Keep all training reports in one place

TTU members were asked to cite differences between the "Trainer" and "Master Trainer" roles. The following box illustrates these perceived differences:

Box 2: Perceived differences between trainers and master trainers by TTU members

Trainers	Master Trainers
▪ Normal resource person ▪ Sub-specialist on subject ▪ Almost the same ▪ Provides the environment to learn ▪ Attend the Training of Trainers (TOT)	▪ Facilitator ▪ Super trainer ▪ Knows training methodologies, evaluation, subject area ▪ Provides skills, knowledge and standards of training ▪ Conducts the TOT

Some of the professionals in the TTU stated they were both trainers as well as master trainers, although none believed their Master Trainer status to be nationally or internationally recognized.

Performance feedback and organizational support

The survey asked about both the respondents' own experience within their organizations and, when applicable, about the feedback they supplied to trainees in the field. Organizational support has been included in this section because questions regarding feedback often related to organizational support.

Within the organization

When asked who their immediate supervisor was, TTU members expressed confusion. Respondents said they had between two and six supervisors. Only one respondent replied he had one supervisor. Others stated that even though they had supervisors within the TTU, they regarded the LD-IST, as their immediate supervisor. The TTU members were then asked questions about what sort of support they received from their supervisors. The majority of the respondents felt positive about the support their supervisors gave them. Some of the respondents reported they would like more time with their supervisors to better understand the activities they were to undertake. They felt this would avoid confusion. As to the type of support received, the respondents listed administrative, financial, and organizational support. Some said they got "any kind of support I need." The great majority felt they were getting the type of supported they needed most. However, some respondents felt they needed more time with their supervisors and better follow- up. Many wanted to spend more time with the LD-IST.

The TTU members were asked how often they were evaluated. Seventy percent stated they had not been formally evaluated (Table 2). Of these, some said they had been evaluated verbally ("you did a good job") or informally. Several TTU members stated they wished they would be given better direction and more encouragement when they did a good job.

Table 2: TTU response on monitoring, follow-up and performance feedback system (n=10)

Subject	Yes	No
	% (n)	% (n)
Has monitoring and follow-up plan	0 (0)	100 (10)
Is evaluated by supervisors	30 (3)	70 (7)
Follows up trainees in the field using checklist	10 (1)	90 (9)
Has minimum level of performance required	50 (5)	50 (5)
Shares results of supervision with trainees	50 (5)	50 (5)

When asked whether they had ever been observed during a training session, 66% of those staff members directly involved in training (excluding technical and office support personnel) answered that they had been observed and received a letter grade (A, B, etc.). But they did not mention any follow-up in terms of supportive supervision, such as suggestions about how they could improve their performance.

When asked how their supervisor reacted if they did a "good job" or a "bad job," most TTU members said they received praise for doing good work, though only occasionally. One respondent reported that the LD-IST was the only supervisor who had ever complimented him/her for work well done. Several of the respondents reported they would like to be given more encouragement. Several respondents reported that, when their work was poor, their supervisors tried to help them improve, told them to do the job over, or asked why they had not done the job properly. One respondent said he had never been told he had done a bad job.

Follow-up in the field

The survey asked TTU members if they followed trainees up in the field. Only one of the respondents said he evaluated trainees in the field after training courses (Table 2). This respondent said he had followed up four individuals and one group of 90 persons in the past month. He used the ESP Training Guidelines Checklist to complete the follow-up evaluation. The other respondents stated they had never done follow-up. (Technical and support staff said follow-up was not part of their responsibility.) When asked what supportive supervision meant to them, TTU members gave the following answers:

- Giving guidance in a non-threatening, non-punishing way
- Coaching on the job
- Giving support as and when needed
- Seeing if a person is not doing a job well and telling them how they can improve their performance
- Identifying the problem and the solution without making the participants feel threatened or afraid
- Informing a person if their performance is poor

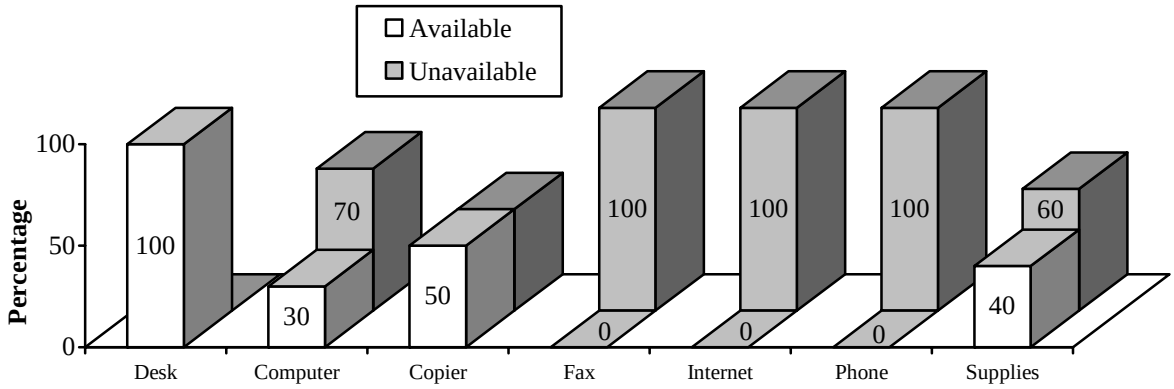
Fifty percent of the TTU members who responded agreed there was no minimum level of performance required of trainees to pass a training course (Table 2). They believed trainees should meet standards of performance before receiving a certificate of completion. They felt frustrated that even though some trainees were obviously deficient,

all trainees got certificates. Most felt this policy should be changed. One respondent said that 80% should be the passing level and that if trainees did not meet requirements successfully, they should have to attend re-training sessions. As far as sharing positive or negative results from post tests with trainees in the field, half of the TTU members answered they shared the results. The method of sharing results varied. Some felt sitting with the trainee and going over the positive and negative points was important. Another respondent felt it was acceptable to read the scores aloud to the class. Most respondents felt they should be kind and choose their words carefully when sharing negative results with a trainee.

Adequate physical environment and tools

The survey asked TTU members about their physical environment and training and other work tools. As shown in Figure 1, some of the equipment and supplies needed to manage and carry out training efficiently was unavailable.

Figure 1: Availability of TTU supplies and equipment



Forty percent of the TTU members felt they had enough work materials and supplies to do their jobs effectively. Their response to the question of how often they received supplies ranged from "never" to "I have to buy my own" to every two to six months. Thirty percent of the respondents said they had sufficient work materials and supplies. The remaining 70% said they lacked paper, pencils, markers, transparencies, fax, telephone, computers, calculators, stapler, adhesive tape, floppy disks, towels, toilet tissue, and water. Some also complained about the dirty environment, especially in the bathrooms, because of the lack of cleaning supplies. There was general confusion about the proper procedure for getting materials and supplies. One recurring complaint was that the stores facility often did not have what they needed and that getting necessary supplies took too long. Resources needed to improve TTU members' work environment were identified as follows:

- Computers and laptops with Internet access
- Printer
- Air conditioning
- Phone
- Fax machine

- Accountant
- Conference room to hold meetings
- Computer operator or programmer

Motivation

The survey asked TTU members to describe interpersonal relationships within their organization, suggest ways to improve those relationships, and recommend non-monetary motivators. Forty percent of respondents said there were "good" relationships within the organization. The remaining 60% mentioned some problems (Box 3).

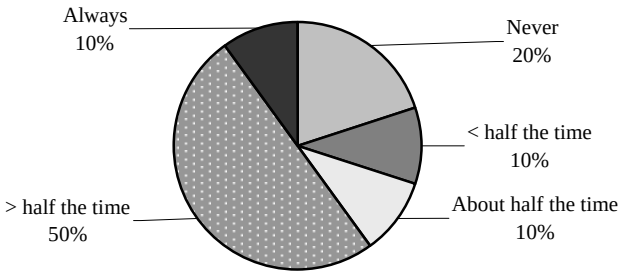
Box 3: TTU response on interpersonal relations and non-monetary motivators

Interpersonal relationships within their institutions	Suggested non-monetary motivators
▪ "Not good, not bad" ▪ Misunderstandings between personnel ▪ Lack of respect ▪ Resentment ▪ Too much bureaucracy ▪ People avoid responsibility ▪ "Everyone tells me what to do, and gives different directions, so I am confused"	▪ Appreciation of others ▪ Picnics ▪ Thank each other more ▪ Small trip within the country ▪ Continuing education ▪ Have the Line Director attend the weekly meeting ▪ Weekly motivational meeting ▪ Develop positive interpersonal relationships through workshops, etc. ▪ Give certificates of appreciation ▪ Tell those who are not doing their job (in front of others) ▪ LD-IST should listen and respond to the needs of the TTU (doesn't have enough time for this)

When asked to identify non-monetary motivators in their work environment, 60% of TTU members were unable to identify any. The remaining 40% mentioned a range of possible motivators (See Box 3 above).

The TTU members were asked whether they felt they were listened to when they made a suggestion. Figure 2 shows their response:

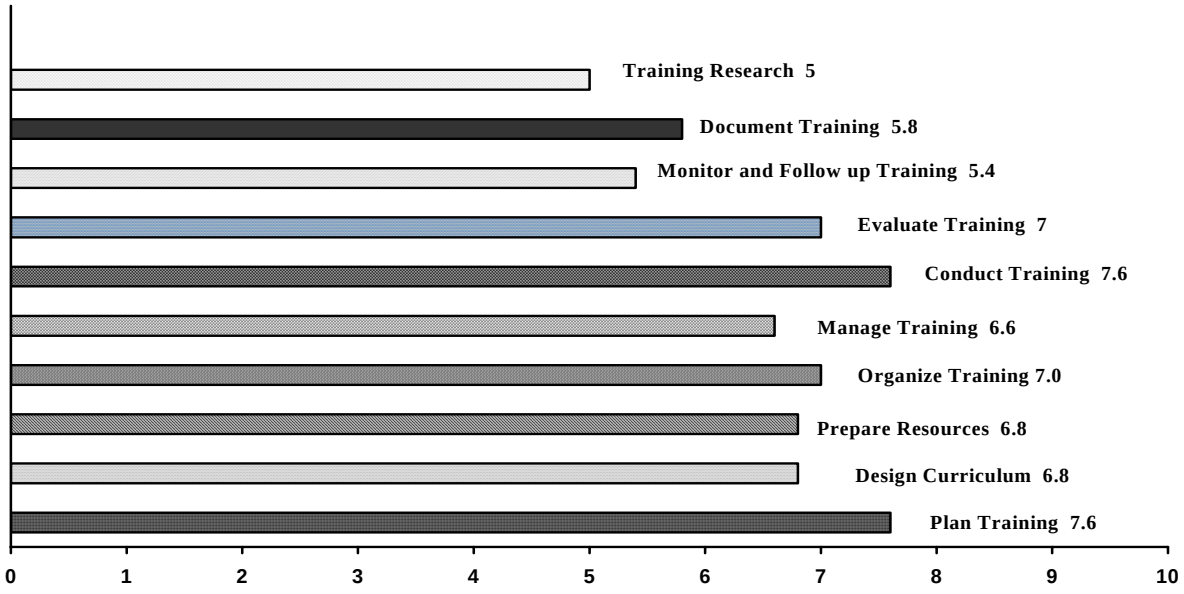
Figure 2: Perception of TTU members of being listened to when making suggestions



Appropriate knowledge and skills

TTU professional staff members were asked to rate themselves as trainers on a scale of one to ten. As shown in Figure 3, most TTU personnel involved in training felt they had average training skills. They felt most competent in planning and conducting training.

Figure 3: TTU self-assessment of current abilities in training roles



There was a great diversity of experience and education within the professional and technical staff. Before joining the TTU, staff members had worked in the following jobs: sociology lecturer, computer specialist, physician, quality assurance officer, biomedical equipment technician. Others had clinical training.

Although 70% of TTU members reported their organization had no policy for continuing education, 90% had received some type of continuing education, most within the past year. Only one member of the TTU was aware of a policy for continuing education for government employees, related to age. ("Younger than 40 years old are eligible for PhD training, those above 40 years old are only eligible for diploma education, and after 45 years old are only eligible for orientation courses"). Most respondents had been to training courses within the country, but several had been abroad for specific training related to their TTU responsibilities. All personnel with training responsibilities had attended a TOT course within at least the last two years.

The survey asked TTU members whether they felt they had adequate skills and knowledge to do their jobs well. Sixty percent felt they lacked sufficient skills and knowledge. The remaining 40% felt they had adequate skills, but were interested in continuing education to improve their job performance. When asked what sort of continuing education would help them to do a better job, they made the following suggestions:

- Modern training techniques
- English language skills
- Planning
- Organizing
- Needs assessment
- Behavioral change communication
- Managerial skills
- Financial training
- Preparing AV aids
- Computer training, technology, Management Information System (MIS), programming
- Latest governmental rules, circulars, financial rules

LTOs

Introduction

Three LTOs (ICMH, NIPORT and TTT) are responsible for providing ESP training of district and Upazila trainers. The other two LTOs (PSTC and GUS) provide management support for district and Upazila orientation and training, respectively.

Knowledge of jobs and responsibilities

The trainers in the LTOs had held their current jobs for different lengths of time. Seventy percent of the trainers had been in their positions for more than three years. Twenty percent of the trainers had been in their positions for one to three years. The remaining 10% had held their positions for six to twelve months. Table 3 shows that 80% of the trainers had written job descriptions and 70% performed tasks not included in their job descriptions (Table 3). However, 50% of these trainers felt that their additional activities did not interfere with their primary training responsibilities. Ninety percent of the trainers said they had to conduct training other than ESP training, although the majority felt that they were able to make ESP training their priority.

Table 3: LTD response on job descriptions, ESP training and targets (n=10)

Subject	Yes	No
	% (n)	% (n)
Has clear job description	80 (8)	20 (2)
Is involved in activities other than job description	70 (7)	30 (3)
Is involved in training other than ESP	90 (9)	10 (1)
Knows target to be achieved	20 (2)	80 (8)
Knows achievement by target	30 (3)	70 (7)
Had read training documents		
ESP IST Strategy	40 (4)	60 (6)
21-day Basic ESP IST Guidelines	90 (9)	10 (1)
National Training Standards	40 (4)	60 (6)

Experience in ESP Training

LTO trainers faced some problems in conducting ESP training. The most frequent problems mentioned by respondents were:

- **Trainers**: LTOs used resource persons from different institutes/organizations to teach in TOT courses. Some of these resource persons had not received TOT; sometimes they came to the class without any preparation, and they deviated from the topic of discussion.
- **Conflicts about who will do the training**: LTOs had some confusion about their roles and responsibilities in the implementation of training courses.
- **Large groups**: LTOs trained groups of 32 in Basic ESP and of 25 in TOT.
- **Training finances**: Money did not arrive in time; sometimes preventing LTOs from achieving their targets.
- **Duration of training**: TOT was too short. Trainees needed more practice time. Hartals/strikes posed difficulties in scheduling.

Table 3 shows that most trainers (80%) did not know the exact target number; and 70% did not know how many had already been trained. Ninety percent of the trainers stated they wrote training reports after each course while the remaining 10% completed training reports monthly or at other intervals. Suggestions to improve the reporting system included keeping daily records, so the final training report could be done with less confusion, and including trainee evaluations on the TMIS form.

Trainers were asked if they had read certain documents about ESP training in Bangladesh. Forty percent of the trainers stated they had seen or read the National In-Service Training Strategy and forty percent said they had seen or read the National In-Service Training Standards. Ninety percent reported reading the ESP Training Guidelines (Table 3).

The overwhelming majority of the LTO trainers (80%) said they had a reporting system for monitoring or evaluating training. Only 40% said they received funds before training commenced. There seemed to be a consensus among trainers that obtaining funding was up to their supervisors, although some suggested that opening accounts at the Upazila level would make it easier to get funding. Training supervisors viewed obtaining funding as one of the biggest challenges to conducting ESP training.

The trainers were asked to explain the difference between a "trainer" and a "master trainer." The following box shows how they responded.

Box 4: Perceived differences between trainers and master trainers by LTO staff

Trainers	Master Trainers
▪ Does not regularly teach ▪ Is involved in all areas of training ▪ Conducts training and supervises the workers)	▪ Highly skilled and experienced ▪ Trains other trainers ▪ Has expertise in every step of training ▪ Explains planning, designing, managing and organizing to trainers

One half of the trainers stated they had Master Trainer certification, which was recognized locally (10%) or nationally (30%), and 10% said their Master Trainer status was not recognized.

Performance feedback and organizational support

Performance feedback included both the feedback trainers received within their organization and the feedback they gave to trainees in the field. Organizational support was included in this area, as questions regarding feedback often related to organizational support.

Within the organization

When asked about support received from their supervisors, trainers gave positive responses. Trainers seemed to rely on their supervisors mainly for administrative support, but they also received information on new programs, guidelines, clarification of job responsibilities, technical support, and on the spot training. Although a great majority (80%) felt they received sufficient support from their supervisors, some said their supervisors were unable to help them effectively with computer technology, management, or planning. Twenty percent of the trainers felt their supervisors should provide more encouragement, explain programs better, and represent them more effectively. Ninety percent felt they could rely on their supervisors to help solve problems. Many stated they tried to work problems out for themselves, but they knew their supervisors would help them find a solution if they could not.

Respondents had different experiences with respect to the evaluation process. Twenty percent had never been evaluated; 10% were evaluated irregularly; 50% were evaluated annually, and 20 percent, semi-annually. (These were not specific evaluations of the respondents' performance as trainers. They were evaluations done to fulfill administrative requirements. In some cases, however, these evaluations did include training activities.) Most trainers felt their evaluations were fair. Some said their supervisors encouraged them to discuss differences of opinion about evaluations. They added that their supervisors gave them immediate feedback on their performance after evaluations.

Most trainers said their supervisors praised them privately or in front of others for doing a "good job." They said they were congratulated for specific jobs they had done well or for shouldering additional responsibilities. One trainer had been granted a study tour. Some

of the trainers, however, felt they should get more positive recognition for good performance. When asked how their supervisors reacted to a "bad job," most trainers replied that their supervisors gave them objective feedback privately. Some described this process as a discussion to "identify problems" and "find ways to improve performance." One trainer said "bad jobs" were never addressed within the organization.

Follow-up in the field

Fifty percent of the trainers said they followed-up their trainees in the field. Thirty percent reported they had followed-up between one and 15 trainees in the field over the past month. Twenty percent reported following-up more than 15 trainees.

Trainers were asked about their understanding of and experience with supportive supervision. Their statements are illustrated in the following box.

Box 5: LTDs' understanding of supervision

Supportive supervision means:	Supervisory field visit means:	Sharing good or bad results means:
1. Guidance 2. Sharing problem solving techniques 3. Providing solutions to problems	1. Observing and documenting performance using a checklist 2. Sharing findings with trainees to improve performance	1. Trainers shared strengths and weaknesses with individual trainee directly. 2. Trainers were hesitant to share poor results or did so indirectly.

Sixty percent of the trainers reported using checklists to evaluate trainees' performance. Two trainers described the supervisory visit as something that "doesn't happen" or as more of an administrative issue that needed to be discussed with the providers' supervisor, not with the provider. On the other hand, most trainers felt hesitant and uncomfortable sharing poor performance results with trainees.

One-half of the LTO trainers said they had their own M&E Plan, but few were able to show surveyors a document, stating that it had not been written down. This indicates they may misunderstand how a M&E Plan is defined.

Table 4: LTD response on monitoring, follow-up and performance feedback system

Subject	Yes	No
	% (n)	% (n)
Has a monitoring and follow-up plan	50 (5)	50 (5)
Has a training reporting system	80 (8)	20 (2)
Follows up trainees in the field	50 (5)	50 (5)
Compares pre-post test score	50 (5)	50 (5)
Requires minimum level of performance	50 (5)	50 (5)

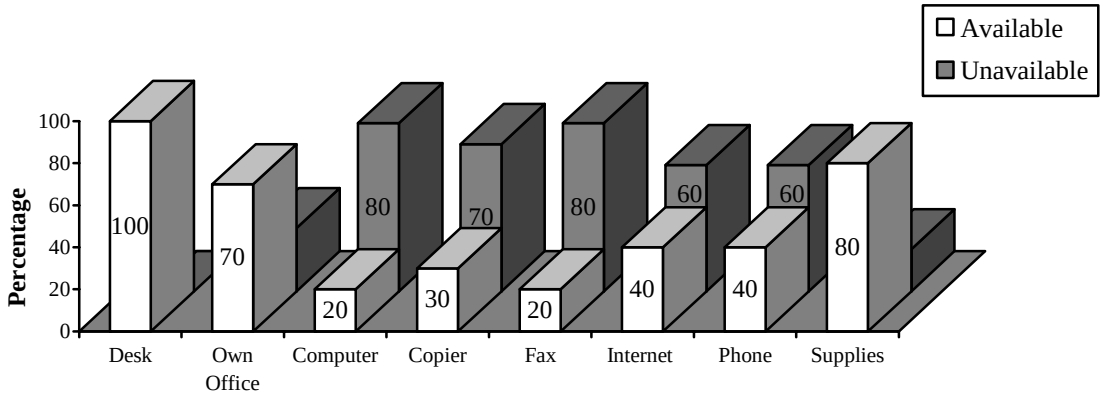
When asked if there was a minimum level of performance required of trainees to pass a training course and if pre-post test results were compared, the trainers were equally divided (Table 4). Trainers said they gave individual guidance to "weak" trainees, informed supervisors if a trainee was weak in certain areas, or had the trainee undergo refresher training. Giving certificates to all trainees frustrated trainers, because they felt

that successful trainees were not differentially rewarded. Trainees who did not attend lessons or did a poor job received the same certificate as those who had applied themselves and done a good job. Most trainers felt the system should be changed to reward those who successfully passed the course.

Adequate physical environment and tools

The trainers were asked about their physical environment and training tools. As shown in Figure 4, although trainers did have equipment and supplies, they lacked some needed tools, making them less productive and hampering their ability to carry out training activities.

Figure 4: Availability of LTD equipment and supplies



Fifty percent of the trainers reported receiving training supplies as needed. The remaining 50% said they got supplies monthly or "infrequently." This made it difficult for some trainers to provide instruction in a professional manner. Some trainers stated that the only time they received supplies was when they took them from those just before going into the field. When asked how training supplies reached the field, most trainers said that supplies were purchased elsewhere and brought to the field or purchased locally at the training site.

According to LTDs surveyed, equipment and supplies needed to improve their work environment include:

- Computers
- Air conditioning
- Own office
- Internet
- Photocopier
- AV materials
- More storage space
- Window screens

Box 6: LTD response on available and needed non-monetary motivators

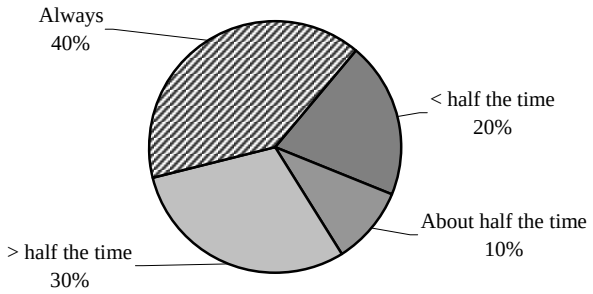
Available non-monetary motivators	Suggested non-monetary motivators (training courses)
▪ Support for personal problems.	▪ Modern training methodologies.
▪ Value for gender.	▪ Computer programming.
▪ Family needs are honored.	▪ Monitoring and Evaluation.
▪ Sharing responsibility.	▪ Reporting and documenting.
▪ A sense of ownership.	▪ BCC skills.
▪ Professional training.	▪ Advanced course in TOT.
▪ Ability to make own decisions.	▪ Clinical training.
▪ Freedom to express own opinions.	▪ Group facilitation skills.
▪ Periodic picnics.	▪ Modern AV aids
▪ Sharing in special occasions, e.g., birthdays.	▪ Survey methodology

Motivation

Trainers were asked about interpersonal relationships in their organization and how they could be improved. All of the trainers (100%) felt there were good interpersonal relationships within their organization. They felt supported by others and able to work as a team. Suggestions to further improve interpersonal relationships included: workshops to strengthen interpersonal relationships; workshops to improve performance; and peer management groups. When asked which non-monetary motivators their organization used, trainers provided a list of those available as well as suggesting additional ones, as shown in the Box 6.

The trainers were asked whether they felt their suggestions were listened to. Figure 5 shows their responses.

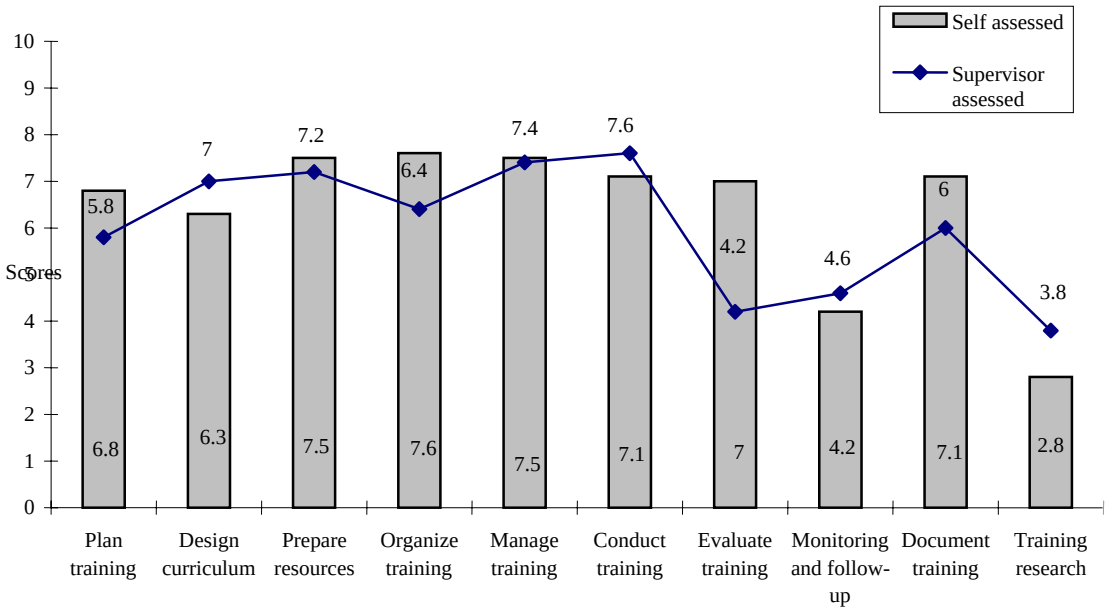
Figure 5: LTD perception of being listened to when making a suggestion



Appropriate knowledge and skills

The trainers were asked to rate themselves as trainers on a scale of one to ten. At the same time, Directors of Training (trainer supervisors) rated their staff (the respondents) using the same form. Their responses are shown in Figure 6.

Figure 6: Skills rating on training related activities by trainers and their supervisors



In some areas, there were major difference in how trainers rated their own performance and how their supervisors did. For instance, trainers rated themselves as having less skill in the areas of research and curriculum design, than their supervisors did. But they rated themselves as having more skill in planning, organizing, evaluating, and documenting training.

Trainers were asked about their background and experience before becoming a trainer. They had a great deal of experience in diverse fields, such as communications, finance, management, and computer technology. Some had clinical skills and training. Most trainers had at least a Masters degree, though the areas of concentration were diverse.

Although 80% of trainers reported that their organization had no written continuing education policies, 60% reported having had a continuing education or training course during the previous year. The remaining 40% had had continuing education within the past two to five years. All trainers had completed a TOT course within the last five years; 70% had done this within the last two years.

The trainers were asked whether they felt they had adequate skills and knowledge to do their jobs well. Although 90% said they had adequate skills and knowledge, 60% stated they needed additional skills and knowledge to continue to do their jobs well. When asked what specific skills or knowledge would help them to do a better job, a long list of needs was given as follows:

Desired skills and knowledge

- Modern training methodologies
- Computer programming
- Monitoring and Evaluation (M&E)
- Reporting and documenting
- Behavorial Change Communication (BCC) skills
- Advanced course in TOT
- Clinical training
- Group facilitation skills
- Modern AV aids
- Survey methodology

DTCC

Introduction

The DTCC plays a vital role in the implementation of the IST of health and population sector personnel in Bangladesh. The DTCC is designed to decentralize training to the Upazila level. It is responsible for coordinating, planning, implementing, monitoring, and documenting training activities conducted within each district and Upazila. The DTCC has the following five members:

- The Civil Surgeon (CS) is the Chairman;
- The Deputy Director, Family Planning (DDFP), is the Co-chairman;
- The Deputy Civil Surgeon (DCS) or Medical Officer in Civil Surgeon (MOCS) Office is a member;
- The Assistant Director Clinical Contraception (ADCC), or Medical Officer Clinical Contraception (MOCC), is a member; and,
- The Senior Health Education Officer (SHEO) is the Secretary.

Job and responsibilities

The respondents had varied lengths of service in their present positions. The majority of the respondents (74%) had held their jobs between six months and three years. Eighty-seven percent of the respondents said that they had a job description. They mentioned administration, finance, coordination, monitoring and supervision, training, clinical services, and BCC as their main responsibilities (Table 5).

Table 5: DTCC members' length of service and job responsibilities (n=23)

Categories	% (n)
Length of service in present position	
Less than 6 months	9 (2)
Between 6-12 months	30 (7)
Between 1-3 years	44 (10)
More than 3 years	17 (4)
Main job responsibilities*	
Administration, Finance and Coordination	83 (19)
Monitoring and Supervision	39 (9)
Training	48 (11)
Clinical service	39 (7)
Behavioral Change Communication	13 (3)
Treats patients	
Never treated patients	34 (8)
Treated patients within last week of survey	52 (12)
Treated patients within last six months	9 (2)
Treated patients within last year	4 (1)

* *The respondents gave multiple responses*

Most respondents had not yet received key documents from the TTU, which they needed to guide and support the implementation of training, such as the ESP training strategy, standards and guidelines. Thirty-four percent of the respondents did not treat patients because they were not medical professionals. Fifty-two percent of the respondents were actively involved in clinical practice while the rest were involved irregularly (Table 5).

Training Status

All of the respondents had received some IST. Seventy-eight percent of them had received training during the past year. Eighty-seven percent of them had had a TOT course. Thirty percent of them received TOT in Basic ESP Training. Only 9% of the respondents had received training in supervision and follow-up. Almost all of the respondents felt the need for more training. The majority of the respondents (61%) expressed a need for training in administration and financial management (Table 6).

Table 6: Training status of DTCC members (n=23)

Areas Assessed	% (n)
Most recent training	
Within last year	78 (18)
Within 1 - 2 years	9 (2)
More than 2 years ago	13 (3)
Received training documents*	
ESP Training Strategy	13 (3)
ESP Training Guidelines	0 (0)
Training Standards	4 (1)

Areas Assessed	% (n)
Type of training*	
TOT on ESP clinical services	13 (3)
TOT on ESP field services	17 (4)
TOT on other services	87 (20)
Monitoring and supervision	9 (2)
Desired future training in:*	
Administration and financial management	61 (4)
Training methodology	22 (14)
Monitoring and supervision	39 (9)
Specialized clinical skills	39 (9)
HPSP and health sector reform	17 (4)
Logistics and supply	4 (1)

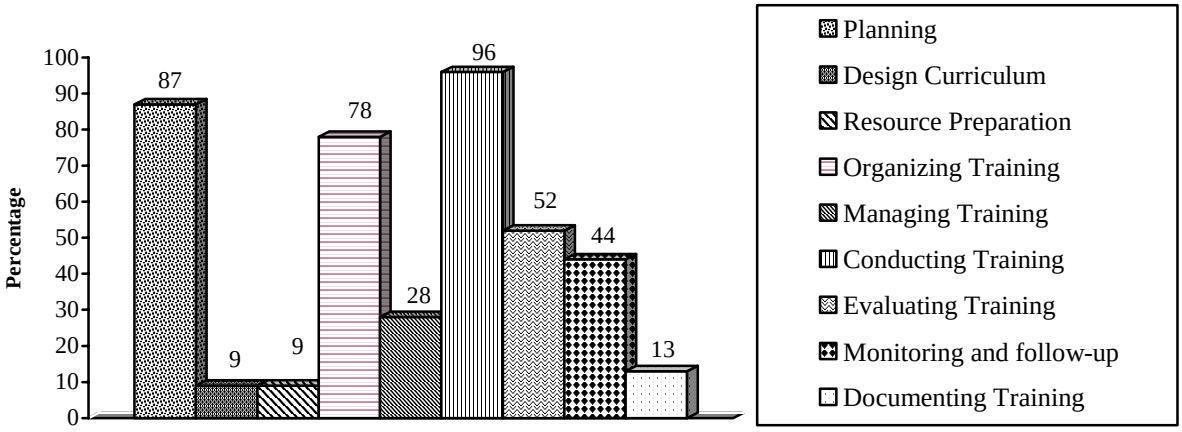
* *The respondents gave multiple responses*

Training activities

Ninety-six percent of the respondents reported that they were involved in training activities; 41% of them reported that training did not interfere with their ability to complete their main jobs, while 59% of them felt that training interfered with their main jobs occasionally.

When asked about involvement in nine major training related activities, which are considered standard training tasks, most of the respondents reported taking part in planning, organizing, and conducting training. Involvement in designing the training curriculum, preparing resources, and documenting training was low (Figure 7).

Figure 7: Percent of DTU respondents involved in training related activities

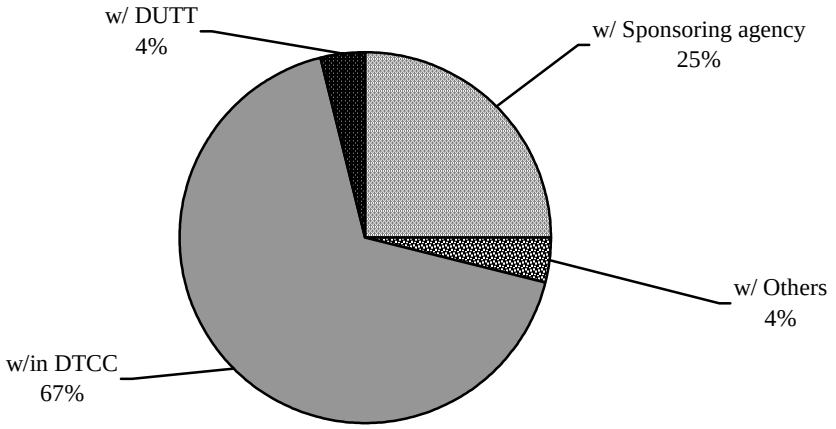


Twenty out of 23 respondents had received funds for organizing training; but 15 had faced some problems with funding. Fourteen of them mentioned that the funds did not arrive on time. When asked about the frequency of this problem, nine out of the 14 stated that they had problems less than half of the time, while four respondents had problems more than half of the time.

Very few respondents reported using a training calendar to organize training or training guidelines to plan for training. Ninety-one percent of the respondents reported that they did

not use a training calendar and 83% stated that they did not use training guidelines for planning and organizing training programs. Thirty-three percent of DTU members reported that they had planned training jointly with other stakeholders. In most cases (67%), the DTCC members planned training among themselves (Figure 8).

Figure 8: Percent of respondents involved in planning within DTCs and among other stakeholders



Seventy-four percent of the respondents reported that they had used their own venue for conducting training, while 26% of them rented private venues. Ninety-six percent reported difficulties in such areas as funding, logistics, accommodations, teaching aids, trainer skills, monitoring, and follow-up. The respondents made some suggestions regarding these problems (Table 7).

Table 7: Suggestions regarding training problems (n=23)

Suggestions to overcome problems*	% (n)
Timely supply of logistics	61 (14)
Advance communications	52 (12)
Improved financial management	35 (8)
Suitable accommodations for trainees	35 (8)
Sufficient supply of teaching aids	35 (8)
Improvement of trainer skills	26 (7)

* *The respondents gave multiple responses*

Performance feedback and organizational support

Twelve out of 23 respondents (52 %) had been followed-up while they were conducting training: eight of them (67%) were followed-up by their trainers and four of them (33%) were followed-up by their supervisors. Five of them (42%) were followed-up with use of a

checklist, five were followed-up verbally, without a checklist, and two did not respond. Ten of the 12 respondents (83%) received feedback on their performance.

Training monitoring and follow-up

With regard to monitoring training, 13 respondents (57%) reported that they had monitored training activities at the district and Upazila levels. Seven of them had monitored training with some kind of checklist. Only one of them had used TTU supplied checklists.

Twelve respondents out of 23 (52%) reported that they had followed up trainees at worksites. The mean number of the trainees followed up by the respondents in the last month of the survey was 29 with standard deviation 50.4 and a median of 18. This number seems to be higher because one respondent reported following up 180 trainees in the last month of the survey. Eight of them had used checklists to follow-up trainees. Ten of them followed up monthly, while the others followed up as required.

When asked how they gave feedback on follow-up results to providers, 33% of the respondents said they provided feedback through monthly meetings held at the UHC, while 38% provided feedback verbally on the spot, and 29% provided feedback via written notes.

Fourteen respondents reported using results of the training monitoring and follow-up for different purposes. Eight of them used it for planning; five of them used it for problem identification; one of them used it for designing interventions.

When asked to whom they gave results, six said they gave results directly to the field workers, while two of them passed results on to the divisional level supervisors, three to the district level supervisors and one to the Upazila level supervisors.

Documentation and reporting

Sixteen out of 23 respondents stated that they kept records of training: 11 in files, two in registers or computers, and one in other ways. Seventy-four percent of the respondents sent training records to different stakeholders. Forty-eight percent sent training records to the respective LDs and PMs, 33% sent them to TTU, and 19% sent them to others.

When asked about the TMIS, 22% of the respondents reported that they knew about it; 60% of them described TMIS as a facility for information management. Most of the respondents (91%) did not know the person responsible for sending information to TMIS. Of the 9% who said they knew the person responsible, 5% mentioned the Statistician and 4% mentioned the Office Assistant.

Districts and Upazila Training Team

Introduction

DUTTs have been formed in each Upazila to help plan and conduct ESP training as part of the effort to decentralize the training system. DUTT members are also responsible for following-up the performance of the trainees (ESP providers) at their SDPs and providing on-the-job training if any trainee is found to be under performing. Thus, the DUTT contributes to performance improvement at SDPs.

DUTT members receive TOT by LTOs to train field service providers. Along with the DTCCs, the LTO trainers are responsible for following up performance of DUTT members at

the Upazila training sites and providing on-the-job training if any member is found to be under performing. The DUTT consists of eight members: two from the district level and six from each Upazila. The members of the DUTT are:

At district level:

- The ADCC or MOCC;
- The DCS or MOCS;

At the Upazila level:

- The Upazila Health and Family Planning Officer (UHFPO);
- The Upazila Family Planning Officer (UFPO);
- The Resident Medical Officer (RMO);
- The Medical Officer, Maternal and Child Health (MO MCH);
- The Medical Officer (MO), Field Service; and,
- The Regional Training Center (RTC) or Family Welfare Visitor Training Institute (FWVTI) Representatives[5] or the Assistant Upazila Family Planning Officer (AUFPO).

Jobs and responsibilities

As in the case of DTCC members, DUTT members had different lengths of service. The majority of the respondents (56%) had been in their current positions between six months and three years. Thirty-four percent (36 out of 70) had held their positions for more then three years. Respondents mentioned administration and financial management, monitoring and supervision, limited curative care, logistics management, training, RH services, and child health care as their main jobs (Table 8). Ninety-three percent (65 of 70) reported that they had a job description.

5 The National Institute of Population Research and Training (NIPORT) operates a network of the 20 Regional Training Centers (RTCs) at the Upazila level and 12 Family Welfare Visitors Training Institutes (FWVTIs) at the district level.

Table 8: Length of service and job responsibilities of DUTT members (n=70)

Subjects	% (n)
Length of services in present position:	
Less than 6 months	10 (7)
Between 6-12 months	14 (10)
Between 1-3 years	42 (29)
More than 3 years	34 (24)
Main job responsibilities:*	
Administration and finance management	74 (52)
Monitoring and supervision	60 (42)
Limited curative care	43 (30)
Logistics management	36 (25)
Training	24 (17)
Reproductive health services	9 (6)
Child health care	9 (6)
Patient care:	
Never treated patients	30 (21)
Treated patients within last week of survey	61 (43)
Treated patients within last six months	1 (1)
Treated patients within last one year	1 (1)
Other	7 (4)

* *The respondents gave multiple responses*

Thirty percent of the respondents did not treat patients because they were not medical professionals. Sixty-one percent of the respondents were actively involved in clinical practice while the rest (9%) were involved irregularly.

Training Status

All of the respondents had received some IST and 73% had received TOT courses. Table 9 shows that 91% of the respondents had received training during the past year. Sixty-three percent of respondents had received the five-day ESP orientation course. Sixty-one percent had received TOT on the Basic ESP course. Only a few (10%) of the respondents had ever received training in monitoring and supervision. Almost all of the respondents felt the need for some additional training. The majority of the respondents expressed a need for training in administration and financial management (63%) as well as further training in specialized skills (58%).

Table 9: Training status of DUTT members (n=69)

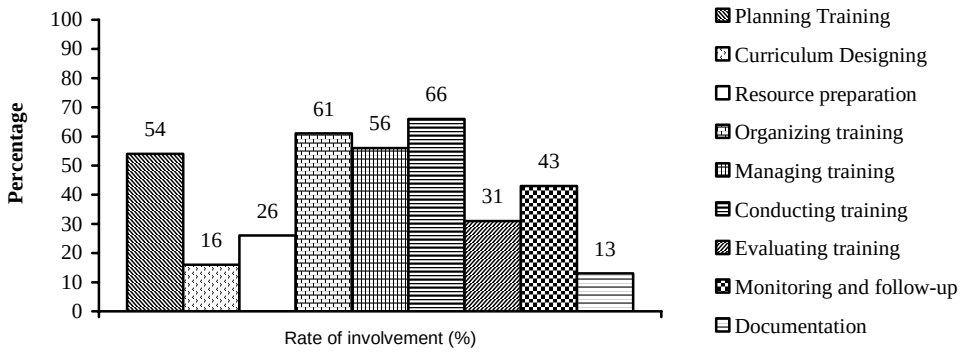
Training Status	% (n)
Time of last training:	
Within the past year	91 (64)
Within the past 1-3 years	3 (2)
More than 2 years ago	4 (3)
Training received:	
ESP orientation	63 (44)
TOT courses:*	
TOT on ESP clinical services	16 (11)
TOT on ESP field services	61 (43)
TOT on other services	21 (15)
Monitoring and supervision	10 (7)
Desired future training in:*	
Administration and financial management	63 (44)
Specialized clinical skills	58 (39)
ESP training	29 (20)
Store management	11 (8)
MIS and computer	7 (5)
Hospital management	4 (3)
Other	21 (15)

* *The respondents gave multiple responses*

Training activities

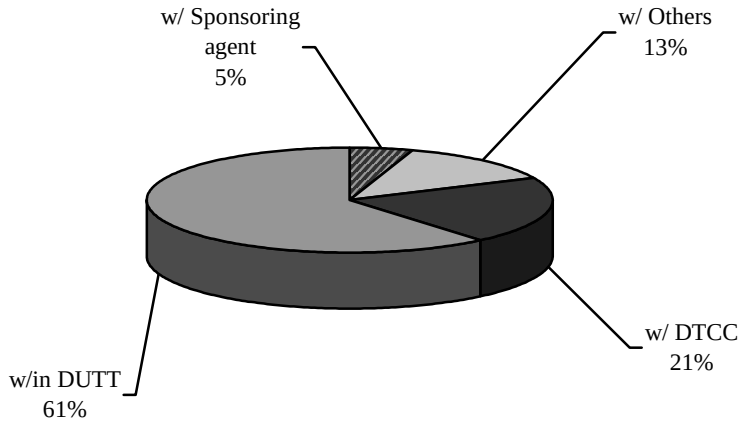
Eighty-one percent of the respondents said they were involved in training: 36% of those involved in training said that it did not interfere with their main jobs, while 64% of them felt that training activities did interfere. When asked about specific involvement in nine major training related activities, which are considered standard tasks for trainers, most of the respondents reported being involved in planning, organizing, managing, and conducting training. Their involvement in designing curriculum and documentation of training was low (Figure 9).

Figure 9: Percent of the respondents involved in training related activities



To find out how involved they were in planning, the respondents were asked if they had used a training calendar and followed training guidelines. The majority of the respondents (81%) reported that they did not have a training calendar to organize training and 66% did not use any planning guidelines. The following graph (Figure 10) shows involvement of the DUTT respondents in planning with other DUTT members, DTCC members, and other stakeholders.

Figure 10: Percent of respondents involved in planning within DUTT and among other stakeholders (n=36)



Thirty-three out of 70 respondents (47%) had received funds for organizing training: 19 of these respondents faced some problems with funding and 14 of them reported that funds did not arrive on time. Six stated that they had problems getting funding more then half of the time, and eight said that they had problems less than half of the time.

When asked about the training venue, 86% of the respondents stated that they conducted training in their own building. The rest of them rented space or used other public or private facilities.

Major problems were getting funding, teaching aids, logistics, and supplies, securing accommodation for trainees, finding trained trainers, and timely communications. They made the following suggestions about how to overcome these problems (Table 10):

Table 10: Suggestions regarding training problems (n = 70)

Areas	% (n)
Suggestions about how to overcome problems*	36 (25)
Adequate accommodations for trainees	43 (30)
Timely supply of logistics	36 (25)
Sufficient supply of teaching aids	36 (25)
Timely funds flow	27 (19)
Skilled trainers	24 (17)
Better monitoring and follow-up	17 (12)
Advance communications	10 (7)

* *The respondents gave multiple responses*

Performance feedback and organizational support

Twenty-four out of 70 respondents stated that they were followed up during their training activities: eight of them (33%) were followed up with a checklist and the rest (67%) were followed up without a checklist. Sixteen of the 24 respondents got follow-up help from their supervisors and the rest got help from their trainers. Eighteen also received feedback on their performance.

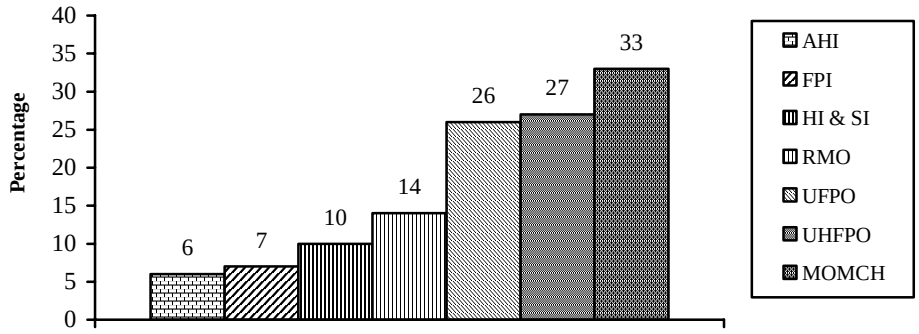
Most respondents had not yet received key documents from the TTU, needed to guide and support their training, such as the ESP training strategy (70%), standards (84%), and guidelines (67%). Of those who had received the Basic ESP course guidelines, only 30% (seven of 23) had used the checklists for following up trainers and providers.

Monitoring and follow-up

Thirty-seven of 70 respondents (53%) mentioned that they had a supervision and monitoring plan for following the performance of the providers at the Upazila level and below. The majority (89%) said it was a routine monthly monitoring plan.

Forty-three percent (30 of 70) mentioned that they had followed up service providers at worksites after training. The mean number of the providers followed up by the respondents was 12 with standard deviation of 13.9 and a median of 14. The respondents listed those responsible for follow-up, as shown in Figure 11.

Figure 11: Persons responsible for follow-up *(Respondents gave multiple answers)*



Among the respondents who had followed up service providers at their worksites, only 43% (13 of 30) of them used checklists. Only 23% of the respondents reported that the trainers prepared the follow-up plan according to Basic ESP Training Guidelines.

Table 11: DUTT follow-up of providers after training

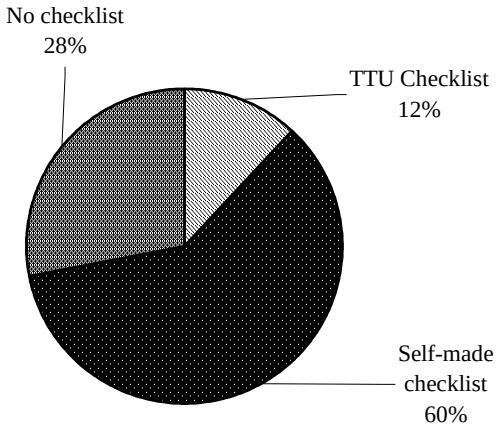
Areas	% (n)
Follow-up instrument	**100 (30)**
Checklist	43 (13)
Direct observation (verbally)	57 (17)
Follow-up plan prepared by	**100 (30)**
Someone assigned (supervisor)	40 (12)
Trainers	23 (7)
Others	14 (4)
Did not respond	23 (7)
Frequency follow-up	**100 (30)**
Monthly	37 (11)
Weekly	23 (2)
As and when necessary	33 (10)
Did not conduct follow-up	7 (2)
Use of monitoring results	**n=25***
To identify problems and design interventions	44 (11)
To give feedback	36 (9)
To develop planning	32 (8)

* *The respondents gave multiple responses; does not add up to 100%*

When asked about the frequency of follow-up visits, 37% of the respondents said they conducted follow-up of the providers monthly.

Thirty-six percent (25 out of 70) of the respondents said they were involved in the M&E of training activities at the Upazila level and below. Of these, only 12% (three out of 25) used the TTU-provided checklists (Figure 12).

Figure 12: Percent of DUTT respondents who used checklists for monitoring trainees (n=25)



When asked how the results of monitoring were used, the majority (64%) could not report any use. Only 16% of the respondents said they had used the results for identifying problems or developing interventions (Table 11).

Among the respondents who had used monitoring results for feedback (nine out of 25), only a few (two out of nine) provided feedback to the trainers. On the other hand, most of these respondents (seven out of nine) provided verbal feedback to providers on the spot (Table 12).

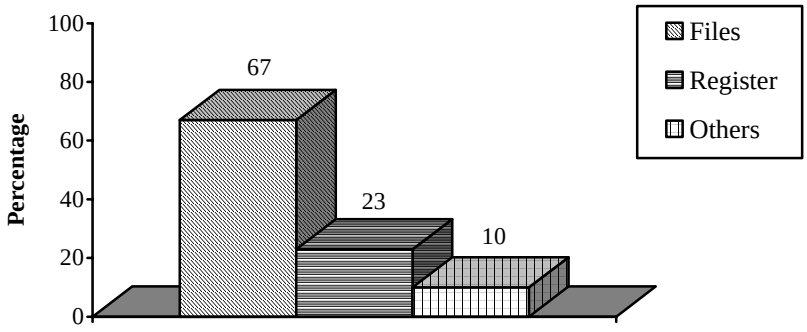
Table 12: Mode of feedback given by DUTT members (n=9)

Areas	n
Feedback given to	
Providers	7
Supervisor	4
Trainers	7
Mode of feedback given	
Verbal on the spot communication to providers	7
Written notes	2
Discussion at monthly meetings	2

Documentation and reporting

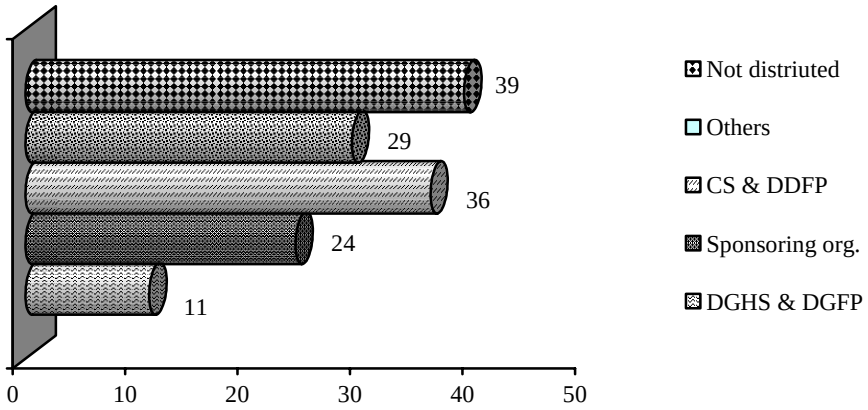
The respondents were asked if they had kept records of training. Seventy-three percent (51 out of 70) reported that they kept records of training. Of these, 67% (34 out of 51) kept records in files (Figure 13).

Figure 13: Types of recordkeeping at Upazila level



Thirty-nine percent (27 out of 70) of the respondents reported that they did not send training records anywhere. Sixty-one percent of the respondents reported that they sent training reports to different places, such as, CS and DDFP offices, DGHS and Directorate General of Family Planning (DGFP) offices, respective LDs, training sponsoring organizations, and others (Figure 14).

Figure 14: Communication of training reports *(respondents gave multiple responses)*



The respondents were asked if they knew about the TMIS. Only 24% (17 of 70) of the respondents reported that they knew of the TMIS. The majority (13 out of 17) defined it as a system for storing training information. When asked whose responsibility it was to send information to TMIS, 47% (eight out of 17) of the respondents said the UHFPO was responsible, while 24% said it was the Statistician's responsibility.

Performance of Immediate Supervisors

Introduction

The AHIs and FPIs are the immediate supervisors of the HAs and FWAs at the CCs. They are front-line supervisors based at union level, typically spending the majority of their time supervising service providers. One AHI and one FPI are responsible for supervising all four or five CCs in the union. Immediate supervisors must have enough knowledge of good management practices to know which factors will encourage high performance among the clinic staff. This will enable service providers to meet client needs by providing quality services.

Background characteristics and training status of immediate supervisors

The survey asked supervisors about the nature of their responsibilities. All of the respondents (100%) said they were the immediate supervisors of service providers (HAs and/or FWAs), working in CCs. Only 26% of the respondents (40 out of 153) had ever received management training and only 30% (46 out of 153) had ever received training as supervisors. Moreover, of these respondents the majority (77% in management and 65% in supervision) had received the training more than three years ago (Table 13).

Table 13: Responsibilities and training status of immediate supervisors (n = 153)

Subject	% (n)
Responsibilities of immediate supervisors	**100 (153)**
Supervised only HA	11 (17)
Supervised only FWA	13 (20)
Supervised both HA and FWA	76 (116)
Received training in management	**100 (40)**
Within past year	15 (6)
Between 1-2 years ago	8 (3)
More than 3 years ago	77 (31)
Received training in supervision	**100 (46)**
Within past year	15 (7)
Between 1-2 years ago	20 (9)
More than 3 years ago	65 (30)

As Table 15 shows, 76% of the immediate supervisors stated that they supervised both HAs and FWAs at SDPs. The rest said they supervised either the HAs (11%) or the FWAs (13%).

Performance of Field Service Providers

Introduction

The HPSP has reformed the health care system of Bangladesh. Under this program, all previously vertical projects of the health and FP sectors will be unified at a "one stop" SDP, including some 13,500 newly constructed CCs. The HAs and FWAs are the designated field service providers of the CCs. They are working under the immediate supervision of the AHIs and FPIs, to deliver ESP. The 21-day Basic ESP Training course prepares these field service providers, and their supervisors, for these new roles in the CCs.

In cases where CCs had not yet been constructed, or not yet equipped, field service providers were interviewed and observed at SCs, which operate in different communities one day per month. The range of services is more limited than that planned for CCs, but providers and supervisors are the same. The SCs will eventually be phased out completely.

Background characteristics of Field Service Providers

Forty-eight percent of the respondents had been working in the clinics (CCs and SCs) for one year or less within the majority having worked in CCs and SCs for less than six months (86% and 87%, respectively). Fifty-two percent of the respondents had been working in the clinics for more than one year. Most of these respondents (89%) were from SCs.

Table 14: Length of service in clinics and availability of job description

Subjects	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Providers' length of service	**100 (160)**	**100 (173)**	**100 (333)**
One year or less	87 (139)	11 (19)	48 (1582
More than one year	13 (21)	89 (154)	52 (175)
Providers' job description	**100 (160)**	**100 (178)**	**100 (333)**
Has job description	44 (70)	43 (74)	43 (144)
Does not have job description	56 (90)	57 (99)	57 (189)

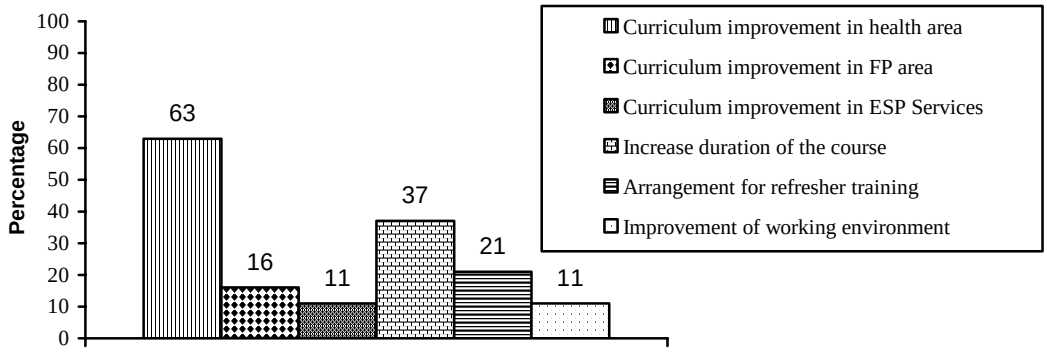
In the CCs, the service providers were to be working under a new job description that was prepared after the inception of the HPSP. When asked about this job description, 43% (144 of 333) of the respondents reported that they had their new job description (Table 16). However, of those who had job descriptions, only 7% (23 out of 144) could show it to the interviewer.

Training status, performance feedback and condition of clinic facility

Only 26% of the respondents reported that they had been trained in BCC. Most of the respondents (93%) reported that they had not yet received the 21-day Basic ESP Training Course. Of those who had the ESP training (25 of 333), 13 had received it in the year 2000, while ten of them had received it in 2001, and two had received it in 1999.

Sixty-eight percent (17 of 25) of the trained respondents felt that they could use almost all the information they had learned during training at the clinic. Sixteen percent (four of 25) felt that they could utilize half, and another 16% (four of 25) felt that they could utilize less than half of the information they had learned. Seventy-six percent (19 of 25) of the trained respondents felt that the course would be more useful if it were improved in certain areas. Figure 15 shows suggested improvements for the 21-day Basic ESP Training Course.

Figure 15: Suggestions for improvement of 21-day basic ESP training



After receiving training, service providers should be followed up by the trainers at their worksites. Forty-four percent of the respondents who had completed the 21-day Basic ESP Course (11 of 25) reported that they had been followed up at their worksites. Seven of 11 were followed up by the AHIs, nine of 11 were followed up by the FPIs, and six of 11 were followed up by the Health Inspectors. Only two of 11 were followed up by the trainers (DUTT members). Overall, six of 11 were followed-up with the use of a checklist and the

other five reported no checklist. Of those who were followed up with a checklist, one of six achieved a level of "competent," three of six achieved a level of "acceptable," and two of six required "improvement".

Respondents were asked if their clinic had enough waiting space, supplies, and equipment. Sixty-six percent of the respondents reported that their clinics had enough waiting spaces (Table 15). This was true for 80% of the respondents from CCs and 51% of the respondents from SCs. Regarding the availability of supplies, the majority of the respondents (65%) reported that they had enough supplies to treat patients always or most of the time. Respondents from SCs were more likely to have sufficient supplies (80%) than respondents from CCs (48%).

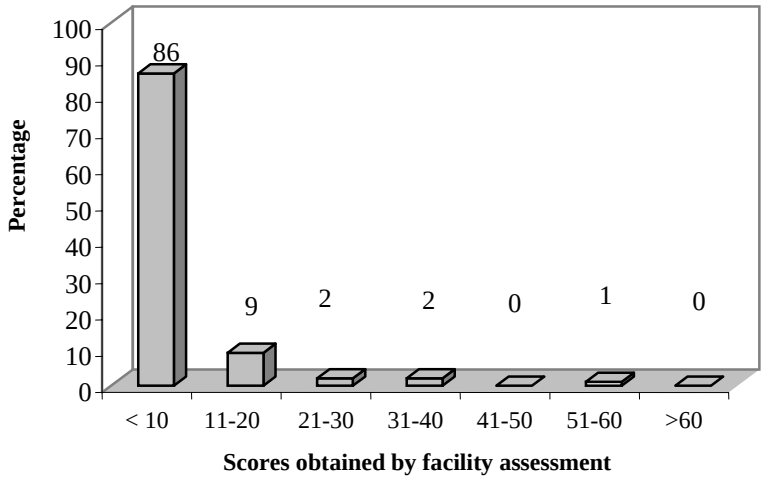
Table 15: Adequacy of waiting space and supplies in the clinics

Subjects	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Waiting space	**100 (156)**	**100 (141)**	**100 (297)**
Enough space	80 (125)	51 (72)	66 (197)
Inadequate space	20 (31)	49 (69)	36 (100)
Sufficient supplies	**100 (155)**	**100 (168)**	**100 (323)**
Always or most of the time	48 (75)	80 (134)	65 (209)
Half of the time	15 (24)	7 (11)	11 (35)
Less than half of the time	14 (22)	8 (13)	11 (35)
Never	22 (34)	6 (10	14 (44)
Types of supplies or equipment clinics lacked*			
Medicines	76 (97)	85 (79)	80 (176)
Instruments/Equipment	76 (96)	32 (30)	57 (126)
Logistics	14 (18)	15 (14)	15 (32)
Forms and registers	5 (6)	8 (7)	6 (13)
First Aid Boxes	8 (10)	0 (0)	5 (10)
Length of time without stocks	**100 (149)**	**100 (160)**	**100 (309)**
Never	39 (58)	55 (88)	47 (146)
Less than one month	39 (58)	29 (46)	34 (104)
2-3 months	17 (25)	11 (18)	14 (43)
4+ months	5 (8)	5 (8)	5 (16)
Availability of reference materials at worksite	**100 (158)**	**100 (168)**	**100 (326)**
Available	44 (70)	52 (88)	48(158)
Not available	56 (88)	48 (80)	52(168)

* Respondents gave multiple answers

The respondents were asked which type of supplies or equipment they lacked. The majority (80%) of the respondents said they lacked necessary medicines. Fifty-seven percent said they lacked some needed instruments, however, CCs and SCs differed in response. Seventy-six percent of CCs reported that they lacked equipment, compared with 32% of SCs (Table 15). None of the CCs studied in this baseline survey had received all of the equipment they expected (Figure 16).

Figure 16: Facility assessment scores of community clinics (n = 84)



Of the respondents, 47% said they had never run out of drugs. This included 39% of the CCs and 55% of the SCs. In other words, most of the CCs had run out of drugs. The respondents were asked if they had reference materials to help them treat clients. Forty-eight percent stated that they had reference materials at their clinics. Again, availability of reference materials was less frequent among the respondents from CCs (44%) than among respondents from SCs (52%).

Provider performance in the clinic

The respondents reported that 84% of their clinics opened before 9:00 a.m. Most of the respondents (79%) arrived at work before the 9:00 a.m. opening. Clients were found waiting in 28% of the clinics upon their arrival. Eighty-two percent of the respondents reported that they saw their first clients before 10:00 a.m. (Table 16). The median opening time of clinics and arrival of the providers at the clinic was 9:00 a.m. The median time of serving the first patient was 9:30 a.m.

Table 16: Visiting time of providers and clients at the clinic

Subjects	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Clinic opening time	**100 (160)**	**100 (171)**	**100 (331)**
Before 9 a.m.	93 (149)	75 (129)	84 (278)
After 9 a.m.	7 (11)	24 (42)	16 (53)
Arrival time of providers	**100 (159)**	**100 (169)**	**100 (328)**
Before 9 a.m.	89 (142)	69 (116)	79 (258)
After 9 a.m.	11 (17)	31 (53)	21 (70)
Clients waiting on arrival	**100 (153)**	**100 (167)**	**100 (320)**
Clients were waiting on arrival	24 (36)	32 (54)	28 (90)
No clients were waiting on arrival	76 (117)	68 (113)	72 (230)
Time of seeing first patient	**100 (152)**	**100 (153)**	**100 (305)**
Before 10 a.m.	90 (137)	74 (113)	82 (250)
After 10 a.m.	10 (15)	26 (40)	18 (55)

In addition to being interviewed, 248 service providers were observed on performance at the workstation while attending to patients. The observations were conducted with a performance checklist containing ten items that characterize the providers' routine tasks and expected set of skills, against which providers were assessed. Each item was scored on a scale of one to four representing lowest to highest performance, respectively. Table 17 presents the results of the percentage of providers at each type of facility (CCs and SCs) who scored at least three on this scale (those considered to have fulfilled the items). For each provider, a composite performance score was calculated (by summing the number of fulfilled items from the ten observed) and used to obtain average performance scores of all service providers as shown in Table 17. For five of the ten items, there are statistically significant differences in scores between the two types of facilities: using correct history taking and physical examination methods; using proper equipment and materials for treatment; providing correct treatment; providing follow-up instructions to client; providing health education to client; explaining how client could solve problems. The difference in average performance scores between providers at CCs and SCs is also significant ($p<0.01$).

Table 17: Percentage of providers who fulfilled each performance item and average performance scores of all providers[1]

No.	Performance Items	Community Clinics n=130	Satellite Clinics n=118	Total n=248
1.	Attends worksite on time	16.5%	24.5%	20.1%
2.	Deals with clients' opinions and concerns	16.5%	25.4%	20.6%
3.	Ensures clients' privacy	4.6%	7.6%	6.0%
4.	Adheres to infection control measures	1.5%	4.2%	2.8%
5.	Uses correct history taking and physical examination methods	6.1%	14.4%**	10.1%
6.	Uses proper equipment and materials for treatment	2.3%	11.8%**	6.9%
7.	Provides correct treatment	1.5%	8.5%*	4.8%
8.	Provides client with follow-up instructions	10.8%	22.9%*	16.5%
9.	Provides client with health education	5.3%	14.4%*	8.5%
10.	Explains how client could solve problems	3.0%	12.7%**	8.9%
AVERAGE PERCENTAGE SCORE		**6.4%**	**14.7%****	**10.4%**

[1] Percentages of total valid observations
*p<.05 Yates Corrected
**P<.01 Yates Corrected

Clients' Perception of Clinic Services

Background characteristics of the respondents

Two hundred and eighty nine clients were interviewed immediately after receiving services at the clinics. The ages of the clients ranged from two months to 75 years. It should be noted that some errors were made in recording the ages of young clients. In some cases, the age of the parent or guardian (i.e., the respondent) was recorded instead of the actual patient. However, we tried to resolve this problem by treating all the attendants of the clients as potential clients of the clinics and hence potential baseline survey respondents. The mean age of these respondents was 28.7 years. The majority of the respondents (70%) were between 21 and 40 years old (Table 18).

Table 18: Distribution of respondents by age groups and gender

Age group	Male	Female	Total clients
			% (n)
< 10 years	10	9	7 (19)
11- 20 years	3	32	12 (35)
21-30 years	11	121	46 (132)
31-40 years	10	58	24 (68)
41-50 years	7	12	7 (19)
51-60 years	4	6	4 (10)
More than 60 years	2	4	2 (6)
Total	47	242	100 (289)

Out of the 289 respondents, 242 were female. More than half of the clients were women between 21-40 years old. Male respondents were more evenly distributed by age (Table 18).

Only 24 respondents reported that they were employed outside of their household activities or main business. Male respondents were more likely to be employed (21%) than the female respondents (6%). Likewise, the spouses of female respondents (25%) were more likely to be employed than the spouses of the male respondents (3%).

Clients' knowledge

The clients were asked if they knew the clinic's opening and closing times and days of operation. As shown in Table 19, the majority of the clients (63%) reported that their clinics opened between 8:00 a.m. and 9:00 am. Of the 246 respondents that answered the question about days of operation, 54% reported that the clinics were open five to six days per week. Clients of CCs were more likely to say their clinic opened five to six days a week (96%) than the clients of SCs (8%). Forty-five percent of the respondents reported that their clinics were open one to two days a month. Clients of SCs were more likely to attend clinics open only one to two days a month (92%) than clients of CCs (3%). This result was consistent with the mode of operation of the CCs and SCs. When asked about clinic closing times, 98% said that the clinics closed after 12:00 noon.

Table 19: Distribution of respondents by clinics' schedule of operation

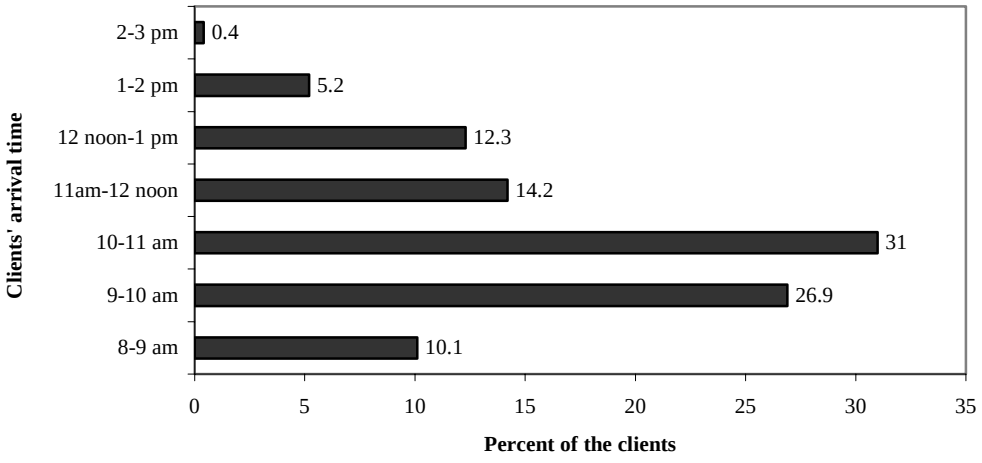
Subject	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Clinic opening times	**100 (107)**	**100 (98)**	**100 (205)**
Between 8-9 a.m.	72 (77)	54 (53)	63 (130)
Between 9-10 a.m.	26 (28)	44 (43)	35 (72)
After 10 a.m.	2 (2)	2 (2)	2 (4)
Days of operation	**100 (128)**	**100 (118)**	**100 (246)**
6 days a week	74 (95)	6 (7)	42 (102)
5 days a week	22 (28)	2 (2)	12 (30)
1 day a week	1 (1)	0 (0)	1 (1)
2 days a month	2 (3)	34 (40)	17 (43)
1 day a month	1 (1)	58 (69)	28 (70)
Clinic closing times	**100 (80)**	**100 (88)**	**10 0(168)**
Before 12 noon	1 (1)	4 (3)	2 (4)
Between 12-1 p.m.	8 (6)	11 (10)	10 (16)
Between 1-2 p.m.	23 (18)	24 (21)	23 (39)
Between 2-3 p.m.	34 (27)	41 (36)	38 (63)
After 3 p.m.	35 (28)	20 (18)	27 (46)

In addition, 44% of the respondents reported that their clinics followed the schedule set by the government, while 11% reported that their clinics did not follow the government's schedule.

Clients' access to the clinics

Out of the 289 respondents, 268 were able to state their time of arrival at the clinic. The majority of these respondents (82%) reported that they had come to the clinics between 8 a.m. and 12 noon (Figure 17).

Figure 17: Arrival time of the clients to the clinics



Reasons for coming to the clinics

Out of the 289 respondents, 284 explained why they had come to the clinics. Most said they came for three major services: RH services (36%), immunization (26%), and limited curative care (45%), which included treatment of peptic ulcers, pain, fever, coughs, etc. (Table 20). It should be noted that SCs are not designed to deliver limited curative care. Most SC clients wanted RH care (42%) or immunization services (39%). On the other hand, clients at the CCs were more likely to be seeking limited curative care (58%). When asked how long it took them to walk to the clinic from their homes, the majority of the respondents at the CCs (89%) said it took them 1-30 minutes (Table 20).

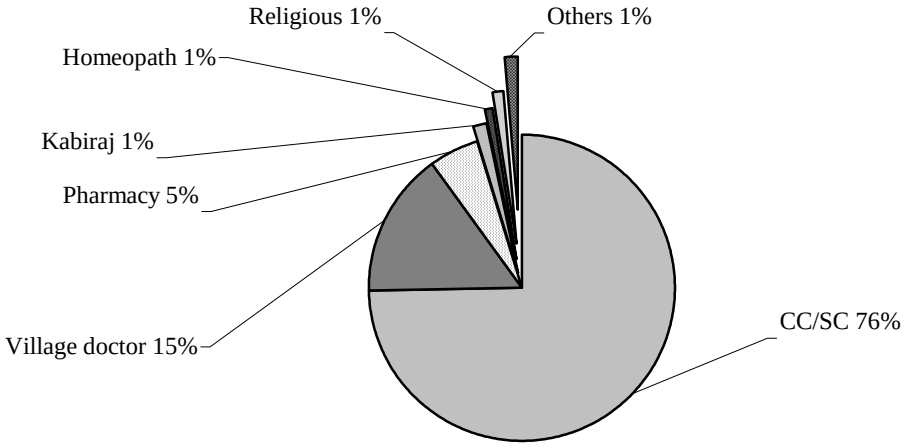
Table 20: Client's access and reasons for coming to the clinics

Subject	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Amount of time needed to walk to clinic	**100 (157)**	**100 (132)**	**100 (289)**
1-30 minutes	89 (139)	85 (112)	87 (251)
31-60 minutes	11 (17)	13 (17)	12 (34)
More than one hour	0 (1)	2 (3)	1 (4)
Reasons for coming to the clinic (n=284)*			
Reproductive Health Services	30 (45)	42 (56)	36 (102)
Child Health Services	5 (8)	5 (6)	5 (14)
Communicable Disease Control	1 (1)	1 (1)	1 (2)
Behavioral Change Communication	1 (1)	0 (0)	0 (1)
Limited Curative Care	58 (88)	31 (41)	45 (129)
Immunization	14 (22)	39 (52)	26 (74)

* Respondents gave multiple responses

The clients were asked if they had sought medical advice for the same complaint elsewhere before coming to the clinic. Twenty-four percent (70 of 289) of the respondents reported that they had sought services from other sources, such as village doctors, pharmacists, kabiraj (harvalists), homeopaths, religious healers, and others (Figure 18).

Figure 18: Clients' first source of services



Client opinions about clinic services

When asked about waiting time, most of the respondents (>70%) reported that the providers saw them immediately after their arrival at the clinics (Table 21).

Table 21: Providers' visiting time by clients' arrival times (n=243)

Client Arrival Time (Hour)	Providers' Visiting Time (Hour)							
	8-9 a.m.	9-10 a.m.	10-11 a.m.	11 a.m.-noon	noon -1 p.m.	1-2 p.m.	2-3 p.m.	Total
8-9 a.m.	12	7	2					21
9-10 a.m.		44	18	1	1	1		65
10-11 a.m.			58	17	1			76
11 am-noon				30	5	1		36
noon -1 p.m.					28	3		31
1-2 p.m.						12	1	13
2-3 p.m.							1	1
After 3 p.m.								
Total	12	51	78	48	35	17	2	243

Ninety-three percent of the respondents (268 of 289) reported that they felt comfortable asking the providers questions. Sixty-seven percent of the respondents reported that the providers had discussed their problems with them. When asked about supplies for treating patients, the majority (72%) of the respondents reported that the clinics had the supplies needed to treat them (Table 22). However, the respondents' opinions about the availability of supplies varied by type of clinic. Sixty-four percent of the respondents at the CCs and 81% of the respondents at the SCs reported that the clinics had supplies to treat patients, which indicates that the CCs (with a wider range of services) were more likely to lack supplies needed for treatment.

The respondents were also asked if they had seen their providers wash their hands. Fifty-four percent of the respondents said yes (Table 22).

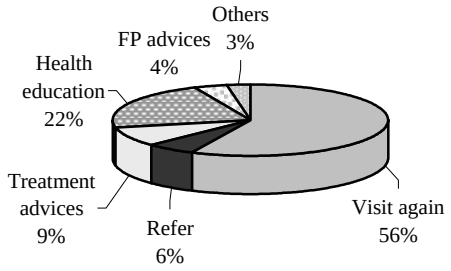
Table 22: Perceptions of clients about providers in the clinics

Subject	Community Clinics % (n)	Satellite Clinics % (n)	Total % (n)
Providers explained what was wrong	**100 (131)**	**100 (116)**	**100 (247)**
Explained	66 (87)	67 (78)	67 (165)
Did not explain	34 (44)	33 (38)	33 (82)
Supplies for treating clients were	**100 (129)**	**100 (113)**	**100 (242)**
Available	64 (83)	81 (92)	72 (175)
Unavailable	36 (46)	19 (21)	28 (67)
Provider washed hands	**100 (70)**	**100 (86)**	**100 (156)**
Saw providers wash hands	54 (38)	55 (47)	54 (85)
Did not see them wash hands	46 (32)	45 (39)	46 (71)
Attitudes of clients for next visit	**100 (144)**	**100 (128)**	**100 (272)**
Will visit the clinic again	85 (122)	77 (98)	81 (220)
Will not visit the clinic again	15 (22)	23 (30)	19 (52)

When asked if they would return to the clinic, the majority (81%) of the respondents said that they would return to the clinics for follow-up visits or for subsequent services as instructed by the providers (Table 22).

When asked if they had received instructions on how to follow-up their care, 65% of the respondents (187 of 289) reported that they had received some advice from their providers, which included “visit the clinic again,” “referrals to other providers/clinics,” “health education,” “treatment instruction,” etc. The following graph (Figure 19) shows the instructions given to clients.

Figure 19: Instructions given to clients by providers after delivering services (n=187)



Discussion and Conclusions

Under the HPSP, the IST of health and FP personnel has been organized and managed through a unified LD system. The LD-IST coordinates all ESP-related IST activities in accordance with the National In-Service Training Strategy and Action Plan for ESP 1999-2003. This strategy uses a highly decentralized approach to implement training, dividing responsibilities as follows:

- The TTU is responsible for planning and coordination;
- The LTOs are responsible for curriculum development, resource preparation, and TOT;
- The DTCCs and DUTTs are responsible for the management and training of field service providers and their immediate supervisors.

This survey should assist policy makers and PMs to assess the current situation, and identify constraints and factors affecting the implementation of the National Strategy. It should also serve as a baseline for future measurements of change over time.

CCs are the centerpiece of ESP service delivery under the HPSP. Some 13,500 are planned, serving (along with 4,500 Union level Health and Family Welfare Centers) rural catchment areas of about 6,000 people. Unfortunately, few CCs had been built - let alone equipped and put into operation - at the time of the baseline survey. The community-level survey instruments were designed to capture baseline data at CCs. The survey's purpose was to establish a baseline for future comparison (post-ESP training and other ESP interventions) at these SDPs. In about 50% of the sample communities, no functioning CCs were available to survey. In these cases, the survey was conducted at SCs, which were also community-based and which employed the same cadres of field service providers and immediate supervisors as found at the CCs. The SCs are essentially mobile clinics that function in a private facility (usually a home) in a given community one day a month mainly to provide FP, ANC and Expanded Program of Immunization (EPI) services. This range of services is much more limited than the ESP to be delivered at CCs; and the physical facilities, equipment, supplies and drugs are not expected to be at the same level as the CC's. Moreover, the SCs will be phased out over the next few years, so there is no expectation of future comparison to SC baseline data. Nevertheless, visiting SCs where CCs did not exist allowed the baseline survey to capture information about the providers, frontline supervisors, and clients who will eventually serve and use the CCs.

For better or worse, the Basic 21-day ESP Training Course, intended to help prepare field service providers for their new "one-stop" ESP delivery role in the CCs, had not yet been widely implemented at the time of the survey. Therefore, the survey represents largely a "pre-Basic ESP training" baseline.

The baseline findings show that, at the time of the survey, the TTU was understaffed. Although there were 15 sanctioned professional positions, only seven staff members had been working in the TTU since mid-1998. Of these, five were deputed from other departments of DGHS and some had very little prior experience in the organization and management of training programs. Moreover, they could be transferred to other departments

at any time. This limited their motivation to try to improve their training skills and the likelihood that they could develop further as professional trainers.

The findings also reveal that some of the TTU personnel did not know their own job descriptions. In fact, there were no written job descriptions for TTU personnel at that time. Due to the lack of specific, written job descriptions, the TTU personnel were confused about their roles, and thought that their actual work exceeded expectations. They felt that their "additional" tasks sometimes interfered with their ability to carry out their primary responsibilities. Written job descriptions would give personnel a clearer understanding of job expectations and help them to meet those expectations.

Although the TTU is responsible for coordinating all IST activities, few TTU personnel knew of or understood IST training targets and achievements under the HPSP. A significant number of TTU personnel had little detailed knowledge of key quality and standardization components of the TTU's program: the National IST Strategy and Action Plan for ESP 1999-2003, the draft national training standards, the IST monitoring and follow-up system, or the documentation and reporting system. Because they were unaware of or unfamiliar with these components, TTU personnel could not conceptualize the overall strategy for IST implementation and quality assurance.

TTU personnel had no clear understanding of the concept of "master trainer" as it pertains to the ESP-related TOT courses under their control, which rely heavily on outside resource persons to serve as the trainers.

In most cases, TTU personnel followed the directives of their supervisors. Some of the TTU personnel wanted more interaction with their supervisors to clear up confusion over their job responsibilities, but they felt that the supervisors were too busy to provide adequate oversight.

Most of the TTU professionals expressed frustration with the management of training, particularly the financial management. They complained about the amount of time it took to process requests for funds. They were concerned that sending funds directly to the LTOs might cause management problems. They wanted higher advance allocations of funding and said that the 20% limitation at the beginning of any training activity made it difficult to implement programs smoothly.

TTU personnel also expressed frustration with what they felt was the automatic certification of all trainees. They thought that there should be standards for certification and that only trainees meeting those standards should get certificates. Otherwise, weaker trainees would not be motivated to improve their performance.

Personnel at the LTOs appeared to be better equipped and supported than those at the TTU. They were well staffed. Most of the professional staff knew their job descriptions and had considerable past experience in training. However, as with the TTU, very few trainers had thorough knowledge of the key IST quality and standardization documents or systems. Although they were familiar with their own LTO's reporting system, they did not understand how it related to the TTU's training management information system (TMIS).

As with the TTU, LTOs also complained of problems with the financial management process for funding training activities. Delays in obtaining funds meant that they fell seriously short

of achieving their contractual training targets. In addition, the LTOs had difficulties using the resource persons for TOT courses. They said some of the resource persons did not maintain expected standards of training, (e.g., they came to class unprepared or deviated from assigned lesson plans).

LTO trainers seemed to rely on supervisors mainly for administrative support, such as giving encouragement, explaining programs and policies, or providing effective representation. Some trainers felt that supervisors provided only limited technical support. Very few supervisors had visited training sites to assess trainers' performance and give feedback. Those trainers who had been evaluated by their supervisors felt that the evaluations helped them to resolve problems or clarify issues. Very few LTO trainers followed up their trainees at the worksite because such follow-up had never been assigned to them as a required extension of the training process. Nor did the LTOs have the funding to do follow-up. Although the national strategy clearly encourages monitoring and follow-up, its importance still needs to be better understood by TTU and LTO personnel. It should be explicitly incorporated into planning and contracting for IST courses.

Respondents from DTCCs and DUTTs were generally clear about their job responsibilities, but they felt that they needed additional or different training to do their jobs well. The majority of DTCC and DUTT members mentioned their roles in administration, finance, and coordination, but very few of them had received training in these areas. They also mentioned the need for future training in monitoring and supervision as well as specialized training in clinical skills. There is a need for more systematic assessment of professional development and IST needs based on the actual job responsibilities of DTCC and DUTT personnel.

Only 48% of the DTCC respondents and 24% of the DUTT respondents considered training their main job. But almost all of these respondents said they were involved in training-related activities. Under the decentralized HPSP, training responsibilities have been increased and imposed on district and Upazila personnel. The survey found that 59% of the DTCC members and 64% of the DUTT members felt that training activities interfered with their main job responsibilities. The job descriptions of DTCC and DUTT members need to be revised to incorporate training-related activities.

The majority of the DTCC and DUTT members surveyed were found to be involved in planning, organizing, and conducting training; but very few of them followed the National IST Strategy, Basic ESP training guidelines and National IST Standards. DTCC and DUTT members need further orientation on these key elements of the IST program to be able to perform to standard as trainers and managers of training.

Almost all the DTCC and DUTT members surveyed encountered problems with funding, trainee accommodations, and the distribution of logistics and supplies, teaching aids and training materials, etc. Training facilities should be assessed to assure that all of these essential elements arrive on time, before the start of training courses.

DUTT trainers should be followed up, observed, and given feedback (based on the available standard checklist) at the training sites in order to improve their performance. They should also be encouraged to make recommendations concerning curricula and the TOT. As mentioned above, although the national strategy calls for monitoring and follow-up, it has not translated these plans adequately into LTO assignments or budgets. This principle needs to

be better understood and resources made available to the LTOs, but there are practical limits to how often the LTOs can visit training sites. The Basic ESP course guidelines also provide for "peer trainer" monitoring, whereby DTCC members assess the trainers using the checklists. More systematic monitoring of the trainers, using different approaches, is needed to assess and improve their performance.

Similarly, trainees should be followed up at their worksites, receiving feedback on how to improve their performance. For example, DUTT trainers should follow-up trainees at CCs, using the available checklists, as specified in the national guidelines. In reality, very few DUTT trainers followed up their trainees in any systematic and supportive manner. The principle of follow-up, as an extension of the training process and a form of supportive supervision, is not well established. DTCC and DUTT members need further direction and orientation in order to improve performance. Field service providers themselves suggested improvements in this area.

Documenting training activities and reporting on their results is vital to help the TTU and LTOs monitor trainer and trainee performance and to implement the decentralized IST program. This requires TTU and LTOs to develop the capacity to plan, organize, prepare sites, manage, monitor, and follow-up training. The survey reveals confusion about documentation and reporting. DTCCs and DUTTs disagreed on how to document their training activities and where to submit reports. Although a TMIS had been established in the TTU, very few DTCCs and DUTTs were even familiar with it. This suggests the need for further direction and orientation of DTCC and DUTT members.

The survey shows there is a large cadre of frontline supervisors, working between the field service providers and the Upazila managers, who are responsible for assisting the providers at their worksite to properly deliver the ESP at the CC level. Very few of these immediate supervisors (especially those coming from the health sector) had had any training to prepare them for these responsibilities. Only 30% had been trained in management and supervision and most of these had been trained more than three years ago. Fortunately, these supervisors had been included, along with field service providers, in the 21-day Basic ESP training course. A brief additional course might be organized to acquaint frontline supervisors with the principles of supportive supervision and performance improvement.

Survey results show that the majority of field service providers did not know or understand the new job descriptions developed after the inception of HPSP. In addition, only 7.5% (25) of providers interviewed had taken the 21-day Basic ESP training, which is very important to help them undertake their new CC-based ESP responsibilities. Of these trained providers, the majority (68 percent) felt that they could utilize more than half of the knowledge and skills covered in the Basic ESP course in their work at either CCs or SCs. However, based on the survey team's observations, change in basic skills performance is only 10%. There is a need to assess the adequacy of the Basic ESP curriculum, TOT programs, and the 21-day training course and/or the appropriateness of the observation checklist.

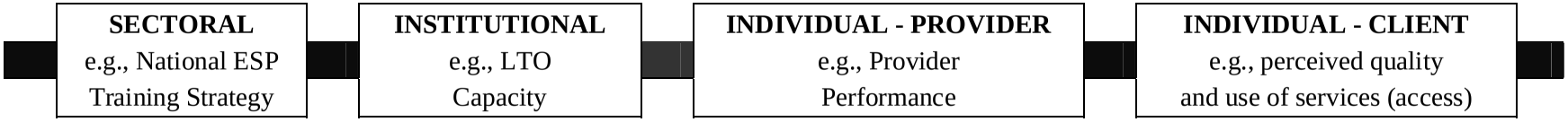
The facility assessment results also raise performance concerns. Almost all of the CCs lacked standardized equipment, supplies, and medicines that were supposed to be present in all clinics.

Clearly this baseline survey revealed several performance areas and their factors that need addressing among the categories of supervisors and providers in the HPSP project.

Appendix A: Monitoring and Evaluation (M&E) Plan of ESP and In-Service Training Program, Bangladesh, 2000 - 2003

Conceptual framework

The Monitoring and Evaluation (M&E) plan for the In-Service Training of the Essential Services Package Program relates to achievement of the Six Strategic Project Objectives. These objectives cover three distinct levels of evaluation: individual (provider and client), institutional and sectoral levels. The conceptual framework upon which the plan is formulated is presented below.



PROJECT OBJECTIVES	- PROCESS - MONITORING INDICATORS (TMIS)	- RESULTS - EVALUATION INDICATORS	PRIME II PMP	PRIME-HPSP Indicator	EVALUATION DATA COLLECTION SOURCES/METHODS	EVALUATION DATA PERIOD (S) OF APPLICATION
I. Strengthen the Central-level capacity to plan, implement and follow-up ESP Training.	▪ Creation & annual update of National Strategy Plan for ESP Training ▪ Establishment of IST structure, workplans and calendars ▪ Establishment of TTU structure, staff & equipment	1. Existence of a National ESP Training System 2. TTU functioning at optimal performance	2	1.1, 1.3 1.7	▪ Project Documentation ▪ Review and In-depth interviews with key informants	▪ At baseline, mid-term and end-of-project evaluations
II. Standardize process of planning, implementation follow-up of in-service and training	▪ Development of National Training Standards and Guidelines ▪ Development of ESP Training Curricula (at various levels)	3. National standards and guidelines created and applied at facilities post dissemination 4. TTU with capacity to review and evaluate ESP curricula	21 10	1.6 1.5	▪ Documentation Review plus Facility Survey ▪ Institution Capacity Assessment	▪ At baseline, mid-term and end-of-project evaluations ▪ At baseline, mid-term and end-of-project evaluations

PROJECT OBJECTIVES	- PROCESS - MONITORING INDICATORS (TMIS)	- RESULTS - EVALUATION INDICATORS	PRIME II PMP	PRIME-HPSP Indicator	EVALUATION DATA COLLECTION SOURCES/METHODS	EVALUATION DATA PERIOD (S) OF APPLICATION
III. Strengthen the Capacity of Lead Training Organizations (LTOs) as coordinators of ESP Training of Upazila trainers	▪ Orientation, education/ training and certification of LTO trainers ▪ Participation of LTO members in curriculum development ▪ Design and use of training M&E evaluation ▪ Improvement of training site performance	5. Number of LTOs with capacity for ESP training at the Upazila level 6. LTOs with capacity to develop and evaluate ESP curricula 7. Number of LTOs using tools and systems to monitor & evaluate training effects on performance and quality of service 8. Number of training sites and centers performing to quality standards	 10 18 11	2.1 1.5 2.2, 2.4, 2.6 2.3, 2.5	▪ Institution Capacity Assessment ▪ Institution Capacity Assessment ▪ Documentation review plus verification ▪ Institution Capacity Assessment	▪ At baseline, mid-term, end-of-project evaluations or when required
IV. Strengthen the District and Upazila level capacity to plan, implement, manage, supervise and evaluate ESP Training	▪ Orientation, education/TOT and certification of DUTT trainers (including planning and management) ▪ Distribution and use of Training Guidelines ▪ Maintenance of clinical competence ▪ Supervision to the trainers and trainees ▪ Improvement of training site performance	9. Number of District and Upazila levels with capacity for ESP training (incl. planning and management) 10. Guidelines created and applied post dissemination 11. Training coordinators and trainers performing to standard (clinical competence, training and supervision) 12. Number of training sites and centers performing to quality standards	11 21 14 11	 1.6 2.6 	▪ Institution Capacity Assessment ▪ Documentation review plus verification ▪ Performance evaluation (at training and worksite) ▪ Institution Capacity Assessment	▪ At baseline, mid-term and end-of-project evaluations ▪ According to need ▪ At regular periods ▪ At baseline, mid-term and end-of-project evaluations

PROJECT OBJECTIVES	- PROCESS - MONITORING INDICATORS (TMIS)	- RESULTS - EVALUATION INDICATORS	PRIME II PMP	PRIME-HPSP Indicator	EVALUATION DATA COLLECTION SOURCES/METHODS	EVALUATION DATA PERIOD (S) OF APPLICATION
V. Conduct training and follow-up at the community clinic level to improve service quality and increase service coverage	▪ Community clinics with HA/FWA trained in Basic ESP Curriculum ▪ Status of the enabling factors for performance improvement in trained providers ▪ Supervisors trained and applying supportive supervision at clinics ▪ Service quality: Provider skills ▪ Service quality: Client satisfaction ▪ Service quality: Facility inventory ▪ Service coverage: Client load & characteristics ▪ Service coverage: Range of services offered ▪ Community perceptions on and input into service delivery/training programs	12. Percent of providers providing ESP services to national standards 13. Performance Gaps (by each Factor) 14. Percentage of providers who have received a supervision/FU visit in the last three months 15. QoC index: Provider 16. QoC index: CPI 17. QoC: Facility 18. Coverage: # of clients by age, sex, status, etc. 19. Coverage: # of clients attending each ESP service by month, 6 months before and after training 20. Number of service delivery/training programs incorporating community-based input	1 28		▪ Community Clinic Survey	▪ At Baseline and End-of-Project Evaluations

PROJECT OBJECTIVES	- PROCESS - MONITORING INDICATORS (TMIS)	- RESULTS - EVALUATION INDICATORS	PRIME II PMP	PRIME-HPSP Indicator	EVALUATION DATA COLLECTION SOURCES/METHODS	EVALUATION DATA PERIOD (S) OF APPLICATION
VI. Develop TMIS and evaluation capabilities at all levels to monitor training and evaluate its effects on quality of and access to ESP services	▪ Establishment of TMIS structure, staff & equipment ▪ Development of Monitoring tools, periodic reporting system and M&E plan	20. Existence of a functioning TMIS in place 21. Capacity of District and Upazila levels to use tools and systems to monitor & evaluate training needs & resources and training effects on performance and quality of service	17 18		▪ Documentation review and verification ▪ Institution Capacity Assessment (at District and Upazila levels)	▪ At baseline, mid-term and end-of-project evaluations

i Monitoring indicators are collected at different periods (e.g. monthly, quarterly or semi-annual)
ii PMP indicator # 2
iii PMP indicator # 21
iv PMP Indicator # 10
v A framework to assess Capacity Building in Training will be utilized
vi PMP Indicator # 10
vii PMP Indicator # 18
viii PMP Indicator # 11
ix A framework to assess Capacity Building in Training will be utilized
x PMP Indicator # 21
xi PMP Indicator # 11
xii PMP Indicator # 1
xiii PMP Indicator # 28
xiv PMP Indictor # 17
xv PMP Indicator # 18

Appendix B: List of Baseline Survey Participants

PRIME-HPSP

1. Dr. Kazi Belayet Ali, National Consultant for Training Evaluation, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212
2. Mr. Mark A Robbins, Executive Program Advisor, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212
3. Mr. Golam Ahad, National Consultant for Performance Training, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212
4. Dr. Lorraine Bell, Senior Training Adviser, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212
5. Mr. Nazrul Islam, National Consultant for Training Management Information System, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212
6. Ms. Monomita Dasgupta, Administrative Assistant, PRIME-HPSP, TTU, DGHS, Mohakhali, Dhaka 1212

GUS

1. Mr. Abdus Sattar Bhuyan, Executive Director, Gana Unnayan Shangstha, Dhaka
2. Mr. Abul Khair, Sr., Trainer, Gana Unnayan Shangstha, Dhaka
3. Md. Zakir Hussain, Manager (MIS), Gana Unnayan Shangstha, Dhaka
4. Ms. Mahmood Ara Begum, Trainer, Gana Unnayan Shangstha, Dhaka
5. Ms. Hasina Begum, Trainer, Gana Unnayan Shangstha, Dhaka
6. Mr. Mozammel Hossain, Monitoring Officer, Gana Unnayan Shangstha, Dhaka
7. Mr. Mozammel Hoq. Mozumder, Monitoring Officer, Gana Unnayan Shangstha, Dhaka
8. Ms. Sayema Haque, Training Consultant, Gana Unnayan Shangstha, Dhaka
9. Ms. Hasina Begum, Monitoring Officer, Gana Unnayan Shangstha, Dhaka
10. Mr. Shushanta Kumar Chakraborti, Trainer, Gana Unnayan Shangstha, Dhaka
11. Mr. Tosaddaque Hossain, Trainer, Gana Unnayan Shangstha, Dhaka
12. Mr. Tosaddaque Hossain, Field Service Member, Gana Unnayan Shangstha, Dhaka
13. Mr. Aris Hossain, Trainer, Gana Unnayan Shangstha, Dhaka
14. Ms. Tahsin Akhter, Trainer, Gana Unnayan Shangstha, Dhaka

NIPORT

1. Dr. Wahab Howladar, DD (Clinical Training), NIPORT, Dhaka
2. Md. Mahfuzur Rahman, Instructor, NIPORT, Dhaka.
3. Mr. Biswajit Baishya, Instructor, NIPORT, Dhaka
4. Mr. G N A Rashid, Sr., Instructor, NIPORT, Dhaka

PSTC

1. Dr. Mokammel Hasan, Associate Editor, Projonmo, PSTC, Dhaka

JICA

1. Mr. Golam Mustafa, National Consultant for Evaluation, JICA, TTU, DGHS, Mohakhali, Dhaka 1212

Appendix C: Summary of LTOs' Performance Needs Assessment (PNA)

ICMH	NIPORT	TTT	GUS	PSTC
Organizational Support				
Supportive supervision				
▪ Trainers understand concept ▪ Feel they get full support from supervisors ▪ In a supervisory visit the supervisor gives direction and communicates well ▪ Can depend on supervisor to help resolve problem	▪ Trainers understand concept ▪ Receive directives and managerial support from supervisors, ask for what is needed and get good cooperation, one stated that sometimes supervisor has conceptual limitations on computer, management, and planning process ▪ Can depend on supervisor to help solve problem	▪ Trainers understand concept ▪ Feel they get full support from supervisors ▪ In a supervisory visit trainers get feedback from their supervisors as directives and cooperation ▪ Can depend on supervisor to help resolve problem	▪ Trainers understand concept ▪ Feel they get full support from supervisors ▪ In a supervisory visit trainers get guidance, clarity and coaching from supervisors ▪ Can depend on supervisor to help resolve problem	▪ Trainers understand concept ▪ Feel they get full support from supervisors ▪ In a supervisory visit trainers get directives, guidance, new assignment and technical support from their supervisors ▪ Can depend on supervisor to help resolve problem
Training reporting mechanisms				
▪ Difference of opinions: One explained that it is course-wise and the other yearly ▪ Recommendations for improving reporting include guidelines on how to evaluate training and the participants, reporting should be per course	▪ Difference of opinions: 50% report per batch according to own reporting format, others report course-wise ▪ Recommendations for improving reporting include keeping records everyday to make it easier to finish final report, incorporate participants' course evaluation, give orientation to personnel, update on TMIS, introduce LAN/fax/computer at RTC	▪ 100% trainers explained that they have course-wise reporting system in their own reporting format as well as TMIS formats ▪ Recommendations: will continue existing computerized database	▪ 100% trainers explained that they have course-wise and used TMIS formats ▪ Recommendations: Continue TTU adopted TMIS formats	▪ 100% trainers explained that they have course-wise and used TMIS formats ▪ Recommendations: Continue TTU adopted TMIS formats

ICMH	NIPORT	TTT	GUS	PSTC
Knowledge of guidelines/standards				
▪ 50% had read the National In-Service Training Strategy for ESP and ESP guidelines; none had read the National Training Standards draft	▪ All had read ESP guidelines and at least participated in discussions on the National In-Service Training Strategy for ESP and others had participated in discussion; 50% had read National Training Standards draft	▪ 50% had read the National In-Service Training Strategy for ESP, ESP guidelines and National Training Standards draft	▪ None had read the National In-Service Training Strategy for ESP and 50% had read ESP guidelines and participated in development process of National Training Standards draft	▪ All had read the ESP guidelines and National Training Standards draft but not National In-Service Training Strategy for ESP
Monitoring and Evaluation (M&E)				
▪ Not all know if there is a M&E plan for the LTO or if there is a reporting system to plan, implement or evaluate training	▪ 100% stated there is no M&E plan for the LTO; no budget for it; is a reporting system for planning, implementing or evaluating training	▪ Have their own M&E plan and also have own reporting system with budget provisions for planning, implementing and evaluating training	▪ Have their own M&E plan and also have own reporting system with budget provisions for planning, implementing and evaluating training	▪ Do not have their won M&E plan but they have own reporting system with little budget provisions for planning, implementing and evaluating training
Finances for training				
▪ Don't always get money before training starts; difficult to get from MOH	▪ Don't always get money before training starts ▪ **Suggested improvements include:** placing training petty cash to Director of Training, find easier money transactions so don't have to take money from other budget until all get paid	▪ Only 20% of the fund they received before training ▪ **Suggested improvements include:** placing entire fund to Director of Training, find easier money transactions so don't have to take money from other budget until all get paid	▪ Difficult to release fund for training ▪ Only 20% of the fund they received before training ▪ **Suggested improvements include:** find easier money transactions so don't have to take money from other budget until all get paid	▪ Difficult procedure to release fund for training through DGHS, PFC, B. Bank to PSTC account. ▪ **Suggested improvements include:** find easier money transactions so don't have to wait for long time

ICMH	NIPORT	TTT	GUS	PSTC
Job Expectations				
Job Description				
▪ 50% have one, 50% do not	▪ 100% have one	▪ 100% have one	▪ 100% have one	▪ 100% have one
Job Expectations				
▪ Conduct ESP TOT for DUTT ▪ Have training activities other than ESP training but do not affect them from doing ESP training.	▪ Conduct ESP TOT for DUTT, 5 day orientation for doctors, curriculum development and review, organize resources	▪ Conduct ESP TOT course ▪ Have training activities other than ESP training but do not affect them from doing ESP training.	▪ Conduct 21 days basic ESP course for providers ▪ Have training activities other than ESP training but do not affect them from doing ESP training.	▪ Conduct 5 days ESP orientation course for medical graduates and paramedics ▪ Have training activities other than ESP training but do not affect them from doing ESP training.
Problems conducting training activities				
▪ Low turnout ▪ Not all participants appropriate or interested in being trained ▪ Should have different trainee selection criteria	▪ Absence of multimedia, updated relevant videos, flipchart ▪ Too many participants per course (25 in TOT) ▪ Training finance	▪ No organizational trainer involved in ESP TOT course ▪ Trainers are not used to advanced training aids available	▪ Difficulties in selection of trainees and trainers ▪ Conflicts among DUTT members for unequal distribution of training session	▪ Hartal/strike interfere with smooth implementation of training ▪ Conflict among SACMO and Medical Assistants about their roles in the field
Training targets and numbers reached				
▪ Don't know how many DUTT members are expected to train ▪ Only 1 knew exact number trained already ▪ Below target due to low turnout, was able to meet number of batches	▪ Only 50% know targets and how many already trained ▪ Below target due to funding not being available at start time; first AOP passed late; budget inadequate	▪ Knew targets and achievement ▪ Target depends upon LD-IST and fund flow ▪ Low turnout	▪ Knew targets (50 batch) and achievements (38 batch) ▪ Only 20% fund placed in advance ▪ Irregular fund flow	▪ Knew targets (38 batch) and achievements (33 batches) ▪ Delayed fund flow

ICMH	NIPORT	TTT	GUS	PSTC
Performance Feedback				
Trainer performance evaluation				
▪ No fixed schedule for being evaluated, 50% stated never having been evaluated ▪ Have never been observed in a training session	▪ Evaluated once a year as per GOB system ▪ Have been observed in a training session by faculty members, point out strengths and areas for improvement	▪ 100% Evaluated half yearly ▪ Fairly evaluated ▪ Have been observed in a training session by faculty members and given feedback	▪ 100% Evaluated once a year ▪ Fairly evaluated ▪ Have been observed in a training session by faculty members, point out strengths and areas for improvement	▪ 100% Evaluated once a year ▪ Fairly evaluated ▪ Never been observed in a training session by faculty members
Trainee evaluation and follow-up				
▪ 50% do follow-up of 12 trainees using a checklist ▪ NIPHP: there is a minimum level of performance for a trainee to pass a course ▪ ESP: no minimum level; everyone gets a certificate ▪ If trainee doesn't get passing score on posttest, inform trainee and ask what problems having, have them read again and then take test ▪ NIPHP courses: share results, ESP: don't share results	▪ Conduct few if any follow-ups; not in contract ▪ ESP: no minimum level; everyone gets a certificate ▪ If trainee doesn't get passing score on posttest, inform supervisor that trainee was weak in certain areas, during class coaching is done for weak ones ▪ Show trainee results to the class	▪ No follow-up of trainee ▪ Not included in MOU ▪ No minimum level performance identified ▪ 80% post test score should be the cut-off point to pass ▪ Share post test score with participants, trainers and TTU ▪ Every one gets certificate after training by policy, which should be changed.	▪ Conducted follow-up of trainee at worksite in collaboration with GOB ▪ Within last two months 16 to 28 trainees were followed in different Upazilas ▪ Not included in MOU ▪ No minimum level performance identified ▪ Suggested refresher training for participants with poor score ▪ Share score with trainers and indirectly to the trainees	▪ No follow-up of trainee ▪ Not included in MOU ▪ No minimum level performance identified ▪ Share score indirectly to the trainees

ICMH	NIPORT	TTT	GUS	PSTC
Problems preventing doing a great job				
▪ Lack of manpower ▪ Lack of training coordination ▪ Too many jobs to do	▪ New people not trained properly ▪ Teaching materials not always available, sometimes have to use own materials from home ▪ 20% advance not given ▪ Need computer data base development ▪ Time constraint	▪ Kills time to coordinate TTU ▪ No fund from own organization ▪ Need computer data base development	▪ Organizational limitation on transportation ▪ Can not participate as trainer ▪ Too many jobs to do	▪ Can not participate in relevant workshops for self development ▪ Need computer data base development ▪ 20% advance not given
Suggestions to fix problems				
▪ Recruit more capable people who can do training coordination and management	▪ Time to prepare tools ▪ Have new people teach more so can get things done ▪ Orientation for seniors, managers, directors, coordinators ▪ Communication among NIPOR, DGHS TTU, and within NIPORT	▪ Improve coordination between TTU and other LTOs	▪ Improve coordination between TTU and other LTOs ▪ Fund should be available more easily ▪ Needs more skills in training	▪ Organization should allocate some fund for PSTC trainers ▪ Fund should be available more easily

ICMH	NIPORT	TTT	GUS	PSTC
Physical Environment and Tools				
▪ Trainers have sufficient supplies ▪ Have own office/desk; lack computer, phone, fax, internet ▪ Receive stationary supplies as needed or yearly by submitting an indent; get supplies immediately after	▪ Trainers have sufficient supplies ▪ Have own desk, copier and fax at headquarters ▪ Receive stationary supplies as needed, based on training course, received right away, based on indent ▪ **Suggestions for change:** desk top computer with internet, working photocopier	▪ Trainers have sufficient supplies ▪ Have own office/desk computer, phone, fax, internet ▪ Receive stationary supplies as needed or yearly by submitting an indent; get supplies immediately after ▪ **Suggestions for change:** working photocopier	▪ Trainers have sufficient supplies ▪ Have own office/desk ; lack fax, internet ▪ Receive stationary supplies as needed or yearly by submitting an indent; get supplies immediately after ▪ GUS manage stationeries and training materials ▪ **Suggestions for change:** transportation and working photocopier	▪ Trainers have sufficient supplies ▪ Have own office/desk computer, phone, fax, internet ▪ Receive stationary supplies as needed or yearly by submitting an indent; get supplies immediately after ▪ PSTC manage stationeries and training materials ▪ **Suggestions for change:** transportation and working photocopier and computer

ICMH	NIPORT	TTT	GUS	PSTC
Motivation				
Non-monitory motivators within organization				
▪ Are good interpersonal relationships in the organization ▪ Feel listened to when make a suggestion at least half the time ▪ Complimented by supervisor if do a good job; if do bad job, supervisor tells them about it, yells ▪ Organization has non-monetary motivators: a good library, commitment/sensitivity of direction, honesty	▪ Are good interpersonal relationships in the LTO ▪ Feel listened to when make a suggestion more than half the time ▪ If do good job, are complimented by supervisor and praised by fellow trainers and authority; if does a bad job, receives feedback from supervisor and discusses to identify problems; not done in front of others ▪ Organization has non-monetary motivators: can make own decisions, free to express opinion, can lead the junior colleagues, flexibility, professional development opportunity	▪ Are good interpersonal relationships in the organization ▪ Feel listened to when make a suggestion at least half the time ▪ Organization has non-monetary motivators: Picnics, cultural functions, sending abroad and official parties	▪ Are good interpersonal relationships in the organization ▪ Feel listened to when make a suggestion at least half the time ▪ Organization has non-monetary motivators: Ownership, team spirit, commitment, gender value, fellow feelings	▪ Are good interpersonal relationships in the organization ▪ Feel listened to when make a suggestion at least half the time ▪ Organization has non-monetary motivators: good working environment, and modern facilities
Suggestions for other non-monetary motivators				
▪ Praise for good work, receiving training, better training logistics	▪ Personal evaluation of training performance followed by career build up; scope for professional training in and outside country	▪ Gifts and promotion	▪ Overseas training in advance management	▪ Official transportation and overseas training

ICMH	NIPORT	TTT	GUS	PSTC
Skills and Knowledge to do the Job				
Skills, knowledge and felt needs				
▪ Last received training course in 1998 ▪ 50% felt they don't have necessary skills/knowledge to do job, 50% say yes, but always more to learn ▪ Like to learn modern training methods, training energizers, training evaluation, monitoring and follow-up, research in training	▪ Last training included TOT for Master Trainer in 1999 or other continuing education in Feb 2001 ▪ Felt they have necessary skills and knowledge but can always learn more ▪ Like to learn BCC, improve conduct of clinical trainers, occupational psychology, HRD and HRM, advanced computer programming, HIV/AIDS research, training methodology	▪ Last training five months back ▪ Have policy for regular basis continuing education ▪ 100% felt they have necessary skills and knowledge ▪ Like to learn more on IT, MBA, ESP TOT, on the job training	▪ Last TOT training on Arsenic mitigation one year back ▪ Have policy for regular basis continuing education ▪ 100% felt they have necessary skills and knowledge ▪ Like to learn more on computer programming, ESP TOT	▪ Last training one year back ▪ Have policy for regular basis continuing education ▪ 100% felt they have necessary skills and knowledge ▪ Like to learn more on computer programming, advance management course, ESP TOT
Difference between Master Trainer and Trainer				
▪ Could not define difference; defined them as being able to transfer knowledge and skills in an area	▪ Differed in definition; 50% defined both as being able to train others; other 50% said MT is involved in all areas of training	▪ Could not define difference ▪ Defined them as being able to transfer knowledge because of experience and skills	▪ Could define differences ▪ 100% defined master trainers as skilled in training methodology and other training skills in specific areas ▪ Able create trainers	▪ Could define differences ▪ Master trainers are skilled in steps of training methodologies to create trainers. While trainers are able to transfer knowledge to provide

Appendix D.1: Tool to Review Current Status of Performance Issues in the Technical Training Unit (TTU)

Purpose

The purpose of this tool is:

1. To obtain information on the Technical Training Unit (current performance).
2. To generate realistic indicators and targets for improved performance of TTU (desired performance).
3. To identify gaps and possible solutions for an improved performance of TTU.

Methodology

a. Conduct a desk audit of existing data from reports available

Information will be obtained from existing data and sources at TTU.

b. Discussions with the LD-IST and TTU staff

To collect further information that is not available through above sources, discussions will be held with experts involved with the program. The above information will be fine-tuned based on the discussions.

c. Discussions with TTU key personnel

- Focus Group (semi-structured group interviews) with the TTU.
- In-depth interviews with two Training Coordinators in the TTU.

Focus Group (Semi-structured Group Interview) for TTU

Clarity of Responsibility/Organizational Support

Do you have a job description?

Do you do any other activities not mentioned in your job description?

Do these other jobs interfere with you getting your stated job responsibilities done?

Do you do any activities that require you to do training?

What types of services are you expected to provide? (List below)

What types of services are you expected to provide? (See chart below; tick areas)

	Services
	TOT for DUTT for 5 day orientation program
	TOT for trainers of Basic 21-day Course for service providers
	5-day orientation for doctors and other categories
	Management of training sites at UZ training team level

Do you have any problems in conducting these activities?

Do you have training activities other than ESP training?

(If yes) Do these activities block you from doing ESP training in any way?

As of today, how on track is the IST Division in reference to the DUTT members you are expected to train with TOT?

How many DUTT members have actually been trained?

If not up to the target, what do you think has been the reason that the target has not been met?

What about reporting on the training? How is this done (monthly, course wise, irregular, other) (specify)?

Do you see any improvements that could be made in the reporting system?

Using the chart, what are the different roles you play?

Trainers Roles and Responsibilities	**Current Performance**	**Desired Performance**
Plans training		Work-plan, planning checklists
Design curriculum		Evidence, steps
Prepare resources		Checklists
Organize training		Organizational checklists
Manages training		Checklists
Conduct training		Classroom and clinical checklists
Evaluate training		Evaluation checklist
Monitor and follow-up training		Mentoring checklist
Document training		Evidence, formats, how to use
Research (any kind)		Evidence, description
Other		Evidence, description

Are you classified as a Trainer or Master Trainer?

What is the difference between a Master trainer and a trainer?

Have you had the opportunity to read the National In-Service Training Strategy for ESP?

_____ Yes _____ No _____ Don't know

How about the National Training Standards?

_____ Yes _____ No _____ Don't know

And the ESP Training Guidelines?

_____ Yes _____ No _____ Don't know

Using the chart, what are the different roles you play?

Trainers Roles and Responsibilities	Current Performance	Desired Performance
Plans training		Work-plan, planning checklists
Design curriculum		Evidence, steps
Prepare resources		Checklists
Organize training		Organizational checklists
Manages training		Checklists
Conduct training		Classroom and clinical checklists
Evaluate training		Evaluation checklist
Monitor and follow-up training		Mentoring checklist
Document training		Evidence, formats, how to use
Research (any kind)		Evidence, description
Other		Evidence, description

Is there a monitoring and evaluation plan for your organization?

_____ Yes _____ No _____ Don't know

Do you have any type of reporting system to plan, implement or evaluate training?

How do you get the money you need to run your ESP programs? Do you get it all before training begins?

Are there improvements you could suggest to improve funding within the system?

Performance Feedback

Who is your supervisor?

What kind of support do you receive from him/her?

Is this the kind of support you feel you need?

How often are you evaluated? Is the evaluation fair?

What happens in the supervisory visit? How long is it?

Do you conduct follow-up visits with trainees after your trainings?

If yes, how many trainees have you followed up in the last month?

Do you use a checklist?

Is there a minimum level of performance required for trainees to pass a course or the clinical part?

What happens if a trainee does not get a passing score on the post-test or clinical practice checklist?

Do you share the results (good or bad) with the trainee? How is this done?

What does supportive supervision mean to you?

If you do a good job, does your boss compliment you?

What if you do a bad job?

Has anyone observed you in a training session? Do they give you feedback? Tell me about that feedback process.

If you have a problem, can you depend on your supervisor to help resolve it?

What are the main problems you feel block you from doing a great job?

What are your suggestions to fix these problems?

Are there realistic changes in policy and regulations you would recommend to help you improve performance?

Environment

Do you have your own desk? Office? Computer? Copier? Fax? Internet? Telephone?

Do you have enough supplies? What is lacking?

How often do you get supplies? Do you have to order them? What is the procedure for getting supplies?

Tell me about the procedure for getting training supplies and equipment to training sites…

What would you like to see changed in your work environment (physical facilities and supplies)

Incentives, motivation

In general, do you feel there are good interpersonal relationships in your organization?

What do you think could improve relationships in your organization?

Do you feel you are heard when you make a suggestion?

What non-monetary motivators does your organization have?

Do you have suggestions for non-monetary motivators that would encourage people to do a better job?

Knowledge and skills

When did you last receive a continuing education or training course?

How often does your organization say you should have continuing education or training…..is this every year, every two years or as necessary?

When did you have a TOT course?

What kind of training did you have before you began working in the TTU?

Do you feel you have all necessary knowledge and skills to do your job?

What skills/knowledge would you like to learn in order to do the best in your job?

What type of learning style would you like new information presented?

What other types of continuing education, overseas education or training would help you in doing your job?

Thank you for participating in this P/TNA. I want to emphasize that your individual answers will remain confidential.

To be given to TTU Members at time of Focus Group

Using the chart, what are the different roles you play?

Trainers Roles and Responsibilities	Current Performance	Desired Performance
Plans training		
Design curriculum		
Prepare resources		
Organize training		
Manages training		
Conduct training		
Evaluate training		
Monitor and follow-up training		
Document training		
Research (any kind)		
Other		

Appendix D.2: Tool to Review Current Status of Performance Issues in the Lead Training Organizations (LTOs)

Purpose

The purpose of this tool is:

1. To obtain information on the Lead Training Organizations (current performance).
2. To generate realistic indicators and targets for improved performance of LTOs (desired performance).
3. To identify gaps and possible solutions for an improved performance of LTO.

Methodology

a. Conduct a desk audit of existing data from reports available.

   Information will be obtained from existing data and sources at TTU.

b. Discussions with the LD-IST and TTU staff.

   To collect further information that is not available through above sources, discussions will be held with experts involved with the program. The above information will be fine-tuned based on the discussions.

c. Discussions with LTO Training Coordinator, Master Trainers and other key personnel.
   - Focus Group (Semi-structured group interviews) with the LTO Master Trainers or Trainers.
   - In-depth interviews with two Training Coordinators in the LTOs.
   - Discussion with the LTO Director.

(Structured Interview) for LTOs

Begin with: General Statement of Purpose, Confidentiality

Clarity of Responsibility/Organizational Support

How long have you been in your position?

_____ Less than 6 months _____ 6-12 months _____ 1-3 years _____ over 3 years

Do you have a job description?

_____ Yes _____ No _____ Don't know

Do you do any other activities not mentioned in your job description?

_____ Yes _____ No _____ Don't know

If yes, do these other jobs interfere with you getting your training responsibilities done?

_____ Yes _____ No _____ Don't know

What types of services are you expected to provide? (See chart below; tick areas)

	Services
	TOT for DUTT for 5 day orientation program
	TOT for trainers of Basic 21-day Course for service providers
	5-day orientation for doctors and other categories
	Management of training sites at UZ training team level

Do you have any problems in conducting these activities?

Do you have training activities other than ESP training?

_____ Yes _____ No _____ Don't know

(If yes) Do these activities block you from doing ESP training in any way?

As of today, how many DUTT and members are you expected to train with TOT?

How many DUTT members have actually been trained?

If not up to the target, what do you think has been the reason that the target has not been met?

What about reporting on the training? How is this done (monthly, course wise, irregular, other) (specify)?

Do you see any improvements that could be made in the reporting system?

Using the chart, what are the different roles you play?

Trainers Roles and Responsibilities	**Current Performance**	**Desired Performance**
Plans training		Work-plan, planning checklists
Design curriculum		Evidence, steps
Prepare resources		Checklists
Organize training		Organizational checklists
Manages training		Checklists
Conduct training		Classroom and clinical checklists
Evaluate training		Evaluation checklist
Monitor and follow-up training		Mentoring checklist
Document training		Evidence, formats, how to use
Research (any kind)		Evidence, description
Other		Evidence, description

What is the difference between a Master trainer and a trainer?

Have you had the opportunity to read the National In-Service Training Strategy for ESP?

_____ Yes _____ No _____ Don't know

How about the ESP guidelines?

_____ Yes _____ No _____ Don't know

How about National training standards?

_____ Yes _____ No _____ Don't know

Is there a monitoring and evaluation plan for your organization?

_____ Yes _____ No _____ Don't know

Do you have any type of reporting system to plan, implement or evaluate training?

_____ Yes _____ No _____ Don't know

How do you get the money you need to run your ESP programs?
How Money Gotten:

Do you get it all before training begins?

_____ Yes _____ No _____ Don't know

Are there improvements you could suggest to improve the system?

Performance Feedback

Who is your supervisor (administrative authority)?

What kind of support do you receive from him/her?

Is this the kind of support you feel you need?

How often are you evaluated? Is the evaluation fair?

What happens in a supervisory visit? Tell me about how a supervisory visit is conducted…

Do you conduct follow-up visits with trainees after your trainings?

If yes, with how many trainees?

If yes, do you use a checklist?

Is there a minimum level of performance required for trainees to pass a course or the clinical part?

What happens if a trainee does not get a passing score on the post-test or clinical practice checklist?

Do you share the results (good or bad) with the trainee? How is this done?

What does supportive supervision mean to you?

If you do a good job, does your boss compliment you?

If you do a bad job, what does your boss do?

Has anyone observed you in a training session? Do they give you feedback? Tell me about that feedback process.

If you have a problem, can you depend on your supervisor to help resolve it?

What are the main problems you feel block you from doing a great job?

What are your suggestions to fix these problems?

Environment

Do you have your own desk? Office? Computer? Copier? Fax? Internet? Telephone?

Do you have enough supplies? _____ Yes _____ No _____ Don't know

If yes, what is lacking?

How often do you get stationary supplies?

_____Once a week _____Once a month _____Other (explain)

Do you have to submit an indent? _____ Yes _____ No _____ Don't know

What is the procedure for getting stationary supplies?

How do training supplies reach the training sites? (Explain)

What would you like to see changed in your work environment (physical facilities and supplies)

Incentives, motivation

In general, do you feel there are good interpersonal relationships in your organization?

If not, what do you suggest would improve relationships in your organization?

_____ Yes _____ No _____ Don't know

If NO, explain:

Do you feel you are listened to when you make a suggestion?
_____ Always
_____ More than half the time
_____ Less than half the time
_____ Never
_____ Don't know

What non-monetary motivators does your organization have?

Do you have suggestions for non-monetary motivators that would encourage people to do a better job?

Knowledge and skills

When did you last receive a continuing education or training course?

How often does your organization say you should have continuing education or training…..is this every year, every two years or as necessary?

When did you have a TOT course?

What kind of training did you have before you became a trainer?

In your organization, when did you receive a certification of Master Trainer or Trainer?

_____Have not received certification _____Date (_____)

Where is this certification recognized (locally, nationally, etc.)?

_____ Yes _____ No _____ Don't know

_____ Locally _____ Nationally _____ Not recognized _____ Not Applicable

Do you feel you have all necessary knowledge and skills to do your job?

What skills/knowledge would you like to learn in order to do the best in your job?

What type of learning style would you like new information presented?

What other types of continuing education, overseas education or training would help you in doing your job?

Thank you for participating in this interview. The results of this interview will be held in confidence, and reported only in a general sense, such as "the LTOs feel…."

Chart to be given to LTO members

Using the chart, what are the different roles you play?

Trainers Roles and Responsibilities	Current Performance	Desired Performance
Plans training		
Design curriculum		
Prepare resources		
Organize training		
Manages training		
Conduct training		
Evaluate training		
Monitor and follow-up training		
Document training		
Research (any kind)		
Other		

Appendix D.3: District level P/TNA and Baseline Capacity Assessment Tool

(Two interviews from the DTCC in each District)

Thank you for participating in this interview. These interviews are all confidential and we would appreciate your open attitude and honest responses to help us to improve In-Service Training in Bangladesh. This is a BASELINE interview for the ESP Program and we will be doing a similar survey in mid-2003. It will take approximately 45 minutes to one hour to complete this interview.

Note to Interviewer: **Rephrasing of questions may be required**.

Person Doing Interview:_____ Date_____

Title of Interviewee (**NO NAME**)_____ District _____

Place of interview_____

Personnel Data		
1. How long have you been in your present position?	1 = Less than 6 months 2 = 6 months up to one year 3 = One to three years 4 = Over 3 years	
2. Do you have a job description?	1 = Yes, 2 = No, 3 = Don't know	
3. What are your three (3) main job responsibilities?	1. 2. 3.	
4. When was the last time you treated a patient?	1 = Never 2 = Within the last week 3 = Within 6 months 4 = Within 6-12 months 5 = Over one-year 6 = Other	
5. Are you involved in training? [If **No, go on to question 6]**	1 = Yes, 2 = No, 3 = Don't know	
5.1 If **Yes**, tick those that apply	1 = Planning Training 2 = Designing Curriculum 3 = Preparing Resources 4 = Organizing Training 5 = Managing Training 6 = Conducting Training 7 = Evaluating Training 8 = Monitoring and Follow-up of Training 9 = Documenting Training	

6. Does training interfere with your ability to get your main job responsibilities done?	1 = Always 2 = More than half of the time 3 = Less than half of the time 4 = Occasionally 5 = Never	
7. When did you last have any training?	1 = Never 2 = In the last year 3 = In last 2 years 4 = Longer than 2 years ago	
8. What kind of training would help you in your job? (Write in response)		
9. If you do training, have you ever been followed up in your training activities? [If **No** or **Don't know**, go to **question 10**]	1 = Yes, 2 = No, 3 = Don't know 4 = Don't do training	
9.1 If **Yes**, did you receive feedback on your performance?	1 = Yes, 2 = No, 3 = Don't know	
9.2 How did the follow-up occur? **(explain)**		
9.3 The follow-up was done by? (trainer, supervisor, etc.)	1 = trainer, 2 = supervisor	
Planning		
10. Do you have a training calendar to organize Training in your District?	1 = Yes, 2 = No, 3 = Don't know	
10.1 If **Yes**, for what kind of training?	1 = ESP Other (list) 2 = 3 =	
11. Do you use a training guideline to plan for training?	1 = Yes, 2 = No, 3 = Don't know	
12. Do you do joint planning?	1 = Yes, 2 = No, 3 = Don't know	
12.1 If Yes, who is the joint planning done with?	1 = Group of people in the District 2 = DTCC 3 = DUTT 4 = Other	
13. Have you received a copy of:		
13.1 National Strategy for ESP In-Service Training?	1 = Yes, 2 = No, 3 = Don't know	
13.2 National Training Standards?	1 = Yes, 2 = No, 3 = Don't know	
13.3 National Training Guidelines for ESP Training	1 = Yes, 2 = No, 3 = Don't know	
13.4 If **Yes** to National Training Guidelines, do you use the supervision checklist to follow-up trainers/providers?	1 = Yes, 2 = No, 3 = Don't know 4 = Not applicable	
Training		
14. Have you attended a five day ESP Orientation Course?	1 = Yes, 2 = No, 3 = Don't know	
15. Have you ever had a TOT Course?	1 = No, 2 = ESP Field Service 3 = ESP Clinical Service Others (specify) 4= 5=	

16. Have you ever received a supervision follow-up course (how to follow-up participants)? [If **No** or **Don't know**, go on to **question 17**.]	1 = Yes, 2 = No, 3 = Don't know	
16.1 If **Yes,** when was this course?	_____ (approximate date)	
17. Have you ever gotten funds for training (materials, logistics, allowance)	1 = Yes, 2 = No, 3 = Don't know	
17.1 If **Yes**, do you have any problems with this	1 = Yes, 2= No, 3= Don't know	
17.2 If **Yes**, do the funds arrive on time?	1 = Always, 2 = Over half the time 3 = Less than half the time 4 = Never, 5 = Don't know	
18. Is the training venue you use for district training your own building	1 = Yes, 2 = No, 3 = Don't know	
18.1 If **no**, how do you manage to put on training courses?		
19. What kind of problems do you see in training? (In terms of training materials, logistics, the way things are managed, finances, provider performance, Lead Training Organizations, etc.) **(Write in response)**		
20. Do you have any suggestions on how to improve training at the District Level? **(Write in response)**		
Monitoring, Follow-up, Evaluation		
21. Does the District have a supervision and monitoring plan (for monitoring performance of providers)? [If **No** or **Don't know**, go on to **question 22**.]	1 = Yes, 2 = No, 3 = Don't know	
21.1 If **Yes**, what kind of plan is this? (Write in answer)		
22. Do you do any follow-up after Training to evaluate if providers are giving the appropriate care at the worksite? [If **No** or **Don't know**, go on to **question 23.]**	1 = Yes, 2 = No, 3 = Don't know	
22.1 If **Yes,** how many people have you done follow-up with in last month?	_____ Put in number	
22.2 If **Yes**, what kind of evaluation instrument do you use to follow-up? **(Write answer here)**		
22.3 Who is responsible for follow-up of training?	List titles 1. 2. 3.	
22.4 How do you plan for this follow-up of training?	1 = Do not follow-up training 2 = Assign People to follow-up 3 = Trainers follow-up according to ESP Guidelines for Training 4 = Don't know 5 = Other (specify)	

22.5 How often is follow-up done?	1 = Weekly, 2 = Monthly 3 = As necessary, 4 = Not on schedule, 5 = Not done 6= Guidelines provided by TTU, 7= Other	
23. Do you monitor and/or evaluate the training activities in the district, Upazila or Community? [If **No** or **Don't know**, go on to **next 24**.]	1 = Yes, 2 = No, 3 = Don't know	
23.1 If **Yes**, what kind of evaluation instrument do you use?	1 = TTU Provided, 2 = Self made 3 = Other made, 4 = Do verbally 5 = None, 6 = Don't know	
23.2 How do you use the monitoring evaluation results? **(Write in answer)**	1 = not applicable for me 2 = 3 =	
23.3 To whom do you give feedback to regarding the monitoring and evaluation results? **(Write in answer)**	1 = not applicable for me 2 = 3 =	
23.4 (If **Feedback is Provided**) How do you give the feedback to a provider? Can you describe for me? **(Write in answer)** [If **No Feedback** provided, leave blank.]		
Reporting		
24. Do you keep records of training in your District? [If **No** or **Don't know**, go on to **question 25**.]	1 = Yes, 2 = No, 3 = Don't know	
24.1 If **Yes**, how are the records stored? (Write answer here)		
25. Do you send training records to anyone?	1 = Yes, 2 = No, 3 = Don't know	
25.1 If **Yes**, to whom?	1. 2. 3.	
26. Are you aware of any Training Management Information System in your District? [If **No** or **Don't know**, **you have ended interview**.]	1 = Yes, 2 = No, 3 = Don't know	
26.1 If **Yes**, what is it? **(Write in answer)**		
26.2 If **Yes,** who is responsible for sending records to a Training Management Information System? **(Write answer here)**		

Thank you for participating in this interview.

Results of individual responses will remain **confidentia**l.

Appendix D.4: Upazila Level P/TNA and Baseline Capacity Assessment Tool

(Two interviews from the DUTT in each Upazila)

Thank you for participating in this interview. These interviews are all confidential and we would appreciate your open attitude and honest responses to help us to improve In-Service Training in Bangladesh. This is a BASELINE interview for the ESP Program and we will be doing a similar survey in mid-2003. It will take approximately 45 minutes to one hour to complete this interview.

Note to Interviewer: **Rephrasing of questions may be required**.

Person Doing Interview: _____ Date_____

Title of Interviewee (**NO NAME**) _____ District _____

Place of interview_____

Personnel Data		
1. How long have you been in your present position?	1 = Less than 6 months 2 = 6 months up to one year 3 = One to three years 4 = Over 3 years	
2. Do you have a job description?	1 = Yes, 2 = No, 3 = Don't know	
3. What are your three (3) main job responsibilities?	1. 2. 3.	
4. When was the last time you treated a patient?	1 = Never 2 = Within the last week 3 = Within 6 months 4 = Within 6-12 months 5 = Over one-year 6 = Other	
5. Are you involved in training? [If **No, go on to question 6]**	1 = Yes, 2 = No, 3= Don't know	
5.1 If **Yes**, tick those that apply	1 = Planning Training 2 = Designing Curriculum 3 = Preparing Resources 4 = Organizing Training 5 = Managing Training 6 = Conducting Training 7 = Evaluating Training 8 = Monitoring and Follow-up of Training 9 = Documenting Training	

6. Does training interfere with your ability to get your main job responsibilities done?	1 = Always 2 = More than half of the time 3 = Less than half of the time 4 = Occasionally 5 = Never	
7. When did you last have any training?	1 = Never 2 = In the last year 3 = In last 2 years 4 = Longer than 2 years ago	
8 What kind of training would help you in your job? (write in response)		
9. If you do training, have you ever been followed up in your training activities? [If **No** or **Don't know**, go to **question 10**]	1 = Yes, 2 = No, 3 = Don't know 4 = Don't do training	
9.1 If **Yes**, did you receive feedback on your performance?	1 = Yes, 2 = No, 3 = Don't know	
9.2 How did the follow-up occur? **(Explain)**		
9.3 The follow-up was done by? (Trainer, supervisor, etc.)	1 = trainer, 2 = supervisor	
Planning		
10. Do you have a training calendar to organize Training in your Upazila?	1 = Yes, 2 = No, 3 = Don't know	
10.1 If **Yes**, for what kind of training?	1 = ESP Other (list) 2 = 3 =	
11. Do you use a training guideline to plan for training?	1 = Yes, 2 = No, 3 = Don't know	
12. Do you do joint planning?	1 = Yes, 2 = No, 3 = Don't know	
12.1 If YES, who is the joint planning done with?	1 = Group of people in the District 2 = DTCC 3 = DUTT 4 = Other	
13. Have you received a copy of:		
13.1 National Strategy for ESP In-Service Training?	1 = Yes, 2 = No, 3 = Don't know	
13.2 National Training Standards?	1 = Yes, 2 = No, 3 = Don't know	
13.3 National Training Guidelines for ESP Training	1 = Yes, 2 = No, 3 = Don't know	
13.4 If **Yes** to **National Training Guidelines**, do you use the supervision checklist to follow-up trainers/providers?	1 = Yes, 2 = No, 3 = Don't know 4 = Not applicable	
Training		
14. Have you attended a five day ESP Orientation Course?	1 = Yes, 2 = No, 3 = Don't know	
15. Have you ever had a TOT Course?	1 = No, 2 = ESP Field Service 3 = ESP Clinical Service Others (specify) 4 = 5 =	

16. Have you ever received a supervision follow-up course (how to follow-up participants)? [If **No** or **Don't know**, go on to **question 17**.]	1 = Yes, 2 = No, 3 = Don't know	
16.1 If **Yes,** when was this course?	_____(approximate date)	
17. Have you ever gotten funds for training (materials, logistics, allowance)	1 = Yes, 2 = No, 3 = Don't know	
17.1 If **Yes**, do you have any problems with this	1 = Yes, 2 = No, 3 = Don't know	
17.2 If **Yes**, do the funds arrive on time?	1 = Always, 2 = Over half the time 3 = Less than half the time 4 = Never, 5 = Don't know	
18. Is the training venue you use for Upazila training your own building	1 = Yes, 2 = No, 3 = Don't know	
18.1 If **No**, how do you manage to put on training courses?		
19. What kind of problems do you see in training? (In terms of training materials, logistics, the way things are managed, finances, provider performance, Lead Training Organizations, etc.) **(Write in response)**		
20. Do you have any suggestions on how to improve training at the Upazila level? **(Write in response)**		
Monitoring, Follow-up, Evaluation		
21. Does the Upazila have a supervision and monitoring plan (for monitoring performance of providers)? [If **No** or **Don't know**, go on to **question 22**.]	1 = Yes, 2 = No, 3 = Don't know	
21.1 If **Yes**, what kind of plan is this? (write in answer)		
22. Do you do any follow-up after Training to evaluate if providers are giving the appropriate care at the worksite? [If **No** or **Don't know**, go on to **question 23**.]	1 = Yes, 2 = No, 3 = Don't know	
22.1 If **Yes,** how many people have you done follow-up with in last month?	_____ Put in number	
22.2 If **Yes**, what kind of evaluation instrument do you use to follow-up? **(Write answer here)**		
22.3 Who is responsible for follow-up of training?	List titles 1. 2. 3.	
22.4 How do you plan for this follow-up of training?	1 = Do not follow-up training 2 = Assign People to follow-up 3 = Trainers follow-up according to ESP Guidelines for Training 4 = Don't know 5 = Other (specify)	

22.5 How often is follow-up done?	1 = Weekly, 2 = Monthly 3 = As necessary 4 = Not on schedule, 5 = Not done 6 = Guidelines provided by TTU, 7 = Other	
23. Do you monitor and/or evaluate the training activities in the district, Upazila or Community? [If **No** or **Don't know**, go on to **question 24**.]	1 = Yes, 2 = No, 3 = Don't know	
23.1 If **Yes**, what kind of evaluation instrument do you use?	1 = TTU Provided, 2 = Self made 3 = Other made, 4 = Do verbally 5 = None, 6 = Don't know	
23.2 How do you use the monitoring evaluation results? **(Write in answer)**	1 = not applicable for me 2 = 3 =	
23.3 To whom do you give feedback to regarding the monitoring and evaluation results? **(Write in answer)**	1 = not applicable for me 2 = 3 =	
23.4 (If **Feedback is Provided**) How do you give the feedback to a provider? Can you describe for me? **(Write in answer)** [If **No Feedback Provided, Leave Blank.**]		
Reporting		
24. Do you keep records of training in your Upazila? [If **No** or **Don't know**, go on to **question 25**.]	1 = Yes, 2 = No, 3 = Don't know	
24.1 If **Yes**, how are the records stored? (Write answer here)		
25. Do you send training records to anyone?	1 = Yes, 2 = No, 3 = Don't know	
25.1 If **Yes**, to whom?	1. 2. 3.	
26. Are you aware of any Training Management Information System in your Upazila? [If **No** or **Don't know**, **you have ended interview**.]	1 = Yes, 2 = No, 3 = Don't know	
26.1 If **Yes**, what is it? **(Write in answer)**		
26.2 If **Yes,** who is responsible for sending records to a Training Management Information System? **(Write answer here)**		

Thank you for participating in this interview.

Results of individual responses will remain **confidentia**l.

Appendix D.5: Competence Assessment Tool of Immediate Supervisors of Field Service Providers

(Do when you get to clinic; speak with person in charge of the clinic - AHI/FPI)

Person Doing Interview (name): _____ Date: _____

Upazila: _____ Community/Satellite Clinic: _____

Title of Person in Charge of the Community Clinic (NO NAME): _____

1. Are you a supervisor?	1 = Yes, 2 = No	
2. If yes, whom do you supervise?	1 = HA, 2 = FWA Other (write in) 3.	
3. Have you been trained in management?	1 = Yes, 2 = No	
3.1 If yes, when was this training?	_____ (Date)	
4. Have you been trained in supportive supervision?	1 = Yes, 2 = No	
4.1 If yes, when was this training?	_____ (Date)	
5. When does the clinic open in the morning?	_____ (Insert time)	
6. When does the clinic close?	_____ (Insert time)	
7. What days of the week are you open?	1. Monday, 2. Tuesday, 3. Wednesday, 4. Thursday, 5. Friday, 6. Saturday, 7. Sunday	
8. Is this Community Clinic built and run by the government, or donated space?	1. Built/run by government, 2. Donated Space, 3. Part of the Union Health Center, 4. Other	
How many clients were seen at the Community Clinic in the last month?		
9. Total number of clients during last month	_____	
10. How many were women? (age 15 to 49)	_____	
11. How many were men? (age 15 to 49)	_____	
12. Female Children? (13 months to 14 years old)	_____	
13. Male Children? (13 months to 14 years old)	_____	
14. Female Babies? (age 0-12 months)	_____	
15. Male Babies? (age 0-12 months)	_____	

Interviewer: Proceed to the Worksite Evaluation Checklist

Appendix D.6: Service Providers' (HA and FWA) Competence Assessment Tool

(Do Worksite Provider Performance Checklist first)

Interviewer Name: _____ Date: _____

Title of Person Being Interviewed (NO NAME): _____

Upazila: _____ Community/Satellite Clinic: _____

1. How long have you been working at this Community Clinic?	1. Less than six months 2. One year 3. More than one year	
2. Have you been trained in the Basic ESP Curriculum training?	1 = Yes, 2 = No, 3 = Don't know	
2.1 If **Yes**, when was this training	_____ (Date)	
3. How much of the information gained from the ESP course are you able to use in your work here at the clinic?	1. All of it, 2. Most of it, 3. About half of it, 4. Less than half of it, 5. None of it	
4. Do you have any suggestions that might improve the Basic ESP Course?	1 = Yes, 2 = No, 3 = Don't know	
4.1 If **Yes,** what are your suggestions? (Write suggestions)		
5. Have you been followed up at your worksite after the ESP Course?	1 = Yes, 2 = No, 3 = Don't know	
5.1 If **Yes**, what month and year	Month _____ Year _____	
6. Who did the follow-up? (insert **Title**, no name)	1. _____ 2. _____ 3. _____	
7. What level did you receive on your evaluation checklist?	1. Unacceptable (under 70%) 2. Needs Improvement (70-85%) 3. Acceptable (85-90%) 4. Competent (90-100%) 5. Did not have an evaluation checklist	
8. Do you have an immediate supervisor?	1 = Yes, 2 = No, 3 = Don't know	
8.1 If **Yes**, who is it? (**enter only title, no name**)	1. _____ 2. _____ 3. _____	
8.2 When was your last visit from the supervisor?	1. Less than one month ago 2. In last one month to 6 months 3. Never had a visit 4. Not sure/Don't know	

9. Do you have a job description?	1 = Yes, 2 = No, 3 = Don't know	
9.1 May I see it?	1. Able to see, 2. Unable to see	
10. Do you feel there is enough waiting space in the clinic?	1 = Yes, 2 = No, 3 = Don't know	
11 How often do you have enough supplies to treat the clients?	1. Always, 2. Most of the time, 3. About half of the time 4. Less than half of the time 5. Never, 6. Don't know	
12. What supplies or equipment do you most lack?	1. Do not lack any List of supplies or equipment most lacking: 2. _____ 3. _____ 4. _____	
13. When was your last stock out of a drug?	1. Never, 2. One month or less 3. 2-3 Months ago 4. 4-6 months ago 5. More than six months ago	
14. Do you have reference materials here at the clinic that helps you to treat clients? (These may be procedure books, referral instructions, etc.)	1 = Yes, 2 = No, 3 = Don't know	
15. Have you had training in BCC, specifically related to interacting with clients?	1 = Yes, 2 = No, 3 = Don't know	
16. What time did you arrive today?	_____ (write in time they say	
17. What time does the clinic open?	From _____ to _____	
18. Were there any clients waiting when you arrived?	1 = Yes, 2 = No, 3 = Don't know	
19. What time did you see your first client?	_____ (write in time they say)	
20. When does the clinic close?	_____ (write in time they say)	

Appendix D.7: Service Provider's Performance Observation Checklist at Worksite

Who Will Complete This Checklist: Evaluator from TTU, DUTT, DTCC
Whom S/he Will Evaluate: HA and FWA at Community Clinic
Evaluation Will Take Place At: Provider's Worksite (Community Clinic)

Date: _____ District: _____ Name of Upazila: _____

Title of Provider: _____

Interviewer's Name: _____ Community/Satellite Clinic: _____

Rating scale: Worst performance = 1, Fair performance = 2, Good Performance = 3, Best Performance = 4

** Starred items are mandatory

SL	Task/Activity (After each item, place a 1,2,3 or 4 in the Rating Scale column)	Rating scale	Remarks
	Attitude/behavior		
1	Is at worksite on time as agreed by GOB		
2	Respects clients' opinions and concerns (i.e., demonstrates friendly and helpful behavior to the clients, makes the client feel comfortable in the center**		
3	Ensures privacy arrangement for the client at the worksite		
	Skill		
4	Adheres to universal infection control principles (i.e., hand washing, other hygienic conditions)**		
5	Performs correct methods for history and physical examination		
6	Uses proper equipment and materials in examination/treatment **		
7	Provides correct management/treatment and/or referral for the client**		
8	Provides follow-up instructions to clients in written or verbal form followed by documentation in the client's chart **		
	Counseling		
9	Listens attentively to clients' concern**		
10	Performs adequate history taking		
11	Provides health education in the particular area of client's complaint		
12	Explains possible solution to the problem		
13	Asks client if s/he understands what was discussed in the counseling **		
	Knowledge		
14	Explains GOB provision of standard/facilities for a community clinics **		
15	Explain the job description of HA/FWA/AHI/FPI		
16	Defines each component of ESP**		
17	Explains community's local health problems and practices		
18	Explains community clinic management responsibility of Government and local community		

Appendix D.8: Exit Interview Tool for Clients at Service Delivery Points

Exit Interview
(to be done when client exits the clinic)

Interviewer Name: _____ Date: _____

District: _____ Upazila: _____ Community/Satellite Clinic: _____

1. Age of Client		
2. Sex:	1. Female, 2. Male	
3. Are you employed?	1 = Yes, 2 = No, 3 = Don't know	
4. Is your husband (or wife) employed?	1 = Yes, 2 = No, 3 = Don't know	
5. What was your main reason for coming to the clinic today? (Write in client's words)		
6. How long did it take you to walk from your home to the clinic?	1. 1-30 minutes 2. [31-60 minutes] 3. [Over one hour]	
7. Did you seek any medical advice elsewhere for the same complaint before coming here?	1 = Yes, 2 = No, 3 = Don't know	
7.1 If Yes, by whom?	1. Village doctor, 2. Pharmacy, 3. Kabiraj, 4. Homeopath, 5. Religious	
8. Do you know what time the clinic opens?	1. Yes (write time _____) 2. Don't know	
9. What days are the clinics open?	1. Monday, 2. Tuesday, 3. Wednesday, 4. Thursday, 5. Friday, 6. Saturday, 7. Sunday	
10. When does the clinic close?	1. (insert time _____) 2. Don't know	
11. Is the clinic open when it says it will be open?	1 = Yes, 2 = No, 3 = Don't know	
12. Do you feel welcomed by the clinic staff?	1 = Yes, 2 = No, 3 = Don't know	
13. Do you feel comfortable asking questions of the staff?	1 = Yes, 2 = No, 3 = Don't know	
14. When did you arrive here today?	1. (write time _____) 2. Don't know	
15. When were you seen by the HA or FWA?	_____ (Write in time)	
16. Were there supplies to treat you?	1 = Yes, 2 = No, 3 = Don't know	
17. Did the HA or FWA tell you what was wrong with you?	1 = Yes, 2 = No, 3 = Don't know	
18. Did you see the person who cared for you wash their hands?	1 = Yes, 2 = No, 3 = Don't know	
19. Did you get instructions on follow-up before leaving? (Write in client's words)		
20. Are you supposed to return here?	1 = Yes, 2 = No, 3 = Don't know	
21. If **Yes**, what date?	_____ (Write in date)	

Appendix D.9: Facility (equipment, furniture and logistical supplies) Assessment Checklist for SDPs

Technical Specifications, Package No. G-390.18

Name of Person filling out Checklist: _____ Designation: _____ Date: _____

District: _____ Upazila: _____ Community/Satellite Clinic: _____

Item #	Description	Required Units	Actual Units	Item Present Yes or No	Comments
1	**First Aid Kit Box** (used for multi purpose first-aid kit) Royal Blue, rectangular PVC Coated Nylon Bag, lined and Padded with 4 mm Molitan/Sponge rubber on top and Bottom, durable Blue Zipper With Two Fasteners (Cursors) Sewn on top of three side panels, emblem ”First-Aid Kit” and a red cross printed in white background on the outer top panel of the bag • Approximate Size: 4 1 cm wide * 28 cm deep * 8 cm high to be supplied without any content	1		Y N	
2a	**Gauge Cutting Scissor** Stainless Steel made, Smith pattern, straight, sharp-blunt, with thumb and double finger rings, 200 mm (8 inch)	1		Y N	
2b	**Surgical Scissor** Stainless Steel made, curved, sharp-blunt points, 150 mm (6 inch)	1		Y N	
3a	**Toothed Dissecting Forceps** Stainless Steel made, straight, 1*2 teeth, box lock, multiple ratchet, 150 mm (6 inch)	1		Y N	
3b	**Tissue Forceps** Stainless Steel made, Allis design ,4*5 teeth, box lock, multiple ratchet 150 mm (6 inch)	1		Y N	
3c	**Haemostatic Forceps** Stainless Steel made, Kelly design, straight, box-lock, multiple ratchet, 140 mm (5-1/2 inch)	1		Y N	
3d	**Haemostatic Forceps** Static less Steel made Halstead-Mosquito design, Curved, box-lock, multiple ratchet, 125 mm (5 inch)	1		Y N	

Item #	Description	Required Units	Actual Units	Item Present Yes or No	Comments
4	**Curved Cutting Needle** Made of corrosion-resistant steel, 3/8 circle, curved, cutting edge, triangular cutting point, regular eye , reusable	24		Y N	
5	**Needle Holder** Stainless Steel made, Mayo-Haeger design, Multiple ratchet, and box-lock, central groove 160 mm (6-1/2 inch). Both curved and straight. Set of two.	1 Set		Y N	
6	**Tongue Depressor** Stainless steel made, Mayo pattern, and size: 170*22 mm ,tapering to 15 mm at narrow end, both ends slightly curved in opposite direction.	2		Y N	
7	**Blood Pressure Instrument** Aneroid model, portable type. Range up-to 300 mm Hg. Apparatus consisting of Gauze with die cast case, Pocket clip and white dial (50 mm) Armband, valve, inflating bulb and durable rubber tubing. To be supplied complete with all fittings in a pouch case	1		Y N	
8	**Stethoscope** Littmans design: light-weight; Stainless steel binaural with ear tips, y-shaped vinyl tubing, chest piece, bell & flat, tube length: 700 mm	1		Y N	
9	**Mouth Gag** Rubber made; Size: Adult, maximum expansion jaws: 70 cm	1		Y N	
10	**Thermometer, Clinical** Glass made; Graduated in degree Fahrenheit; Length 110 mm Range: 90; Graduation: 0.10 F; To be supplied in case	4		Y N	
11	**Tourniquet** Latex rubber made, Size: 7mm 8 10mm 8 750mm	2		Y N	
12	**Naso –Gastric Ryle's Tube** Rubber made; Adult, child and infant type; Set of three	1 Set of three		Y N	
13	**Automatic Timer** Clock type with alarm; Time-setting lever; Battery –operated. Range: 1 to 60 minutes	1		Y N	

Item #	Description	Required Units	Actual Units	Item Present Yes or No	Comments
14	**Bathroom Scale** Mechanical Type, metal construction, vinyl top surface; Clearly marked dial beneath a protective window; Zero Adjustment, Graduated both in ibs & kgs , Weighing Capacity : 125 kg, Division: 1 kg, Sensitivity: 500 gm, Overall size; 300*270*70 mm (approx)	1		Y N	
15	**Hanging Weighing Scale (baby weighing scale)** Mechanical type; accurate and easy to use; large bowl to place baby, Capacity: 0 to 16 kg; Graduation: 10 gm; Bowl Size: 580*350*140 mm (approx).	1		Y N	
16	**Instrument Tray** a) With flat cover and recessed handle; made of stainless steel, 20 gauge. Smooth contour, polished, open hygienic edge; a.350 mm * 250 mm * 50 mm; b.320 mm*240 * mm* 50 mm	1 Set of 2		Y N	
17	**Kidney Tray** Made of stainless steel, 20-gauge edge with stainless lid cover, hygienic lids to have raised handle; Sizes : one 250mm and one 300mm	1 Set of 2		Y N	
18	**Kerosene Stove** Body made of brass alloy; Diameter: 30cm (12 inches) Height: 30 cm (12 inches) Capacity – 2 liters	1		Y N	
19	**Saucepan with Lid** Aluminum; Capacity-2 litres (approx.)	1		Y N	
20	**Hurricane (Lantern)** Height- 32-33cm; Length of the glass chimney: 13-14cm; Diameter of 10-12cm; Diameter of the oil container: 14-15 cm; Capacity of the oil: minimum ¼ litre.; Chimney to be held to the body by a cross –barred wire; Body of the Hurricane : Made of tin ,painted; A ribbon made of cotton, about 2cm wide should be present with adjustment system for high/low illumination	2		Y N	
21	**Bucket with Lid** Plastic Made with SS handle; Capacity: 20,16 & 12 litres each (set of three)	1 Set		Y N	
22	**Mug** Plastic made; Color: deep blue; Capacity: 1 litre	3		Y N	
23	**Badna** Plastic Made, 1.5 litre capacity	2		Y N	

Item #	Description	Required Units	Actual Units	Item Present Yes or No	Comments
24	**ORS Measuring Mug** Complete with glass and spoon; Made of plastic (transparent); Mug with Graduation 1 litre capacity; rim 15cm(6 inches) in size	2		Y N	
25	**Soap box** With cover; Made of plastic; Deep rose/pink color; Size: 10cm * 7cm *3 cm (approx.)	3		Y N	
26	**Measuring Tape** Plastic Made; 5-meter length; width 12-13 mm; Graduation in both inches and cm.	2		Y N	
27	**Rubber Sheet** Clear, Washable Size: 1500-1550mm * 1100-1150mm	2		Y N	
28	**Apron** With Neckband, Plastic made, Opaque, Washable, water-proof; Adult size	2		Y N	
29	**Blood Slides** Made of transparent glass; Size: 25 * &75 mm (1 * 3 inches)	2 boxes of 72		Y N	
30	**Test tube** Without rim, Made of borosillicate Glass, Size: 150mm* 16mm; Thickness: 1.0 to 1.2mm	12		Y N	
31	**Test Tube Holder (standard size)** (Commonly used for holding glass made test tubes 150*16mm) Stainless steel made	2		Y N	
32	**Lancet (Pricking Needle)** (To take blood samples) sterile, disposable; box of 200	1 Box of 200		Y N	
33	**Silk Thread** Black, Braided, Sterile, size 2 USP, length 750mm.	2 750 mm rolls		Y N	
34	**Surgical Gauge** Bleached32c * 32c/16-18 *16-18; 91.44cm width * 16.46m long Weight: 539-567 gm (19-20 Oz)	5 yards		Y N	
35	**Surgical Bandage** Grey; 32c * 32c; 22-24 * 18-20; 91.44 cm width * 16.46m long per than Weight: 539-567gm (19-20 Oz)	5 yards		Y N	
36	**Absorbent Cotton** Non–sterile, 250gm roll	20 Rolls of 250gm		Y N	

Item #	Description	Required Units	Actual Units	Item Present **Yes** or **No**	Comments
37	**Cloth Duster** Made of thick cotton cloth, like a large handkerchief, sewed all around for dusting table, chair, black board etc. Size: 45 cm*45 cm (18 inch*18 inch) (approx.)	12		Y N	
38	**Sensor Testing Kit**	1		Y N	
39	**Uristix Test Kit** Bottle of 100	1 Bottle of 100		Y N	
40	**Savlon cetrimidine** (chlorhexidine Gluconate) Hospital Conc. Pharmacopoeial Standard: BP/USP	1 Jar or Litres		Y N	

Add up number of “Yes” responses_____

Add up number of “NO” responses_____

Additional Comments:

Appendix E: Workplan of ESP-ISP Baseline Survey Data Collection

Date	Team A	Source of team members				Place of visit	Activities to cover		
	Chittagong Division	Central	DTCC	DUTT	FWVTI/RTC		DTCC	DUTT	CC
22nd Feb	Subteam-1	2	1	1		B. Baria CS/DDFP Office & Sadar UHC	2	2	2
	Subteam-2	2		2		Kashba UHC		2	2
	Subteam-3	2		2		Akhaura UHC		2	2
24th Feb	Subteam-1	2	1	1		B. Baria Sadar UHC			3
	Subteam-2	2		2		Kashba UHC			2
	Subteam-3	2		2		Akhaura UHC			2
27th Feb	Subteam-1	2	1	1		Feni CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		2		Sonagazi UHC		2	2
	Subteam-3	2		2		Sonagazi UHC			2
28th Feb	Subteam-1	2	1	1		Feni Sadar UHC			3
	Subteam-2	2	1	1		Feni Sadar UHC			2
	Subteam-3	2		2		Sonagazi UHC			2
1st March	Subteam-1	2				Chittagong CS & DDFP office	2		
	Subteam-2	2		2		Anwara UHC		2	2
	Subteam-3	2		2	1	Sitakund UHC		2	2
3rd March	Subteam-1	2		2		Anwara UHC			2
	Subteam-2	2		2	1	Sitakund UHC			2
	Subteam-3	2		2		Hathazari UHC		2	2
14th March	Subteam-1	2		2		Hathazari UHC			2
	Subteam-2	2		2		Rangunia UHC		2	2
	Subteam-3	2		2		Rangunia UHC			2
15th March	Subteam-1	2		1	2	Rangamati CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		1	1	Kaptai UHC		2	2
	Subteam-3	2		1	1	Nannerchar UHC		2	2

Date	Team A	Source of team members				Place of visit	Activities to cover		
	Chittagong Division	**Central**	**DTCC**	**DUTT**	**FWVTI/RTC**		**DTCC**	**DUTT**	**CC**
18th March	Subteam-1	2		1	2	Rangmati Sadar			2
	Subteam-2	2		1	1	Kaptai UHC			3
	Subteam-3	2		1	1	Nannerchar UHC			2
Total		**54**	**5**	**41**	**10**		**8**	**24**	**55**

Workplan of Team B for Baseline Survey of In-Service Training

Date	Team B	Source of team members				Place of visit	Activities to cover		
	Chittagong Division	Central	DTCC	DUTT	FWVTI/RTC		DTCC	DUTT	CC
24th March	Subteam-1	2	1	1		Panchagor CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		1		Boda UHC		2	2
	Subteam-3	2		2		Boda UHC			3
25th March	Subteam-1	2	1	1		Panchagor Sadar			3
	Subteam-2	2		1		Boda UHC			2
	Subteam-3	2		2		Panchagor Sadar			3
27th March	Subteam-1	2	1	1	1	Dinajpur CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		2	1	Chirrirbandar UHC		2	2
	Subteam-3	2	1	2	1	Birganj UHC		2	3
28th March	Subteam-1	2	1	1	1	Dinajpur Sadar UHC			3
	Subteam-2	2		2	1	Chirrirbandar UHC			3
	Subteam-3	2	1	2	1	Kaharol UHC		2	3
29th March	Subteam-1	2	1	2	2	Sirajgonj CS/DDFP office & Raigonj UHC	2	2	2
	Subteam-2	2		2		Kamarkhand UHC		2	2
	Subteam-3	2		3		Belkuchi UHC			2
31st March	Subteam-1	2	1	2	2	Raigonj UHC			3
	Subteam-2	2		2		Kamarkhand UHC			3
	Subteam-3	2		3		Belkuchi UHC			3
7th April	Subteam-1	2	1	2	1	Rajshahi CS/DDFP office & Paba UHC	2	2	2
	Subteam-2	2		2	1	Mohanpur UHC		2	2
	Subteam-3	2		2	1	Bagmara UHC		2	2
8th April	Subteam-1	2	1	2	1	Paba UHC			3
	Subteam-2	2		2	1	Mohanpur UHC			3
	Subteam-3	2		2	1	Bagmara UHC			3
Total		**48**	**10**	**44**	**16**		**8**	**22**	**61**

Workplan of Team C for Baseline Survey of In-Service Training

Date	Team B Chittagong Division	Source of team members				Place of visit	Activities to cover		
		Central	DTCC	DUTT	FWVTI/RTC		DTCC	DUTT	CC
28th March	Subteam-1	2	1	1		Jhinaidaha CS/DDFP office &Sadar UHC	2	2	2
	Subteam-2	2	1	2		Kotchandpur UHC		2	2
	Subteam-3	2	1	1		Jhinaidah Sadar			3
29th March	Subteam-1	2	1	1		Jhinaidaha Sadar			3
	Subteam-2	2	1	2		Kotchandpur UHC			3
	Subteam-3	2		2		Kotchandpur UHC			2
28th March	Subteam-1	2	1	1		Chuadanga CS/DDFP office & Sadar UHC	2	2	1
	Subteam-2	2	1	2		Jiban Nagar UHC		2	2
	Subteam-3	2	1	2		Damurhuda UHC		2	2
29th March	Subteam-1	2	1	2		Jiban Nagar UHC			3
	Subteam-2	2	1	2		Damurhuda UHC			3
	Subteam-3	2	1	1		Damurhuda UHC			2
20th May	Subteam-1	2	1	1		Jessore CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		2		Bagherpara UHC		2	2
	Subteam-3	2		2	1	Manirampur UHC		2	3
21st May	Subteam-1	2	1	1	1	Jessore CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		2	1	Jhikargacha UHC		2	3
	Subteam-3	2		2	1	Manirampur UHC		2	3
22nd May	Subteam-1	2	1	1	1	Bagherhat CS/DDFP office & Sadar UHC	2	2	2
	Subteam-2	2		2	1	Chitalmari UHC		2	3
	Subteam-3	2		2	1	Kachua Sadar		2	3
3rd May	Subteam-1	2	1	1		Bagherhat Sadar			3

Date	Team B Chittagong Division	Source of team members				Place of visit	Activities to cover		
		Central	DTCC	DUTT	FWVTI/RTC		DTCC	DUTT	CC
	Subteam-2	2		2	1	Rampal UHC		2	2
	Subteam-3	2		2	1	Kachua UHC			3
Total		**48**	**15**	**39**	**10**		**22**	**68**	**60**
Grand Total		**126**	**26**	**103**	**31**		**22**	**68**	**172**