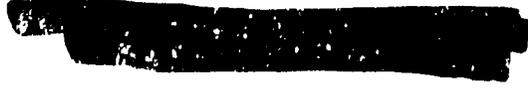


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WORKING PAPER SERIES # 9

Quantity of Work and Quality of Care:  
An Analysis of Field Workers in Bangladesh

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## INTRODUCTION

Since the Alma Ata Conference endorsed primary health care as the means to achieve Health for All by the year 2000, governments, with donor support, have proceeded to plan and implement delivery of health and family planning services along primary care lines. One general assumption underlying this strategy is that all developing societies, because of limited resources and the need to improve access to care for sizeable populations, require large-scale public delivery systems based on paraprofessionals distributing simple and safe technologies. (Chen, 1986) Influenced strongly by the Chinese barefoot doctor system, several countries, including both India and Bangladesh, are attempting to reach villagers through a system of health and family planning field-workers selected from the villages in which they work and scheduled to deliver selected health services and contraceptives to the households. While household visits by such workers have been associated with increased contraceptive prevalence and decreased infant and childhood mortality in at least 15 community-based distribution programs (Kols and Waver, 1982), the quality of the care being given has only recently received attention (Simmons et al., 1986; Schuler et al., 1985)

Quality of care refers to the content of the services provided, and to a delivery system that encourages continuous interaction with clients. Quality is best measured at the interface between the client and worker - where the program actually meets the client. During the interaction with the client, quality can be measured by the competence with which the appropriate services are provided and the manner in which they are delivered. An analysis of three community-based programs in India and Bangladesh led to the hypothesis that

the frequency of contact between field-workers and villagers is one important predictor of quality in such programs: that workers who visit clients frequently have the potential for establishing good relations with them (Simmons et al., 1986). Good relations with clients are considered an important element in effecting improved health care utilization (including improved self-care behavior) and increased or continuous use of contraception. Other predictors of quality care include an acceptable style of interaction, and the availability and convenience of services.

This paper explores the quality of care of community-based services through a study of the client relations of the national maternal and child health and family planning program of Bangladesh. It examines the interactions between female health and family planning field-workers, the Family Welfare Assistants (FWA), and village women in rural Bangladesh, placing the workers in the context of their work system. It builds on a conceptual model presented in an earlier paper (Simmons et al., 1986), and is informed by the work of the MCH-FP Extension Project, a collaborative venture of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Ministry of Health and Family Planning (Phillips et al., 1984). The aim of the research is to diagnose organizational constraints to quality care and provide a feasible strategy for program managers to overcome the barriers.

It has been argued that contextual factors, including socioeconomic, political, and cultural influences, play a major role in determining use of services, including contraceptive use, and that they shape the nature of client relations. Simmons et al., (1986) have argued that these influences operate through two major causal pathways: They affect the way the program functions and the manner in which clients respond. However, as these authors continue, "Programs are not total captives of their social environment".

Specific factors within the management of a program can be manipulated to improve its responsiveness to clients.

Through study of the interaction between clients and workers, workers' relations with clients are observed to be composed of three major elements as is shown in Figure 1 -- the substance of the interaction with clients, including the discussions held and services provided, the style of the interaction, and the time available and used in these interactions. Each of these three elements is affected by decisions at the policy, implementation and field management levels. For example, discussions with clients and services provided reflect the workers' job description and training, plus their back-up with supplies and medical assistance as needed. While these factors are determined at policy level, the program manager supervising front-line workers generally has latitude within his span of control to improve the logistics and referral systems, thus influencing the substance of the interaction.

The style of the interaction may depend on worker characteristics which in turn relates to selection criteria, another policy level factor. It is affected also by the use of a record-keeping system, a system the program manager can ignore or work with to improve its use and effectiveness. A recording system that allows workers to know the history of a client's needs and services rendered means they do not begin each interaction afresh; they know what the woman's name is, what method of family planning she has or is using, her past complaints, and how they were handled. Perhaps of even greater influence on the style and work emphases observed during interactions with clients, however, are the performance incentives of the organization and the goals communicated to the workers by their supervisors--factors that affect the motivation of workers.

The quantity of client interaction, determined by the frequency and duration of contact with clients, is a function of the ratio of workers-to-population, the mandated work schedules, and the supervision in place. While policymakers determine the numbers of each cadre, work schedules and the supervisory system are generally detailed by the implementation units which translate program plans into orders and regulations. However, front line managers have a large say in how the supervisory system is effected within his/her area, and can emphasize standards for the quantity of work performed.

This paper focuses specifically on only one of these programmatic determinants of quality care--the mandated work schedules. The frequency and duration of contact with clients is a key element affecting both their style and the substance of the interaction; it is also one of the elements more amenable to change by implementors and managers. The opportunity to explore the relationship between the quantity of interaction with the quality of field-worker visits was presented to the MCH-FP Extension Project when the Government of Bangladesh desired to know the implications of adding more tasks to the duties the field-workers were already performing, at the same time that they planned to phase in hiring more workers.

Increasing the tasks of a particular worker immediately raises questions about the quality of the services presently being provided. For workers who interact directly with clients, their communication and social skills are as important as the appropriate level of technical knowledge and skills for the care being provided. An adequate amount of time with a client is needed to utilize any of these assets, to establish the rapport required to influence a client's health or family planning behavior and to communicate the technical information and provide the service. The time needed to deliver quality care has major implications for policies guiding the program, specifically the

worker-to-population ratio needed, and workers' schedules for their daily and monthly work.

A range of methodologies has informed this research. Longitudinal surveys of clients, interviews and observations of workers, and a review of documents, have been utilized to provide a micro-diagnosis of organizational factors. First, a diagnostic assessment contrasts the plans and regulations of the national program with the observed average home visit day and frequency of contacts with clients over a year's period. The quality of the care provided is estimated, judging the adequacy, appropriateness, and completeness of discussions held and services provided by field-workers, from field notes of observers and quantitative data from a longitudinal survey. Extrapolating from these data, we estimate the time needed by two hypothetical FWAs with different interaction styles to provide quality family planning care for women and basic maternal and child health care. We then examine the likely impact of increasing the number of workers on the FWA's ability to complete her rounds and provide quality care. This diagnosis of the FWA's work context provides feasible means of improving the quality of care provided by field workers--means that are amenable to change by high-level program managers. Research cited was carried out in the rural upazilas of Bangladesh where the MOHFP - ICDDR, B MCH/FP Extension Project is operating - Sirajganj of Sirajganj district, and Abhoynagar of Jessore district, and the comparison areas.

#### **BACKGROUND: THE PLAN GUIDING HOME VISITS**

In 1976, family planning activities were integrated into the Ministry of Health of the Government of Bangladesh, later to be titled the Ministry of Health and Family Planning. Services were extended to the household level through a newly-recruited female field-worker, the Family Welfare Assistant

(FWA). While originally recruited as a family planning worker, she has had maternal and child health (MCH) duties recently added to her job description. As described in a 1983 memo from the Ministry, her job is to visit the homes of all eligible women (married, menstruating women between the ages of 15 and 44 years) in her area to motivate them to accept family planning, to distribute oral pills/condoms/foam tablets, and to refer women for other family planning methods. Her MCH tasks include education and referral for antenatal/perinatal/postnatal care, distribution of ORS and education about its preparation from a packet and from local materials, referral for immunization, Vitamin A distribution, and some administrative duties.

Criteria for FWA recruitment include age (18-30 years), education (a secondary school certificate which is equivalent to 10 years of education) and location of residence. One FWA is selected from each ward to serve the people living in that ward. A ward is the lowest administrative subunit of the Government and has a present (1986) average population of 7500, typically distributed over 6-7 villages. As married women of reproductive age comprise approximately 18 percent of the rural Bangladeshi population, it is estimated that the FWA should serve an average of 1,335 eligible women within the mandated 3-month period for a round of household visits.

Supervising the FWA is the Family Planning Assistant (FPA), a male field supervisor recruited locally. The FPA works at union level (one union has 3 wards, approximately 20,000 population) and oversees the duties of three FWAs. He is to visit with each FWA at least once per week during her home visits, check her records, motivating techniques and educational messages provided to villagers, and ensure her contraceptive supplies. Once or twice a month, the FPA collects the FWA's records of numbers of contraceptives distributed to report to his supervisor, the Family Planning Officer (FPO) at upazila level.\* The FPO is administratively in charge of all family planning

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\*Approximately 8 unions make up an upazila

activities of the upazila; he sets the daily and monthly schedules for his workers, both FPAs and FWAs, following government guidelines. It is the task of the FPA to meet with the FWA each month to determine which houses she will cover during each home visit day. Knowing her daily schedule, the FPA can then meet her on any specific day to ensure her presence on the job and to supervise her performance.

When the FWA was first recruited in 1976, the average worker-to-population ratio was approximately 1:6000. With the growth in the population since then, it has been assumed that the FWA has continually reduced the amount of time spent with at least some of the women in her area in order to complete her three-monthly rounds, to meet her schedule for re-supply of contraceptives to acceptors, and to recruit new clients. However, to provide quality care requires time - not only an adequate amount of time during each home visit with a client, but also a frequency of visits that sustains the rapport between the worker and client. Education and motivation, two of the FWA's primary tasks both for family planning as well as for MCH, are client-specific and hence require time to develop an understanding with the client and assess her needs. It can be argued that the FWA has continually seen the same women for several years and hence time required per woman should have decreased over this period. However, as the FWA only meets each woman four times a year, if she keeps to her work schedule, and, as she maintains no records of her previous interactions with each woman, rapport must be reestablished and the woman's history retaken with each visit.

Two components of the FWA's schedule with important implications for the quantity of worker-client interactions are the official monthly and daily work routines. The monthly work routine includes the number of days per month scheduled for various tasks for the FWA; these include specific days set aside for home visits, satellite clinics, staff meetings, and days for

follow-up and referral of clients, primarily for clinical methods. The daily work routine for home visits includes a listing of all eligible women to be visited on that day; implicit in this is the time required by an FWA to travel to her work site, interact with all eligible women scheduled by her supervisor for that day, and return home.

If the FWA is to complete her round of 1,335 eligible women within the mandated 3 months, the average FWA must visit at least 32 women during each home visit day, and could spend from 11 to 14 minutes per woman. This calculation is based on the 14 days per month allotted for home visits by the Ministry of Health and Family Planning and a workday of 6 to 7.5 hours. Travel time, a major component of the FWA's daily schedule, is included in this 11 to 14 minutes per interaction so that actual time available for discussions with women is less.

It has been assumed by planners that these relatively short visits per woman four times a year are sufficient to develop the rapport needed to motivate a woman for family planning and/or to provide her with the other services listed in the FWA's job description. At least with regard to family planning, this assumption appears to be valid according to studies measuring the impact of FWA contacts in Bangladesh. It is known that contact with the FWA increases contraceptive prevalence by nearly 3.0 points per round if the prevalence is low (Phillips and Koblinsky, 1984). Also, for those women who are not acceptors, contact with a FWA is known to be a significant factor in contraceptive acceptance, especially of reversible methods (Phillips et al., 1985). Hence, the FWA is seen as the primary link between the nationally-sponsored family planning services and eligible rural women. Her success may be due in part to the fact that she is able to bring services to women in their homes, thus overcoming the hesitation, even strong unwillingness, rural Bangladeshi women feel in moving outside their compound or "bari".

In recognition of her importance in improving the contraceptive prevalence rate, the Bangladesh Government has stated in the Third Five Year Development Plan that 10,000 new FWAs will be recruited between 1986-1990 to join the present FWA work force of 13,500. This would bring the worker-to-population ratio to 1:4300 from its present 1:7500 level, if the population remained at its 1986 level of 102 million. Work rounds are anticipated to decrease to 2 months. However, by the time all new FWAs have been recruited in 1990-91, the average worker-to-population ratio may reach 1:4800, based on the projected population growth of the Bangladesh Bureau of Statistics. In the intervening years the 1:7500 ratio will decrease slowly. Hence, maximum use of the FWA's time must be ensured to meet the goals stated in the country's Third Five Year Plan to achieve a total fertility rate of 4.1 as well as to lower infant and maternal mortality rates.

#### METHODOLOGY

The paper is based on full-day observations of nine of the 35 FWAs working within the two rural upazilas involved in the MCH-FP Extension Project, and their 207 interactions with village women on the days observed. The FWA's daily work activities are examined in the context of the schedules and mandates set by her immediate supervisors and government officials in the MOHFP. Full-day observations were made to document each FWA's discussions and the services provided to rural women (e.g. contraceptives, ORS, Vitamin A distributed) as well as time spent in travel to and from the FWA's home to her work site, travel time between households ("baris"), and time spent with eligible women.

Four female paramedic workers, Lady Family Planning Visitors (LFPVs), were selected from ICDDR,B project staff to conduct the observations. They had been working in the project areas for at least 18 months and were considered part of the MOHFP working environment by the government staff, thus reducing

observer bias. In addition, the social status of the observers is close to that of the FWAs being observed. However, the LFPVs' level of technical expertise is more than sufficient to cover all aspects of tasks required in the FWA's job description. Whereas the FWA has seven weeks of basic training and may have several weeks of refresher training provided intermittently, LFPVs are certified only after 18-24 months of specialized training in MCH and family planning following 8 to 10 years of general education.

At least two different FWAs were observed by each observer for a full work day. Each observation began at the home of the FWA and continued throughout the day until the FWA returned home. Travel times and interactions were noted in the LFPV's notebook, including travel time to the work site and the return to the FWA's residence, travel time between "baris" (household compound), and the time spent visiting eligible women, including brief details about the visit itself--educational discussions held and/or services given. Immediately following the day-long observations, the LFPV filled out an Observation of Household Visit Form with much greater detail of the visits. This form for recording the observations was field-tested and developed with the LFPVs. Each completed observation form written in Bengali was translated by a female Operations Researcher working with the project, reviewed by a nurse-educator for completeness and clarity, and then discussed in detail with the appropriate LFPV to determine the accuracy of translations, details of "missed opportunities", and situations that may have affected the observations (Brechin and Baqee, 1986). Missed opportunities include services or discussion points which the FWA could have provided according to her job description that would have enhanced the quality of care provided. Estimations of the time necessary to complete these additional tasks were made based on project staff experience as counterparts to government workers (Brechin et al., 1986a). From these estimations, the total time needed to provide quality care was calculated for each worker-client interaction.

The project and government Medical Officers technically in charge of the family planning program in the upazila selected the FWAs to be observed based on considerations of geography and location of residence to work site. The FWAs observed are considered representative of those in their upazila.

While these observations are limited in that they only capture one day in a process that already has a history and the presence of an observer undoubtedly influences the FWA's work style towards providing her "best performance", they are supported by data drawn from surveys and focus group discussions. A longitudinal survey of a sample of eligible women in the Extension Project upazilas has documented government field-worker-client contacts every 90-days since April, 1984 (Mozumdar et al., 1985). Interviewers collect recall data on the number of field-worker visits that an eligible woman has received by worker gender, topic discussed, and services delivered in the 3-month period since the interviewer's previous visit. Analyses presented in this paper are based on the total sample of 6200 women and on a subsample of 3400 eligible women present during each of four consecutive interview rounds in 1984-1985 (Clark et al., 1986; Clark et al., 1987).

Focus group discussions to explore the patterns of work observed over time were held with ICDDR,B female community health workers (CHW) from the Matlab Family Planning Health Services Project who acted as counterparts to 18 FWAs in the Extension Project upazilas for a three-month period, as well as with ICDDR,B paramedics posted to the Extension Project upazilas.

Travel time from a FWA's residence to eligible women in her work area was confirmed by clocking the walking time from the home of each of 35 FWAs in the experimental upazilas to a central area of their work site, and adding the estimated walking time to each scheduled client's home in a given area from that central point. These data were averaged to calculate the median travel time needed for each FWA to reach her work site.

## FINDINGS

### 1. FWAs visit women briefly and infrequently.

While contact with FWAs has been shown to increase contraceptive prevalence, the time each FWA uses for interactions with women is less than assumed by planners (Table 1). Although the official work day of the FWA is stated to be 5-7.5 hours, only one of the nine FWAs was observed to work over six hours. The total time observed for a FWA's work day (including travel and interaction time) ranged from 3.5 to 6.3 hours with an average of nearly 5 hours. During focus group discussions, ICDDR,B staff posted to the Extension upazilas confirmed this finding, indicating that FWAs work up to five hours a day. Project staff acting as counterparts to FWAs stated a 2 to 4 hour work day (excluding residence to work site travel) was most common for FWAs. Generally, the FWAs start for work after completing familial chores, reach their work site around 10 to 11 a.m. and return home by 2 p.m.

Within the 5 hours available, however, over an hour on average is spent walking between the work site and the FWA's residence. Approximately 40 minutes is spent by each FWA travelling one way between her home and her work site. The 40 minute estimate is the median time for this travel one way in the cool dry season as calculated for 35 FWAs and 7500 eligible female clients in the Extension Project upazilas, meaning that half the FWA's client households take her less than 40 minutes to reach, while others were noted to take as long as 3 hours. As these data were collected under optimal weather conditions, it can be assumed that this travel time is greatly increased during the 4 months of the monsoon season.

Observations of the nine FWAs during a full day's work in the dry season confirm this finding. As shown in Table 1, the average round-trip travel time was 81 minutes or 40 minutes each way. The shortest amount of travel time between a worker's residence and her first scheduled home was about 30 minutes

while the longest observed was double that amount. As the bari are highly clustered in both observed upazilas, the between-bari travel time ranged from two to four minutes.

This leaves less than four hours to interact with the women scheduled for each day. By dividing the interaction time by the number of women visited, an average of 8 minutes was observed spent in discussions per woman. To save time, the FWAs were often observed engaging all women in the bari in a discussion together, providing only a few messages directly to individual women.

This 8 minute interaction time is actually longer than anticipated given the short work day, the long walking distances between the FWA's residence and work site, the 14 days available for home visits per month and the 3 monthly mandated rounds. Inserting these factors into the equation, we find that a FWA could cover her average 1335 eligible women only if she spends 5 minutes or less in discussions per woman. Hence it was not a surprise to find that FWAs economize further on the work time available by not visiting all women in their assigned areas. Using data from the longitudinal sample survey, a subgroup of nearly 3400 eligible women present during each of the quarterly visits of the interviewer over a year-long period (July, 1984 - June, 1985) was analyzed for frequency of female field-worker visits. (Clark et al., 1987) Results show that some FWAs decrease their workload by not visiting all women in their ward even once during a year, and most FWAs do not keep to their mandated schedule of one visit every 3 months. The pattern of visits varies widely, however, both among upazilas and unions, and over the seasons in a year in any one area. In one upazila, approximately 81 percent of the women recalled at least one visit of the female worker over the year, whereas in another, only 40 percent of the women said they had been visited during the year. The proportion of these women who stated that they had received the

scheduled four (or more) visits by a female worker over the year ranged from 5 percent in one upazila to 23 percent in another. Even in the upazila where most women had been visited once in the year, the FWAs could not keep to their work schedules: 69 percent of women recalled that they were visited less often than mandated -- 17 percent received only one visit in the year, 20 percent two visits and 22 percent three visits.

2. Few women receive a memorable discussion on health or family planning when visited, and even fewer receive any tangible services.

Among the women visited by the nine FWAs, Table 1 shows that nearly 40 percent received no direct discussion or services. Further analyses of the 207 worker-client interactions observed show that while nearly a quarter of the women were involved in a discussion of family planning, only one in ten received any discussion on health, and only two in ten received a service (either a contraceptive, ORS, or vitamin A)(Table 2). Specifically, thirteen percent of the observed visits resulted in a contraceptive being provided while only 5 percent received a combined health and family planning service (usually a contraceptive given along with health education or referral messages); no one received a health service only (e.g. ORS or vitamin A) (Koblinsky et al, 1987).

These observations imply a greater degree of tangible effort on the part of the FWA than is documented through the longitudinal survey of eligible women. Confirmed by the survey data, however, is the fact that more women report a visit than recall a health or family planning discussion or services. Almost half of all eligible women interviewed over a year period stated they had not had even one discussion about family planning in the year, while those recalling four or more such conversations ranged from less than 1 percent in one upazila to over 12 percent in another. Discussions on health

were even fewer - only 5 percent of all eligible women recalled having one or more such discussions in the year. Provision of contraceptives by the FWA were few - 8.3 percent of all eligible women interviewed reported one or more such visits in the year. However, the proportion of visits associated with a family planning service increases among those visited more frequently: while only 4.8 percent of those visited once received a service, 25 percent of those visited four or more times received a service. A higher frequency of visits is associated with provision of contraceptives.

These survey recall data are subject to memory bias and, by definition, some services which may result from FWA efforts but are not directly provided by them (e.g. IUD insertion, sterilization or tetanus toxoid immunization), may not be reported since they do not occur in the household. Also these results are limited to women who were "eligible" at the time of interview. Criteria for eligibility are far more strict for the survey than those used by the average FWA. Given the above, we must be cautious in extrapolating from these survey results, although the observations and the recall data generally agree.

3. The quality of the client-worker interactions could be improved.

The observed "best performance" of the FWAs demonstrates that even the family planning care provided is not comprehensive, and in some cases is inappropriate or incorrect. While education and motivation were delivered well in many cases, it was rare that a FWA would assess the woman's understanding of the educational discussion. Screening for method suitability for new family planning clients, assessment of family planning acceptors for side effects and satisfaction with their family planning method, and screening and assessment of antenatal and postnatal women were almost never done.

Examination of the observations of two FWAs (FWA 4 and FWA 8) representing opposite ends of the spectrum in terms of interaction time per woman visited reveal striking differences in worker interaction style and substance.

(See Annex 1 for detailed worker observations.) Both of these FWAs lived fairly close to their work sites. However, FWA 8 attempted to visit 29 women (one absent) during a 4-hour workday spending on average nearly 5 minutes per woman visited. FWA 4, on the other hand, visited 13 women (one absent) during a 3.9-hour workday, spending an average of 12 minutes per woman visited.

The type of care that each FWA provided was very different. FWA 8 covered her 29 women in 26 different bars. Of those whom she saw, she held no discussion nor gave any service to 12 (only checked them in her record book), gave information about family planning or motivated 10 women, and provided oral pills or condoms to 3 women; she gave MCH services or advice to 3 women.

FWA 4 visited 13 women in 13 bars. She was conscientious about talking to each woman, motivating 7 women for family planning and referring one for IUD insertion, re-supplying pills to 2 women, and managing or discussing side effects in 3 cases. She gave MCH advice in 4 cases and linked her work with her support system by referring one woman for paramedical care. Only one woman seen did not receive any service or discussion.

The difference in the types of messages provided by each FWA is noticeable, with FWA 4 providing more in-depth client-specific information than FWA 8 who disregarded over 40 percent of the women she saw that day. Of the 9 FWAs observed, 3 gave no service or discussion to 50 percent of the women, 4 to over 40 percent, and 7 of the 9 FWAs gave neither service nor discussion to 20 percent or more of the women. These observations show that FWAs are only covering some aspects of family planning care while leaving other areas untouched (e.g. counseling, follow-up); they provide little or no MCH care of any kind.

Longitudinal data support these observations. Using total numbers of visits instead of eligible women as the denominator, we find that between 30 to 52 percent of all visits during a year, depending on the upazila, resulted in no memorable health or family planning discussions. The vast majority of the female field-worker contacts (92 to 99 percent) included no advice or discussion about health and only 1 to 2 percent involved discussion of both health and family planning. (Clark et al, 1987) It cannot be assumed that when a visit has occurred, a meaningful dialogue or service has happened. This represents a significant lost opportunity for health and family planning education.

The National MCH Task Force of the Ministry has emphasized the need for the FWA to carry out tasks already assigned to her in her 1983 job description, but not necessarily performed at present. These include distribution and education about ORS packets for diarrheal management, referrals for the immunization program, and assistance with identifying and counselling pregnant and lactating mothers. Other MCH tasks such as nutrition education and children's health care are also in the FWA's job description and could be performed more regularly than observed.

If the present tasks of the FWA are broadened to address both the family planning plus maternal health needs of women as stated in the job description, then the content of the care she is to deliver could be envisioned to include the following components:

For the non-contracepting woman:

- discussion and assessment of the woman's reproductive health status since the worker's previous visit, including identification of and care or referral for antenatal, post-partal, and lactating women, and those suffering from infections of the reproductive tract,
- assessment of the client for her desire for suitable contraceptives,
- family planning motivation appropriate to the woman's status,

- screening to determine suitability and contraindications and
- distribution of or referral for contraceptives along with education about use, side effects, complications, and management or referral.

For the family planning acceptor:

- assessment of the woman's menstrual history and reproductive health, and management (or referral) if needed,
- identification, management or referral for possible side effects of complications, and assessment of client satisfaction with the family planning method, and
- resupply of the contraceptive (oral pills, condoms, foam).

Taken together these tasks address the reproductive health needs of women and imply a service that is of high quality as defined by its content. In determining the "quality" of the interactions of the FWAs observed and detailed in this paper, only the content of the messages and services are judged for appropriateness and adequacy. No time estimates have been made of the more subjective aspects of quality, such as rapport building. Hence the times proposed for quality of care can be viewed as the minimum needed.

The observations of the 9 FWAs are analyzed for the opportunities missed by the FWA for giving "quality" reproductive health care (as defined above) and some health care for infants and children as determined by the individual household needs. The time needed to accomplish these additional task is estimated as seen in the examples of FWAs 4 and 8 in Annex 1. Neither FWA 8 nor FWA 4 provided all of the above services for each woman, although FWA 4 met these criteria of quality care more often than did FWA 8. It is estimated that all nine FWAs observed would need to nearly double the interaction time to provide the content of care described as a quality service for the situations observed. Interactions would hypothetically range from 12 to 19 minutes per interaction, meaning an increase of 6 to 9 minutes over the observed interaction time.

Interestingly, the FWAs whose actual interaction times were low continue to have lower interaction times for quality care as well. This continued differential is created by their varying initial approaches (including their techniques in rapport building which is not quantified), and the differences in types of women seen on that day (pregnant, contracepting, non-contracepting and not motivated, and those not-contracepting, but motivated). It is obvious that the time required for the provision of quality care will vary among FWAs, depending on their individual styles.

It is important to note that ideal interaction times do not reflect the addition of all MCH tasks from the FWAs' job description. In the Annex tables, missed opportunities are noted only as they relate to the situation observed. For a woman who was amenorrheic for 2 months postpartum, "opportunities missed" include provision of postpartum advice, motivation for family planning, assessment of the infant's health and nutrition, and referral of the infant for the appropriate immunizations. If the FWA were to provide child health care for other children of the family, times would increase considerably. However, it is readily apparent that, for the FWA to give quality reproductive health and infant health care to the client and her newborn, she must at least double her present interaction time. To compensate for this increased time, the frequency with which a FWA could visit each woman would likely be decreased.

## DISCUSSION

### Implications of the FWAs' Home Visit Pattern on Visit Frequency

Presently, each FWA must cover an average of 1335 eligible women in a 3-month round. This means she would meet each women 4 times per year, a frequency shown above to be more likely to result in provision of

contraceptives than if the woman is visited less often in the year. However, estimates of months needed to complete rounds from the observational and quantitative data imply that the 3-month period mandated is too short even to provide good family planning care, let alone the MCH tasks of her job description. In order to estimate the probable completion of a work round for FWAs (the number of months needed to visit all eligible women in her ward) providing services as they do presently, we build upon the information of time spent working per day, plus that used in daily travel and interactions as observed and confirmed by survey data. Using hypothetical FWAs with different interaction styles and numbers of eligible couples to serve, we then make calculations of the time it is likely to take a FWA to complete one work round. These estimates incorporate the observed FWA work day of nearly 5 hours, an average 80 minute round trip travel time and a one-minute travel time between women.

Estimates of the average number of FWA interactions per day are based on the observations (see Table 3). The short time FWA X spends per woman (5 minutes) represents a brief interaction with essentially no dialogue and only messages directed at family planning usage (similar to FWA 8), while the longer time of FWA Y (12 minutes) represents more dialogue about method use and side effects with some MCH advice (as with FWA 4).

As daily total work time varies among FWAs and within an individual FWA's monthly work routine, we have taken two examples, a short work day of 3.5 hours and a longer day of 6.3 hours. As FWAs probably spend some short days and some long work days during a month, the average of interaction time multiplied by daily work hours gives the average daily number of interactions by worker type for the month. FWA X who spends little time with her acceptors or prospective clients could average up to 37 interactions per day, while FWA Y may see an average of only 17 in her attempt to engage each woman in a

discussion of her status, rather than just give a mechanical message.

Given the scheduled 14 days for home visits per month, our hypothetical FWA X with her brief interactions per client would be able to cover over 500 clients per month and her average 1335 eligible women within the mandated 3 months. However, FWA Y, with her longer dialogue with each client could only complete her work round with the same number of couples in nearly 6 months time. Attempting to improve the quality of services provided would certainly lengthen this round completion time, and hence the frequency with which she visits each women.

One strategy to offset this would be to increase the number of home visit days per month. Analysis of the monthly work schedule reveals some latitude to increase the monthly home visit days by a further 5 days. While the work week is 6 days, the Government has stated that only 14 days of the FWA's monthly work routine (based on a 30-day month) is to be spent on home visits and the remainder on other tasks. Observations found that the FWAs spend at least the 14 days, and sometimes one or two days more, going house-to-house to motivate for family planning, while other duties (e.g. satellite clinics, union-level meetings of workers and supervisors, and follow-up care) are not being performed as scheduled, primarily because no system is in place to support these activities.

As shown in table 5, one of the FWA's mandated tasks is to spend one day per week on contraceptive follow-up and referral for clinical methods. Although the FWA has a target of two clients each per month for sterilization and for IUDs, the average number of clients for 11 FWAs drawn from two Project upazilas over a 17-month period (July, 1983 - November, 1984) was 1.4 IUD referrals/month and nearly one sterilization/month. As the FWA usually accompanies the client to the clinic or upazila health complex for a clinical method, three days per month have been subtracted for these tasks from a 30-day month in the potential work routine in Table 5. This may underestimate

what is needed since a sterilization referral may require up to 2 days for the FWA to accompany the client to and from the hospital.

While the mandated work routine stipulates only 4 days per month for holidays (weekend days), absenteeism among field-workers appeared to be very high in the Extension Project upazilas. This has been mentioned often as a major problem and obstacle to success in many government health and family programs (Simmons, et al., 1986). Upon closer examination, however, it was discovered that several leave options are officially available to workers. Beyond the 4 weekend days and approximately 2 official holidays per month (the latter are not recognized in the mandated work schedule), there is annual leave which is accumulated at the rate of 33 work days per year (if over 3 years of employment), emergency/casual leave of 20 days/year (not cumulative), and medical/maternity leave of 90 days. Emergency leave does not have to be applied for in advance. A survey of 27 FWAs in the Extension Project upazilas showed that FWAs take emergency leave at least once a year and many had taken it three times or more, with four or more days taken at a time. This is done in lieu of using annual leave which can be accumulated towards early retirement. Unfortunately, emergency leave does not allow for supervisors to plan for coverage of scheduled clients, nor are clients missed usually covered by the FWA upon her return from leave. The potential work routine sets aside three days (beyond the 4 weekend days) for holidays and emergency leave.

One day per month is mandated and used for picking up salaries and supplies at the upazila headquarters. Although union-level meetings also appear in the mandated work routine, they were not observed by the workers.

By using the field experience of the Extension Project to build a picture of the Government's family planning program in the "normal upazila," we find that the average FWA could have 19 days per month available for domiciliary visits, not 14 as in the mandated work routine. Building upon the varying

possible numbers of daily interactions shown in Table 3, Table 4 presents the monthly coverage and round completion time using the potential monthly work routine. Monthly coverage may vary from about 320 interactions to slightly over 700, depending on the style the FWA adopts in her interactions.

The number of months needed to complete a worker's round can be calculated by taking into account these data and the ward's eligible couple density. While the work area of a FWA contains an average 1335 eligible couples, eligible couple densities in the Extension areas vary from 125 per ward to a little over 2000 per ward. Three densities have been selected in Table 4, giving the range over which most Extension area wards cluster. It can be seen that if a FWA provides only the most basic family planning messages within 5 minutes per eligible woman, and works 19 days a month, she can cover her round in just over 2 months, even if it has a high population density. However, if the same FWA were to follow the mandated work routine of 14 home visit days per month, it may take her 3 months to cover all the eligible women in her ward if it is very densely populated. The FWA who attempts to hold a dialogue about family planning methods with her acceptors or prospective clients and gives some basic MCH care (FWA Y) could only complete her round in 3 months if it is a ward with a small population. She could spend up to almost 7 months if the number of eligible couples is high and only 14 days per month are used for domiciliary visits.

#### Implications of Increased FWA Density on the Present Field Situation

During the Third Five Year Development Plan, 10,000 FWAs will be hired nearly doubling the present work force. It is anticipated that this increase will make a 2-month work round feasible for FWAs. It is assumed that this increase in the frequency of contact with village women will increase contraceptive prevalence. This section examines whether the time estimates

are feasible, basing the calculations on the two hypothetical FWAs presented above.

By increasing the FWA density, both travel time from home to work site and the number of eligible women to be served per FWA will be decreased. The recruitment policy for the new FWAs changes the criteria for selection of the FWA from an areal basis to population size (i.e., from a ward to a population of 4000). The plan is to demarcate that population closest to the present FWA's home and recruit new FWAs for the more remote or difficult-to-reach parts of the ward. We estimate that this will cut FWA travel time by a factor of two, at best, such that the average work site may be 20 minutes of walking time each way.

If the FWA continues to work approximately a 5-hour work day but has decreased round-trip travel time, then the number of interactions that an FWA can complete per day will increase by nearly 25 percent. FWA X could cover 46 interactions per day, and FWA Y, 21 interactions per day.

Analysis of the effect of increased FWA density on round completion time shows that FWA X could complete her rounds in approximately two months, even with a population of 6000 to cover and only making home visits 14 days per month. FWA Y, on the other hand, could only complete her round in less than two months if she could make home visits 19 days per month with only a population of 4000 to cover. It could take her more than 3-1/2 months to cover a population of 6000, making home visits 14 days per month.

Because the worker-to-population ratio will not reach 1:4000 even when all new FWAs are recruited, the more likely scenario, a population to service of 5000 to 6000, will continue to mean rounds of 2 to 4 months at least. However, it is anticipated that, as the population to be served resides closer to the FWA's home, she will be more inclined to visit them. The percentage of women not visited is expected to decline and the number of women receiving at

least 4 visits per year to increase. Should the quality of the services be improved, however, lengthier round times, meaning a decreased frequency of visits with women, are likely.

### CONCLUSION

Providing quality reproductive health care to each eligible woman requires time, not only during the interaction, but also, it is assumed, a frequency of contact that allows a continuous rapport between the worker and the woman. At present, only brief, fairly mechanistic interactions between most FWAs and the eligible women in their area are possible if FWAs are to complete their round within the 3-month period mandated by Government. The FWAs compensate for the pressure of their workload by not visiting all women in their area, by visiting even fewer during the monsoon, and by not holding a memorable dialogue about family planning or health with some of the women they do visit.

The monthly work routine is a management tool that could be manipulated within the Ministry's plans. By increasing the days available per month for home visits, the FWAs could increase the time spent in discussions with each woman without decreasing their frequency of contact. As frequency of contact appears associated with increased contraceptive provision, the solution is not to diminish the frequency, but to increase the time available during each interaction. We believe that the decision to increase home visit days per month would improve the possibility for field-workers to provide quality care, and ultimately to increase contraceptive prevalence.

Other strategies to improve the quality of care provided by field-workers may be operationally far more complicated and expensive. For example, the field-workers and their supervisors could be retrained such that a higher proportion of the visits would result in a tangible and memorable interaction with the client. It should be noted that all the FWAs observed had been

retrained the previous year in a special four week course sponsored by the Extension Project. Retraining alone without concomitant improvements in the supervisory and technical support system does not appear to improve the quality of services. Another strategy to improve quality is being implemented -- increasing the density of workers. While this strategy should increase the frequency and duration of contact with clients, it could be further enhanced by increasing the monthly home visit days available.

In public sector health and family planning programs, diagnostic techniques are much needed to assist program managers, policy officials, and planners to readjust the limited available resources to improve program performance. Dissecting the field worker's job description into tasks and observing how these tasks are carried out, provide useful information to government officials to understand the disjuncture between program plans and program performance. Such research provides officials with feedback on the constraints to performance, as well as the opportunities for improvement. This study has determined an option within the span of control of the program managers that is not likely to impinge on other segments of the present program.

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Figure 1

Determinants of Quality Care

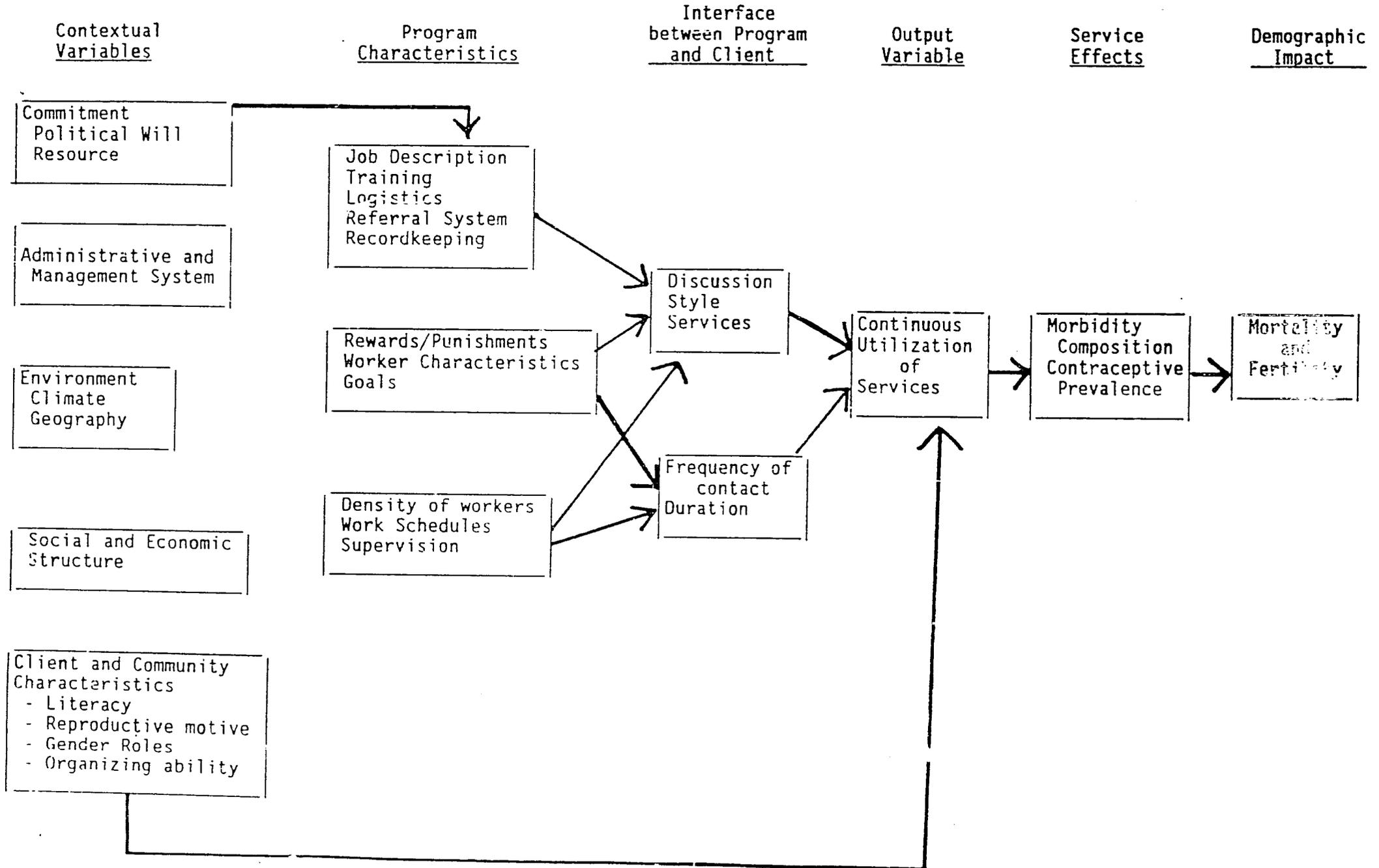


TABLE 1: SUMMARY OF OBSERVED FWA DAILY ACTIVITIES, 1986

F W A	Total time (travel & work) [min.][hr.]	Round- trip travel time (a)	Avg. between- bari travel time(b)	Total Time spent on interactions [min.][hr.](c)	No. of women sched. (d)	No. of women visited (e)	No. of women absent (f)	Avg. length inter- action (f)	% Women receiving no disc. or serv.(g)
	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
1	277 4.6	100	4.3	140 2.3	17	17	2	8	20
2	378 5.3	75	4.1	257 4.3	26	26	2	10	21
3	358 5.6	110	2.1	207 3.5	37	37	4	6	55
4	237 3.9	52	2.1	150 2.5	9	13	1	12	8
5	215 3.5	95	2.4	98 1.6	6	11	1	9	30
6	299 4.9	60	1.9	180 3	26	33	2	6	52
7	332 5.5	120	3.4	167 2.5	21	21	0	8	5
8	244 4.0	55	2.1	137 1.6	34	29	1	5	43
9	260 4.3	55	1.9	178 3	36	34	1	5	52
AVG	288 4.8 min. hrs.	81.3 min.	2.7 min.	168 2.8 min. hrs.	24	25	--	8 min.	37 AVG. %

- (a) Time required for FWA to walk from home to first client's house and to return home from the last client's house.
- (b) Average of time required for FWA to walk from one bari to the next beginning with the first bari visited.
- (c) Interaction time is a lump sum of all time spent by the worker from arrival at the household or compound to her departure time. Documentation of the duration of each particular activity within an interaction was not possible since education was often given in the context of a larger discussion and usually happened with more than one woman interacting with the worker at the same time.
- (d) Figures obtained from supervisor's copy of FWA monthly program.
- (e) Total number of women visited includes those women seen plus those women absent as time is required for FWAs to attempt to locate missing women and to record their absenteeism in their reporting books.
- (f) The denominator includes women absent since work time was also required to trace them (Column 4 divided by column 6).
- (g) Percentages include only women actually seen (column 6 - column 7).

TABLE 2: DISCUSSIONS AND SERVICES<sup>a</sup> PROVIDED BY FWAs OBSERVED

	Total no. women seen	#Women rcving Health discus- sion	#Women rcving FP discus- sion	#Women rcving H&FP discus- sion	#Women rcving FP ser- vice	#Women rcving H&FP ser- vice	Routine docu- menta- tion only	#Women rcving no disc or service
FWA 1	15	0	0	5	6	1	0	3
FWA 2	24	3	8	0	8	0	0	5
FWA 3	33	1	6	1	6	1	0	18
FWA 4	12	1	7	1	0	2	0	1
FWA 5	10	5	1	1	0	0	0	3
FWA 6	31	7	3	2	2	1	0	16
FWA 7	21	1	5	10	0	4	0	1
FWA 8	28	2	10	1	3	0	0	12
FWA 9	33	3	7	2	1	1	2	17
TOT.	207	23	47	23	26	10	2	76
%	100%	11%	23%	11%	13%	5%	1%	37%

<sup>a</sup>"Service" means a contraceptive (i.e. pill, condom), ORS, or Vitamin A was given to the woman.

Note: No woman received a health service.

TABLE 3

DAILY WORK ROUTINE FOR FWAs; NUMBER OF INTERACTIONS PER DAY  
with time of interaction and total workday varying.

	<u>Total Workday</u>		<u>Average no.</u> <u>Interactions</u> <u>per Workday</u>
FWA (Interaction Time)	3.5 hrs	6.3 hrs	5 hrs
FWA X (5 min/woman)	22	50	37
FWA Y (12 min/woman)	10	23	17

**TABLE 4**  
**MONTHLY COVERAGE AND ROUND COMPLETIONS TIME**  
Varying interaction time, household visits per month  
and ward density

<u>HOUSEHOLD VISITATION</u>	<u>MONTHLY COVERAGE</u> (No. of eligible Couples)	
	<u>FWA X</u> (5 min/int) <u>*Avg 37 int/day</u>	<u>FWA Y</u> (12 min/int) <u>*Avg 17 int/day</u>
<u>MONTHLY ROUTINE</u>		
Mandated work routine (14 days/month)	518	238
Potential work routine (19 days/month)	703	323
 <u>WARD DENSITY</u>	 <u>ROUND COMPLETION TIME</u> (No. of months)	
712 Eligible Couples (pop 4000)		
14 days/month	1.4	3.0
19 days/month	1.0	2.2
1335 Eligible Couples (pop 7500)		
14 days/month	2.6	5.6
19 days/month	1.9	4.1
1602 Eligible Couples (pop 9000)		
14 days/month	3.1	6.7
19 days/month	2.3	5.0

\* Based on Table 3

TABLE 5  
COMPARISON OF PRESENT, AND POTENTIAL  
MONTHLY WORK ROUTINES FOR FWAs

<u>Present Official Work Routine (MOHFP)</u>	<u>Days (No.)</u>
Home visits (FP/ORT/Pregnancies and high-risk cases)	14
Immunization	3
Sterilization/IUD referrals	4
IUD referrals	1
Satellite Clinic	1
Union level meetings	2
Upazila level meetings	1
Weekend	4
<u>Potential Work Routine</u> (Based on Extension Project experience as possible for most upazilas)	
Home visits	19
FP referrals/follow up	3
Staff meeting (salaries/supplies)	1
Weekend	4
Holidays and emergency leave	3

Note: All calculations are based on a 30 day-month.

ANNEX 1  
ABBREVIATIONS LIST

hx	=	history
nutr.	=	nutrition
imm.	=	immunization
re	=	about
OCP	=	Oral Contraceptive Pills
w/	=	with
abt.	=	about
menstr.	=	menstrual
y.o.	=	year old
mo.	=	month
incl.	=	including
bstfdg.	=	breast feeding
RKB	=	Record-Keeping Book
inad.	=	inadequate
F.U.	=	follow-up

FMA 4																		
Bari	Travel	Work Time	#	FP Method	M/F	Complaint from client	Advice/Discussion by FMA	Observations/opportunities missed by FMA	Add. Time	Subtotal	Full Tot.							
A	25 min.	12 min.	1	PPA x 18 mos.	1/2	PPA x 18 mos.	General FP motivation	a) Educ. abt. possib. of pregnancy despite PPA b) Refer to FWV for work-up of PPA to rule out pregnancy c) Assess health of 18 mo.-old child d) Refer for appropriate immunizations	3 min. 3 min. 3 min. 2 min.	11 min.	48 min.							
B	1 min.	5 min.	2	PPA x 2 mos.	1/1	PPA x 2 mos.	a) Copper T motiv. b) Condom motiv.	a) Assess woman's status at first postpartum visit b) Educ. woman abt. possib. of pregnancy despite PPA c) Motivate for FP, according to breastfeeding status d) Assess health of 2-mo. old child e) Motivate mother to take baby for immunization and educ. on other appropriate topics	5 min. 3 min. 3 min. 2 min. 2 min.	15 min.	21 min.							
C	1 min.	5 min.	1	None	0/1	Wants a child	General FP motivation	a) Assess woman's health incl. menstr. hx. and desire for FP b) Determine age of child for child-spacing motiv. c) Educ/referral for nutr./immuniz. as appropriate	3 min. 1 min. 3 min.	8 min.	14 min.							
D	2 min.	10 min.	4	None	3/2	General weakness (newborn died 2 wks ago)	General FP motivation	a) Assess woman's status at first postpartum visit b) Postnatal FP motiv., to allow mother time to recover before another pregnancy	5 min. 3 min.	8 min.	20 min.							
E	7 min.	6 min.	5	PPA x 6 mos.	3/1	Wants injectable	Copper T and condom motiva (Child fully postfdg.)	a) Screen and assess for suitable FP methods(s) b) If suitable for inj., teach abt. admin./side effects c) Refer to FWV for injectable administration d) Assess health of child e) Weaning food educ.	5 min. 3 min. 2 min. 2 min. 2 min.	14 min.	27 min.							
F	1 min.	15 min.	6	None	3/6	Wants injectable	a) Copper T motiv. b) Tubectomy motiv. c) Nutrition educ. d) Menstr. irreg. advice	a) Screen and assess for suitable FP methods(s) b) If suitable for inj., teach abt. admin./side effects c) Refer to FWV for injectable administration	5 min. 3 min. 3 min. 2 min.	10 min.	26 min.							
G	2 min.	5 min.	7	None	1/0	None	None	a) Assess woman's health incl. menstr.hx/desire for FP b) Determine age of child for future FP use c) FP motivation as appropriate d) Educ./referral for nutr./immuniz. for child as bec.	3 min. 2 min. 3 min. 2 min.	10 min.	17 min.							
H	1 min.	15 min.	8	Tubectomy x 1 yr.	1/2	General weakness	Nutrition educ.	a) Assess woman's health incl. menstrual hx. b) Refer to FWV	3 min. 2 min.	5 min.	21 min.							
I	2 min.	5 min.	9	ABSENT	?	---	---	---			7 min.							
J	4 min.	15 min.	10	None	0/3	Wants Copper T	Adv. wait for next menstrual to go w/FMA to FWV	a) Screen and assess for suitable FP methods(s) b) If suitable for IUD, teach abt. admin./side effects	5 min. 3 min.	8 min.	23 min.							
K	1 min.	12 min.	11	PPA x 6 mos.	2/2	Inj. after "Ramazan"	Copper T motiv.	a) Assess woman's health incl. desire for FP b) Educ. abt. possib. of pregnancy despite PPA c) Do New User FP Screening Suitability Checklist d) If suitable for inj., teach abt. admin./side effects e) Refer to FWV for injectable administration	3 min. 3 min. 5 min. 3 min. 2 min.	16 min.	29 min.							



FWA 8

Bar#	Travel	Work	Time	#	FP Method	M/F	Complaint from client	Advice/Discussion by FWA	Observations/opportunities missed by FWA	Add. Time	Subtotal	Pull Tot.
A	10 min.	10 min.		1	None	2/3	None	a) Oral Pill Motivation b) Ligation motivation	a) Assess woman's health incl. menstr. hx. and desire for FP b) Screen and assess for suitable FP method(s) c) Educ. on where to obtain suitable methods	3 min. 5 min. 3 min.	11 min.	51 min.
B	2 min.	5 min.		2	Other FP Methods x 3 years	1/2	None	None	a) Assess health incl. menstr. hx./desire for modern FP method b) Assess health of child c) Educ./referral for nutr./immuniz. for child as nec.	3 min. 3 min. 2 min.	8 min.	15 min.
C	1 min.	5 min.		3	None	4/1	None	FP Motivation	a) Assess health incl. menstr. hx./desire for modern FP method b) Assess health of child c) Educ./referral for nutr./immuniz. for child as nec.	3 min. 3 min. 2 min.	8 min.	14 min.
D	1 min.	5 min.		4	None	1/0	None	a) EPI referral b) Breastfeeding educ.	a) Assess woman's health incl. menstr. hx./desire for FP b) Determine age of child for future FP use c) FP Motivation as appropriate. assess to breast status d) Educ./referral for nutr./immuniz. for child as nec.	3 min. 2 min. 3 min. 2 min.	10 min.	16 min.
E	1 min.	10 min.		5	None	2/2	None	None	a) Assess woman's health incl. menstr. hx./desire for FP b) Determine age of youngest child for future FP use c) FP Motivation as appropriate d) Educ./referral for nutr./immuniz. for child as nec.	3 min. 2 min. 3 min. 2 min.	10 min.	21 min.
F	1 min.	5 min.		6	None	2/6	None	FP Motivation	a) Assess health incl. menstr. hx./desire for modern FP method b) Assess health of child c) Educ./referral for nutr./immuniz. for child as nec.	3 min. 3 min. 2 min.	8 min.	14 min.
G	2 min.	3 min.		7	None	2/4	None	Condoms supplied	a) Assess health incl. menstr. hx./desire for modern FP method b) Assess health of child c) Educ./referral for nutr./immuniz. for child as nec.	3 min. 3 min. 2 min.	8 min.	14 min.
		2 min.		8	OCPs x 5 mos.	0	None	None	a) Assess for probs/side effects/satisfaction w/FP method b) Resupply of OCPs	5 min. 3 min.	8 min.	
		3 min.		9	OCPs x 7 yrs.	1/1	None	Gave 3 months supply of OCPs	a) Assess for probs/side effects/satisfaction w/FP method b) Motivate for tubectomy due to length of time on oral pill	5 min. 3 min.	8 min.	
		2 min.		10	OCPs x 1 yr.	0/1	None	None	a) Assess for probs/side effects/satisfaction w/FP method b) Resupply of OCPs	5 min. 3 min.	8 min.	44 min.
H	2 min.	3 min.		11	ABSENT	?	---	---	---			
I	2 min.	5 min.		12	OCPs x 5 yrs.	2/4	None	Motiv. for other FP method due to length of time on OCPs	a) Assess for probs/side effects/satisfaction w/FP method b) Resupply of OCPs	5 min. 3 min.	8 min.	15 min.
J	2 min.	5 min.		13	None	3/3	None	DRPA motiv. for next period (FWA can give DRPA as she lives nearby)	a) Assess health incl. menstr. hx./desire for FP b) Screen for contraindications and assess woman to determine her suitability for injectables	3 min. 5 min.	8 min.	15 min.

Best Available Document

FWA #	Date	Travel	Work	Time	#	FP Method	R/F	Complaint from client	Advice/Discussion by FWA	Observations/opportunities missed by FWA	Add. Time	Subtotal	Full Tot.
K		2 min.	5 min.	14		OCPs x 4 mos.	1/2	None	None	a) Assess for pros/side effects/satisfaction w/FP method b) Resupply of OCPs	5 min.		
L		1 min.	5 min.	15		Condom x 2 years	0	None	Condoms supplied	Assess health (incl. menstr. hx./desire for a child)	3 min.	8 min.	15 min.
M		1 min.	5 min.	16		Pregnant x 7-8 mos.	1/2	None	Referral to URC for TT immuniz.	a) Screen and assess antenatal condition b) Educ. abt. safe delivery, nutrition, future FP, birthpl. as appropriate	5 min.		
N		1 min.	5 min.	17		Vasectomy x 3 yrs.	1/0	None	None	a) Assess woman's health (incl. menstr. hx.) b) Assess health needs of child	3 min.	10 min.	15 min.
O		2 min.	5 min.	18		None	0	None	None	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Refer for TT vaccination because eligible woman now	3 min.	6 min.	12 min.
P		1 min.	3 min.	19		Pregnant (estm. 7 mos.)	1/2	None	a) Referral to URC for TT immuniz. b) Tried to find out LMP	a) Screen and assess antenatal condition b) Educ. abt. safe delivery, nutrition, future FP, birthpl. as appropriate c) Refer to TEA/FW for delivery	3 min.	5 min.	12 min.
Q		1 min.	2 min.	20		None	2/0	None	FP motivation	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Assess health of children c) Educ./referral for nutr./immuniz. for child as nec.	5 min.	13 min.	19 min.
R		3 min.	2 min.	21		None	1/3	None	FP motivation	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Assess health of youngest child c) Educ./referral for nutr./immuniz. for child as nec.	3 min.	3 min.	11 min.
S		1 min.	2 min.	22		None	0	None	None	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Refer for TT vaccination because eligible woman now	3 min.	3 min.	18 min.
T		1 min.	3 min.	23		None	1/3	None	None	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Assess health of youngest child c) Educ./referral for nutr./immuniz. for child as nec.	3 min.	5 min.	8 min.
U		10 min.	1 min.	24		OCPs x 2 yrs.	2/1	None	None	a) Assess for pros/side effects/satisfaction w/FP method b) Resupply of OCPs	3 min.	8 min.	12 min.
V		1 min.	2 min.	25		None	2/4	None	FP motivation	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Assess health of youngest child c) Educ./referral for nutr./immuniz. for child as nec.	5 min.	3 min.	19 min.
W		3 min.	5 min.	25		None	2/3	None	FP motivation	a) Assess woman's health (incl. menstr. hx. and desire for FP) b) Assess health of youngest child c) Educ./referral for nutr./immuniz. for child as nec.	3 min.	3 min.	11 min.
											2 min.	8 min.	15 min.

18

10

FWA 8

Bar#	Travel	Work Time	#	FP Method	M/F	Complaint from client	Advice/Discussion by FWA	Observations/opportunities missed by FWA	Add. Time	Subtotal	Full Tot.
X	1 min.	25 min.	27	Pregnant (estim. 8 mos.)	1/3	Weakness	None	a) Screen and assess internal condition b) Assessment of weakness c) Educ. on safe delivery, immuniz., nutrition, future FP, fluids, as appropriate for length of pregnancy	5 min. 3 min.		
Y	1 min.	2 min.	23	None	1/0	Amenorrhea - "I think I'm pregnant & I don't want it"	URC referral for MR	b) Screen and assess for suitable FP methods; c) FP motivation for suitable methods after MR d) Do Antenatal Monitoring Checklist to determine risk.	5 min. 3 min. 5 min.	12 min.	38 min.
Z	1 min.	2 min.	29	None	0	None	None	a) Assesses woman's health inc. menstr., and desire for FP b) General health education	3 min. 2 min.	5 min.	8 min.

To Home 25 min.

Sub Tot. 107 min. 137 min.  
1.23 hrs.

Real Tot. = 244 min. Real work time/woman seen = 4.72 min.  
= 4.0 hrs.

Ideal grand total: 475 min. = 7.91 hrs.

Ideal work total: 368 min. = 6.13 hrs.

Ideal work time/woman seen: 12.6 min./woman