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**PRACTICES AND PROBLEMS OF  
FEMALE HEALTH/MEDICAL TECHNICIANS IN NWFP**

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# Table of Contents

Executive Summary . . . . .	i
Background and purpose . . . . .	1
Objectives of the study . . . . .	4
Methods . . . . .	5
Findings . . . . .	10
Percentage of FMTs/FHTs in service	
Reasons for leaving or not joining the service	
Appraisal of the practices of FHTs/FMTs	
Interview findings on other practices of FHTs/FMTs	
Interview findings on problems hindering practices	
Medical officers perceptions about FHTs/FMTs Practices	
Percentage of client interaction with the FHTs/FMTs	
Inferences of the study team	
Suggestions and recommendations . . . . .	36
Acknowledgements . . . . .	40
Appendices	
Appendix I - Observations checklist of FHT/FMT practices	
Appendix II - MO interview guideline	
Appendix III - Patient attendance from registers	
Appendix IV - FHT/FMT interview guideline	
Appendix V - Home visit guideline	

## EXECUTIVE SUMMARY

Medical Technicians (MTs) were introduced in the health system in 1977 to provide basic medical services at the Basic Health Units (BHUs) and Rural Health Centers (RHCs). With the policy of placement of doctors at the BHUs in early eighties, the role and nomenclature of MTs was redefined to that of Health Technician (HT) with emphasis on preventive activities.

A new curriculum of 18-month duration was designed and thirteen HT schools were constructed throughout the country with the assistance of USAID, out of which three were established in NWFP in 1989. The first class began the studies with the new curriculum in 1986 in the old MT school at Peshawar. Two classes have received training in each of the new HT Schools at Peshawar, Abbottabad and D.I. Khan with an emphasis on practical experience.

Further, to orient the inservice MTs with their new role, six-days workshops were held to introduce them to the newer concept of their changed role and practices.

The objective of this study is to estimate the percentage of graduated female MTs and HTs in service, understand the reasons for not joining or leaving the service, appraise their practices in comparison to the expected performance, identify and report academic and operational problems, and recommend measures to

resolve problems and improve performance.

The study was carried out by collecting information about female technicians from various government departments and DHO offices. The appraisal of practices and identification of problems was done at health centers and homes.

Thirty health centers were selected through two stage random sampling from 802 BHUs and RHCs in the NWFP. The technicians, however, were found at only two of the sampled sites. Therefore the teams visited other centers in the sampled districts in search of the FHT/FMT. During the study period, 53 centers were visited and the female technicians were found in 17 places; 4 in Charsadda, 4 in Mardan, 4 in Karak, 4 in Bannu, 1 in Kohat and none in Kohistan and Orakzai Agency.

At these centers, the practices of female technicians were observed for periods ranging from 1 hour to 3 1/2 hours, medical officers were interviewed, and home visits were made with the technicians.

The overall study findings show that 400 female technicians have graduated since the inception of the technician program and 66% (265) are in service. It could not be identified which 135 females are not in service. Twenty five HTs who had not joined the service and were known to the study team were requested to respond to a questionnaire. Only 12 responded, out of which 4 mentioned that

they have not yet been given appointment letters inspite of their consistent effort to join the service.

It was anticipated to observe 250 interactions of technicians with the clients at 30 centers, but only 20 interactions (4 with children <5, 2 with pregnant women, 12 with CBA women and 2 with women over 45) were observed. Eight visits were made to the homes with those technicians who claimed to be performing regular home visits. The performances of these technicians at the center and at homes was much below the expected level.

The major problems identified by the study are:

1. Supervisors and the health center staff are unaware of the job description of female technicians and therefore they are neither well respected nor assigned responsible tasks which they are trained to perform.
2. LHVs are restricting them from interacting with patients and make them work as their assistants. Technicians are seen as a threat to their private practice.
3. Community-based activities and community participation is not being initiated by the technicians for several reasons.
4. Supervision is non existent.
5. Performance of the technicians is not up to the expectations, probably due to lack of hands-on practice during training and on the job.

Recommendations are as follows:

1. Various cadres of female paramedics with almost similar responsibilities such as LHV, FHT, FMT be abolished and merged into a single category.
2. If this change is unacceptable then immediate measures must be taken to inform the DHOs and the health staff of the centers about the job description and duties of the female technicians.
3. There is need for strengthening hands-on practices during the training in the school and on-the-job.
4. Adequate technical and managerial supervision at regular intervals must be ensured.
5. Incentives such as travel allowance for field workers and rural allowance should be provided.
6. DHOs should encourage the staff of the centers to initiate community participation.
7. Reassess whether or not it is possible for the female paramedics to work on outreach activities or not.

## I. BACKGROUND AND PURPOSE

In 1977, the Ministry of Health introduced a new cadre of mid-level health workers called Medical Technicians. Their job description was to provide emergency aid and basic medical services at Basic Health Units (BHUs) and Rural Health Centers (RHCs). With the induction of several hundred doctors in government service, and the policy of their placement in Basic Health Units (BHUs) in the early eighties, the role and nomenclature of Medical Technicians was redefined to that of Health Technician (HT). They were assigned duties with emphasis on preventive activities instead of working as doctor's substitute.

Thirteen HT training schools have been constructed throughout the country with the assistance of USAID to provide training to HT's. The Health Technician course runs for eighteen months and provides theoretical knowledge and practical experience in community health aspects and clinical training for management of maternal and child health, and a few other diseases related to primary health care. The schools are located at Abbottabad, Peshawar, D.I. Khan, Sialkot, Jhang, D.G. Khan, Bahawalpur, Attock, Quetta, Khuzdar, Mirpurkhas, Sukkur and Hyderabad. Each school is required to admit 25 females and 25 males for each course, with the exception of schools at Peshawar, Abbottabad, D.I. Khan and Khuzdar which admit 50 females and no males.

In NWFP, the first class began the studies with the new curriculum in 1986 in the old premises of the medical technicians school at Peshawar. This class was trained with two staff members and had very limited field experience. The three new schools started functioning in 1989 and since then two batches have graduated from each school. The graduates of the new HT Schools have received training according to the prescribed curriculum.

In addition, six-days workshops were held for in-service medical technicians to introduce them to the newer concept of their role and the expected change in their practices. Training ranging from 3-6 days on EPI, family planning, World Food Program, and Control of Diarrhoeal Diseases has also been provided. They are considered equivalent to health technicians in the health department and are expected to perform in the same way.

Since the inception of the new curriculum, a special effort is being made to recruit female students in the schools as 70% of Pakistan's population are women and children, and women prefer to seek help from female health workers. It was decided to assess the practices of female HT's and MT's as their desired performance can bring a significant positive change in the health status of females and children and to recommend measures to improve their performance and effectiveness. Even though the HT's and MT's have been trained in different ways, they are being studied together as the general assumption is that they are equivalent.

## II. OBJECTIVES OF THE STUDY

In the province of NWFP :

1. Estimate what percentage of trained female medical technicians (FMT's)/female health technicians (FHT's) are presently in service.
2. Understand the reasons for leaving or not joining the service by the trained FHT's/FMT's.
3. Appraise the practices of at least 30 FHTs/FMT's in comparison to the expected performance as outlined in the new curriculum.
4. Identify and report the academic and operational problems affecting the performance of FHTs/FMTs at their work place.
5. Recommend measures to resolve problems and improve the performance of FHT's/FMT's.

### III. METHODS

To begin with, the Director Health Services NWFP was requested for permission to conduct the study and also to inform the concerned officials, if needed. The Health Directorate and related departments were approached to obtain list of names and addresses of the FMTs and FHTs trained in the province and those who are in service since the introduction of this cadre in the health system. Later, the graduates of the last two years who have not joined the service were identified, and were approached through letters to understand the reasons for this undesired action.

There are 802 BHUs and RHCs in the NWFP. The plan was to select 30 health facilities through two stage random sampling to appraise the practices and problems of FHTs/FMTs. The number thirty was chosen on the basis of availability of the field workers (FWs) and funds for the study. First, 6 districts/agencies were randomly sampled from the 23 districts/agencies of NWFP. The sampled districts/ agencies were Karak, Bannu, Kohistan, Mardan, Charsadda and Orakzai Agency. From each sampled district 1 RHC and 4 BHUs were randomly selected as the principle sites to conduct the study. It was decided that if any of the sampled sites showed major problems of accessibility through road, or threatened the security of the field workers, then an alternate site would be selected. Similarly, FWs were advised to select the nearest RHC/BHU as an alternate site for each principal site in case the FHT/FMT is

absent from the principal facility on the visit day.

Appraisal of the practices of the FHTs/FMTs and identification of their problems was done through interviews and observations of their practices at the health facilities and during home visits. The tools and the data collection methodology were developed in consultation with the prospective FWs.

Four tutors of Peshawar FHT School formed two teams of FWs to perform the field work. One of the authors supervised the work of FWs in the field. The FWs were given a planned schedule to visit the facilities. The schedule was only known to the FWs and the authors. They visited the RHC/BHU unannounced as a two person team and conducted the observations and interviews if the FHT or FMT was present. It was essential to send them in a team for security and social reasons. Upon reaching the RHC/BHU, the FWs met the medical officer incharge, provided him with a copy of the permission from the DHS to conduct the study, and explained the purpose of the visit. Technicians were contacted directly if the MO was not available.

After consent was obtained, one field worker (FW1) then spent an average of two hours with the FHT/FMT of that facility and observed key practices. A checklist of key practices which were expected to be performed on a routine day were prepared in consultation with these tutors (see Appendix I). It was planned to observe a maximum

of three encounters with pregnant women, three with children under 5, three for family planning, and three other general patients.

Meanwhile, the second field worker (FW2) interviewed the medical officer to assess his understanding of the job and the role of the FHT/FMT (see Appendix II). She also reviewed the medical officer's and LHV's registers for the last five days to identify the patient numbers in different age-groups. She then reviewed the FHT's/FMT's register, if available, to assess what percentage of under five children and child bearing age women coming to the RHC/BHU were interacting with the FHT/FMT (see Appendix III). She also noted whether these registers were mutually exclusive or not.

After the last patient was seen or where patients were not coming to the facility for at least 1 hour, FW1 and FW2 interviewed the FHT/FMT to inquire about those practices which could not be observed at the facility and also about the problems that hindered her practices (see Appendix IV). Efforts were made to cross check the replies to assess their validity during home visits, which were made at the end of the interview (wherever applicable), and also through inferences from the day's observations.

FW1 and FW2 made home visits with those FHTs/FMTs who claimed to be performing field visits. Those HT's who make home visits are required to make entries for each visit in a register with detailed information on mothers and children under five. Attempts to

confirm their claim of home visits was made by review of the register. They were requested to perform a routine follow-up visit, as prescribed in the curriculum, to any house which was scheduled to be visited in the next few days or was visited in the last 30 days (see Appendix V). The FWs observed the rapport of the HT with the family, her performance of the required activities and entry of previous and recent data about the relevant family members.

Some concern was expressed that the use of tutors as FWs will introduce observer's bias. This was discussed with the tutors in detail. They were confident about collecting data without distortion. They were not afraid to report even the worst scenario as they do not believe that the poor practices will reflect on their training. They understood that it is not an evaluation of their teaching but of the practices of the HTs in the field. Further, the number of HTs trained by these tutors is about 10% of the total trained in NWFP. Since these tutors are aware about the desired performance of technicians in the field, they are confident, motivated and were keen to conduct the study, the authors considered them the most appropriate choice for field work.

The tools for the study and the process for data collection were pretested in four facilities near Peshawar in December 1992. Necessary changes in the tools and study methodology were made following the pretest and the study was conducted in the month of

January 1993 at 30 health facilities from 6 districts and 1 Agency of NWFP. The Fws visited Islamabad in the second week of February to collate and interpret the collected data and observations, with one of the authors. Analysis and a preliminary report was prepared in March and finalized in June 1993.

## IV FINDINGS

### PERCENTAGE OF FMTs/FHTs IN SERVICE

It took more than five months to acquire the information about the number of females who have graduated as technicians since the inception of the program in 1981 and the number in service at present.

To begin with, a request was made to the statistical officer at the Provincial Health Directorate to provide these figures. He did not have records about the number of graduates but informed that 113 female technicians were in service. However, he mentioned that the latest information on postings of female technicians will be provided later on after updating from all the Divisional Director Health Services, who are responsible for their postings.

Following this, the Secretary of Medical Faculty, an examining body for all paramedical cadres was contacted. They informed in writing that 400 female technicians have graduated since 1981 and provided a complete list with their names and addresses.

The five Divisional Director Health Services were directly approached to acquire the names and addresses of female technicians working in their divisions. They were unable to provide this information as, according to them, the postings of female

technicians are done by the District Health Officers.

Subsequently, the Field Officer TBA Program, who is working under the Inspectress Health Services and conducting regular field visits, was requested to visit all DHOs during her field visits to collect the information in person. On compilation of these reports it was concluded that 265 female technicians have been officially posted at BHUs, RHCs and HT Schools in NWFP. This provides an encouraging figure that at least 66% of the graduates of the program are in service.

## **REASONS FOR LEAVING OR NOT JOINING THE SERVICE**

The steps to identify which 135 female technicians out of the 400 graduates are not in the service, whether they ever joined or left, would have been an arduous and very time consuming task. Fortunately, the field workers knew the female health technicians of the last two graduating classes of the Peshawar HT School who had not joined the service. Therefore it was decided to approach only these FHTs to inquire the reasons for not joining the service.

Twenty five such FHTs were identified and a questionnaire written in Urdu was delivered at their homes. Only 12 responded back and mentioned the following reasons:

1. Have not yet received the appointment despite several

visits to the DDHS and/or DHO offices (4 FHTs).

2. The place of posting was far away, with no facility at the site for lodging and schooling of the children.
3. One decided to increase her qualifications and has taken admission in BA courses. Plans to join the service on completion.
4. Fiance has prohibited her from joining the service.
5. Has the responsibilities of managing the home after the death of her mother.
6. Have been employed by other organisations with better service terms and conditions.

## **APPRAISAL OF THE PRACTICES OF FHTs/FMTs**

The study target was to assess the practices of 30 FHTs/FMTs for at least two hours. It was anticipated that this will provide the opportunity to observe interaction with at least 90 children, 50 pregnant women, 60-70 CBA women, 30-40 other general cases. Instead of these expected 250 observations only 20 were possible and the reasons for this limited number of observations are mentioned below.

**1. AVAILABILITY OF FHTs/FMTs:** It was very difficult to identify the centers with female technicians. In the effort to locate the FHTs/FMTs, the methodology for restricting the observations to the sampled site or one alternate site had to be abandoned in 4 districts and the Agency.

In **Charsadda** district, the team had to visit 9 BHUs to find 4 female technicians. At two places technicians were absent, one was out to do survey work with an NGO and at another two places no female technician was posted. Similarly, FHTs or FMTs were not appointed in either of the two RHCs in the district.

In **Mardan** district, the team had to visit 7 BHUs to locate 3 female technicians. At two places FHTs or FMTs were not appointed, at one place she was absent, and in the other, the technicians had gone out to do survey work with an NGO. One observation was conducted at a RHC.

In the district of **Karak** female technicians are posted in 3 BHUs out of 19, and in 1 RHC out of 5. All these four facilities were visited and the study carried out. The staff was present.

In **Bannu** district, the District Health Officer (DHO) informed the field workers that FHTs/FMTs were posted in only 17 facilities out of 55 in the district. Out of these 17 facilities two were found locked, at 1 place the female technician was absent, at nine centers they were not posted, at 1 place she was on leave, but fortunately they were present in 4 BHUs.

At **Orakzai Agency**, the Agency Surgeon (AS) informed the team that no FHT/FMT is posted in the Agency for safety reason. The AS

informed them that even he was kidnapped some months back. As the information given by the DHO of Bannu about the postings of female technicians was not very accurate, the field workers visited 5 centers in Orakzai Agency to cross check the given information. They did not find any FHT or FMT at either of these centers and the staff at these facilities confirmed the Agency Surgeon's information. A LHV was present at one of the centers.

At this stage the field workers and the Investigators decided to add another district to the sample. In order to save time and money, District Kohat was chosen as it was closest to the Orakzai Agency.

In Kohat district only two FHTs are appointed and the study was carried out at one center as the technician was absent in the other. In most of the centers male health/medical technicians have been posted against female posts. According to the DHO, females do not come to work in this area.

In Kohistan district, the team visited 2 RHCs and 4 BHUs but did not find the FHT or FMT in any of these facilities. Later, they were informed by the DHO that no FHT/FMT is posted in the district.

In summary, the field workers visited 53 facilities (45 BHUs and 8 RHCs) in 6 districts and 1 agency of NWFP and found 17 female technicians (13 FHTs and 4 FMTs) working in 15 BHUs and 2 RHCs.

Out of these 17 centers, only 1 BHU and 1 RHC was from the randomly sampled list of facilities.

**2. GENERAL INFORMATION ABOUT FHTs/FMTs AND OBSERVATIONS:** The four FMTs were graduates of 1981 to 1985 and their service period ranged from 7 to 11 years depending on the year of graduation. Three FHTs graduated in 1988, 3 in 1990, 2 in 1991 and 5 in 1992. Their service period ranged from less than 1 year to 4 years. These 17 female technicians were observed for interactions with patients at the health centers for a total period of 33 hours and 35 minutes. The observation period ranged from 1 hour to 3 1/2 hours.

Out of the 17 female technicians observed, only 9 were observed to interact with women and children purposefully. The important point to note is that the LHVs were not present at 8 of these centers on that day. The total number of observed interactions of the female technicians at the centers were as follows:

Patients	Frequency
Children < 5	4
Pregnant women	2
CBA women	12
Women over 45	2
TOTAL	20

**3. INTERACTIONS WITH CHILDREN < 5:** During the observations at 17 facilities, children < 5 came at 6 centers and at 3 places the female technicians (2 FHT, 1 FMT) were allowed to provide care. The total number of interactions were 4. At the other 3 places the medical officer (MO), male medical technician (MMT), or Lady Health Visitor (LHV) provided the care.

The female technicians were observed for their activities related to nutrition, diarrheal diseases and immunization (See observation protocol in Attachment I).

Out of the 4 cases observed, in only one case the female technician made an effort to estimate the age correctly and inquire about breastfeeding and weaning. Feeding inquiry was applicable in 3 cases. None of the children were weighed, therefore, no growth chart was made and nutritional status was not determined. Later, when asked about this, the technicians mentioned that they do not have weighing machines and growth charts to do growth monitoring. Out of the 3 required cases, weaning was discussed in two but breastfeeding was not discussed with two mothers whose children were below 2 years.

Only one interaction for a child with diarrhea was observed. The technician made the assessment of the degree of dehydration and explained to the mother how to prepare and use ORS. She did not initiate therapy at the center, nor did she give any advice

regarding feeding and when to come back. She also did not explain any preventive measures.

In two cases the technicians assessed the need for immunization and referred them to the EPI room, while in the other two cases they did not inquire about immunization but the mothers requested measles immunization. The measles vaccination was not given as the EPI Center was closed.

**4. INTERACTIONS WITH PREGNANT FEMALES:** During the observation period only two pregnant females came to seek care at two places for the treatment of some minor ailment. Female technicians (1 FHT and 1 FMT) were allowed to see them. An LHV was present at each center.

Both the technicians inquired about the age of the mother and outcome of previous deliveries. They recorded blood pressure, assessed anaemia clinically, examined the height of the fundus, listened to the fetal heart sounds, advised diet for pregnancy, inquired about tetanus toxoid vaccination and advised it. One of them also vaccinated the woman, but the other could not as the EPI center was closed. Similarly, one of the technicians advised on future family planning and follow-up. Neither of them took weight, measured height, or checked urine for sugar or albumin. They later explained that the reason for failure in carrying out these tests was the non availability of instruments and chemicals. They did

not examine the patient's breasts and one did not estimate the expected date of delivery. No records were made for these two cases.

**5. INTERACTIONS RELATED WITH CBA:** Female technicians were observed interacting with 12 women of child bearing age (CBA) with different problems, in 6 centers. The focus was to assess their practices related to family planning.

Three CBA women were given advice for family planning by the technicians in addition to the required treatment. They were told about the different types of contraceptives and methods of their use, but the use of contraceptives was explained inadequately in 1 case. In the other nine cases no assessment was made of the number of children these women had or the need for family planning. Thus, the opportunity was missed in 9 cases. Out of the 3 cases, only two were advised to come for follow-up.

**6. OTHER SERVICES:** Two FMTs and 3 FHTs were observed providing services to female patients other than those listed above. These were:

1. Examination and prescription writing for minor ailments.
2. Giving injections and IV infusions
3. Evaluation of a postnatal patient
4. Dispensing drugs
5. Health education according to the need

**7. PRACTICES RELATED TO DATA ENTRY:** The female technicians are trained to maintain some important registers at the BHU and the RHC. This duty is carried out in higher frequency than other practices as is evident from the table below:

Register	Maintains	
	YES	NO
1. OPD	13	4
2. Abstract	9	8
3. Stock and Expense	5	12

The other registers that were found to be maintained by at least three female technicians were Family Folder, Antenatal Register, Confinement Register. At least two technicians maintained Confinement Register, Birth Register, Infant Register, Toddler Register, Home Visits Register and EPI Register

Out of the 3 places where technicians were maintaining antenatal register the LHV was present in 1 center. The EPI Register was maintained by the technicians at two places, in one she was vaccinating the patients and at the other the technician was responsible for maintenance of all registers.

**8. HOME VISITS:** Eight female technicians mentioned during the interview (which will be described later), that they perform home

visits. Therefore the field workers requested them to make a home visit and carry out routine procedures. The plan was to assess their familiarity with the family and observe their actions related to newborns, children <5, pregnant women, sick persons, cleanliness of the home environment, and any other relevant activity.

Observation periods lasted for 30 minutes in two homes and 15 minutes in the remaining six homes as the technicians only inquired about a few minor things. Seven of the eight female technicians had good rapport with the family and they were welcomed into the homes. Since there were no recent births in these homes, activities related to newborns could not be observed. In 6 houses children <5 were present and in 5 the technicians inquired about the illnesses of these children in the past month. At none of these places were the children weighed. As mentioned earlier, they did not have weighing machines and growth charts, not even at the center.

In one home a pregnant female was identified. The technician only enquired about the general condition of the lady and did not perform any antenatal examination or give advice about extra food and follow-up.

In 3 houses sick persons were present, other than those mentioned above. At two places the technicians made an effort to identify the problems and gave prescriptions. Seven houses required advice

on improving cleanliness but it was given in only four houses.

The interesting thing to note was that these technicians, with the exception of one, took no apparatus or register with them to the homes. The whole interaction was that of a social visit rather than a well defined health visit. Only one technician took along a BP apparatus, thermometer, tongue depressor, torch, stethoscope and diary. No effort was made to use this opportunity for health education of the family.

## **INTERVIEW FINDINGS ON OTHER PRACTICES OF FHTs/FMTs**

All 17 female technicians were interviewed about some areas of their practices which were not likely to be observed but are considered important activities for provision of better health care. At the same time, enquiries were made about the administrative, social and personal problems (see guidelines - Attachment IV) which are mentioned in the following section. Findings from the discussions are summarized below:

**1. MAP OF THE AREA:** Only 4 female technicians had prepared a map of the area. Thirteen technicians could not give any satisfactory reason for not performing this activity, which is considered very essential in order to provide comprehensive health cover to all.

**2. CONTACT WITH COMMUNITY INFLUENTIALS:** Three female technicians

met the landlord of the area, one met the MPA and another met the chairman Union Council when they were posted in the facility and informed them about their role in community health with special reference to home visiting. The other 12 technicians did not meet any formal leader. None of these 17 technicians established contact with any informal leader in the community.

**3. HOME VISITS:** Eight female technicians reported that they made home visits in the last month, these ranged from 3 to 15 visits. Most of these visits were made in the area surrounding the center, with the exception of one visit which was 5 to 6 kms distance, and two that were 2 to 3 kms distance. Out of these 8, only 1 had a written schedule for the home visits and two had records of previous visits.

The field workers made a home visit with each of the eight female technicians who reported making home visits regularly. The findings have been presented in the earlier section on pages 19-21.

**4. HEALTH EDUCATION:** Four female technicians mentioned that they have a schedule for health education sessions. They had made entries of their activities in diaries or copies and were following a plan. Six showed the list of topics that they had planned to discuss, and 7 informed that they conduct health education regularly. Their claim could not be verified.

**4. HOME DELIVERIES:** A very encouraging finding was that 12 of the female technicians mentioned that they have conducted home deliveries in the last six months. The details of mentioned frequencies are given below in the table:

Serial #	Deliveries Conducted	Entry in Register
1	12	Yes
2	24	Yes
3	49	Yes
4	1	No
5	8	Yes
6	1	Yes
7	10	No
8	35	No
9	14	Yes
10	3	No
11	11	Yes
12	6	Yes
<hr/> Total: 174		<hr/> Yes = 8  No = 4

The technician who conducted 49 home deliveries in the last 6

months had initial training as an LHV. Later she also took the Medical Technician Course as more medical care was taught during MT training.

Out of the five who did not perform any deliveries, one was prohibited by the doctor of the center and the other by the LHV. Two gave no reasons, while one mentioned that she was never called upon for this job.

**6. INSERTION OF IUDs:** Five technicians informed that they do insert IUDs. In the last 6 months, one had inserted 33 IUDs, another 16, two had inserted 4 each and one had inserted 1 IUD. The technician who inserted 16 IUDs mentioned that she brings them herself from different sources. It was felt that the technicians were taking this initiative as they were most probably charging for this demanded service, but this could not be verified.

The 12 technicians who do not perform this activity gave different reasons for not doing so. Two said that the DHO had prohibited them from doing so, six said non availability of IUDs was the reason, while four gave no reason at all.

**7. VACCINATION:** Thirteen female technicians mentioned that they perform vaccinations regularly. The frequency of vaccination was mentioned as follows:

Average vaccination per week	No. of Technicians
30	1
20	3
10-15	2
< 10	7

Vaccine most commonly being administered was tetanus toxoid to pregnant females. At some places children also were being vaccinated by the technicians. One technician mentioned that she brings vaccines through her personal effort as they are not supplied at the center.

**8. PREPARATION OF MONTHLY REPORTS:** The monthly reports from the Abstract Register and the OPD Register are prepared by 3 FHTs independently and 2 FMTs in collaboration with the MMTs. In 11 places these reports are prepared by the MMTs and at one center by the MO.

### **INTERVIEW FINDINGS ON PROBLEMS HINDERING PRACTICES**

The female technicians mentioned several problems, which according to them, are hindering their practices and not allowing them to perform up to their capabilities.

Most of them identified some **logistical and administrative problems** as major factors. The most commonly mentioned ones are:

**1. UNAWARENESS OF THEIR JOB DESCRIPTIONS:** Medical officers and the other staff are not aware of the job descriptions of FHTs/FMTs, therefore, they are asked to do different odd jobs at the center. They mostly perform as the twelfth man of the cricket team, filling in for the absent LHV, MMT, dispenser or EPI technician. Some female technicians mentioned that even DHOs are not aware of their job descriptions and at one place the DHO prohibited the technician to perform deliveries.

**2. DOMINANCE OF LHVs:** At places the female technicians expressed a lot of frustration at the dominance of LHVs over them. They mentioned that they have been prohibited by the LHVs from interacting with patients. At one place the MO, and at another place the MMT also restricted them from interacting with patients. Some mentioned that they are only allowed to work as assistant to the LHV to pass her the stethoscope, gloves, etc. One technician mentioned that the LHV keeps all the registers with her and locks them in a cupboard provided to her and when the LHV is absent the patients are sent to her home. Another technician mentioned that her chances of interaction with patients at the center depends on the mood of the LHV.

**3. LACK OF PROPER PLACE:** The female technicians and LHVs are

placed in the same room, but the rooms are referred to as the LHV's room. At at least at 10 places the female technicians expressed their discomfort at having to work in somebody else's room, especially as working relations with the LHVs are strained.

**4. NON COOPERATION OF DAI:** At least 8 female technicians had serious complaints about the non-cooperative attitude of the Dai working with them. Dai work under the LHVs and follow instructions given by her. This was also noted at a couple of places by the field workers. At one place the FHT asked the Dai to bring some chairs for the field workers but she refused and stated that she will bring the chairs if asked by the LHV.

**5. LACK OF REGISTERS:** Nine female technicians expressed their desire to have separate registers for themselves as used by the LHV and MO. They thought that separate registers would give them authority to see their own patients and to record their performance.

**6. NO TA/DA:** Eleven technicians identified the nonavailability of TA/DA as one of the reasons for not making home visits. They mentioned that the catchment area is spread over several kilometers and they should be given daily allowances and travelling allowance for work in the field.

**7. LACK OF SUPERVISION:** Some technicians mentioned that nobody

from the health department has ever made any supervisory visit to check their performance. DHOs, if they do visit, interact only with the MO, LHV and MMT.

During the interviews some **social and personal problems** were also identified as barriers to the expected practices of the female technicians. The major ones as mentioned by the FHTs/FMTs are:

1. **SOCIAL UNACCEPTABILITY:** At places the technicians mentioned that the people of the area consider it a bad practice for a female to move openly in the community. This claim could not be verified.
2. **SAFETY:** Six female technicians mentioned that they do not have support of any staff of the center to visit with them. They cannot go alone for home visits as it is culturally inappropriate and also not safe. One expressed the fear of being kidnapped and the other mentioned that her posting is in the area where family enmity exists. But she was keen to perform her work and her father accompanied her to the center every day and also during home visits.
3. **TRANSPORT & LODGING:** Five mentioned that daily commuting is a major problem for them as they lived far from the center and the transport system was unsatisfactory. Two technicians were residing at the center with the LHV. They expressed their desire for separate quarters as they were obliged to be obedient to the LHV

during working hours also.

**4. LACK OF INTEREST:** Only two female technicians did not appear to be interested in their job and one was uncooperative.

## **MEDICAL OFFICERS PERCEPTIONS ABOUT FHTs/FMTs**

### **PRACTICES**

Medical officers were found present in 22 facilities out of the total 53 facilities that were visited by the field workers. In the remaining 31 centers, they were absent in 10, on leave in 4, not posted in 15, and could not get the information at 2 places.

Of the 17 centers where female technicians were observed, medical officers were present in 10. They were interviewed about the responsibilities and performance of FHTs/FMTs at their facility.

The job description of the FHTs lists 11 major responsibilities. The MOs were asked to mention the duties and responsibilities of female technicians at their centers. Only 5 MOs mentioned at least 5 duties and responsibilities being performed by the female technician at the center which are listed in the job description. One MO mentioned 4 responsibilities and three identified only 1 responsibility being performed which was in relation to the job description. The commonly mentioned responsibility of the female

technician at the center was immunization of women and children and conduction of health education sessions. The other two responsibilities which were mentioned by atleast 4 MOs were home visits and record keeping. The other tasks and responsibilities which the MOs have assigned to these technicians and which were mentioned by them do not belong to the prescribed job description of the female technicians. These other tasks were dispensing drugs, making O.P.D. chits, assisting LHV, giving injections, washing dusters, etc.

This finding confirms the apprehensions of the female technicians about the lack of understanding of their job, duties and responsibilities by the MOs incharge of the facility. This was further strengthened when 8 MOs mentioned that they were satisfied with the work that the female technicians perform at their centers.

The reasons for which two MOs were not satisfied with the female technicians were that one technician observed strict purdah and her interaction was limited, and the other was not interested in BHU work and focussed her attention in establishing private practice.

The medical officers were also probed for assessing their perspective about the performance of the female technician at their centers. The responses are given below:

**1. HOME VISITS:** Four out of ten MO's confirmed that the technician

at their center makes home visit. Three mentioned that the female technicians are not interested. One did not allow the technician to go as she was assigned the duty of dispensing drugs and maintaining registers which kept her very busy at the center. One MO considered it unsafe to send the technician out in the field and the other observed strict purdah and was not willing to go.

**2. DELIVERIES:** Five medical officers confirmed that the female technicians perform deliveries. At the other five centers where they were not conducting deliveries, it was not due to any restriction by the MO.

**3. FAMILY PLANNING:** Four MO's stated that the female technicians provide family planning services. At the remaining six centers the doctors neither encouraged them nor restricted them from activities related to family planning.

**4. ORT:** Four MOs mentioned that the technicians give ORT to children suffering from diarrhoea. Four agreed to encourage her to give ORT but two refused. These two MOs thought that it is their duty to see sick children and not the responsibility of the female technicians.

**5. GROWTH MONITORING:** One MO mentioned that the technician does growth monitoring. Six MOs mentioned that they do not have growth charts and weight machines. One did not know what growth

monitoring is. The other two gave no response.

The medical officers were also asked about the **problems being faced by the female technicians at their center**. Six MOs did not specify any problem, while three mentioned non availability of satisfactory transport for commutation, and one mentioned lack of proper working place as the problem.

Medical Officers were also invited to give **suggestions to improve the training and practices of female technicians**. The few general advises given by them are as follows:

**TRAINING:**

1. Emphasize more on practical work (probably meant curative work)
2. Teach examination of males and curative treatment.
3. Motivate more for home visits.
4. Give more attention to data entry in registers

**PRACTICES:**

1. MO should be made aware of the job description of female technicians.
2. Establish frequent supervisory visit.
3. Arrange regular refresher courses for them.
4. Provide allowances for home visits.

## PERCENTAGE OF CLIENT INTERACTION WITH THE FHTs/FMTs

An effort was made to establish the workload at the centers and to identify the percentage of interactions of mothers and children with the female technicians. For this, registers of medical officers or MMT, LHVs and FHTs/FMTs were reviewed for the last five working days. The results are as follows:

Table: Patient Attendance in Last Five Days

	Day 1	Day 2	Day 3	Day 4	Day 5	Total	Average/ day/center
1. <u>MO + MMT Register</u> (17 Centers)							
a. Total patients	220	253	147	231	255	1106	13
b. Children < 5	36	48	30	41	44	199	2
c. Females 15-45	72	74	30	60	91	327	4
2. <u>LHV Register</u> (7 Centers)							
a. Total patients	31	28	24	15	40	138	4
b. Pregnant women	8	4	3	5	5	25	
c. Family Planning Cases	-	-	2	3	3	8	
3. <u>FHT/FMT Register</u> (3 centers)							
a. Total patients	7	11	15	21	11	65	4
b. Children < 5 (1 center)	1	-	1	-	-	2	
c. Females 15-45	6	11	14	21	11	63	4

The utilization of the centers appears to be very low if inferred from the above table. But at several places it was noted that many patients were being charged by the health center staff for consultation and were being given prescriptions to purchase medicine from outside. These patients were not entered in the registers. Only those patients who were provided some medicines from the center were being entered in the registers.

Medical Officer and MMT share the register. LHVs were present at

9 centers but at two places their patients were recorded in the OPD register maintained by the MO or MMT. The three centers where female technicians were maintaining the registers were those where LHVs were not present.

Considering the number (17 on an average per day) and category of patients seen at a BHU/RHC, female technicians can independently manage at least 60% cases, if allowed to do so.

## **INFERENCES OF THE STUDY TEAM**

In summary, the FHT/FMT program is working much below expectation with very little benefit to women and young children as desired, and it needs urgent attention for bringing appropriate changes.

Several features about the performance of FHTs/FMTs were observed or probed. It was good to note that among those female technicians found at the facility 82 % (14 out of 17) were interested in their work but it was disturbing to see that about 50 % of them were not allowed to work. The dominance of LHV as pointed out by the technicians appears to be a genuine problem. The female technicians are given much less respect at the center as compared to LHVs. It was felt that the LHV and Dai do not see them as partners but as a threat to their private practice.

Another grief of the female technicians that holds true is that

their job description is not known to the other staff of the center and DHOs. As stated earlier only 50% of the MOs could identify 50% of the duties and responsibilities. Similarly, even the four DHOs and 1 ADHO who were met during the study, were not aware of the job description of female technicians.

These two factors appear to be most important in keeping the female technicians from interacting with women and children visiting the center. But the most disturbing feature was that at the places where they are interacting with women and children, their performance is much below the expected level as indicated earlier. Even the home visits made under known observations were nothing more than social calls. Could this be attributed to lack of supervision as pointed out earlier or is there lack of hands-on experience during training ?

Non availability of TA/DA was mentioned as one of the reasons for not making home visits. But these were not being made by at least 50% of the technicians in the nearby homes and those who visited did not have a schedule or plan.

Another noticeable area of deficiency is lack of community involvement in the activities of the center. It appears that a genuine effort was not made by most of the technicians to initiate effective community participation, which is one of the important duties of the technicians.

## **SUGGESTIONS/RECOMMENDATIONS**

### **SUGGESTIONS GIVEN BY FHTS/FMTs TO IMPROVE TRAINING AND THEIR PRACTICES**

The FHTs/FMTs were invited to give suggestions to improve their training and practices. The suggestions mentioned commonly by more than three technicians are listed below:

1. Six technicians suggested that the DHO, MO and LHV should be briefed about the technician's job description.
2. Six technicians requested for provision of an appropriate place for them at the centers.
3. Five technicians asked for initiating regular supervision of their work , and six desired to be provided with separate registers.
4. Four technicians demanded inclusion of midwifery training in their curriculum, and provision of diplomas in MCH. This would bring them at par with the LHVs. An equal number of technicians requested for refresher courses to update their knowledge and skills.
5. Three technicians asked for training and permission to do more curative care at the center.
6. Three demanded provision of travel allowance to initiate field work.

## **RECOMMENDATIONS OF THE AUTHORS:**

1. It is strongly recommended that various **cadres of female paramedics with almost similar responsibilities such as LHV, FHT, FMT, be abolished and merged into a single category** incorporating the job description of all these cadres. Since LHV is an established position which commands respect from the medical officers and the other health staff, it is suggested that this nomenclature is maintained. This change will subsequently require merging and renaming of the Public Health Schools and the Health Technicians Training Schools and also the **revision of the curriculum** with appropriate balance of preventive, promotive and curative approach, including midwifery.
2. If this change is not acceptable to the authorities then immediate measures must be taken to **inform the DHOs and the health staff of the RHCs and BHUs about the job description of the female technicians.** They should be advised to encourage, support and allow the female technicians to perform according to their job description. The medical officers should make active efforts to end the cold war between LHVs and female technicians and facilitate them to work as a team for the patients benefit, rather than being threatened by each others presence.
3. The Health Department must **reassess whether or not it is**

**possible for the female paramedics to work on outreach activities.** The validity of various social reasons inhibiting field activities as mentioned by the technicians need to be explored further. Based on the findings, an appropriate and effective strategy for preventive and promotive work be designed.

4. The inadequate performance of the technicians observed during the limited interactions identifies the need for **strengthening hands-on practices during training in the schools and on-the-job.**
5. Supervision at present is almost non-existent. District supervisors must **ensure adequate technical and managerial supervision at regular intervals.** The visits, when made, should not only be limited to check the registers but utilised as an opportunity to enhance the knowledge and skills of the staff and to help them solve problems.
6. **Incentives such as travel allowance for field work and rural allowance should be provided.** Technicians working in rural areas are deprived of house rent equivalent to 40% of basic pay, which is available to them in cities. This disparity could be removed by providing rural allowance equivalent to 50% of basic pay.

7. DHOs should encourage the staff of the BHUs and RHCs to **initiate community participation**. This will not only serve to enhance the utilization of services at the center more effectively but will also encourage the female staff, including technicians, to improve their outreach activities.

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**CHECKLIST FOR RECORDING OBSERVATIONS ABOUT PRACTICES OF FHT/FM**  
 (Please tick for yes, X for NO, or NA for NOT APPLICABLE)

Introduce yourself and the purpose of the visit:

Assalaam-o-Alaikum. I am a tutor from the HT School Peshawar. We are conducting a survey to look at the practices of FMTs/FHTs to identify the problems being faced by them. This will help us to recommend measures to improve the practices of FHTs/FMTs and to make their training more relevant to the practical needs. This survey has been approved by the DHS NWFP. Do we/I have your permission to sit with you in the center and to ask you some questions?

Name of FHT/FMT observed: \_\_\_\_\_

Graduation year: \_\_\_\_\_ Period of Service: \_\_\_\_\_

Place: \_\_\_\_\_ Date: \_\_\_\_\_

Observed by: \_\_\_\_\_

Duration of Observation: From \_\_\_\_\_ To \_\_\_\_\_ Total Hrs. \_\_\_\_\_

**1. INTERACTION WITH PREGNANT FEMALE:**

1.1. Pregnant women attended the Center: Yes/No

1.2 FHT/FMT allowed to provide care: Yes/No

If NO, who provided the care: \_\_\_\_\_

If allowed to provide care then assess the following activities:

ACTIVITIES	PATIENTS			REMARKS *
	1	2	3	
1.3 Inquires Age **				
1.4 Inquires outcome of previous pregnancies				
1.5 Estimates EDD correctly **				

\* Add relevant remarks, e.g. wt not taken as machine broken

\*\* Applicable for the first visit only

1.6	Measures height **				
1.7	Takes weight				
1.8	Records BP				
1.9	Checks urine for: a) Sugar b) Albumin				
1.10	Examines height of fundus				
1.11	Hears fetal heart sounds				
1.12	Examines breasts				
1.13	Assesses Anemia clinically				
1.14	For Tetanus Toxoid: a. Inquires b. Advises c. Gives				
1.15	Advise diet for pregnancy***				
1.16	Advise for future family planning to term 3 women***				
1.17	Advise for follow-up examination***				
1.18	Uses record in follow-up cases***				
1.19	Refers high risk and complicated cases***				

2. INTERACTION WITH CHILDREN < 5

2.1 Children < 5 attended the Center: Yes/No

2.1 FHT/FMT allowed to provide care: Yes/No

If NO, write who provided the care: \_\_\_\_\_

\*\*\*Assessing only basic awareness and not quality of advice

If allowed to provide care then assess the following activities:

GENERAL ACTIVITIES	PATIENT			REMARKS
	1	2	3	
2.3 Makes effort to estimate age correctly				
<b>ACTIVITIES RELATED TO NUTRITION</b>				
2.4 Inquires <sup>****</sup> about breastfeeding				
2.5 Inquires about weaning <sup>*****</sup>				
2.6 weighs the child: a. With clothes				
b. Without clothes				
2.7 Makes/updates growth chart				
2.8 Explains nutritional status to mother				
2.9 Gives advise for: <sup>***</sup> a. Exclusive BF(upto 4 months)				
b. Weaning (for 4 to 12 months)				
c. Extra food for malnourished				
<b>ACTIVITIES RELATED TO DIARRHOEA</b>				
2.10 Child has diarrhoea If No go to number 2.19 If yes mark the following:				
2.11 Assesses dehydration status				
2.12 Rehydrates at the facility				

<sup>\*\*\*\*</sup> Applicable for children upto 2 years

<sup>\*\*\*\*\*</sup> Inquires about children between 4-24 months

12

2.13	Explains ORT:				
a	a. Use of ORS				
b	b. Proper feeding				
c	c. Demonstrates preparation of ORS				
2.14	Explains giving extra meals for 1 week				
2.15	Explains signs and symptoms for need to come back				
2.16	Discourages bottle feeding				
2.17	Explains other preventive measures				
<b>ACTIVITIES RELATED TO IMMUNIZATION</b>					
2.18	Assess Immunization appropriate for age				
2.19	Child requires immunization				
2.20	Does she vaccinate those who require				
2.21	Are syringes sterilized properly by her				

3. INTERACTIONS RELATED TO FAMILY PLANNING

3.1 Provides care to married CBA women (other than pregnant women) YES/NO

If yes, then assess the following activities:

FAMILY PLANNING ACTIVITIES	PATIENT			
	1	2	3	REMARKS
3.2 Provides family planning advice to married CBA women				
3.3 Correctly explains the use of contraceptives				
3.4 Gives follow-up advise.				

4. BESIDES ABOVE, ANY OTHER SERVICES RENDERED:

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PRACTICES RELATED TO DATA

ACTIVITIES	YES	NO
5.1 Maintains register:		
a. OPD <span style="float: right;">a</span>		
b. Abstract <span style="float: right;">b</span>		
c. Stock and Expense <span style="float: right;">c</span>		
d. World food <span style="float: right;">d</span>		
e. Any other (Specify) _____		
_____		

Place: _____	Date: _____
Dr. Absent/Present (Name): _____	
Interviewed by _____	

Introduce yourself and the purpose of the study and interview:

Assalaam-o-Alaikum. I am a tutor from the HT School, Peshawar. We are conducting a survey to look at the practices of female Health Technicians. This survey has been approved by the Director Health Services, NWFP. This BHU/RHC has been selected through random sampling for the survey. This survey will help us to improve the practices of FMTs/FHTs and will also help us to make the teaching more relevant to the practical needs. We request you to answer some questions. Your name will be kept confidential and your identity will not be revealed. Do I have your permission?

1. What are the responsibilities of FHT in your BHU/RHC.  
(Don't ask the following, just mark the answer given)

	Put a mark in front of the mentioned responsibility
a. Make home visits and provide family health services	
b. Give ORT to diarrhoea cases	
c. Immunize children < 5	
d. Growth monitoring of children < 5	
e. Provide antenatal care	
f. Conduct deliveries	
g. Give T.T. to pregnant women	
h. Conduct health education sessions	
i. Encourage community participation	
j. Record keeping	
k. Giving first aid	
Any other _____ _____ _____	

Circle the appropriate answer for questions 2 to 10

2. Are you satisfied with her work? YES/NO

If NO, then ask why not? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How is her attitude with other colleagues? Satisfactory/Unsatisfactory

4a. Does she make home visits? YES/NO

4b. If NO, then would you like her to make home visits? YES/NO

5a. Does she conduct deliveries? YES/NO

5b. If No, then would you like her to conduct deliveries? YES/NO

6a. Does she provide family planning services? YES/NO

6b. If No, then would you like her to provide F.P. services? YES/NO/NA

7a. Does she give ORT to dehydrated children? YES/NO

7b. If No, then would you like her to give ORT? YES/NO

8a. Does she perform growth monitoring? YES/NO

8b. If NO, then do you refer children to her for growth monitoring? YES/NO

9a. Does she have any problems? YES/NO

9b. If YES, then what are they? (write them down)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

10. Do you hold any meetings with her to discuss her problems or job performance? YES/NO

11. Would you like to give any suggestions to improve her training and practice?  
(Write down suggestions, if any)

YES/NO

TRAINING

PRACTICE

a. \_\_\_\_\_

\_\_\_\_\_

b. \_\_\_\_\_

\_\_\_\_\_

c. \_\_\_\_\_

\_\_\_\_\_

d. \_\_\_\_\_

\_\_\_\_\_

e. \_\_\_\_\_

\_\_\_\_\_

Name of the place: \_\_\_\_\_

Registers reviewed by: \_\_\_\_\_

**PATIENT ATTENDANCE IN LAST FIVE DAYS**  
(Calculate from MO's, FHTs/FMTs and LHV's Registers)

	Day 1	Day 2	Day 3	Day 4	Day 5	Total
<b>1. <u>MO Register</u></b>						
a. Total patients						
b. Children < 5						
c. Females between 15-45 years						
<b>2. <u>LHV Register</u></b>						
a. Total patients						
b. Pregnant women						
c. Family Planning Cases						
<b>3. <u>FHT/FMT Register</u></b>						
a. Total patients						
b. Children < 5						
c. Females between 15-45 years						
<b>TOTAL CASES 1a+2a+3a</b> (if mutually exclusive)						
<b>% Being seen by FHT/FMT</b> <u>3a</u> 1a+2a+3a						
<b>EPI Cases</b>						

REMARKS (if any):

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4/8

FHT/FMT INTERVIEW GUIDELINES  
(Identify 3-5 major problems affecting her practices)

Name of the FHT/FMT: \_\_\_\_\_

Place: \_\_\_\_\_

Names of the Interviewers: \_\_\_\_\_

I. Enquire about practices which could not be observed:

1. Have you prepared a map of the area:  
If yes, then check.  
If no, then why not?
2. Have you contacted community influentials:  
Specify which ones.
3. How many days did you make home visits last month:
4. How far from BHU/RHC do you go?
5. Do you have a schedule for home visits?
6. Please show the previous record of the home visits (family health register).
7. Do you have a schedule for health education sessions?

8. Have you prepared a list for health education topics?  
If yes, then check
  
9. Do you conduct sessions? If yes then request to see the health talk register.
  
10. Do you conduct deliveries at home?  
If no, then why not?  
If yes, then how many conducted in the last 6 months
  
11. Do you insert IUDs?  
If yes, how many inserted in the last 6 months?
  
12. Do you vaccinate (if not observed in the day). On an average how many per week?
  
13. Who makes the monthly report?  
Abstract :  
OPD :  
Medicines expense:

II. Inquire about other problems hindering proper practices.

Administrative & Logistic problems

- Availability of proper place for work
  
- Do others understand her work (job description)
  
- Relationship with other staff members (cooperation)

- Does MO allow home visits
- Are there any restrictions on her to perform deliveries
- Transport (to come to work)
- Does she get TA/DA for travel beyond 10 kilometers e.g. bus ticket.

**Social**

- Does she have Dai or chowkidar to accompany her for visits to villages.
- Is she allowed to work with the Dai
- Any restrictions from the community

**Personal**

- Does she have accommodation
- Any restriction for outreach work from her own family

**III. Ask suggestions to improve practices in the field and training at the schools**

**PROBLEMS IDENTIFIED**

- 1.
- 2.
- 3.
- 4.
- 5.

**REMEMBER: This is a guideline, you may ask other questions related to practices which you consider related and important.**

HOME VISIT GUIDELINES

Name of FH/FMT with whom visit is made \_\_\_\_\_

Place \_\_\_\_\_ Date \_\_\_\_\_

Visit made by FWs \_\_\_\_\_ And \_\_\_\_\_

OBSERVE	YES	NO	NOT APPLICABLE
1. Familiarity with the family			
2. Actions taken for environment			
a. Encourages mother for cleanliness			
b. Advises mother for cleanliness (if dirty)			
3. Actions taken for newborns			
a. Weighs the child			
b. Examines the cord			
c. Checks/advises for immunization			
4. Actions taken for children < 5			
a. Inquires about illnesses in the last month			
b. Weighs the child			
c. Checks/advises for immunization			
5. Actions taken for pregnant women			
a. Inquires about general condition			
b. Records BP			
c. Performs abdominal examination			
d. Examines breasts			
e. Encourages to eat extra			
f. Advises to come for follow-up			
6. Actions taken for any other sick person			
a. Identifies the problem			
b. takes action (treats/refers)			