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Refreshers' Training of MCH-FP Paramedics and Field Workers:



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*Experience from a Low-Performing
Rural Area of Bangladesh*

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Barkat-e-Khuda



International Centre for Diarrhoeal Disease Research, Bangladesh

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Abstract

Wide regional variation exists in the performance of the Bangladesh Family Planning Programme. The knowledge and skills of the service providers is one of the important factors for improved performance.

The conduct of periodic refresher training can enhance the knowledge and skills of the service providers. However, on the job training at the local level has not been institutionalised nationally.

When a refresher course was undertaken at Mirsarai Thana an appreciable gain in the knowledge of trainees has occurred. The project experience showed that with very little input a training program can be organised at the local level. There is a need to organise a group of trainers which could contribute to the establishment and institutionalisation of a system of on-the-job training for the workers in the national programme, and would also ease the problem of conducting any short training at the local level.

Background

While the success of the Bangladesh Family Planning programme has been acclaimed, there are wide regional variation in the impact of the programme. For example, in most divisions, the contraceptive prevalence rate (CPR) is in the range of 49-62 percent, whereas it is 20 percent in Sylhet Division and 37 percent in Chittagong Division, as reported in the Bangladesh Demographic and Health Survey (BDHS) 1996-97 [1]. The BDHS 1993-94 recorded 29 percent CPR in Chittagong Division, which included present Sylhet Division [2]. The people of Chittagong Division are known to be more conservative. Out-migration of adult males is more common. The socioeconomic conditions are better than other divisions; both male and female literacy and articles owned by household are higher. The family planning programme in Chittagong Division, however, has not been developed compared to that of other divisions, as 31 percent of the eligible women were visited by the FWAs in the last six months in Chittagong Division and 22 percent in Sylhet Division compared to 36-46 percent in other divisions. Twenty-one percent of the eligible women indicated an unmet contraceptive need which was highest in both Chittagong and Sylhet Divisions. They do not want additional children but at the same time they do not use any method [1]. The low performance of health and family planning programme in Chittagong Division and its high demand for children, and low use of contraception are the result of a number of cultural, social, economic, and programmatic factors.

Vacancies in field workers position, knowledge and skills of paramedics, supervisors and field workers, regularity of field workers' contact with eligible women, adequate supervision and holding of satellite clinics, screening potential users, follow-up of users of contraceptive methods, management of side-effects, referral and timely transportation of pregnancy complications are key programmatic issues to ensure high-quality services and sustained performance. Improvement in workers' knowledge and skills and the involvement of males supported by strong programme management are some of the factors that can enhance accessibility to and increase the use of and demand for services.

In an attempt to improve the family planning performance of Chittagong Division, the Ministry of Health and Family Welfare (MOHFW) decided to use the expertise of the Operations Research Project [formerly known as MCH-FP Extension Project (Rural)] of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The Project has a long history of providing technical assistance to the MOHFW in field-testing various interventions to improve the performance of the national MCH-FP programme. During the past decade, the project concentrated its activities in two thanas, Sirajganj Sadar of Sirajganj District in Rajshahi Division and Abhoynagar Thana of Jessore District in Khulna Division. Many interventions field-tested in these two thanas have already become an integral part of the national programme. The Ministry decided that various interventions should initially be field-tested in Mirsarai Thana and gradually scaled-up to other thanas of Chittagong District, eventually to Chittagong Division.

During June-July 1994, the Project undertook a needs assessment survey in Mirsarai to determine the reasons of low performance, identified the need for MCH-FP services, and internal strengths, weaknesses, external opportunities and threats to the programme [3].

The survey was undertaken with the aim to develop a plan of action, and based on the results of the survey, to design appropriate interventions that would increase the accessibility to MCH-FP services. The survey included interviews with 581 married women of reproductive age (MWRA) and self-administered questionnaires for all Family Welfare Assistants (FWAs) and Family Planning Inspectors (FPIs). Focus group discussions were held with ten FWAs of two unions, seven Health Assistants (HAs) of three unions, and all sixteen FPIs. Meetings were also held with thana and district officials. The results of the survey showed that the FWAs, FPIs, Family Welfare Visitors (FWVs) and Medical Assistants (MAs) had knowledge deficiencies in the areas of screening and follow-up of contraceptive methods, MCH care, and record-keeping and reporting. The survey revealed that the majority of FWAs and FPIs had poor knowledge on the use of screening and follow-up checklist for potential pill and injectable acceptors, correct definition of eligible couple and calculation of their correct age, use of correct codes for FP methods, antenatal care (ANC) and referrals for

recording, as well as defining a new acceptor and calculation of contraceptive acceptance rate (CAR) for the purpose of reporting. The knowledge of FPIs, supervisor of FWAs was much weaker in comparison with FWA. The FWAs faced problems in preparing the monthly report. Eighty-two percent of the MWRAs never visited a satellite clinic (SC) and the majority of them were not aware of services offered at the SC. About 50 percent of the women ever visited the Health and Family Welfare Centre (H&FWC), and the majority of those were not aware of services offered at the H&FWC.

The knowledge of FWVs on diarrhoeal management, treatment of acute respiratory infection (ARI), post-partum counselling on FP, use of pills and injectables was weak.

Observations at the SC and the H&FWC showed that, despite the availability of FP methods, drugs and equipment, and physical presence of staff, the knowledge of equipment use and the quality of care were weak. The survey report recommended a series of actions needed to strengthen the MCH-FP programme, including a refresher training. Following that survey the project conducted a refreshers training of FWA, FPI, FWV and MAs of Mirsarai thana.

This paper describes the experiences of the refresher training conducted in Mirsarai during August-October 1994.

Objective of the Training

The refresher training was undertaken to enhance the knowledge and skills of FWAs, FPIs, FWVs and MAs concerning their duties and responsibilities in providing MCH-FP services to their clients.

Organization of Training

Since both the nearest Regional Training Centre (RTC) and the Family Welfare Visitors Training Institute (FWVTI) were busy with other trainings,

the training was undertaken locally. Time limitations prevented the undertaking of any programme to teach local health and family planning managers. The Project took the lead in organising this training.

A group of experienced trainers was already available to the Project. The trainers designed the curriculum, which included sections on the role of the FWA, FPI, FWV and MA in the national MCH-FP programme, communication, motivation, counselling, contraceptive technology, MCH care, and use and maintenance of FWA register and reporting of performance. While preparing the training curriculum, materials used by NIPORT-GTZ, UNICEF and the Directorate of Health Services were extensively consulted [4-10]. All training materials were then shared with the concerned resource persons of the Project and local government health and family planning officials of Mirsarai for their review and recommendations. This resulted in the preparation of three volumes of training materials: (a) the role of the FWA and FPI in MCH-FP service delivery; (b) the role of the MA and FWV in MCH-FP service delivery; and (c) record-keeping and reporting. Detailed descriptions of the learning objectives, learning topics, time allotted for each topic, instructional methodology, resource materials to be used, were included in each volume, etc. Three volumes are currently available in the Project library and can be used as resource materials for designing refresher training at the thana level. The areas of training, number of participants, duration of training and number of batches have been described in the attached Training Calendar (Appendix-A).

Management of Training

The training was originally planned to be held in the H&FWC at the union level to reduce the travel time of the trainees, but it was not possible, because of unwillingness of thana managers. As per recommendation of thana managers, the meeting room attached to the office of the Thana Family Planning Officer (TFPO) and an empty staff quarter in the campus of the Thana Health Complex (THC) were selected as the training venues.

Unfortunately, the two venues could not be used throughout the training period, because the TFPO was not willing to withdraw enough trainees for two sessions of training. The TFPO felt that too many work days had already been lost due to the involvement of the FWAs and FPIs in the preparatory work for National Immunization Day (NID) and that the loss of additional work days would not be appreciated by the Deputy Director, Family Planning (DD-FP). Despite repeated attempts by the members of the Project staff, it was not possible to convince local thana officials to support two training sessions simultaneously.

Although all the medical doctors of the THC were cooperative, their involvement caused many management problems, because they often had to leave the classroom to attend patients and emergencies. There was a problem with one trainer who presented too much material and used many English words which were not understood by many trainees. Sometimes this trainer brought up issues not relevant to the topics or not important to the FWAs and FPIs. Also, thana officials were not enthusiastic to encourage their junior colleagues to take responsibilities for training. A training of trainers (TOT) for thana managers would have been ideal but could not be organised due to time constraints.

There was some dissatisfaction among the participants when the local Member of Parliament (MP) visited one training venue. The MP referred to some findings of the needs assessment survey conducted by the Project and advised both the trainees and trainers to avail of the training support provided by the Project.

The emphasis was on training the FWAs, FPIs, FWVs and MAs, who were most involved in the planned intervention, the training of HAs and AHIs was not a high priority. A training course will be developed for HAs and AHIs as required. Ultimately, 130 trainees of the 190 who were in need of training attended.

Due to some problems in the national programme and an unfavourable political situation, the training had to be postponed. The training began on August 8, 1994 and was completed on October 30, 1994. The DD-FP of Chittagong opened the training of the first and fourth sessions.

The training was conducted in each of the two venues by a team consisting of one ICDDR,B and one government thana official. Each venue had a maximum of 20 participants. Although two training venues could not be continued, as previously mentioned, 20 participants, however, attended in one session throughout the training period.

Methods and Materials

The instructional methodology was mostly lecture-oriented followed by questions and answers. In addition, there were small group work followed by presentations to the large group. Case studies were designed and used as exercise in the class room. This was aided by role playing and games.

Handouts, posters, white board and marker, izle board, brown paper and marker, overhead/slide projectors and video shows were used for supporting the training. A standard pre- and post- evaluation was conducted using two different questionnaires – one for the FWAs and FPIs, and one for the FWVs and MAs.

Results

The refresher training provided the first opportunity for the Project staff members to have face-to-face communication with the FWAs, FPIs, FWVs and MAs of Mirsarai. The socio-deomographic profile of the trainees is presented in Table 1. The data were collected as a part of ice breaking for the trainees.

Table 1: Percentage distribution of trainees by their sociodemographic characteristics

Socio-demographic characteristics	FWA (n=78)	FPI (n=16)	FWV (n=17)	MA (n=11)
Religion				
Islam	56	69	53	27
Hinduism	43	25	41	64
Buddhism	01	06	06	09
Formal education				
Below SSC	79	00	00	00
SSC or above	21	100	100	100
Length of service				
Less than 5 years	08	08	28	18
More than 5 years	92	92	72	82
Spouses occupation				
Unemployed	06	00	00	00
Business	19	00	35	00
Agriculture	04	00	06	00
Salaried job	72	25	59	27
Housewife	00	75	00	73
Number of children				
No children	03	06	18	00
Either a son or a daughter	16	19	24	18
One son + one daughter	56	63	24	55
Two sons or daughters	25	13	36	27
Contraceptive use*				
Non-user	35	26	77	27
Pill + condom	38	40	06	64
CuT	10	20	10	00
Injectables	12	07	00	09
Sterilization	05	07	06	00

* Four widowed FWAs and one separated FWV are not included.

With the exception of the MAs, the majority of the trainees were Muslims. More than 30 percent of the trainees were either Hindus or Buddhists. Seventy-nine percent of the FWAs had below secondary-level education. This is not unusual, as the educational requirement (above secondary level) for the FWAs was only introduced in 1989. However, education below the secondary level may have implications for programme management, especially in the area of record-keeping and reporting. With the exception of the FWVs and MAs, the majority of the workers had more than five years of service.

Salaried jobs, such as school teacher followed by business, were the most prominent occupations of the spouses of the trainees. In contrast, the majority of spouses of FPIs and MAs were housewives.

Except for the FWVs, the majority of workers had one son and one daughter. Some of them had more than two children, contrary to the nationally advocated policy of "2 children are enough." This is not unusual in the context of Bangladesh. Quite a sizeable number of FWVs and FWAs did not use any contraception. Almost an identical number of MAs and FPIs were non-users. The majority of all workers were either non-users or temporary users. The use of injectables, IUD and sterilization among the providers was not very popular. Despite the fact that FWVs are the principal providers of injectables and IUD, the use of these two methods was not prominent among them.

During the early 1990s, a review of the job description [11] of all field-level personnel of the family planning wing was revised and published in the form of a booklet. To assess the job knowledge of the trainees, they were asked to list at least four items from their job descriptions. Only 20 percent of the FWAs could indicate at least four items from their job descriptions. It rose to 87 percent after the training. The FPIs began with better knowledge, which increased from 73 percent to 100 percent. Only 11 percent of the FWVs could indicate four items from their job descriptions. It rose to 83 percent after the training. Only 10 percent of the MAs could identify four items, but it increased to 64 percent after the training.

The FPIs and MAs appeared to have gained more (Figure 1). There was no significant difference between FWAs and FPIs in their base knowledge level. However, the FPIs appear to have gained more compared to FWAs. The FWVs had a better base knowledge level compared to the MAs, but the MAs superseded the FWVs after the training.

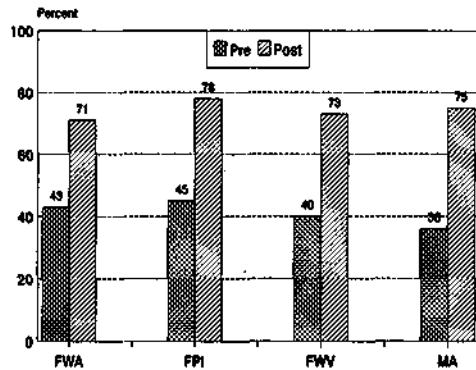


Fig. 1. Mean percentage score of the FWAs, FPIs, FWV and MA

To assess the trainee's knowledge of screening for contraceptive methods, the FWAs and FPIs were asked to write any of the contraindications recommended in the checklist of the FWA register. The average base knowledge of FWAs on screening for oral pills, injectables, IUD and sterilization appeared to be higher than that of the FPIs, but an almost identical level of gain occurred after the training. Although the average base knowledge of FPIs in follow-up and MCH advice appeared to be higher than that of the FWAs, the level of gain was similar after the training (Figure 2).

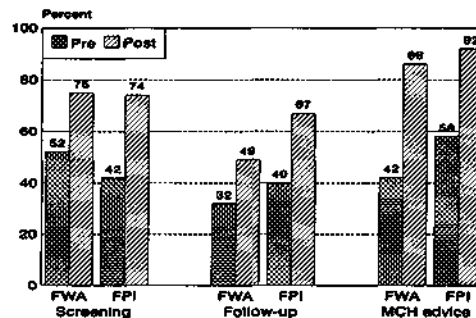


Fig. 2. Percentage of FWAs and FPIs knowledge on screening, follow-up and MCH

The FWVs and MAs' knowledge of screening for all four contraceptive methods was assessed at the beginning of the training. The base-level screening knowledge of FWVs appeared to be better than that of the MAs (Figure 3). The poor screening knowledge of the MAs reflects their limited involvement in screening a client for contraceptives. The nature of the MAs' job does not encourage them to learn more about screening.

Questions on follow-up of oral pills and injectables were not included for two reasons: a) screening, supply and follow-up for oral pills is mainly done by the FWAs; and b) there was a separate training programme exclusively for injectables. Therefore, the FWVs and MAs were asked only about follow-up for IUD acceptors. Worryingly many FWVs showed little interest in follow-up once a client received an IUD, the FWVs tend to be uninterested in follow-up. This issue needs more investigation. The MAs are unlikely to encounter IUD follow-up cases.

With regard to MCH, the base knowledge of ANC appeared to be better for all types of workers, except MAs. This is not unusual as the MAs are not charged with this responsibility. However, there was substantial gain after training. FWV identification of pregnancy complications was surprisingly low. This is also true in the case of postnatal care (PNC). One possible explanation may be that the FWVs do not encounter many complicated cases at the H&FWC, and the issue of PNC may receive less attention. This also requires investigation.

Data on the correct calculation of the expected date of delivery (EDD) by all categories of trainees demonstrated that the base knowledge level of the FWVs and MAs was satisfactory compared to that of the FWAs and FPIs (Figure 4). For the FPIs, correct calculation of EDD is necessary for providing supervisory support to the FWAs.

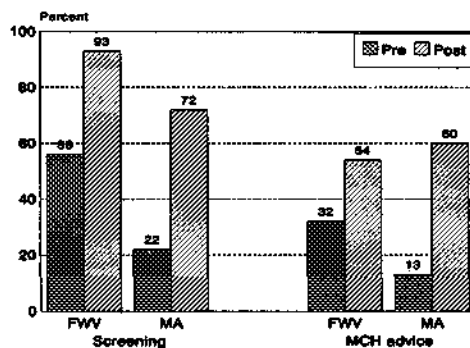


Fig.3. Percentage of FWVs and MAs having knowledge on screening and MCH

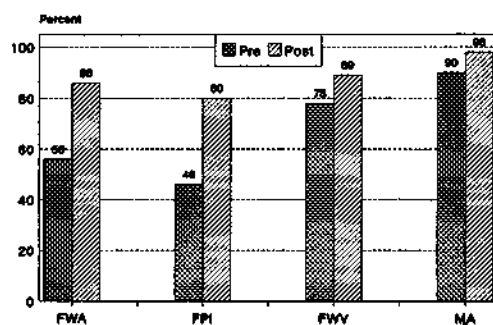


Fig. 4. Mean percentage scores for calculation of Expected Date of Delivery

The FWA register is the main source of family planning performance data generated at the field level. As per the nationwide training plan, the FWAs and FPIs receive five days of training conducted by national trainers. This training should be sufficient to ensure proper use and maintenance of the FWA Register. In the refresher training, the main focus was correct recording and reporting, and, thus, only two days of training were devoted to it.

The overall base knowledge of the FWAs and FPIs was poor. Correct use of designated codes for the type of method used in the FWA register is important for reporting actual performance. At the end of daily home visits, the FWAs are supposed to calculate the CAR in the daily activity compilation sheet to be transferred to the monthly performance report. Correct use of designated codes for method use, filling out the daily activity complication sheet and calculation of the CAR were used for assessing the current knowledge level and the gain that occurred after the training. The FWAs' appeared to have better base knowledge, with the exception of calculating the CAR. The FWAs ability to calculate the CAR did not have any appreciable gain even after the training, as there is a high proportion of the FWAs with a low level of education. Also, it was not surprising to see that the FPIs have a low level of knowledge in filling out the FWA register. Although the FPIs are not supposed to fill out the FWA register, they should have better knowledge to support the FWAs. Their ability to calculate the CAR before training was also surprisingly low. Their low knowledge level may encourage them not to pay attention to the FWAs request for assistance in the field. However, the FPIs gained more than the FWAs after the training (Figure 5).

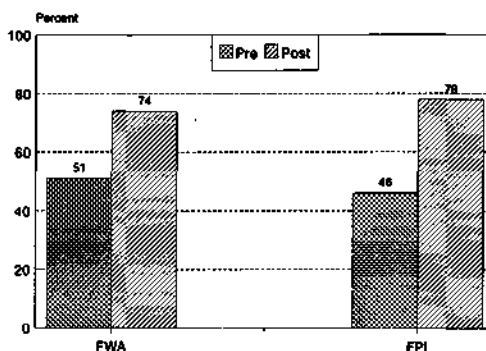


Fig.5. Mean percentage score of the FWAs and FPIs on FWA register use and maintenance

At the end of the training, the trainees were asked to rate the "ICDDR,B training" compared to the last training they received. The rate of non-response was quite high for some questions, which were excluded from the results.

Conclusions and Recommendations

The experience shows, with very little input, a training programme can be organised at the thana level. The need for refresher training for the FWAs, FPIs, FWVs, and FPs is not well developed and adequately emphasised due to the fact that the available training facilities, like RTCs and FWVTIs, are constantly overburdened. The conduct of on-the-job training at the local level is also not possible due to non-availability of trained trainers. There is also a need to develop a set of self-instructional module and a team of trainers from among the thana managers for each district. Therefore, a group of trainers, an adequate Training of Trainers (TOT) should be raised. This would contribute to the establishment and institutionalization of a system of on-the-job training for the workers in the national programme, and would also ease the problem of conducting any short training at the thana level.

The base knowledge level of the workers, supervisors and paramedics appeared to be very low in general. Such a low level of knowledge of the workers can be attributed to the fact that Mirsarai was without a TFPO for about three years. As a result, the workers practically worked without any leadership. The absence of a systematic review of performance, follow-up in the field, and on-the-job training certainly contributed to such a low level of knowledge.

As the FWVs and MAs have different qualifications, it would be ideal to design separate training programmes for them. The MAs often tend to feel superior to the FWVs, because they have completed 36 months of training, while the FWVs have had only 18 months of training.

Using the H&FWC meeting, specific topic-oriented on-the-job training should be conducted to improve the knowledge and skills of the FWAs, FPIs, FWVs and MAs.

The participants made no major recommendations for improving the training, but did indicate that the video, posters and flip-charts were useful.

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TRAINING CALENDAR

Training course	Participants (number)	Duration of training	No. of batches	Date of training
The role of FWAs and FPIs in MCH-FP program	FWAs, FPIs (n = 79 + 16)	4 days	1	Aug 08-11
			2	Aug 08-11
			3	Sept 17-20
			4	Sept 21-25
			5	Sept 26-29
The role of FWVs and MAs in MCH-FP	FWVs, MAs (n = 17 + 18)	6 days	1	Oct 08-13
			2	Oct 15-20
FWA register use, maintenance and reporting for FWAs and FPIs	FWAs, FPIs (n = 79 + 16)	2 days	1	Oct 22-23
			2	Oct 24-25
			3	Oct 26-27
			4	Oct 29-30
			5	Oct 29-30