EVALUATION REPORT

# Mobilization of FCHVs to disseminate family planning messages using Interpersonal Communication (IPC) in Myagdi district, Nepal

**Final report 29th June, 2016**

**HERD International**

**Mott MacDonald**

*This work is funded by the UK Department for International Development (DFID) and the United States Agency for International Development (USAID) in close collaboration with the Government of Nepal.*

# Acknowledgements

The authors would like to express our sincere gratitude to the individuals and institutions who contributed views and information to this assignment. We are grateful to DFID and USAID for their financial support and for commenting on the initial drafts, and to the Ministry of Health and its Family Health Division for facilitation of evaluation tasks in the districts. Thanks to the Health Communication Capacity Collaborative (HC3) team for collaboration from the early concept notes and for providing detailed comments on this report. We are also grateful to our field based monitors Ms Samita Kila and Ms Smriti Maskey for their commitment and hard work to collect quality data. Sincere thanks to Mr Hom Nath Subedi for coordination with national and district level stakeholders throughout the project period. This evaluation required a concerted effort between HERD International and the Mott MacDonald team, who jointly co-author this report.

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Recommended citation:

Abriti A, Marston C, Fairfax J, Maskey S, Giri S, Regmi S, Baral S (2016). Mobilization of FCHVs to disseminate family planning messages using Interpersonal Communications (IPC) in Myagdi district, Nepal. Evaluation Report. HERD International and Mott MacDonald Ltd. Final report, June 2016.

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# Abbreviations

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| DHO | District Health Office |
| FCHV | Female Community Health Volunteers |
| FHD | Family Health Division |
| FP | Family Planning |
| HFOMC | Health Facility Operation and Management Committees |
| HERD | Health Research and Social Development Forum |
| HMIS | Health Management Information System |
| IPC | Interpersonal Communication |
| IPCC | Interpersonal Communication and Counselling |
| IUCD | Intra-uterine contraceptive device |
| KII | Key Informant interview |
| LARC | Long Acting Reversible Contraceptives |
| LSHTM | London School of Hygiene and Tropical Medicine |
| M&E | Monitoring and Evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MM | Mott MacDonald |
| NDHS | Nepal Demographic and Health Survey |
| NHRC | Nepal Health Research Council |
| NHSSP | Nepal Health Sector Support Programme |
| OCP | Oral contraceptive pills |
| QI | Quality Improvement |
| RA | Research Assistant |
| SRO | Senior Research Officer |
| VDC | Village Development Committee |
| WRA | Women of Reproductive Age |

# 1. Summary of key evaluation findings and recommendations

## Introduction

The Nepal Family Planning Programme aims to reduce unmet need for contraception and promote the rights of women to exercise choice when selecting a contraceptive method. Unmet need for contraceptives is very high in Nepal, estimated at 27% in 2011, which increased from 25% in 2006 according to the Nepal Demographic and Health Surveys (NDHS). The overall contraceptive prevalence rate is also low, estimated at 43% in 2011 for modern methods, reduced from 44% in 2006 (NDHS). The Health Communication Capacity Collaborative (HC3) team in collaboration with the District Health Office, Myagdi, implemented a pilot to work with FCHVs, with monitoring and evaluation from Mott MacDonald/HERD.

The pilot aimed to use mobilization and training of FCHV in Interpersonal Communication (IPC) skills to disseminate family planning messages to women of reproductive age in Myagdi district to increase family planning uptake. HC3 selected 15 Village Development Committees (VDCs) where FCHVs received IPC training, supportive supervision, monitoring and follow up by project staff. In these **intensive-focus VDCs**, HC3 provided IPC training and "supportive supervision" to support FCHVs to do their tasks such as filling in the FCHV register correctly, referring clients to health facilities and follow up of the referred client, helping FCHVs facilitate health mothers group meetings, and helping FCHVs to map all eligible women in particular categories within their wards. For the remaining 26 VDCs, a **non-intensive version** of the intervention was implemented, in which FCHVs only received initial orientation training in IPC and in the use of IEC materials, but no supervision, monitoring or follow up were provided. These VDCs will be referred to as 'non-intensive VDCs' hereafter.

## Evaluation focus and main evaluation questions

Ideally we would have addressed the following broad evaluation questions:

1) Do FCHVs deliver more FP services and approach more potential FP users using IPC training? Does FCHV exposure to IPC increase uptake of FP services? Are new women of reproductive age (with particular reference to post-partum mothers) being reached by FCHVs?

2) Does IPC increase the knowledge, awareness and willingness of FCHVs to deliver more FP information services?

3) What is the evidence that FCHVs are delivering the expected FP services in their communities?

4) What factors could increase the likelihood of FCHVs performing their tasks better?

5) What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective?

6) How long are results from the intensive intervention likely to last? Why? What would render results more durable/sustainable?

It was soon realised during evaluation design that it would not be possible to answer most of these evaluation questions, particularly the ones requiring a quantitative measurement as neither pilot implementation nor the available data would allow for that. Furthermore, it was apparent at design that the specific needs of women targeted by this intervention were not well understood: we know from existing literature that lack of information is not the only reason women do not use reliable contraceptive methods when they do not want a pregnancy. It was therefore decided at design that the evaluation would attempt to assess how FCHVs might be in a position not only to provide information, but perhaps address other barriers to use through a better assessment of existing barriers.

## Methods

We used a mix of qualitative and quantitative data collection to explore how the intervention worked in practice. These methods are briefly summarised in the table below. Owing to the design of the intervention, where intensive-focus VDCs were chosen by HC3 (because they were most in need), it was not possible or appropriate to compare the intensive and non-intensive focus VDCs using quantitative approaches. In addition, it was not possible to attribute any changes in service utilisation to the IPC training or to other project interventions because the scope of the evaluation was limited by time and resources, and so a household survey which might have helped answer question 1 was not feasible. Qualitative methods were therefore essential given the major limitations to any quantitative evaluation. We anticipated this might have a major likely benefit of uncovering unexpected findings during the evaluation.

**Table 1.1: Main study questions and evaluation methods**

| Main study questions | Evaluation methods |
|---|---|
| 1. Do FCHVs deliver more services and approach more potential FP users using IPC training? Does exposure to IPC increase uptake of FP services? | Since available data (FCHV registers) and evaluation methods did not allow for a before and after comparison, we collected self-reports from FCHVs about whether more women were approached, but these obviously have major limitations. On the second question of whether exposure to IPC increases uptake, an accurate or even proxy investigation was not possible or attempted given the small size or the intervention (which limits attribution of intervention to output), the unreliability of HMIS data on uptake and the |

| Main study questions | Evaluation methods |
|---|---|
| | limitations of the evaluation methods, since measuring the effect of IPC on uptake would have required at least a population based survey and probably use of control groups. These methods were discarded for time and resource reasons (see detailed methodology in the main report). |
| 2. Does IPC increase the knowledge, awareness and willingness of FCHVs to deliver more FP services? | We conducted qualitative interviews with FCHVs to address this question. A quantitative assessment was not possible in the time and resources available. |
| 3. What is the evidence that FCHVs are delivering the expected FP services in their communities? | We used observation and qualitative interviews with FCHVs and clients to address this question. |
| 4. Are new WRA (with particular reference to post-partum mothers) being reached by FCHVs? | We used indicative statistics based on FCHV self-reports, district level family planning statistics, and qualitative interviews with FCHVs and women of reproductive age to provide some context for this question although all of the limitations mentioned above about quantitative data apply here too. |
| 5. What factors could increase the likelihood of FCHVs performing their tasks better? | We addressed this question qualitatively using interviews with FCHVs and women of reproductive age. |
| 6. What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective? | We addressed these questions qualitatively in FCHV and client interviews. |
| 7. How long are results from the intensive intervention likely to last? Why? What would render results more durable/sustainable? | We addressed this question qualitatively |

## Data collection

The pilot began in August 2015 and ended in December 2015 and the evaluation work began in August 2015 and ended in January 2016. For monitoring and evaluation, we selected 2 VDCs (Singa and Darwang) from the intensive sites, and 1 VDC (Bhagwati) from the non-intensive sites: in these VDCs we collected qualitative data. We also collected quantitative data from FCHVs in all 15 of the intensive VDCs and from one of the non-intensive VDCs (Bhagwati). Intensive VDCs were from PHCC and Hospital clusters so that any demand generation from the programme would be more likely to be met.

Observation: we conducted observations that involved a Research Fellow (RF) living in the community for six months (August 2015 – January 2016), observing two health mothers' groups (HMGs), and shadowing two FCHVs for two days each in order to observe what the FCHVs' work involved first hand. In addition to the formal data collection, the RF made ad hoc observations and conversed with numerous informants over the course of the fieldwork period.

We also conducted client interviews. Clients were selected from the population of women of reproductive age (15-49 years old) from the wards of the VDCs. The aim was to sample as diverse as possible a selection of women in terms of age, parity, ethnic group, and education level. We conducted two group interviews with clients and an additional two group interviews with members of Health Mothers' Groups

We conducted 21 one-to-one interviews with women eligible to be family planning clients i.e. of reproductive age. We conducted 8 interviews with FCHVs - 6 from the intensive VDCs and 2 from the non-intensive VDC. We also conducted 10 key informant interviews with healthcare staff and staff delivering the intervention.

To provide additional data on the background to the intervention, we collected quantitative data from a sample of 55 FCHVs located across all 15 intensive focus VDCs, and from one non-intensive VDC. We used a structured questionnaire to find out about FCHV practices, particularly referrals and recording practices. We also cross-checked the FCHV reports against her ward register and referral slips. The referral slips were introduced as part of the intervention to try to track FCHV referrals.

Finally, to provide further contextual information, and noting the likely problems with the data described above, we requested the district level statistics on contraceptive use at the beginning of the pilot and then for the same period one year later.

We analysed the qualitative data thematically and iteratively, refining themes by discussion and in light of evidence from across the sample. The quantitative data did not require statistical analysis.

## Findings

*Do FCHVs deliver more FP services and approach more potential FP users using IPC training? Does FCHV exposure to IPC increase uptake of FP services? Does IPC increase knowledge, awareness, and willingness of FCHVs to deliver more FP information services?*

FCHVs reported they enjoyed the HC3 IPC training sessions and found them useful. Refresher training was something many said they value. Our survey results suggest that FCHVs receive refresher training from NGOs rather than government sources and we have no information about the quality of any of the training.

It is not possible to say whether the IPC orientation increased FCHV knowledge but in qualitative interviews FCHVs said that it helped refresh their memories and helped them think about how to communicate respectfully and politely with women in their wards.

As a result of this pilot intervention and its IPC training, health mother's group (HMG) meetings have taken place that previously did not exist in many places. These meetings have prompted discussions about health including family planning which may have increased local information and awareness about family planning.

The referral slips (rather than providing information orally) indicated that FCHVs contacted and referred clients, It is not possible to determine whether IPC training increased referrals or increased uptake of family planning, however as we do not have a suitable comparison group. FCHVs said that the referral slip helped them to record their activities and clients said the slips helped them obtain FP services from health facilities (see below).

We would liked to have compared FP uptake before and after the pilot from FCHV registers, notwithstanding their likely inaccuracies, but many FCHVs had not completed their FCHV registers in the previous year, or FCHV registers were unavailable and so this was not possible.

Although FCHVs in intensive VDCs did the exercise of mapping clients, they generally told us they had not used or updated the information in the maps. As FCHVs already know their communities well, they did not visit each household in order to undertake the mapping. The sense is they do not know their community any better than before the mapping work – the main difference is that their extensive knowledge is now documented.

As outlined in Table 1.1 /evaluation question 1) it was not possible to measure whether numbers of users or number of services increased as a result of either IPC training alone (non-intensive VDCs) or as a result of the intervention as a whole (in intensive VDCs).

### *What is the evidence that FCHVs are delivering the expected FP services in their communities?*

We found evidence that FCHVs are working hard to provide family planning services for their communities. They use their own resources (time, cell phones) to contact clients and to provide help and advice. They refer clients to health services and accompany clients to help them obtain the services they need. Nevertheless their knowledge and skills are limited: they often have limited formal education and limited subsequent training. We found evidence that in some cases they were providing inaccurate and even counter-productive family planning advice, such as advising women to discontinue oral contraceptive pills for fear of long-term side effects. FCHVs need more supervision and support, yet the FCHVs sometimes resented the supervision of the HC3 supervisors because this created higher expectations of their work on the pilot, which meant they did not have time for other roles they had been asked to perform e.g. on other projects. They noted that they were not compensated in any way for this extra intensity of effort. Note that the work FCHVs were doing in this pilot was almost all within their existing scope of work e.g. mapping eligible clients and running HMGs, but not all FCHVs were doing this work as a matter of routine.

### *Are new WRA (with particular reference to post-partum mothers) being reached by FCHVs?*

Most FCHVs held health mothers groups near to their own homes and noted that it can take a great deal of time to visit an entire ward. Some FCHVs described using cell phones – paying for this with their own money – to try to facilitate the follow-up process. The FCHVs

tried to find out who was pregnant in their wards but at least one FCHV told us of a woman who successfully concealed her pregnancy until after the baby was born because she was worried the FCHV would scold her for not having disclosed the pregnancy earlier. It is unclear what proportion of potential clients are reached by FCHVs because the denominator (i.e. how many there are in the first place) is unknown. Note that it is also unknown to health service providers, who rely on FCHVs for this type of information. It seems likely that while FCHVs seem to know about many pregnancies in their wards, unwanted pregnancies may be concealed (and women may travel to terminate pregnancies elsewhere to avoid disclosure). Our interviewees described how married women with unmet need for family planning are helped by FCHVs but we came across no accounts of FCHVs helping clients who were having extra- or pre-marital sexual relations. This is not to say that such clients were not helped, just that this was not mentioned as an activity directly to us.

*What factors could increase the likelihood of FCHVs performing their tasks better?*

The supportive supervision that was added in the "intensive" intervention VDCs uncovered numerous areas where further support is needed for FCHVs to be able to carry out their roles. For instance, HC3 supervisors helped them form and run health mothers groups, which had previously been assumed to already be running and this took time. Supervisors also worked with FCHVs to show them how to make accurate records in the FCHV register – again, something that they were nominally already able to do. We have shown in our interviews that FCHVs may also lack important knowledge about family planning that means their advice to clients, while well meaning, may actually be counterproductive (such as the case of one FCHV who strongly promoted withdrawal over OCPs and whose client had an unwanted pregnancy after taking the advice to switch). We checked the FCHV manual, and it does already contain the key basics that the FCHVs should know except for information about withdrawal methods.

There were few FP leaflets for FCHVs to distribute to clients. During our observation we also observed few FCHVs using leaflets while conducting HMGs. Some of the clients interviewed did mention that FCHVs used real devices and leaflets in the HMG they attended. IEC materials were in short supply. Future IEC materials should be developed with participation from members of the target population to ensure that they are understandable for clients with low education levels and also contain the information clients need.

*What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective?*

FCHVs had mixed feelings about the programme: on the one hand, they liked the IPC training and found it useful and inspiring. They also liked using referral slips – introduced within the pilot as part of the evaluation – which they felt gave them additional authority and helped to make their work more visible at the health services. On the other hand, they found the demands of the programme excessive, particularly the mapping exercises to identify potential clients which some said they did not even use.

Clients told us they preferred women providers and would avoid male providers, so even if FCHVs managed to increase demand, they might not affect uptake if female providers are not always available at the health facilities. This is consistent with some of the evaluation findings for the voluntary surgical contraception (VSC+) pilot, which examined the effects of

adding other contraceptive methods to the range available at 'sterilisation camps'. We do not have detailed information but the health facilities we visited as part of this evaluation had at least one female provider (ANM) and so for these facilities is possible that a client desiring a female provider would be able to return at a different time if she was not available when they first tried to obtain the service rather than having no access at all to a female provider.

*How long are results from the intensive intervention likely to last? Why? What would render results more durable/sustainable?*

Many interviewees emphasized the need for refresher training. Our observations of the FCHVs' sometimes patchy knowledge of family planning suggest that refresher training is essential to ensure that they are able to counter rumours and provide balanced information on the risks and benefits of different methods.

The supply side is crucial for sustainability: if an FCHV can refer to services where providers can supply a range of methods and information about these methods, her role is clearly marked out as primarily promotional: raising awareness of different methods and encouraging clients to go to services. If those services are weak, however, our data suggest that the FCHV begins to take on the role that would more properly be held by a trained healthcare provider. In this case, she advises on side effects, counsels women to use (or stop using) particular methods, and so on. This latter role is one that should always be accompanied by referrals: she might for instance reassure a woman that bleeding is a known side effect of injectables, but that the woman should seek professional care. At present, the referral part of the process is sometimes missing, perhaps when the required services are not available, or are limited in scope and quality.

## Discussion

This study shows that there are gaps in family planning provision in Myagdi. The most serious gap is in lack of trained providers to give women accurate and timely information about contraceptive methods and to provide LARCs. The gap is being filled by FCHVs, particularly with respect to sharing family planning information. FCHVs are often (although not always) trusted by local women, who seek their advice. LARCs are not always available, and are sometimes even withheld from women who request them without any alternative method being provided. Some FCHV tasks may be undermined by health system limitations. For instance, if FCHVs refer for LARCs but women are turned away when they seek these at the facility, the FCHV may lose credibility, or stop referring for LARCs at all. To help FCHVs to perform their tasks better, health posts need both the commodities and skilled staff required to provide a range of contraception and abortion services beyond the current condoms-pills-injectables trio that is often all that is available.

The more responsibilities the FCHVs are given, the more supervision they are likely to require to ensure they carry out their tasks correctly. However, some FCHVs said they did not like the supportive supervision because it meant that they had to give extra time to the family planning element of their work when they also needed to spend time on their other tasks, as well as doing their personal household and economic activities. This was not because the scope of work had changed, rather that the supervision meant that tasks

FCHVs had not always been doing routinely (such as mapping eligible clients, running health mothers groups) became part of the day-to-day workload.

FCHVs are currently expected to do a large number of diverse tasks without payment and which sometimes require out-of-pocket expenses as well, such as phone calls to follow up with clients. To do all the tasks adequately takes time and so some tasks are likely to be done less frequently than is ideal, or perhaps skipped altogether. The FCHVs pointed out that when they cover a large geographical area it is very difficult to get to all households and so they rarely do it. FCHVs have excellent reach into even the most remote communities and with greater support their reach could potentially be extended even further.

FCHVs have played a vital role in the Nepal health system for many years, providing a bedrock for numerous interventions and carrying out a large number of duties to help the system run smoothly. Their role as health promoters has been expanding into areas of work more commonly associated with trained community health providers, as we have shown in this report with respect to advice on family planning.

FCHVs' roles as local community health promoters should be redefined and recognised with adequate support measures to advance their historic engagement in community health system strengthening.

## Recommendations

1) *FCHV support mechanisms should be piloted to capitalise on and improve sustainability of FCHV work*

The following options if of interest must be carefully investigated and piloted to identify the best strategy. One option might be to train FCHV supervisors/outreach workers who would be trained healthcare personnel tasked with working in the community. These workers could help to remove some of the excessive burden currently placed on FCHVs, and could also ensure that a) healthcare advice is available in places where women and families already are, rather than them having to travel to what is often a distant health facility; b) higher quality healthcare advice can be given than currently available from FCHVs; c) a trained provider will be able to spot health problems at an early stage and either address them immediately or refer to appropriate services, thus potentially avoiding emergency hospital visits. Another option that could also be investigated might be to train and pay FCHVs who show promise in certain ways e.g. who have higher levels of education, or who have the skills needed for specific roles. A further option might be to develop a new cadre of community health workers to support the work done by the FCHVs. To reiterate: these options would need to be carefully thought through and piloted.

2) *Standard health service operating procedures for family planning should be investigated and amended if necessary to ensure women are not incorrectly prevented from accessing the contraceptive services they seek*

Supply side barriers to access to family planning need to be addressed. We found some evidence that healthcare providers are turning women away for apparently spurious reasons when they request services. Women said they were turned away for being in the 'wrong' part of their menstrual cycle for instance, when in many cases, it appeared they could have been

given the method and advised to use condoms for the first several days. Standard operating procedures for provision of injectables and pills should be examined to ensure they comply with latest guidelines to ensure that services can be delivered to the largest number of women possible who request them. Better provision of LARCs should also be investigated.

*3) Privacy and confidentiality should be improved in the interface between FCHVs and health services*

Quality of the advice is not the only issue with FCHV roles in the health sector. There is also a question about how patient confidentiality is being respected. At present, it seems as if there is a very porous boundary between the health facility staff and FCHVs in terms of information about clients, with FCHVs telling health staff about women in the community and vice versa. While FCHVs may play a key role in finding eligible clients, health service staff should not disclose patient details to FCHVs, or vice-versa. We speculate that lack of privacy may put women off seeking contraception from health facilities or force them to travel long distances to obtain services from facilities where they are not known. Regardless, health facility staff should not share information about clients outside the facility. If information sharing is considered potentially useful, the women most likely to be affected, services and FCHVs should be engaged in a dialogue about how best to achieve this without causing unintended harm.

*4) Emergency contraception should be provided and promoted*

Emergency contraception options should be more readily available across Nepal to help prevent unintended pregnancies. Further research is required on the extent to which emergency contraception could be employed to greater effect in Nepal. From such studies the feasibility of FCHVs providing advice on, and even potentially distributing, emergency contraceptive pills could be further explored. This would require careful piloting to ensure it was done correctly and that women were not being encouraged to switch from more effective methods. Better access to emergency contraception could particularly benefit women whose husbands return unexpectedly from overseas and who therefore have not had time to obtain a more reliable method. For instance, one of our interviewees was given a single oral contraceptive pill by the FCHV and told to go to the service for the rest of the course: emergency contraception could have been a better option under those circumstances to prevent pregnancy. Women who rely on other methods such as condoms should also have access to emergency contraception in case of method failure. Given that the method must be taken as soon as possible after unprotected intercourse, FCHVs appear to be an obvious source in remote areas or where clinics are not staffed full time.

*5) Any changes to services should involve community participation throughout, including at the planning stage*

Improvements in family planning services should be planned and carried out with full participation of clients in the process. For instance, local women may have ideas about how to tackle the issue of lack of female providers, or reluctance to use male providers, which could help improve quality and attract additional clients to the service. Community participation has been shown to lead to innovative solutions previously in Nepal as well as other countries worldwide[1] and is at the heart of the new Global Strategy for Women's

[1] Marston C, Hinton R, Kean S, Baral S, Ahuja A, Costello A, Portela A: **Community participation for transformative action on**

Children's and Adolescents' Health[2]. Nepal has shown leadership in this area, which should be built on to improve family planning provision. Current infrastructure lends itself to participatory approaches. For instance, health mothers groups might work with local healthcare providers to discuss what family planning services would be most useful and how they should best be delivered. While we would advocate involving communities immediately, the best way to do it in the medium to long term would also benefit from piloting different approaches or techniques to identify which approaches are optimal in which contexts.

## Conclusion

FCHV training and support is useful but not sufficient to create better family planning programmes. FCHVs can act as valuable champions of family planning, but they cannot work alone: they do not have the requisite skills or training to provide the healthcare support clients need.

For Nepal to achieve better healthcare coverage for all, FCHVs must be supported more by healthcare professionals and the health system. FCHVs need a clearly defined role within the health system so that they are not simply asked to perform more and more tasks. Our findings suggest that FCHVs would play a very valuable role in championing family planning at the community level. Their role as health promoters and not providers needs to be clarified and appropriate health provider support put in place to ensure FCHVs are not asked to go beyond their training and skill set but instead given the opportunity to play to their strengths: as community health promoters and health champions, in an evolving and improving health system.

**women's, children's and adolescents' health**. *Bull World Health Organ* 2016, **94**(5):376-382.
[2] http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

# 2. Introduction

## 2.1 Background

The UK Department for International Development (DFID) and the United States Agency for International Development (USAID) in collaboration with the Government of Nepal have been providing for more than a decade technical and financial support to increase access to quality family planning services to the population of Nepal. As part of that support, DFID and USAID commissioned in 2014 a series of evaluations of innovative interventions to increase access to family planning by specific population groups or in geographical areas that are known to have limited access to family planning services.

This evaluation report refers specifically to the evaluation of one of the pilot interventions, mobilization of FCHVs to disseminate FP messages using IPC for the population of Myagdi district.

## 2.2 Justification

Note - The information provided herein has been taken from the Concept Note that supports and justifies this pilot. In order to keep this evaluation report short some references included in the original concept note have been omitted.

The Nepal Family Planning Programme aims to reduce unmet need for contraception and promote the rights of women to exercise choice when selecting a contraceptive method. Unmet need for contraceptives is very high in Nepal, estimated at 27% in 2011, increased from 25% in 2006 according to the Nepal Demographic and Health Surveys (NDHS). The overall contraceptive prevalence rate is also low, estimated at 43% in 2011 for modern methods, reduced from 44% in 2006 (NDHS). According to Nepal MICS 2014, the unmet need for contraceptives is 25.2% while the overall contraceptive prevalence rate is 49.6%.

## 2.3 The pilot

The pilot being evaluated aimed to use mobilization and training of FCHV in Interpersonal Communication (IPC) skills to disseminate family planning (FP) messages to increase FP use among women of reproductive age (WRA) in Myagdi district. With technical support from the Nepal Health Sector Support Programme (NHSSP) and Health Communication Capacity Collaborative (HC3) and financial support from the United States Agency for International Development (USAID) and DFID, HC3 in collaboration with the District Health Office, Myagdi, implemented the pilot with monitoring and evaluation from Mott MacDonald/HERD. The HC3 in coordination with National Health Education Information and Communication Centre (NHEICC) designed and implemented IPC training for FCHVs and provided

"supportive supervision" within selected districts to strengthen FCHV's IPC skills. Supportive supervision involved supporting FCHVs to do their basic tasks such as filling in the FCHV register correctly, ensuring they had set up health mothers groups etc. and also to help FCHVs to map all eligible women in particular categories within their wards. The key interventions set out in the concept note (Nov 2014) of this pilot were:

(1) Re-activate FCHVs as family planning promoters and mobilizers (as in their initial roles when the FCHV programme started) by providing training on IPC approaches in family planning.

(2) FCHVs interaction with village women of reproductive age (WRA) and facilitation of mothers' group meetings

(3) Dissemination of appropriate use of family planning IEC materials by FCHVs

(4) FCHV community mapping and targeting of eligible women, including referral to government health facilities of WRA interested in family planning methods that are not offered by the FCHV such as injectable contraceptives and Long Acting Reversible Contraceptives (LARCs).

HC3 was to select 10 Village Development Committees (VDCs) in which FCHVs would receive IPC training, supportive supervision, monitoring and follow up by project staff. In these 10 **intensive-focus VDCs**, data on postnatal mothers and "drop-out cases" would be provided to FCHVs from the health facilities so the FCHV could follow-up as necessary. For the remaining 31 VDCs, a non-intensive version of the intervention was to be implemented, in which FCHVs only received initial orientation training with respect to IPC and IEC materials, but no supervision, monitoring or follow up. These VDCs will be referred to as 'non-intensive VDCs' hereafter.

Implementation looked somewhat different from the plans in the concept note.

In the implemented version:

- There were 15 intensive-focus VDCs, not 10 VDCs. This was because of the 10 "VDCs" chosen, one was in fact a municipality which comprised 6 VDCs. The intervention therefore covered 9 VDCs and one 6-VDC municipality from the beginning (i.e. 15 VDCs where the intensive-focus intervention was implemented).

- HC3, in their concept note, proposed to implement the intervention in 10 intensive VDCs. These 10 intensive VDCs were chosen as 5 VDCs near to the district hospital (hospital cluster) and 5 VDCs near to a Primary Health Care Centre (PHCC) (PHCC cluster). One of the VDCs chosen from the hospital cluster turned out to be a municipality where other adjoining 5 VDCs were merged by government of Nepal. This municipality (the combined 6 individual VDCs) has 6 health facilities. Hence, although there were 9 VDCs and 1 municipality covered by the intervention, in reality the intervention had to cover a total of 15 VDCs.

- Data on postnatal mothers etc. was not provided to FCHVs by the health facility. FCHVs were assisted to map eligible clients in their wards. There were varying reports of how this was done in practice. According to one of the HC3 Field

Supervisors, for 2-3 months (probably in the initial phase) HC3 field supervisors were given a form where they reported the number of mothers on ANC, PNC and immunization registers. One field supervisor said the idea was to look at the numbers of eligible clients listed in the FCHV mapping and if they did not tally with the numbers at the health facility, to tell the FCHVs "indirectly" that their mapping might be incorrect. However another field supervisor who joined the project later said she did not do this. Given issues of client confidentiality, it seems advisable not to pass lists of clients to FCHVs (see later).

The training schedule for FCHVs is provided in translation in Annex 2.

## 2.4 Evaluation methodology

The evaluation methodology that was planned at evaluation design has been included in Annex 1.

The following is a brief summary of the main evaluation questions and design issues.

### 2.4.1 Evaluation focus and main evaluation questions

The specific needs of women targeted by this intervention are not yet well understood. Existing literature from elsewhere overwhelmingly suggests that although information about family planning options is important, lack of information is not the only reason women do not use reliable contraceptive methods when they do not want a pregnancy. In addition, it was not clear at the start what training was proposed for the FCHVs and whether or not that training was evidence-based. Given that information is likely to be only part of the picture, it is important to assess how FCHVs might be in a position not only to provide information, but perhaps address other barriers to use. To do this, it is necessary to investigate three key levels: the individual (client or FCHV), the social interaction between the client and the FCHV, and the environment they are in.

Ideally we would have addressed the following broad evaluation questions:

1) Do FCHVs deliver more services and approach more potential FP users using IPC training?

2) Does exposure to IPC increase uptake of FP services?

3) Does IPC increase the knowledge, awareness and willingness of FCHVs to deliver more FP services?

4) What is the evidence that FCHVs are delivering the expected FP services in their communities?

5) Are new women of reproductive age (with particular reference to post-partum mothers) being reached by FCHVs?

6) What factors could increase the likelihood of FCHVs performing their tasks better?

7) What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective?

8) How long are results from the intensive intervention likely to last? Why? What would render results more durable/sustainable?

### 2.4.2 Evaluation design and overall approach

The process of selecting an evaluation design begins with assessing the best ways to address the questions above. This is briefly discussed next.

The most recent concept note that we had from HC3 when designing the study (January 2015) confirmed that the main expected outcome of the intervention was increased use of effective family planning methods by eligible clients. Unfortunately even if the pilot were delivered in a way that would allow for reliable comparisons, population level outcomes cannot be measured without a population based survey, which is beyond the scope of this evaluation owing to the high cost of such an approach and lack of time available.

As alternatives we considered measuring changes at the level of health facilities using the HMIS, but this option was discarded because the intervention will be too small to lead to measurable changes at the HMIS, particularly in the short timeframe. Another option was to measure reported uptake by FCHVs (using their own registers) although this measurement would be limited to condoms and pills, which are the only commodities that FCHVs can offer. In summary, there is no approach that can be used to measure the outcome level indicator quantitatively.

We then considered the possibility of measuring some of the service outputs delivered by the FCHVs using the following indicators for the intensive-focus VDCs:

1. The number of households with eligible women of reproductive age mapped by FCHVs (using the FCHV register)
2. The number of reported contacts with eligible women through counselling and mothers' groups made by the FCHVs (using the FCHV register)
3. The number of program related IPC materials distributed by FCHVs (using the FCHV register)
4. A measure of self-perceived skills and competency of the FCHVs before and after the IPC training. This would be self-reported and hence subjective and subject to intervention bias. We would also not be able to establish a causal relationship between training and skills in the absence of a control group. Please also note that it would not be possible to disentangle the effect of the IPC training from the effects of the supervision that HC3 or the DHO would provide as part of the pilot in the intensive intervention area.
5. The number of self-reported family planning referrals generated by FCHVs (using the FCHV register)
6. Comparison of all of the above with non-intensive VDCs.

In relation to indicators 1, 2, and 3 HERD/Mott MacDonald did not have the resources to monitor these indicators for all the FCHVs in the 15 intensive VDCs, where an estimated total of 135 FCHVs operate. What we did do, however, was measure these among a sample

of FCHVs. The sample and approach to sampling are discussed later in the evaluation design section. There is within this approach a question to be addressed about the quality of record keeping within the FCHV registers, which we examined as part of this evaluation. For instance, how reliable are the records, how systematically are they kept? How much did the records reflect the activities conducted?

There was no reliable way to measure indicator 5 (number of FP referrals), because FCHVs do not habitually record the number of women they refer, and health facilities do not record the numbers of women referred by FCHVs. We considered measuring changes in family planning uptake in the HMIS from selected facilities and use that as a proxy for referrals (number of women coming to health facilities for FP services in the target area compared with the numbers measured in an equivalent period last year. However, we decided against this approach because the sensitivity of such measurement would be limited (meaning that it would be a very rough proxy anyway) and because the short duration of the pilot makes it unlikely that any effects of the intervention at the village/ward level would be measurable at the health facility level. We arranged to measure referrals as self-reported by the FCHVs in our FCHV sample, but the information generated was anticipated to be of limited value because FCHVs would not know how many of the referred women actually went to a health facility and because the evaluation literature shows a high risk of FCHVs inflating the numbers of referrals reported (intervention bias). Because of this, we also requested that HC3 develop a mini-intervention within the intensive programme area in which FCHVs would be given referral slips.[3] We discussed this intervention with HC3 who agreed to consider it and discuss it as a possibility with the DHO, who eventually did agree to introduce the referral slips. We were aware that introducing new procedures to a government service could be seen as a poor option in terms of sustainability, but we were also conscious of the need to measure results for this pilot.

Finally, in relation to indicator 6 (a comparison between intensive and non-intensive) this could be done, if at all, by selecting a sample of FCHVs within the 26 non-intensive VDCs to use as control/comparison group. However, any such measurement would be problematic because the intensive and non-intensive areas were pre-selected according to baseline characteristics, introducing major bias into any comparisons that assume the intervention would cause any measured differences between them. For this reason, we were unable to collect any meaningful comparative quantitative data. However, we examined qualitatively some of the issues arising from the two intervention types.

We have summarised the possible broad evaluation questions in the table below. Despite the limitations identified above, **this pilot had the potential to answer a number of important questions** that would be useful for future programme design of FP interventions undertaken through FCHVs. For this, we used qualitative methods from a range of stakeholders (WRA living in the village, FCHVs, programme managers), as explained and described below.

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[3] The simplest way of doing this is by issuing each FCHV a known number of referral slips, each having a serial number. The FCHV would keep half of the slip when referring a person for family planning and hand over the other half-slip to the person who would in turn hand it in at the health facility. By counting the referral slips in both health facilities and among FCHVs we should be able to measure the following: how many were referred; how many actually attended referral; proportion of women referred who used the referral service per FCHV (a proxy for FCHV level of effort). In practice, however, health facilities did not always keep the slips.

The final decision was to undertake an evaluation using a mix of qualitative and quantitative data collection to explore how the intervention worked in practice. These methods are briefly summarised in the table below. Please note that although qualitative methods were essential given the major limitations to any quantitative evaluation (as set out above), we considered this had advantages because qualitative methods carried the major likely benefit of uncovering unexpected findings during the evaluation.

**Table 2.1: Main study questions and evaluation methods**

| Main study questions | Evaluation methods |
|---|---|
| 1. Do FCHVs deliver more services and approach more potential FP users using IPC training? | We collected self-reports from FCHVs about whether more women were approached, but these obviously have major limitations. A more accurate investigation was not possible given the constraints of this pilot |
| 2. Does exposure to IPC increase uptake of FP services? | It was not possible to measure overall uptake in this evaluation. |
| 3. Does IPC increase the knowledge, awareness and willingness of FCHVs to deliver more FP services? | We conducted qualitative interviews with FCHVs to address this question as this was not possible to quantify in this pilot. |
| 4. What is the evidence that FCHVs are delivering the expected FP services in their communities? | We used observation and qualitative interviews with FCHVs and clients to address this question. |
| 5. Are new WRA (with particular reference to post-partum mothers) being reached by FCHVs? | We used indicative statistics based on FCHV self-reports and qualitative interviews with FCHVs and women of reproductive age to address this question. |
| 6. What factors could increase the likelihood of FCHVs performing their tasks better? | We addressed this question qualitatively using interviews with FCHVs and women of reproductive age. |
| 7. What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective? | We addressed these questions qualitatively in FCHV and client interviews. |
| 8. How long are results from the intensive | We addressed this question qualitatively |

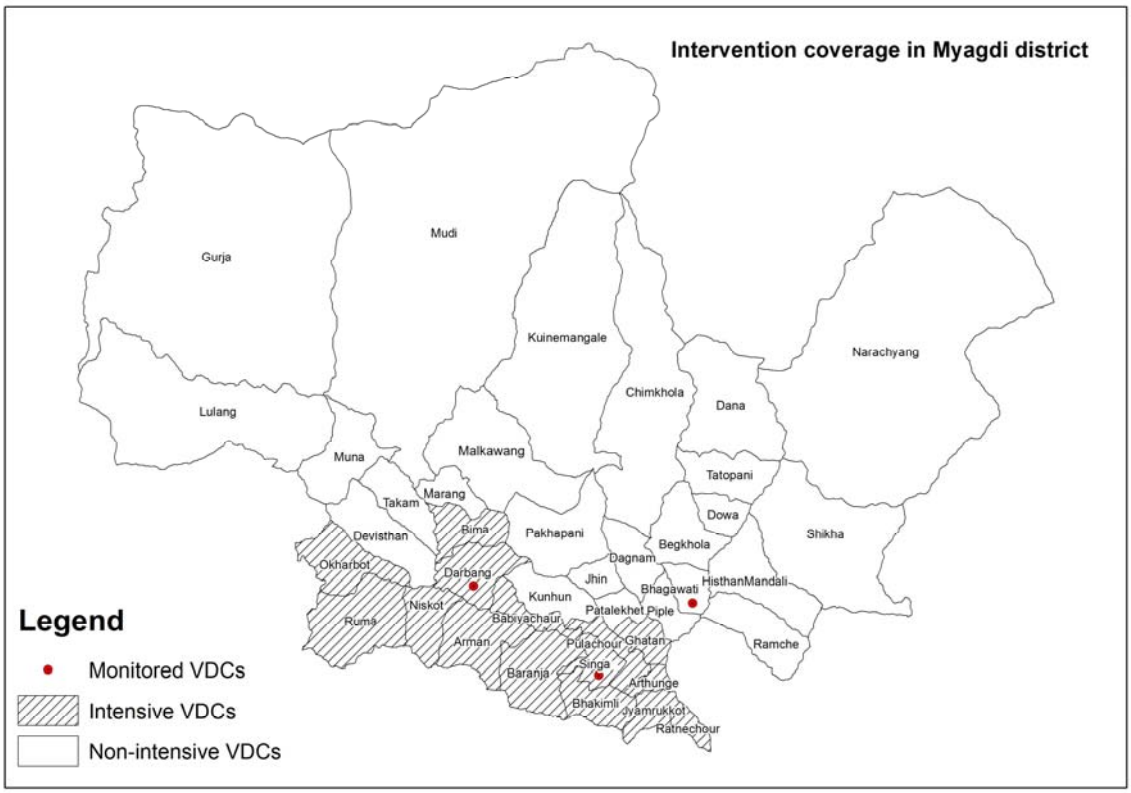
| Main study questions | Evaluation methods |
|---|---|
| intervention likely to last? Why? What would render results more durable/sustainable? | |

### 2.4.3 Monitoring and evaluation sites

Myagdi is one of 75 districts of Nepal. It is a hill district in the Dhaulagiri zone of Western Development region with district headquarters at Beni. In common with many districts, there is considerable labour migration (usually men) from Myagdi to other countries e.g. the Gulf states, India. The pilot began in August 2015 and ended in December 2015 and the evaluation work began in August 2015 and ended in January 2016.

Myagdi contains 31 VDCs and one municipality (Beni). There is a single government district-level hospital in Beni, and one primary health care centre (PHCC) in Darwang VDC (see Figure 2.1). The other VDCs contain one health post each. Some of these were still sub-health posts (which have more limited facilities) during the project. All were scheduled for upgrade or are being upgraded to health posts. The health posts should provide at least three contraceptive methods: condoms, oral contraceptive pills (OCPs) and injectable contraceptives (Depo). If there is a birthing centre and skilled birth attendants (SBAs) are available they may also provide implants and IUCDs. We visited 16 health facilities in 16 VDCs - 13 health posts, 1 primary health care centre (PHCC) and one district hospital in the intensive VDCs and 1 health post in the non-intensive VDCs. Two of the 13 health posts we visited in the intensive VDCs provided implants and four said they provided IUCDs. The health post we visited in the non-intensive VDC provided IUCDs but not implants.

**Figure 2.1: Intervention coverage in Myagdi district**




The PHCC provides condoms, OCPs, injectables, implants and IUCDs: the later two are subject to availability of SBA in position. Medical abortion is also available. Surgical abortion should be available from the PHCC, but the required infrastructure is absent and so in practice it is not.

The district hospital provides the same contraception services as the PHCC, plus, in theory, permanent methods (minilaparotomy and vasectomy) although for the past year there has been no trained service provider for permanent methods and so in practice they are not available. Both surgical and medication abortion are available at the district hospital.

There are 13 health facilities in the district (including the district hospital and PHC) that are authorized to provide medical abortion. In those health facilities, medical abortion should be available. Technical support for medical abortion provision in the 13 locations is being provided by IPAS, a global non-profit organization that works to introduce and expand access to abortion services.

According to the district family planning supervisor, emergency contraceptive pills (ECPs) are not supplied by the government, although district health officials talk about ECPs with clients. ECPs are generally available in private pharmacies.

### 2.4.4 Data collection

Sampling: VDCs in the district are divided into two clusters: one cluster each for the hospital and the PHCC. Among the 15 intensive VDCs chosen by HC3, 10 were in the hospital cluster and 5 in the PHCC cluster (See Figure 2.1). For monitoring and evaluation, we selected 2 VDCs (Singa and Darwang) from the intensive sites, one from each cluster, and 1 VDC (Bhagwati) from the non-intensive site. These VDCs were where we collected qualitative data. All were selected in discussion with the District Health Officer and HC3 team. We also collected quantitative data from FCHVs in all 15 of the intensive VDCs and from one of the non-intensive VDCs (Bhagwati).

Observation: we conducted observations that involved living in the community for six months (August 2015 – January 2016), observing two health mothers' groups (HMGs), and shadowing two FCHVs (The Research Fellow (RF) spent 2 days with each FCHV to see what the FCHVs' work involved first hand). In addition to the formal data collection, the RF made ad hoc observations and conversed with numerous informants over the course of the fieldwork period.

**Interviews**

We conducted client interviews. Clients were selected from the population of women of reproductive age (15-49 years old) from the wards of the VDCs. The aim was to sample as diverse as possible a selection of women in terms of age, parity, ethnic group, and education level.

- We conducted two group interviews with clients. To select the clients, we explained the study to FCHVs from 5 different wards, asking them to suggest 2-3 clients from their wards for our group discussion. From the resulting list, we contacted the clients and explained the study to them until there were enough participants for two groups. A total of 7 participants (from three wards) attended the group discussion from the non-intensive VDC and 9 (from two wards) from the intensive VDC.

- We also conducted two group interviews with members of Health Mothers' Groups. They were first identified with the help of FCHVs in the same way as for the other group discussions and then approached until enough of them agreed that we could hold the discussion. We had planned to recruit four HMG members from two wards (two from each ward) for one HMG discussion. In the intensive VDC however one of the two wards had no HMG and so we held the discussion with two HMG members as distances were too great to recruit additional individuals from other wards. In the non-intensive VDC we interviewed four HMG members from two wards as planned.

- We conducted 21 one-to-one interviews with women eligible to be family planning clients i.e. of reproductive age (see Table 2.2 for characteristics of sampled women). First we met the FCHVs to find out where most clients live, then we visited those locations and asked around to try to find eligible women, i.e. aged 15-49. FCHVs also helped us find 5 women who the FCHVs had referred for family planning services. We also used local contacts and asked people to refer us on until we found women who were eligible and were willing and able to talk to us.

- We conducted 8 interviews with FCHVs of the sampled VDCs, 6 from the intensive VDCs and 2 from the non-intensive VDC. We selected FCHVs who were available and who were willing to give us time.

- We also conducted 10 key informant interviews with District Health Officer (DHO), Public Health Officer (PHO), Public Health Nurse (PHN), FP/FCHV focal person of the district, 3 service providers (2 from both intensive VDCs and 1 from non-intensive VDC), 2 Health Facility Operations and Management Committee (HFOMC) members and the HC3 district co-ordinator.

To provide additional data on the background to the intervention, we collected quantitative data from a sample of 55 FCHVs located across all 15 intensive focus VDCs, and from one non-intensive VDC. We sampled 50 out of the 135 FCHVs from across all of the intensive VDCs, and 5 out of the 9 FCHVs from the single non-intensive VDC in our sample. In the sampled intensive and non-intensive VDCs we selected FCHVs from those who had not already been selected for qualitative interviews, except for one FCHV from an intensive VDC who was included in both because other FCHVs were unavailable. In both intensive and non-intensive VDCs, FCHVs were sampled from a list of FCHVs that we requested from HC3 based on information that they had gathered for each VDC. The names of FCHVs on the lists per VDC were ordered by ward number. We planned to include FCHVs from each VDC, with approximately even numbers per VDC. We contacted each FCHV in the list in turn until we had obtained approval to participate. If FCHVs could not be contacted or were unavailable we contacted the next FCHV on the list. The final sample included 3 or 4 FCHVs from the majority of the intensive VDCs (N=11). In three VDCs we could only sample 2 FCHVs per VDC and in the final VDC we sampled 5. We used a structured questionnaire to find out about FCHV practices, particularly referrals and recording practices. We also cross-checked the FCHV reports against her ward register and referral slips (see below).

Finally, to provide further contextual information, and noting the likely problems with the data described above, we requested the district level statistics on contraceptive use at the beginning of the pilot and then for the same period one year later.

**Table 2.2: Characteristics of sampled woman**

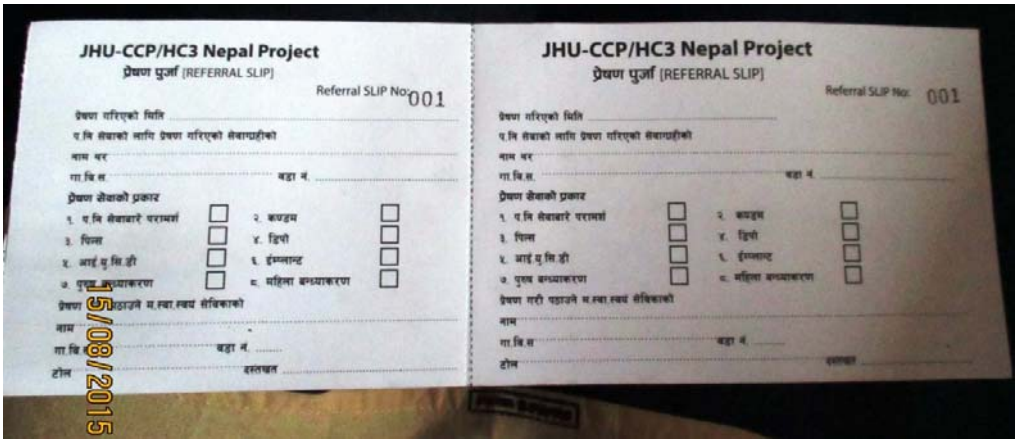
| ONE-TO-ONE INTERVIEWEE CHARACTERISTICS (Women of reproductive age) | N. |
|---|---|
| **Age** | |
| Below 20 years | 2 |
| Above 20 years | 19 |
| **Client's education status** | |
| Illiterate | 1 |
| Non-formal | 3 |
| Primary level | 3 |
| Lower secondary level | 8 |
| Secondary (SLC completed) | 3 |
| Intermediate level | 3 |
| **Husband ever migrated** | |

| ONE-TO-ONE INTERVIEWEE CHARACTERISTICS (Women of reproductive age) | N. |
|---|---|
| Yes | 15 |
| No | 6 |
| **Number of children** | |
| 0 | 2 |
| 1 | 5 |
| 2 | 8 |
| 3 | 4 |
| 4 | 2 |
| **VDC type** | |
| Intensive | 19 |
| Non-Intensive | 2 |
| **Ever used FP method** | |
| Yes | 15 |
| No | 6 |
| **Caste/Ethnicity of the client** | |
| Brahmin/Chettri | 5 |
| Dalit | 9 |
| Janajati | 7 |
| **Total** | **21** |

### Referral slips

We introduced slips to track FCHV referrals because post hoc reports of verbal referrals are likely be very unreliable. HC3 planned to use the slips in all study areas, although from the evaluation perspective we planned only to follow up on them in the intensive VDCs. The slips consisted of two halves (see photo).

**Figure 2.2: Referral slip**



The FCHV wrote the method the client wanted on both halves. The client then took her half to the service provider while the FCHV kept the duplicate half for her records. The Government of Nepal logo was not used at that point of time. When we conducted the structured interviews to collect quantitative data, we could then use the slips to cross-check the FCHV register.

**Summary of data collection**

**Table 2.3: Summary of data collection**

| Data collection method | Quantity | | Total |
|---|---|---|---|
| | Intensive VDCs | Non-intensive VDC* | |
| FCHV in-depth interviews | 6 (from Darwang and Singa) | 2 | 8 |
| In-depth client interview | 14 (from Darwang and Singa) | 2 | 16 |
| Group interview with local mothers' groups | 1 (Darwang) | 1 | 2 |
| Group discussion with clients | 1 (Darwang) | 1 | 2 |
| Health Mothers group observation | 2 (Darwang and Singa) | 0 | 2 |
| Shadowing of FCHV | 1 (Darwang: 2 days of shadowing) | 1 (2 days of shadowing) | 2 |
| Quantitative data collection (number of FCHVs providing data) | 50 (15 intensive VDCs) | 5 | 55 |
| **Key informant interviews** | | | |
| Health facility operation and management committee (HFOMC) member | 1 (Darwang) | 1 | 2 |
| Service provider | 2 (Darwang and Singa) | 1 | 3 |

* Rakhu Bhagwati

### 2.4.5 Dates

Data in registers and about uptake of family planning is expressed using Nepali calendar months. Because Nepal calendar months do not map exactly onto Western calendar months, we used the conversion table here to assist readers not familiar with the Nepali calendar, which begins with Baishakh (mid-April). Our 'translated' dates however, are not exact because months begin and end on different dates in the two calendars. Where both are provided, the precise dates are the ones using the Nepali calendar.

**Table 2.4: Western months and their equivalent Nepali months**

| | |
|---|---|
| January | Magh (mid –January to mid-February) |
| February | Falgun |
| March | Chaitra |

| | |
|---|---|
| April | Baishakh |
| May | Jestha |
| June | Ashar |
| July | Shrawan |
| August | Bhadra |
| September | Ashwin |
| October | Kartik |
| November | Mangsir |
| December | Poush |

### 2.4.6 Staff arrangements

This evaluation was undertaken by an evaluation team comprising HERD staff, with technical support and oversight from Mott MacDonald's International Health Division. HERD appointed one project lead (Sushil Baral), one Senior Research Officer (SRO – Abriti Aryjal) and a Data Management Officer (Santosh Giri) based in HERD Kathmandu and two full-time field Research Fellows (RFs) based in the district. The SRO took the lead on the data collection, managing and advising to ensure high quality. She also conducted 7 interviews in the field with clients to ensure she had a nuanced understanding of the context. The SRO took the lead on qualitative coding and worked with the quantitative data management officer at HERD to ensure all data was presented appropriately for the report. The RFs conducted the fieldwork, coordinated with stakeholders and familiarised themselves with existing health service delivery and monitoring mechanisms in the district. The RFs conducted observations and interviews and collected monitoring data on FP provision. One RF left before the project was completed and so the remaining RF (Smriti Maskey) spent more time collecting data and writing field observations. During the fieldwork, the SRO began the qualitative analysis in order to direct the fieldwork more effectively. A communication officer was responsible for desk-based communication with the RF to co-ordinate field updates The Operations Manager at HERD was responsible for overall operational and logistics management.

The Mott MacDonald team (Cicely Marston, Javier Martinez) provided technical support during visits to Nepal and remotely. Cicely Marston led on study design, provided training and field support for data collection, co-analysed the data, co-wrote the report, and supported dissemination of results. James Fairfax reviewed successive drafts and Javier Martinez performed the final QA.  Lisa Sulis provided logistics support to the international team.

### 2.4.7 Data analysis and quality assurance

Fieldwork began in August 2015 and ended end of January 2016. We used the principles of Grounded Theory[4] to inform an iterative process of data collection and analysis, where preliminary findings were used to orientate subsequent data collection.

[4] For more information on Grounded Theory see - http://www.groundedtheory.com/what-is-gt.aspx

Data took several forms: structured questionnaire, audio-recorded interviews conducted in Nepali, fieldnotes (e.g. observations about different activities, notes of informal conversations), structured interview data on paper questionnaires, and photographs (e.g. of objects or places).

*Fieldnotes* were written in English by the RFs in the field.

*Structured interviews* with FCHVs were handled as follows. Data was collected using a paper questionnaire. The RFs brought the paper questionnaires back with them when they returned to Kathmandu, where HERD staff entered the data into a database at the HERD office. Data quality checking and cleaning were done by the data management officer based at the HERD office. The data did not need to be subject to statistical analysis because the sample was small and the intention was to provide contextual information comprising simple descriptors of FCHV reports of their work.

*Transcription and translation* of audio recordings of interviews were handled as follows. The interviewer transcribed the interview by writing out the content of the audio recording by hand, in Nepali. These transcripts were spot-checked for accuracy by the SRO. Interviewers also added explanatory notes where needed (e.g. noting details of participant body language such as when she indicated a part of her body by pointing). The transcripts were duplicated using a scanner and the originals kept in a locked cabinet. The electronic copies were used for analysis. The transcripts were also translated into English by bilingual staff for use by non-Nepali speaking team members.

It is good practice to work in original languages where possible, and not in translation. The analysis of the client interviews, which were often complex, was therefore done in Nepali by the Nepali/English-speaking SRO (Arjyal - dominant language Nepali) and in English by LSHTM (Marston - dominant language English) using the translated materials. Discrepancies arising from any vagaries of translation were therefore easy to identify and were discussed in detail to avoid nuances being lost in translation. In all cases where there were discrepancies or queries arising from the English versions of the transcripts, we used the original Nepali in the analysis and worked together to improve the translation into English where necessary. For the FCHV interviews, which were more basic (describing who, when, what) we used the English translations as the primary source, going back to the Nepali version for the more complex passages only.

We identified themes emerging from the client interviews, using an iterative approach where we started with general themes and discussed and re-analysed to ensure we were accurately representing the data in our themes. Where relevant, we related themes from the client interviews to themes emerging from the interviews with FCHVs and the observation data. The key themes emerging are presented later in this report. The FCHV interviews were primarily used to understand how the intervention had been carried out, although we also took full account of any passages that provided more nuance.

## 2.5 Limitations affecting the pilot and its evaluation

There were specific limitations for this evaluation that were identified at the planning stage, largely the impossibility of quantifying the effect of the intervention and the need to rely primarily on qualitative data. However, there were additional unforeseen difficulties.

We were unable to observe the training events HC3 conducted because of delays in obtaining ethical approval for the evaluation work. We were able to observe one of the training days (out of two for that training) and tried to obtain information from HC3 about what was contained in the different training sessions (for health workers and for FCHVs) and what exactly the intervention sought to encourage FCHVs to do. Being unable to observe the training means we had less clarity on the messages delivered and the methods used during the training, although the orientation programme schedule provided by HC3 suggests there were sessions on family planning messages and interpersonal communication skills. From what we know so far, the FCHV training used the existing Government of Nepal training kit, so we infer that the basic family planning messages set out in that training kit were delivered to the FCHVs.

The year was overshadowed by the huge earthquake that hit Nepal on 25 April 2015. Not only it did not feel right at the time to do research amid so much suffering and destruction of infrastructures (roads, health facilities, housing, etc) but there was also a need for colleagues in Nepal to focus on relief operations which brought pilot implementation and evaluation activities to an almost complete halt during May and June 2015. The FCHV training continued during the earthquake period although at least one FCHV told us she had missed one day of training because of her fear of aftershocks and it seems possible that others may also have missed parts of the training, or been distracted even if they were present.

In the last week of May 2015 a massive landslide in Bhagwati VDC of Myagdi district blocked the Kali Gandaki river at Baisari for 24 hours, damming it and forming a lake approximately 10km upstream of Beni Bazaar (district headquarters). The flood/lake was 100m deep and 3km long, and contained an estimated three million cubic metres of water. There were no human casualties reported, but this also disrupted the course of intervention to some extent owing to local loss of property and fear of further incidents.

In addition to these two natural disasters, civil unrest in the Terai from August 2015 affected the entire population of Nepal, with a blockade at the border with India causing a severe fuel and commodities crisis from September 2015 to February 2016. Apart from the additional suffering caused over the winter, the fuel crisis affected pilot implementation and evaluation. The earthquake, landslide, and fuel shortages disrupted travel and may have hindered FCHVs efforts to reach clients, and their referrals. The social and emotional disruption was also considerable as people tried to rebuild after the earthquake.

# 3. Evaluation Findings

## 3.1 Characteristics of the intervention and implementation

The intervention was implemented by HC3. It consisted of FCHV IPC training and supportive supervision. A summary is shown in the diagram, and details of each component can be found in Table 3.1. Information on methods of contraception was provided, based on the contents of a leaflet (see photo in Annex 2). The VDCs where the intervention was implemented were divided into 'intensive' and 'non-intensive' VDCs according to HC3 assessment of needs within those VDCs. While all VDCs received the training, the additional supportive supervision for FCHVs was only carried out in the 'intensive' VDCs.

Supportive supervision involved deploying HC3 field supervisors to support FCHVs in facilitating Health Mothers' Group (HMG) meetings, to complete a social mapping exercise to identify and map eligible women in their ward, to help them communicate appropriately about family planning and distribute IEC materials, as well as helping FCHVs refer and follow up eligible women for family planning.

In addition to the FCHV training and support evaluated here, HC3 simultaneously held various IPC orientation events for district health officers and health workers, which additionally included counselling training.

### 3.1.1 Findings from the quantitative survey of FCHVs

In January and February 2016 we interviewed 55 FCHVs using a structured survey questionnaire. During the visit we inspected the FCHV register to corroborate the FCHV accounts. As planned at the outset, most of the FCHVs (N=50) came from the intensive VDCs although there was no obvious difference between them and the small sample of FCHVs from a non-intensive VDC (N=5). Statistical analyses and comparisons were unnecessary for reasons detailed above and so we provide purely descriptive findings here.

Annex 3 contains the full set of tables. Most FCHVs were between 30 and 50 years old, were either Janajati or Brahmin/Chhetri, and had children. Although none were illiterate, over half had either no formal education (9/55) or only education at primary level (20/55). 45/55 reported working in agriculture or animal husbandry.

Well over half had over 10 years of service as an FCHV (35/55) and only 11 said they had 0-5 years of service. Thirteen said they started working as FCHVs 5 months to 4 years before receiving FCHV basic training. The rest received FCHV training before starting FCHV work. Of all 55 FCHVs, 32 said they had received government refresher training of some sort but of those, most (24/32) had received it 6-10 years before our survey.

All but one FCHV had received family planning-related training from other sources, with all 54 who had refresher training from other organisations saying they had received it from the Suaahara programme[5]. Many also reported training from the international NGO IPAS (49/54).

Most of the FCHVs had received the expected IPC training from HC3 (52/55). Table 3.1 shows the numbers of different groups of beneficiaries mapped by the FCHVs during the HC3-supported mapping exercise. Tables 3.2-3.6 show how many of those beneficiaries were subsequently contacted and how.

**Table 3.1: Total number of beneficiaries that FCHVs reported they had mapped, by priority group (Shrawan-Poush 2072/July - December 2015)**

| | Newly married couple (mapped) | Pregnant women (mapped) | Postnatal mothers (mapped) | 1000 days mothers (mapped) | Dalit women (mapped) | Migrants and their wives (mapped) | Total (Married WRA (15-49 years) (mapped) |
|---|---|---|---|---|---|---|---|
| Singa | 4 | 5 | 2 | 29 | 54 | 100 | 207 |
| Jyamrukkot | 8 | 8 | 6 | 47 | 70 | 237 | 565 |
| Ratnechaur | 0 | 2 | 2 | 16 | 10 | 62 | 252 |
| Arman | 2 | 11 | 7 | 62 | 135 | 209 | 1070 |
| Babiyachaur | 2 | 7 | 8 | 35 | 63 | 50 | 95 |
| Baranja | 1 | 7 | 3 | 53 | 116 | 210 | 408 |
| Bhakimli | 2 | 6 | 1 | 44 | 99 | 210 | 265 |
| Bima | 2 | 9 | 1 | 34 | 37 | 59 | 437 |
| Ghatan | 9 | 3 | 1 | 22 | 68 | 93 | 340 |
| Niskot | 2 | 5 | 3 | 38 | 43 | 81 | 258 |
| Okharbot | 4 | 4 | 2 | 29 | 42 | 102 | 165 |
| Ruma | 1 | 16 | 4 | 77 | 161 | 226 | 772 |
| Pulachaur | 4 | 9 | 3 | 70 | 132 | 178 | 440 |
| Darbang | 2 | 6 | 1 | 22 | 12 | 34 | 325 |
| Arthunge | 1 | 2 | 1 | 19 | 34 | 85 | 205 |
| **Total for intensive VDCs** | 44 | 100 | 45 | 597 | 1076 | 1936 | 5804 |
| *Rakhu Bhagwati* ***(Non-intensive VDC)*** | *8* | *10* | *5* | *76* | *78* | *310* | *487* |
| **Grand Total** | 52 | 110 | 50 | 673 | 1154 | 2246 | 6291 |

*N=55

Source: FCHV structured interviews

[5] A multi-sectoral programme focusing on nutrition but also covering other aspects of family health and wellbeing, including family planning.

### Table 3.2: Beneficiaries contacted by FCHVs through home visits (Shrawan-Poush 2072/July - December 2015)

| | Yes | No | Total |
|---|---|---|---|
| Singa | 2 | 1 | 3 |
| Jyamrukkot | 4 | 0 | 4 |
| Ratnechaur | 0 | 2 | 2 |
| Arman | 3 | 2 | 5 |
| Babiyachaur | 1 | 1 | 2 |
| Baranja | 2 | 2 | 4 |
| Bhakimli | 3 | 1 | 4 |
| Bima | 4 | 0 | 4 |
| Ghatan | 1 | 2 | 3 |
| Niskot | 2 | 1 | 3 |
| Okharbot | 2 | 1 | 3 |
| Ruma | 3 | 1 | 4 |
| Pulachaur | 3 | 1 | 4 |
| Darbang | 3 | 0 | 3 |
| Arthunge | 1 | 1 | 2 |
| **Total for intensive VDCs** | **34** | **16** | **50** |
| *Rakhu Bhagwati (**Non-intensive VDC**)* | *3* | *2* | *5* |
| **Grand Total** | **37** | **18** | **55** |

*N=55

Source: FCHV structured interviews

### Table 3.3: Breakdown of types of beneficiaries contacted by FCHVs through home visits (Shrawan-Poush 2072/July - December 2015)

| | Newly married couples | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | Total (MWRA (15-49 years) | Men | Unmarried/Adolescent | Woman aged over 50 | Total n. of beneficiaries | Total n. of FCHVs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Singa | 0 | 0 | 1 | 7 | 4 | 3 | 8 | 3 | 0 | 0 | 11 | 2 |
| Jyamrukkot | 3 | 6 | 3 | 24 | 13 | 20 | 47 | 0 | 0 | 0 | 47 | 4 |
| Ratnechaur | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Arman | 0 | 1 | 5 | 12 | 9 | 10 | 19 | 0 | 0 | 0 | 19 | 3 |
| Babiyachaur | 0 | 1 | 0 | 4 | 3 | 1 | 7 | 0 | 0 | 0 | 7 | 1 |
| Baranja | 0 | 0 | 0 | 0 | 8 | 8 | 16 | 1 | 0 | 0 | 26 | 2 |
| Bhakimli | 1 | 0 | 0 | 14 | 5 | 3 | 17 | 0 | 0 | 0 | 17 | 3 |
| Bima | 0 | 0 | 0 | 8 | 7 | 4 | 18 | 0 | 0 | 0 | 18 | 4 |
| Ghatan | 1 | 0 | 1 | 3 | 9 | 0 | 13 | 0 | 0 | 0 | 13 | 1 |
| Niskot | 1 | 3 | 0 | 12 | 8 | 10 | 16 | 0 | 0 | 0 | 16 | 2 |
| Okharbot | 0 | 0 | 2 | 7 | 5 | 4 | 21 | 0 | 0 | 0 | 21 | 2 |
| Ruma | 0 | 2 | 3 | 8 | 9 | 10 | 20 | 0 | 0 | 0 | 20 | 3 |
| Pulachaur | 1 | 7 | 3 | 24 | 30 | 17 | 38 | 3 | 0 | 0 | 41 | 3 |

| | Newly married couples | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | Total (MWRA (15-49 years) | Men | Unmarried/Adolescent | Woman aged over 50 | Total n. of beneficiaries | Total n. of FCHVs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Darbang | 0 | 2 | 1 | 6 | 1 | 1 | 8 | 0 | 0 | 0 | 8 | 3 |
| Arthunge | 0 | 0 | 0 | 3 | 3 | 0 | 3 | 0 | 0 | 0 | 3 | 1 |
| **Total for intensive VDCs** | **7** | **22** | **19** | **132** | **114** | **91** | **251** | **16** | **0** | **0** | **267** | **34** |
| *Rakhu Bhagwati **(Non-Intensive VDC)*** | *0* | *0* | *0* | *14* | *9* | *6* | *35* | *0* | *0* | *0* | *35* | *3* |
| **Grand Total** | **7** | **22** | **19** | **146** | **123** | **97** | **286** | **16** | **0** | **0** | **302** | **37** |

*N=37

Source: FCHV structured interviews

### Table 3.4: Were beneficiaries contacted through other means? (Shrawan-Poush 2072/July - December 2015)

| | Yes | No | Total |
|---|---|---|---|
| Singa | 3 | 0 | 3 |
| Jyamrukkot | 4 | 0 | 4 |
| Ratnechaur | 2 | 0 | 2 |
| Arman | 5 | 0 | 5 |
| Babiyachaur | 2 | 0 | 2 |
| Baranja | 4 | 0 | 4 |
| Bhakimli | 4 | 0 | 4 |
| Bima | 4 | 0 | 4 |
| Ghatan | 3 | 0 | 3 |
| Niskot | 3 | 0 | 3 |
| Okharbot | 3 | 0 | 3 |
| Ruma | 4 | 0 | 4 |
| Pulachaur | 4 | 0 | 4 |
| Darbang | 3 | 0 | 3 |
| Arthunge | 1 | 1 | 2 |
| **Total for intensive VDCs** | **49** | **1** | **50** |
| *Rakhu Bhagwati (**Non- Intensive VDC)*** | *5* | *0* | *5* |
| **Grand Total** | **54** | **1** | **55** |

Source: FCHV structured interviews

**Table 3.5: Breakdown of beneficiaries contacted through other means (Shrawan-Poush 2072/July - December 2015)**

| | Newly married couples | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | MWRA (15-49 years) | Unmarried people | Total number of beneficiaries | Total FCHVs(N) |
|---|---|---|---|---|---|---|---|---|---|---|
| Singa | 2 | 2 | 0 | 18 | 11 | 21 | 40 | 0 | 40 | 3 |
| Jyamrukkot | 0 | 2 | 2 | 12 | 15 | 31 | 100 | 0 | 100 | 4 |
| Ratnechaur | 0 | 2 | 0 | 7 | 1 | 6 | 51 | 0 | 51 | 2 |
| Arman | 0 | 4 | 0 | 19 | 26 | 31 | 81 | 0 | 81 | 5 |
| Babiyachaur | 0 | 1 | 0 | 6 | 8 | 11 | 43 | 0 | 43 | 2 |
| Baranja | 0 | 4 | 3 | 33 | 19 | 31 | 61 | 16 | 77 | 4 |
| Bhakimli | 1 | 3 | 0 | 17 | 10 | 27 | 75 | 0 | 75 | 4 |
| Bima | 0 | 2 | 0 | 17 | 29 | 29 | 79 | 0 | 79 | 4 |
| Ghatan | 0 | 1 | 0 | 7 | 7 | 31 | 51 | 0 | 51 | 3 |
| Niskot | 3 | 3 | 2 | 37 | 24 | 55 | 80 | 0 | 80 | 3 |
| Okharbot | 0 | 4 | 2 | 25 | 16 | 16 | 65 | 0 | 65 | 3 |
| Ruma | 1 | 9 | 0 | 24 | 24 | 25 | 62 | 0 | 62 | 4 |
| Pulachaur | 1 | 3 | 0 | 15 | 47 | 38 | 67 | 0 | 67 | 4 |
| Darbang | 0 | 3 | 0 | 11 | 2 | 34 | 47 | 0 | 47 | 3 |
| Arthunge | 0 | 0 | 0 | 0 | 10 | 6 | 24 | 0 | 24 | 1 |
| **Total for intensive VDCs** | **8** | **43** | **9** | **24** | **24** | **39** | **926** | **16** | **942** | **49** |
| *Rakhu Bhagwati* ***(Non- Intensive VDC)*** | *1* | *4* | *3* | *31* | *21* | *57* | *80* | *0* | *80* | *5* |
| **Grand Total** | **9** | **47** | **12** | **27** | **27** | **44** | **100** | **16** | **102** | **54** |

*N=54

Source: FCHV structured interviews

**Table 3.6: Methods named by FCHVs as those they mostly used to make contact with eligible beneficiaries (Shrawan-Poush 2072/July - December 2015)**

| | Total Intensive VDCs | | | | | | |
|---|---|---|---|---|---|---|---|
| | First common way | Second common way | Third common way | Fourth common way | Fifth common way | No contacts | Total |
| Home visits | 4 | 22 | 11 | 8 | 4 | 0 | 49 |
| HMG | 43 | 5 | 1 | 0 | 0 | 0 | 49 |
| Health Facility | 0 | 1 | 6 | 22 | 17 | 0 | 46 |
| Phone calls | 2 | 11 | 25 | 8 | 3 | 0 | 49 |
| Meeting at public | 0 | 10 | 6 | 9 | 0 | 0 | 25 |
| No contacts | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| | **Sampled Non-Intensive VDC** | | | | | | |
| Home visits | 1 | 2 | 1 | 0 | 0 | 0 | 4 |
| HMG | 3 | 0 | 1 | 0 | 0 | 0 | 4 |
| Health Facility | 0 | 0 | 1 | 0 | 3 | 0 | 4 |
| Phone calls | 0 | 2 | 1 | 1 | 0 | 0 | 4 |
| Meeting at public places | 1 | 1 | 1 | 2 | 0 | 0 | 5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| No contacts | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

*N=55

Source: FCHV structured interviews

Fifty-one FCHVs reported holding monthly mothers' group meetings and Table 3.7 shows the health topics they report discussing.

**Table 3.7: Health topics that FCHVs holding health mothers group meetings report are discussed in those meetings (Shrawan - Poush 2072/July - December 2015)**

| | Safe motherhood | Nutrition | Hygiene and sanitation | Infectious diseases | Family Planning | Immunization | Safe Abortion | No health topics discussed | Total responses (FCHV) |
|---|---|---|---|---|---|---|---|---|---|
| Singa | 3 | 3 | 3 | 2 | 3 | 0 | 1 | 0 | 3 |
| Jyamrukkot | 1 | 4 | 3 | 0 | 3 | 0 | 2 | 0 | 4 |
| Ratnechaur | 2 | 1 | 2 | 1 | 2 | 2 | 1 | 0 | 2 |
| Arman | 1 | 4 | 3 | 1 | 3 | 0 | 0 | 0 | 4 |
| Babiyachaur | 2 | 2 | 1 | 0 | 2 | 1 | 0 | 0 | 2 |
| Baranja | 3 | 4 | 1 | 0 | 4 | 2 | 1 | 0 | 4 |
| Bhakimli | 2 | 4 | 3 | 1 | 4 | 0 | 0 | 0 | 4 |
| Bima | 2 | 4 | 3 | 2 | 4 | 0 | 0 | 0 | 4 |
| Ghatan | 2 | 3 | 3 | 1 | 3 | 2 | 2 | 0 | 3 |
| Niskot | 0 | 3 | 3 | 0 | 3 | 0 | 0 | 0 | 3 |
| Okharbot | 1 | 2 | 2 | 1 | 3 | 1 | 0 | 0 | 3 |
| Ruma | 1 | 4 | 4 | 0 | 4 | 0 | 0 | 0 | 4 |
| Pulachaur | 0 | 1 | 4 | 2 | 3 | 1 | 1 | 0 | 4 |
| Darbang | 1 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 2 |
| Arthunge | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 |
| **Total for intensive VDCs** | **22** | **42** | **37** | **12** | **43** | **10** | **8** | **0** | **47** |
| *Rakhu Bhagwati **(Non-intensive VDC)*** | *3* | *4* | *2* | *3* | *2* | *3* | *2* | *0* | *4* |
| **Grand Total** | **25** | **46** | **39** | **15** | **45** | **13** | **10** | **0** | **51** |

*N=51

Source: FCHV structured interviews

Most of the FCHVs held meetings very near to their houses – within 10 minutes in most cases (36/51) and all except two reported less than a 30 minute travel time to the meeting place.

FCHVs reported on the numbers of members of their HMGs. Most (41/51) reported HMGs with between 11 and 30 members. The breakdown of attendee characteristics is shown in Table 3.8.

**Table 3.8: Breakdown of types of individuals FCHVs holding health mothers groups report are members of those groups (Shrawan - Poush 2072/July - December 2015**

| | 11 to 20 members | 21 to 30 members | 31 to 40 members | 41 to 50 members | Total responses (FCHVs) |
|---|---|---|---|---|---|
| Singa | 3 | 0 | 0 | 0 | 3 |
| Jyamrukkot | 0 | 1 | 1 | 2 | 4 |
| Ratnechaur | 1 | 0 | 1 | 0 | 2 |
| Arman | 3 | 1 | 0 | 0 | 4 |
| Babiyachaur | 1 | 1 | 0 | 0 | 2 |
| Baranja | 2 | 1 | 1 | 0 | 4 |
| Bhakimli | 1 | 3 | 0 | 0 | 4 |
| Bima | 0 | 3 | 1 | 0 | 4 |
| Ghatan | 3 | 0 | 0 | 0 | 3 |
| Niskot | 1 | 1 | 1 | 0 | 3 |
| Okharbot | 2 | 0 | 1 | 0 | 3 |
| Ruma | 2 | 1 | 1 | 0 | 4 |
| Pulachaur | 2 | 1 | 1 | 0 | 4 |
| Darbang | 2 | 0 | 0 | 0 | 2 |
| Arthunge | 0 | 1 | 0 | 0 | 1 |
| **Total for intensive VDCs** | **23** | **14** | **8** | **2** | **47** |
| *Rakhu Bhagwati* ***(Non-intensive VDC)*** | *3* | *1* | *0* | *0* | *4* |
| **Grand Total** | **26** | **15** | **8** | **2** | **51** |

*N=51

Source: FCHV structured interviews and HMG registers

Data recording in ward registers was not always very reliable. In our survey despite the fact that FCHVs are supposed to keep their registers with them, and record all relevant data, only 21 and 23 FCHVs (out of 55) had data for each month recorded in the register for years 2071 (2014-15) and 2072 (2015-16) respectively (baseline and endline dates). In all other cases, there was either incomplete data (some months had records, while others did not, or the FCHV register was not available for inspection (N=24 for 2072) or the register was not with the FCHV at the time of our visit (N=34 for 2071), or there were no data at all recorded in the register (N=0 and N=8 for 2071 and 2072 respectively).

All but one FCHV reported having received training on recording in the HMIS register. Most reported having had the training < 6 months before. Most FCHVs said they reported to the health facility using the ward register and most made the records on their own. All FCHVs told us they reported to the health facility on a monthly basis except one FCHV who said she reported bimonthly.

Details of number of referrals and whether they were verbal or via referral slip is provided in Tables A30-A33 in Annex 3 and details of number of clients followed up after referrals is shown in Tables A35-A36 in Annex 3. FCHVs sometimes had a few leaflets containing

family planning information but we could not find any records from FCHVs of leaflet distribution.

### 3.1.2 Health mothers groups

Despite the expectation that health mothers groups would already be happening throughout the district, it was discovered almost immediately that they were irregular, non-existent, or were discussing finance and other issues not directly related to health. Determining the distribution of extant groups and their nature was beyond the scope of this evaluation. HC3 Field Supervisors therefore began working to set up HMGs in all of the intensive VDCs.

One of the primary activities carried out by Field Supervisors in the supportive supervision work was to attend the HMG meetings facilitated by FCHVs and help them deliver content regarding family planning as well as in matters relating to interpersonal communication, including referring them for counselling. Not all the HMGs were visited, however, and the field supervisors explained to us that was because of time constraints and difficult terrain. In HMGs that we observed, the family planning content was delivered by FCHVs supported by field supervisors: in one case a field supervisor from HC3 and in both cases field supervisors from the Suaahara programme.

Health workers were also sent with the Field Supervisors to the HMGs. The government manual for health mothers' groups states that regular HMG meetings should be conducted by FCHVs and that the health workers should help with this. For this reason, Field Supervisors in some areas encouraged the health workers to attend.

We interviewed a number of women who said they had attended HMGs and discussed nutrition and family planning, including being shown real examples or photographs of devices such as implants, IUCDs, pills and injectables (IDI 5,710,11,13,14). They said these groups had not existed prior to the intervention, although in the past they had discussed savings and credits in similar groups.

During FCHV shadowing in the non-intensive VDC, we observed a HMG meeting, which had been formed by the health post in-charge the previous year. According to the participants, this particular HMG meeting had not been conducted for 6-8 months and the participants suggested it should be made more regular. In the non-intensive VDC group interview, HMG participants from both wards told us the health service provider and FCHV had formed the HMGs a year before to discuss health related issues. A participant from one HMG said that despite the HMG being formed, they had not had a meeting. Women from that ward, according to the HMG member, did not generally listen to the FCHV and would tell the FCHV that they do not have time to take part in HMG meetings. She mentioned the mothers group and HMG are the same but health is not discussed at the meetings.

In the same group interview, members of the other HMG told us they had a meeting every month. They said it was very helpful as they discuss different aspects of health. They told us the group was formed primarily to disseminate information about nutrition for children and the members were recruited accordingly. In the mothers' group (as opposed to the HMG), they discussed savings, credit and loans, which they did not discuss in the HMG meetings. They told us they discuss in the HMG topics including information for '1000 days mothers',

post partum mothers, and pregnant women such as what foods to consume or feed children, and when they should seek health check-ups.

**Client mapping**

The FCHVs initially thought that the client mapping was an initiative from HC3 and resisted doing it. However, the field supervisors showed them that it was in fact supposed to be part of running HMGs and that the HMG orientation guideline suggests the mapping should be updated every year.

Mapping started in all the wards of the intensive VDCs. This involved sketching a map of the ward and marking in households with the following categories of eligible clients among married women aged 15-49: married young people aged 15-30; 1000 days mothers (i.e. women with children around age two, which is approximately 1000 days since conception – this is also a target group in nutrition programmes); pregnant women; women 45 days postpartum; women from disadvantaged groups; migrant workers (usually this means wives of migrant workers).

The FCHVs said they found the process of mapping very onerous. It took many hours, even with the assistance of the field supervisors and was usually done at the FCHV's house. FCHVs told us later in the intervention period that they had not updated the map to take account of new clients, nor had they used it for anything. It is noticeable that the health services themselves do not appear to have this data.

**Effects of the training**

One FCHV said she had learned more about family planning methods and is now more focused on family planning than before, including following up clients she refers to the health facilities. However, she felt that the workload was considerable and she had to devote time especially to HC3 work because the HC3 field supervisor visits regularly.

FCHVs generally liked the training and some suggested that refresher training should be provided regularly. (FCHV interviews 8,2) They said they learned how to talk to women and understand their needs. (FCHV interviews 1,2,4,7) In particular, they said they had learned that communication should be done using simple local language, and that they should be soft, polite and friendly (FCHV interviews 1,2 Bhagwati, 4,7) to motivate client to visit the FCHV in future.(FCHV interview 7) FCHVs also said they learned how to talk in HMG meetings and had realised they should provide more information about family planning during the HMG meetings, including where the services are available. (FCHV interviews 4, 1) The FCHVs seemed to feel they had learned better communication techniques, although this FCHV emphasises that she was also good at communicating before the training.

> *"Before we used to talk impolitely or directly but now we have learned ways of being friendly with the woman so that we can get her inner thoughts […] It has made it easier to make people understand. To share the inner feelings… before also it was not so difficult for me to deal and speak with the women. It was not so tough to get their [women's] inner feelings and thoughts. Then after attending this training, I learnt about the techniques of the dealing with the client and*

*understanding their opinions.[…] It has enhanced my knowledge and motivated me. I have built up my confidence." (FCHV interview 2)*

FCHVs mentioned that the aim of the training was that the FCHVs should subsequently create awareness among women in the community (FCHV interviews 1,2) about family planning methods and refer clients for contraception. (FCHV interviews 6,4).

The IPC training was 2 days long, but FCHVs varied in their reports, saying they had received 2-4 days of training. The April 2015 earthquake appears to have affected training. For instance, one FCHV said that she could not understand some parts of the training because she was afraid of the regular aftershocks (FCHV interview 4) and another said she did not attend the first day of training, also because she was afraid of aftershocks. (FCHV interview 3).

A public health nurse we interviewed said she had been present at several sessions of the FCHV training and had liked them. She said they were done in a simple way so that anyone could understand them.

Another provider said:

*"If we look at the variety of FCHV work, there are 84 types of activities to be done. Among these family planning is also one. And it is from now [after training] that the FCHVs are focused solely on family planning. They [FCHVs] might feel more responsible [for promoting FP] after being given the referral slips. Maybe because of this, some of them [FCHVs] contacted me by phone and some of them send clients with referral slips. Their focus on family planning services has increased."*

### 3.1.3 Challenges in implementing the intervention

HC3 co-ordinators and field supervisors told us about the following challenges.

- Some of the FCHVs do not know how to read and write well and so it was hard to help them in proper recording and reporting. Two of the FCHVs (FCHV interviews 4,1) we interviewed also mentioned that their low level of education made it difficult for them to perform some of their tasks. A service provider said:

  *"Not all FCHVs have the same educational level. Not all of them are able to write. There is a situation where FCHVs have to seek help from their husband, daughter in law, daughter if they have to write something. There are the FCHVs who have been working for the last 18, 20 years. So they need others' support. They [FCHVs] understand what is taught but some of the FCHVs cannot write."*

- There were no incentives provided for the FCHVs so it was hard to convince them to support the intervention
- In most of the VDCs, the health mothers' group was not functional and so HC3 had to prioritize ensuring health mothers' groups were running

Five of the FCHVs of the intensive VDCs did not live in their catchment areas, making it difficult for them to conduct their work. In at least one case, a helper did some of the work

e.g. vitamin A supplementation, and in another case the FCHV travelled to conduct HMGs but in the other cases we could not ascertain whether or not the FCHV tasks were being carried out or by whom.

Even those living in their catchment areas could be far from the households they served. For instance, one FCHV pointed out that because it takes her three days to reach all the dispersed households in her very large ward she does not go to all the households. She also pointed out that she does not receive any incentives to do the work requested by HC3.

**Other challenges**

The District Health Officer said that it was challenging to implement a new intervention at the end of the fiscal year when the workload is heavy because they could not get involved in the detailed planning and implementation. He suggested that interventions be started mid-year instead.

Although there had been enough leaflets for the orientation activities, part of the intervention involved FCHVs distributing these. The supply of leaflets was inadequate for this to happen in practice (the pilot was using district supplies) and more are needed if FCHVs are to distribute them widely.

## 3.2 Pathways and barriers to women's uptake of family planning: Supply side issues

### 3.2.1 Commodities/trained staff not available

Women who told us they were using contraception had often obtained their method from nearby government health facilities, at least in part because they are available from there free of cost. The methods available were generally limited to condoms, pills and injectables. One FCHV told us that in Bhagwati (a non-intensive VDC) IUCDs and implants are not available in the nearby health facility, and attributed women's non-use of these methods to this unavailability. Some health facilities did offer implants or IUCDs but availability was patchy.

It was not only lack of commodities or trained service providers that prevented women from using methods of their choice, however.

### 3.2.2 Service providers turn away women requesting effective methods

Some women reported being turned away by service providers when they requested injectables. The reasons given were that they were not in the first week of their menstrual cycle (In-depth-interview with woman of reproductive age (henceforth IDI) 16), or that they should agree it with their husbands (IDI 18). It seems likely that women might travel considerable distances, or take time off work, or otherwise suffer inconvenience to obtain a reliable method that they are then refused at the point of delivery.

We were not tasked with checking provider competence, and so we suggest one of the following is happening but further work will be needed to ascertain which: (1) provider assessed that pregnancy was likely and so did not provide the method (NB WHO FP

handbook notes that injectables do not affect established pregnancy (WHO 2011)); (2) provider error; (3) incorrect standard operating procedures (e.g. if these state woman must be in first 5 days of cycle).

One of the interviewees who said she had been turned away when she requested injectables told us that she went on to conceive an unwanted pregnancy (IDI 16).

Another client said her service provider had asked her to come back for her injectable on the fifth day of menstruation, and she did so but did not use any method in between her husband arriving from overseas and her injection – she told us she would have had an abortion if she had conceived during that time.(IDI 21)

Similarly, one participant told us that she had gone to the health facility for an implant and had also been turned away on two separate occasions because of the timing. (IDI13) The woman told us that she had decided herself that she wanted an implant and had gone to the FCHV who had written her a referral slip. She had not looked at what was written on the slip and at first did not want to hand it over to the male provider. The FCHV came to help, but she and two other women were all turned away for not being in the 5$^{th}$ day of their menstrual cycle.

Excluding pregnancy would be in line with standard international procedures for implant insertion. The service provider told her to come back on the fifth day of her period and to use condoms until then. She said they had used condoms but she went away for a few days and once she came back they had not been using anything because there were only a few days left until she was due to get the implant and her husband did not like condoms. This participant did not know about different risks of pregnancy at different times in the menstrual cycle – she simply said there was little risk because of the small number of days.

We cannot tell from our qualitative data how frequently in the general population women are turned away when they ask for effective methods of contraception, or how often they arrive at the facility and find out that their chosen method is unavailable. Having said that, even in our fairly small sample, we have three examples of women being turned away (and two additional women who they mentioned in their accounts) when the commodities and provider are available. It seems possible therefore that women requesting reliable methods are being turned away on a fairly significant scale, either for spurious reasons (e.g. insisting method use must start on 5$^{th}$ day of the menstrual cycle), or possibly for good reasons (e.g. unable to rule out pregnancy in the case of implants) but without being given an adequate alternative.

One service provider said that for such clients she tells them to use condoms and to come back on days 5-7 of menses. Some clients do not take the condoms, (e.g. the provider mentions they might say “If my husband used condoms I would not have had to come for Depo”). In this case, the provider tells them:

*“If no baby is conceived, then that’s good but if you do get pregnant, then there are MA [Medical Abortion] services. You have to wait for your menstrual period in order to start the Depo. When your period starts, come after 5-7 days. If a baby is conceived then come for MA.”*

### 3.2.3 Lack of nearby services

Distance to the health facility unsurprisingly influenced use of the facilities. One woman, for instance, told us that she had previously not used injectables because the health facility was so far away, but now does because she is closer (IDI14). Another woman told us she wanted to use injectables but was using condoms until going to health facility to immunize her child, where she planned to get injected. (IDI17) On the other hand, those nearer health facilities said proximity made it easy to get methods, and one woman said she liked visiting her nearby facility because she knew the people there and felt comfortable (IDI16).

During our fieldwork, we recorded which family planning services were available in each of the intensive VDCs. Results are shown in Figure 3.9 below Condoms, pills and Depo were universally available. By contrast, implants, IUCD and medical abortion services were completely absent in over half (8) of the 15 VDCs, and only 4 provided all three. An additional two provided implants and a further one provided implants and IUCD. Since our visit, we have heard that an additional one has started providing implant services.

**Table 3.9: Family Planning and Medical Abortion services in the Intensive VDCs**

| S. Absent. | VDC Name | Absent. of FP Provider | Absent. of SBA trained HW | Condom | Pills | Depo | Implant | IUD | Medical Abortion |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Jyamrukkot | 5 | 2 | Present | Present | Present | Present | Present | Present |
| 2. | Babiyachaur | 3 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 3. | Baranja | 4 | 2 | Present | Present | Present | Absent | Absent | Absent |
| 4. | Bhakimli | 3 | 2 | Present | Present | Present | Absent | Present | Present |
| 5. | Bima | 2 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 6. | Ghatan | 3 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 7. | Niskot | 2 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 8. | Okharbot | 3 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 9. | Ruma | 6 | 2 | Present | Present | Present | Absent | Absent | Present |
| 10. | Ratnechaur | 4 | 0 | Present | Present | Present | Absent | Absent | Absent |
| 11. | Pulachaur | 5 | 2 | Present | Present | Present | Absent | Absent | Absent |
| 12. | Arman | 4 | 2 | Present | Present | Present | Absent* | Present | Present |
| 13. | Singa | 6 | 2 | Present | Present | Present | Present | Present | Present |
| 14. | Arthunge (District Hospital) | | | Present | Present | Present | Present | Present | Present |
| 15. | Darwang | 5 | 3 | Present | Present | Present | Present | Present | Present |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Total** | | | **15** | **15** | **15** | **4** | **6** | **7** |
| Rakhu Bhagwati (Non-Intensive) | 3 | 2 | Present | Present | Present | Absent | Present | Present |

***Note: Singa and Darwang VDCs are our sampled Intensive VDCs and Rakhu Bhagwati VDC is the sampled non-intensive VDC***

Absent*: the health facility started to provide Implant services from the month of Poush, 2072 (Dec,2015/Jan,2016)

### 3.2.4 Lack of women service providers

Finally, women service providers are preferred. They are seen as easier to talk to (IDI17, 11) with less awkwardness than dealing with a male service provider. Some women said they did not wish to attend certain healthcare/family planning services at all because they only had male healthcare providers. The women said they would wait until there was a woman available or go to another service instead, even if it was far away. In one case, a woman asked for the FCHV to mediate so she could avoid approaching the male provider directly (see below for full account).

### 3.2.5 Lack of high quality family planning advice

When women attend healthcare facilities, it is an opportunity for them to receive counselling on methods. However, this does not always happen. For instance, one woman said she went to a provider to ask for injectables and the provider simply gave her the injection without telling her about other methods. She went back on another occasion and asked for pills, which she also got without further information. While it is not clear how typical this experience is, what does seem to be the case is that many women rely on FCHVs for advice rather than going to the health facilities. Another woman told us that she went to get injectables on the suggestion of the FCHV who told her to visit the facility on day 5-7 of her cycle. She said in this case, the provider did tell her about different methods, suggesting either the pill or Depo because her husband was planning to go abroad. She chose Depo because of its three-month duration (pills were too short, implant too long). The provider only informed her about side effects after she decided to use it, telling her to visit the health facility if she experienced any.

One woman told us that she would first go to the FCHV for instance if she had any side effects from her method, and only go to the health facility if she was not satisfied with the advice she received from the FCHV. This apparent substitution of qualified healthcare provider with the FCHV is concerning as it suggests women are not always receiving quality care.

The FCHVs try to help their clients. However, their knowledge is often not sufficient because they are not clinically trained. One FCHV (FCHV interview 2), for instance, mentioned to us that she provides information about withdrawal to women, telling them that if they are using withdrawal they do not need to use any other methods. The same FCHV also said she provides information to women complaining about side effects of other methods: she tells them that days 14-18 of a menstrual cycle constitute the “unsafe period” and if they abstain from sex during this period then they will not have to use another method. This type of well-

meaning but incorrect advice is clearly problematic in a scenario where women do not always have good access to qualified providers.

**Box.3.1: Women lack quality care: FCHVs substitute for trained family planning providers**

One woman (IDI 20) told us how an FCHV advised her to stop using OCPs because of the risk (according to the FCHV) of long-term side effects such as heart or uterus problems. The woman said the FCHV told her *"This [withdrawal] would be better than doing that [pills]".* The FCHV even offered to phone her husband to tell him to comply. The husband lived abroad and only came back irregularly on holiday. The woman followed the FCHV's advice and switched from OCPs to withdrawal. She subsequently became pregnant, blaming herself for the method failure

*"We, husband and wife, discussed and used the withdrawal method as suggested by the FCHV. We were trying to throw [semen] outside, but we threw it inside [Laughs]"*

The woman already had two sons. She described her husband's reaction to her pregnancy:

*"At first […] he said what happened was good [Laughs]. He wanted to have a daughter and said that his wish had come true. Then I yelled at him, after which he asked me to calm down and do what I want.*"

She said that the FCHV had told her where to obtain an abortion and she opted for medication abortion using pills from a nearby government health post. The pregnancy ended without any complications.

It seems probable that the FCHV was doing her best to provide the woman with information the FCHV believed would improve her health. However, women need quality healthcare if family planning programmes are to be successful. They should not be limited to advice from unqualified providers which, as can be seen very clearly in this case, may do harm rather than good.

FCHVs are officially not allowed to provide women with a first cycle of pills. The women must obtain the first cycle from the health facility and only subsequent cycles from the FCHV. However, one FCHV told us that a woman whose husband was arriving home that night from abroad had come to her for help because she did not have time to visit the health facility to ask for pills. The FCHV gave her a single pill on the understanding that the woman would visit the health facility the next day.(FCHV interview 8) In a similar case, a different FCHV said she had supplied an entire cycle to a woman who she knew had used them before. It is not clear in either case that the woman or FCHV was aware that unless the woman is in the first seven days of her cycle, alternative methods (probably condoms) would also be needed for 7 days.

An FCHV we interviewed told us she tells women to start oral contraceptive pills within 4-5 days of menstruation, and incorrectly informs them that pills will not work if started after the seventh day (FCHV interview 2).

### 3.2.6 Emergency contraceptive pills (ECPs) and post-coital services

Government services did not offer ECPs and FCHVs did not have ECPs to distribute. No women we interviewed mentioned using ECPs. This is a major gap in government provision, particularly given that condoms can fail and so ECP provision alongside condoms is a sensible approach. It seems likely that ECP would be a particularly useful backup method for women whose migrant husbands returned unexpectedly and who had therefore not had time to start a more reliable method such as pills or injectables. It would also be important for others too such as condom users whose method failed. ECPs are available in pharmacies but seem not to be widely used, or promoted.

FCHV postcoital services included in some cases selling pregnancy test kits to local women. FCHVs also provided referrals to abortion services for an IPAS programme that was running at the same time as this project. FCHVs did not mention knowing about, or suggesting use of, emergency contraception.

Further research is required on the extent to which emergency contraception could be a viable solution for Nepali women who have less access to services. From such studies the feasibility of FCHVs providing advice on, and even potentially distribute, emergency contraceptive pills could be further explored. This would require careful consideration and require piloting to ensure it was done correctly and that women were not being encouraged to switch from more effective methods. Emergency contraception is mentioned very briefly in the FCHV manual.

### 3.2.7 Abortion services

Women were generally aware of the availability of safe methods of abortion although they did not always know the details. Medical abortion was fairly widely available in the VDCs we worked in: we found it in seven out of 15 intensive VDCs, including the District Hospital at Beni and a PHCC at Darwang. We also found medical abortion provision in the sampled non-intensive VDC, making a total of eight out of the 16 health facilities we visited. We were told that only 13 facilities in Myagdi are permitted to provide medication abortion and so many VDCs do not have this service available.

Where medication abortion was not available, health facilities referred clients to other facilities or to the district hospital for these services.

### 3.2.8 FCHVs and client confidentiality

The FCHVs are in a difficult situation with respect to client confidentiality. On the one hand, they are instructed to promote family planning and to follow up women who may or may not be using different contraceptive methods. They are also expected to know about who is pregnant in their ward. On the other hand, they are not qualified health workers, have no specific duty of care and have no clear position in terms of sharing data with health services (FCHV giving information to health services or vice versa).

One FCHV told us that health service providers unreasonably expect them to know about every woman,

> *In our ward, there is the "record" that a woman gave birth to her child without even going for a single antenatal check up. I get hurt [by such things]. I told her off, saying that she had disgraced me by letting this happen even though I had gone door to door with information about it. Moreover she gave birth at night without letting us know. They came afterwards in the morning to tell me that she had given birth and to ask what needed to be done. When I asked her why she hadn't told me, she said, "I hadn't had my period. I didn't even know that I had conceived. I thought that I wasn't pregnant. Later on after five months, I knew that I was pregnant when the child moved inside. I didn't know before that." When she said that, we had nothing else to say. Then I told her that she should have told me if she was suspicious so that I could have taken her for a*

*pregnancy test or to the health post for a check up. I asked her why she stayed just like that. She said to me, "I found out that I was pregnant only when I felt the child moving in the fifth month. When you asked me before, I had said that I was not pregnant. I thought that you would scold me if I told you that I was pregnant. So, I didn't tell you." […]*

*"Sometimes I feel bad when something bad happens. That case [the pregnant woman she had mentioned earlier] had happened, so [health post in charge]-sir asked me why I let it happen being an FCHV. I asked him how would I know [that women are pregnant] when they don't tell me? At such times I wonder why I do this work and I feel like quitting" (FCHV interview 1)*

From our interviews and observations, it seems that FCHVs may be under pressure to find out information or even to increase numbers of women taking up family planning (as opposed to ensuring women needing family planning have options to choose from), which may create perverse incentives to pressure women into disclosing information or taking up specific contraceptive methods.

One service provider told us that they ask the FCHVs to follow up FP clients and if the client discontinues method use, ask FCHVs to find out why.

*"We [health workers] call FCHVs to follow up of those people who are using the service, we also ask them to observe those people and if they have any problem call us for help. Or we ask the client to meet the nearest FCHV if they have any problems. Nowadays, we keep in contact with clients with phone calls because network coverage has increased*

Interviewer: Do they call you?

*Yes they do. If they become irregular [i.e. if they don't come for FP services at the time they should come] then we enquire through the FCHV, and then we contact them."*

The question of information sharing with health facilities (e.g. about who is pregnant) is particularly problematic given the possible negative consequences for women if certain information about them becomes known in their communities. The possibility of breach of confidentiality may put women off using local facilities, effectively reducing their access to contraception. While we do not have direct evidence of this, one woman told us that her daughter in law preferred to pay to go to private providers so that no one would know about her using injectables which suggests she might not be confident in the confidentiality of the government service. We also know that women may go to distant clinics to request abortion services, or to see a female provider.

It is crucial to note here that we do not suggest FCHVs are blameworthy, even if they do breach confidentiality, as the system seems to be set up to some extent to encourage this, presumably with the best intentions. FCHVs are 'rewarded' (in praise, if not in monetary terms) for client uptake of family planning; health facilities expect FCHVs to know women's personal business and complain when they do not. Closer attention to privacy and women's rights to a private life would be useful throughout the system. If information sharing is considered essential between health services and FCHVs, clients should be involved in a

dialogue about how this should be managed to help ensure first that women understand what information about them is being shared (they could perhaps consent to such sharing) and also ensure that possible unintended consequences are considered by those directly affected.

## 3.3 Pathways and barriers to women's uptake of family planning: Demand side issues

### 3.3.1 Women's experiences of side effects of contraceptives

Women sometimes discontinued or switched methods that caused side effects, but they also sometimes endured considerable discomfort in order to be protected from pregnancy, illustrating how limited their options were. For instance, one woman whose husband was a migrant worker home for a few months between work assignments overseas secretly used injectables because her husband did not approve of contraception. She suffered severe side effects including heavy bleeding. She said

> *"Soon I will reach 3 months of using injectables and then… my husband is also trying to go abroad. If he goes I won't have to use anything, but if he stays, I will have to think about what to do. […] Nowadays, I bleed over and over again and have started having dizziness, nausea and headaches. I am suffering from all these but I cannot tell [my husband]."*

One of the FCHVs described to us how she had also had experience of heavy bleeding with injectables and had discontinued use. She emphasised that she would nevertheless still recommend them to others.

### 3.3.2 Condoms

Many women used condoms from time to time although not all of them knew how to use them properly. In one HMG we observed the FCHV advising a woman who had complained the condom was too big.

> ***Woman:*** *I told his father [pointing towards her child] that the FCHV had given me condoms. He tried it on just like that before dinner. It was loose and kept falling off.*
> *[General laughter]*
> ***FCHV:*** *That is not how it is used. It should be put on when it [penis] gets bigger. It will obviously fall off if you put it on while it [penis] is small just like a child's. This is how it should be put on when it [penis] gets bigger. [She demonstrates putting on a condom, laughing].*

One district official told us that when they talked to the community, they often heard complaints, especially from the women, about the size of condoms, which they said are too large and so the husband refuses to use them. They said it would be like "wearing bangles" and would not be satisfying. The official said that a study was needed to ensure that the condoms were sized correctly for average-sized Nepali men and that this might improve uptake of the method. Given the discovery by the FCHV that her client had been using the

condom incorrectly, is unclear whether the problem the PHO refers to has been similar i.e. that the men are not using the condoms correctly or if there genuinely is a sizing issue. The possibility that men are using condoms incorrectly may be worth bearing in mind if complaints of this type are made.

Another possible misunderstanding was hinted at by one of our interviewees (IDI 13) who understood 'family planning' to mean 'sterilisation'.

### 3.3.3 Features of hormonal methods, IUCDs, and permanent methods that affect women's choices

Women were generally fairly knowledgeable about the different methods of contraception available to them and many described using reliable methods, primarily injectables but also pills, and less commonly, implants and IUCDs. Some had switched methods after experiencing side effects rather than discontinue contraception altogether, some were planning to use permanent methods.

Women described various factors that they said affected their method choices. These included worries about IUCDs being painful or damaging the uterus, weight gain from injectables, and worries about physical weakness after sterilisation. These worries did not necessarily translate into unwillingness to go ahead with a particular method, however.

> *Most people say that it is better for women to do it [sterilisation] than men because men have to work, they have to try to go abroad, and it will be very difficult for them. Mine [husband] says: "It will be difficult for women. They have to work a lot at home; they have to look after children. It is ok if I get it done [vasectomy] after we have a son."*

Personal experience of side effects – women most commonly talked about disruptions to bleeds and/or heavy bleeding after using injectables – did not necessarily cause women to discontinue use of reliable contraceptive methods. One participant, for instance, said she disliked injectables because of the irregular bleeds and dizziness she experienced. She had not, however, decided whether or not to discontinue use (IDI18). Some participants (IDI17, 16,10) said they had carried out pregnancy tests after injectables stopped bleeds. One interviewee told us how she had suffered from heavy bleeding for 6-7 months after a single dose of injectable (probably Depo). She visited a government health facility and was given oral contraceptive pills to stop the bleeding. She then continued with the OCPs as a method of contraception. (IDI13)

Women often said they made their initial method choices based on friends' and neighbours' experiences, and this was particularly given as the reason for using injectables.

One service provider complained that rumours about contraceptive methods can create problems:

> *"We just tell them about the benefits and disadvantage of the devices. We try our best to convince them saying that thing that they have heard is not true and it is just a rumour. And it is like this; if a false thing is heard many times then it will become true*

*for them. And we are not always in contact with them so they perceive the false thing they have heard many times rather than [believing] what we say".*

### 3.3.4 Natural methods

Some women had heard of the withdrawal method, but many had not. Those who had generally referred to it using a colloquialism that translates literally as 'throwing it outside'. One FCHV (FCHV interview 3) told us how she had recently found out about the method from another FCHV and had laughed "too much" at the idea. Other women seemed to dismiss the idea entirely when we raised it in interviews "How can a man agree to do such thing [withdrawal]? Either we have to use injectables or pills." (IDI13)

Despite the importance of menses in symbolic terms, there was very little evidence of any knowledge of calendar methods of contraception of any sort. Women seemed generally not to have any particular concept that certain times of the menstrual cycle were more risky for pregnancy. Of those who had heard about safe and unsafe days during the menstrual cycle, the proposed period of fertility varied. For instance, one woman said sex after the first week of the menstrual cycle can lead to conception (IDI18), whereas another woman – potentially more problematically in terms of risk of unwanted pregnancy – said she thought that women could not conceive in the part of the menstrual cycle 10 to 12 days after menstruation (IDI11)

Most women said menstruation is important for good health, to get dirty blood out of body. (e.g. IDI8) and most mentioned restrictions during menses such as not being allowed to cook or be involved in religious ceremonies during menstruation. Most also said they did not have any sexual relations for the 4-5 days of menses.

### 3.3.5 Abortion

Some women said they viewed abortion as a sin while others said that it would make them weak and it was therefore better to use contraception. One woman told us that she had obtained abortion pills to terminate her last pregnancy but then had had a change of heart because she was worried it was sinful and so did not take them (IDI14)

During one of the HMG meetings, we observed the FCHV telling a woman to use contraception to avoid having an abortion. The FCHV said: *it is more difficult to have an abortion than to give birth. I also aborted the child that I had conceived after this daughter [showing her daughter]. It had been very difficult for me. I became very weak. So, why suffer? You can become careful right from the start. Why to commit a sin? So, consult properly [with your husband] and think of it [using contraception].*

One FCHV (FCHV interview 2) told us she felt that clients were less worried about contraception because of the availability of medication abortion services although it is unclear whether she had any evidence for this belief. Some health providers said something similar: that women were using abortion instead of contraception. Again, it is unclear what, if any, evidence there is for this. In Myagdi women seemed generally well aware of medication abortion.

### 3.3.6 Effect of migration

A key reason women gave for using short- rather than long-acting methods was that their husbands were often away for long periods overseas. The women said that they would have to remove the implant or IUCD while their husband was away. One FCHV explained that women might choose pills for instance because they can stop at any time without having to return to the health facility. Some women said they had not discussed contraception with their husbands before they came back, and some had not known their husbands were coming back until they had arrived.(IDI13)

### 3.3.7 Women's autonomy

Women reported that generally their communities had a positive attitude towards use of contraception although this did not extend to use of methods by newly-married couples who were expected to have children within a few years of marriage.

Some women said their husbands were supportive of family planning, and for instance described going together to the health facility to obtain contraception (IDI5). Husband agreement was also sometimes seen as crucial for any method to be used (IDI13), and some women described secret use of injectables or pills (IDI13, 2).

Other women, however, talked about how their husband prevented them from using particular methods, either because he wanted a child or because he was worried about side effects of the methods. One woman said her (non-migrant) husband forbids her use of contraceptives to prevent her having extramarital affairs (IDI14). Another woman, who conceived after discontinuing pills because of excessive bleeding, said she wanted to end the pregnancy but her husband would not permit it.(IDI1)

One woman, by contrast, told us she convinced her husband they should not try for another child by talking him through the economic hardship that would entail.(IDI19)

Son preference was mentioned as a way that women's autonomy was restricted. For instance, one woman described how her husband wanted a son (after two daughters) and so would not allow her to use any contraception. She said she wanted to have a gap of at least 2-3 years before the third child and so was secretly using injectables (IDI18). Her mother-in-law had taken her to a traditional healer in case her inability to bear sons was because of an evil spirit. She and her husband were made to drink cow's milk with honey after the healer had performed some chants. She also had to eat herbs and drink hen's blood. She said her husband wanted to test any subsequent foetus and abort the pregnancy if it is another girl. If it is a boy, her husband agreed to undergo vasectomy.

Other participants also mentioned either experiencing or hearing about pressure from husbands, in-laws and community members to give birth to a son (IDI16, 7).

## 3.4 Relationship between the intervention and FCHV work

There was some evidence that the intervention affected uptake, in anticipated, but also unanticipated ways.

### 3.4.1 FCHVs provided referrals and women took them up

The FCHVs reported using the referral slips to record method choice when they had given advice to women about family planning. Clients told us that they had been given information by their FCHV, which they had acted upon by going to a clinic or health post to request the service (IDI 7, 10)

The FCHVs in our quantitative sample said they provided verbal advice (mostly to use depo and sterilisation) and also written advice using the referral slips. The FCHVs collectively reported referring clients for a range of different methods. Referrals for a range of methods is a reasonably good sign because it suggests client needs and preferences might have been taken into account although the numbers are too small to draw any firm conclusions. Note that it is not strictly in the FCHV remit to provide specific advice at all, although FCHVs seemed to be expected to give family planning advice by almost everyone we spoke to. Where possible we double-checked FCHV interview data against the FCHV register and the FCHV portion of the referral slips. It was clear that in some cases, the FCHVs had not correctly filled in the referral slips (e.g. had referred for Depo but had marked “pills” on the referral slip). FCHVs reported that many women they had referred had taken up the service (see tables in Annex 3). The HC3 field supervisors helped the FCHVs keep the records e.g. by supporting them in using the referral slips. The precise proportion of women referred who took up services is unfortunately unclear: not all women were given referral slips, and of those who were, not all presented the slips at the service. Crucially, health services did not always retain the slips despite being asked to do so. We therefore rely on FCHV structured interviews which are cross checked with the examination of FCHV half of the referral slips and the FCHV register.

The HC3 co-ordinator told us of a case where a woman had been referred by the FCHV for injectables and had reported back to the FCHV that she had obtained the method. By chance the field supervisor bumped into the client on a separate occasion and asked her where she had obtained the injectables. The client confessed that she had not gone for the injection because she was afraid to do so. The precise data on referral uptake are therefore, predictably, unreliable although it seems likely that some of the referrals were genuinely taken up.

### 3.4.2 Unexpected positive impact of referral slips

One unexpected finding was the impact of the referral slip. We had introduced this knowing that it might affect the intervention but needing to use something to record referrals. The referral slip was therefore not strictly part of the intervention, although it did modify the intervention because FCHVs had to be trained to fill in the slip and women received a slip they otherwise would not have done. HC3 designed the referral slip and we used it to cross-check the FCHV referral records.

The referral slip had several unexpected impacts.

**Impact 1: Reducing discomfort in asking for family planning**

This was the major positive impact. Clients reported that they liked the slips because they could hand them to the service provider and not have the embarrassment of broaching the subject of contraception. They liked being able to turn up with written information so all the

details were there for the provider. Even with the referral slip, however, barriers were not necessarily removed: one client told us she was uncomfortable handing the slip to the male provider and so she had waited for the FCHV to hand over the slip on her behalf. The provider then gave the client the method she had requested.

**Impact 2: Giving women additional options**

Referral slips have the potential to be used by individual women to help them to achieve their family planning goals in creative ways. One woman told us that she had asked for injectables but had been told she should discuss it with her husband and was sent away without the method. A typical enough scenario, as we have seen in other cases. This time, however, rather than giving up, the woman told us that she went to the FCHV and asked her to write out a referral slip. The woman then returned to the same service with the referral slip two days later, explaining that she had still not asked her husband. This second time, the service provider gave her the injectable. It is unclear whether this was because of the 'official' slip, because the woman had come back and so was clearly determined to use the method, or for some other reason. However, it seems possible that without the slip to provide extra support, the woman might not have returned to try again. In this case, then, she seems to have used the referral slip setup creatively to circumvent the objections of the service provider and obtain the method she wanted.

**Impact 3: Helping make FCHV work look 'official'**

FCHVs told us they liked the slips because it made their role seem more official, and because it provided a way for their referrals to become visible to the service providers and provide 'proof' that they are providing information to clients and not just recording this in ward registers (FCHV interview 5). The slips made it clear to all what work the FCHV had done. It helped the FCHVs keep records. A FCHV mentioned that the referral slips themselves have made their work easier in that they show the referral slip to the client and use it to suggest a method choice.(FCHV interview 8) Another FCHV, however, was worried that clients would simply take the referral slips and throw them away. (FCHV interview 3) The FCHVs were not always clear about how to use the referral slips and the field supervisors helped them.

> *"[Field supervisor] sister tells me that I do not need to "refer" them for condoms. However, at the health facility they say that it should also be referred because it's also a temporary device. I don't know what to do!" (FCHV interview 3)*

The FCHV portion of the referral slips contained the woman's name. This is different from the FCHV registers where only general numbers of referrals etc. are recorded. FCHVs tend to keep their registers and other documents in their bags, or houses. The records were therefore not stored securely.

### 3.4.3 FCHV contact with clients

We asked the participants whether they had interacted with the FCHV in the past few months. Some said that although they had not met in person, they had spoken on the phone (IDI 5, 7,8) e.g. regarding a pregnancy test (IDI5) Some participants said they had seen FCHVs during HMG meetings and when they went to obtain contraception (IDI15,13,11)

FCHVs themselves said they provided information to clients during HMG meetings, on their way to the farm or the community water supply. They sometimes visited their houses or clients might come to the FCHV's house to obtain pills and condoms or for information. One FCHV said they had to visit households to report data on number of clients using any particular method of FP, and of women aged 15-49 who have given birth.(FCHV interview 5)

Three FCHVs mentioned they contacted clients by phone if they were not able to visit them e.g. if they lived far away. (FCHV interviews 3,6,8)

One woman told us she liked getting information from the FCHV because she sees her as knowledgeable and trained, a provider of correct information, and someone that everyone has faith in. She told us that if she had any side effects from an injectable, she would first go and consult FCHV and would only go to health service provider if she were not satisfied with the FCHV's advice (IDI17)

One FCHV said that sometimes members of the community are not cooperative and do not listen to them, making it difficult to do the work (FCHV interview 6). The same FCHV said she is sometimes accused of not doing the work properly, and that there is a misconception that she is paid for the work. Another FCHV said that people sometimes think FCHVs know everything and expect them to handle any case. (FCHV interview 5)

One FCHV (FCHV interview 1) complained that the health facility created a heavy workload for them, which is made worse by the fact that other organisations ask them to do additional, compulsory work.

### 3.4.4 Contraception provision in the intensive VDCs

FCHVs distribute pills and condoms and for these and other methods, women go to health facilities. We found some FCHVs whose stocks of pills and condoms had passed their expiry date, and others who had no pills or condoms at all. HC3 field supervisors told us they had found the same and had reported this to the health facility.

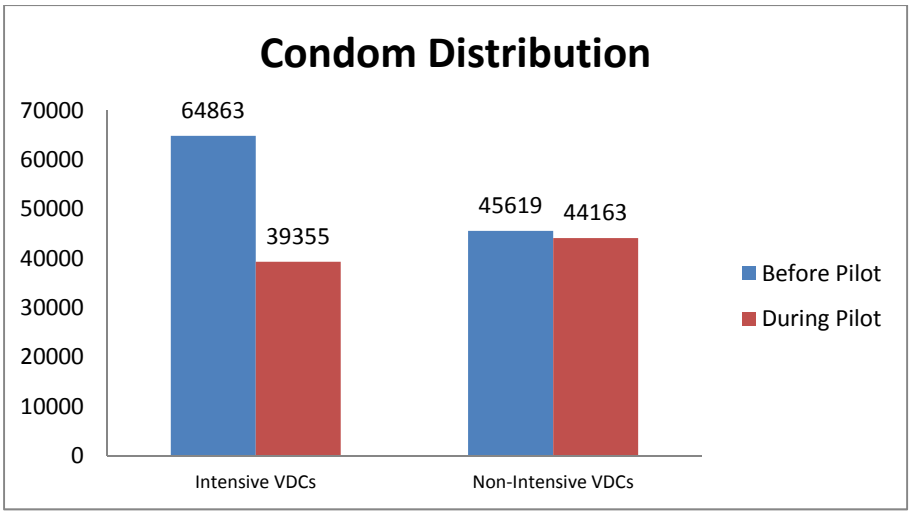
During the intervention period, the DHO held a "sterilisation camp" and asked HC3 to organise it. Some of the FCHVs accompanied clients to the camp. Referral slips were also used. HC3 field supervisors co-ordinated the health workers and the FCHVs to send the clients for the VSC camp.

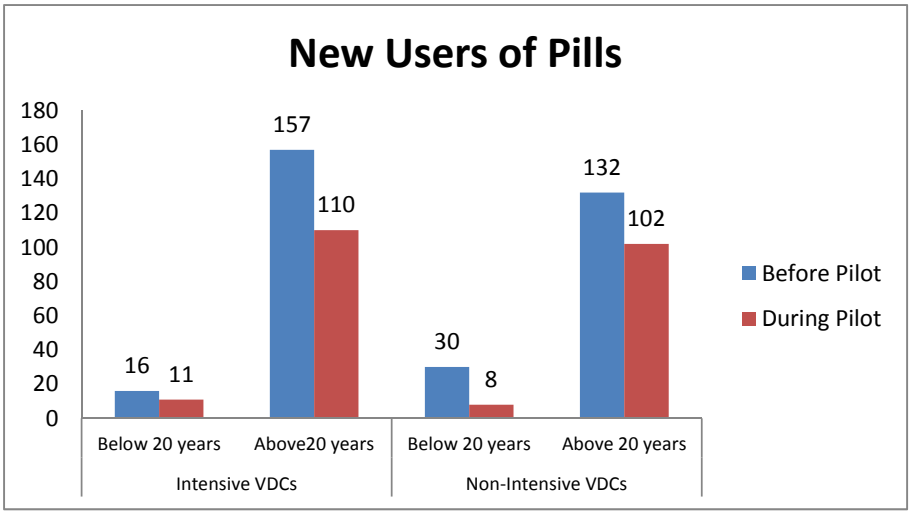
### 3.4.5 Contraceptive uptake in intensive and non-intensive VDCs

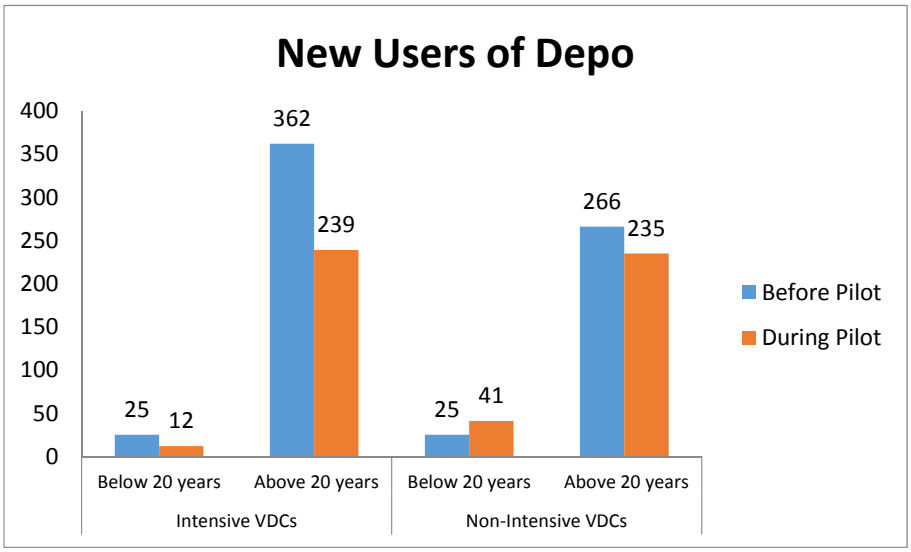
The figures for contraceptive uptake are likely to be unreliable because of the ways that reporting differs between facilities, including with respect to how 'current' versus 'new' users are defined in those facilities. Figure 3.1 shows how reported uptake of contraception recorded by health facilities changed from before the pilot Shrawan-Poush 2071 (July-December 2014) to the endline point, which was during the pilot Shrawan-Poush 2072 (July-December 2015). During the intervention, while there was an increase in IUCD uptake, uptake of condoms, pills and injectables broadly *decreased* by a greater amount than would be accounted for by switching to LARCs in both the intensive and non-intensive VDCs. Please note that these somewhat disappointing-looking figures may be an artefact of the design: the intensive VDCs were picked because they were most in need. If they were less

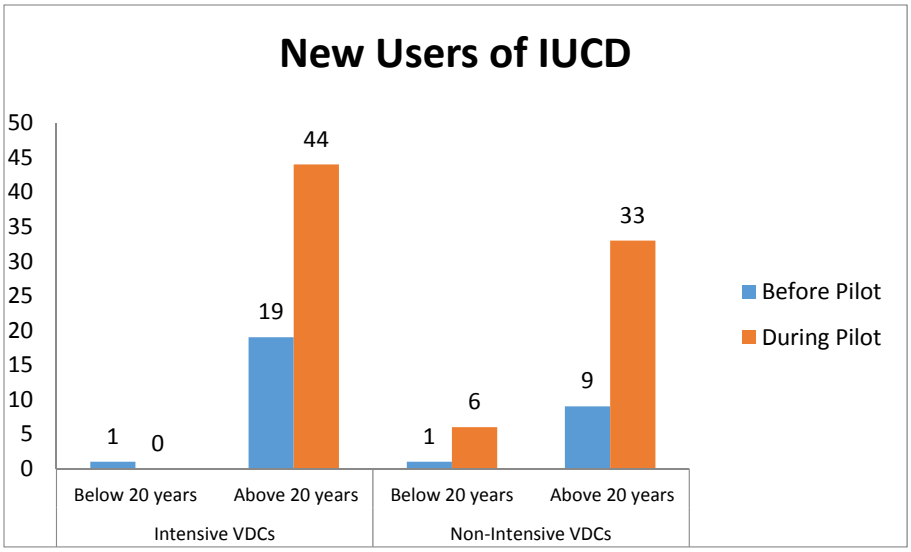
resilient than the non-intensive VDCs, it seems possible that the earthquake and subsequent disruption may have hit these areas harder than the others although Myagdi was not very badly affected. An additional consideration is that some information may not have been entered into the DHO registers for the relevant months when we obtained the data. Whatever the explanation, it is clear there is no obvious link in this data between the modality of the intervention and the uptake of contraception, with external factors likely to play a large role including most obviously whether or not contraceptive services were available. For instance, in the sampled non-intensive VDC, the increase in IUCD uptake is easily explained by the fact that IUCD services were only made available in time for the endline measurements. They did not exist in that VDC at the time measured by the baseline measurements, something that is likely to be independent of the intervention. Having said that, absence of evidence is not evidence of absence: it is possible that real differences are simply masked by the multiple biases affecting the data. Please note that the figures for 'current' use were consolidated so inconsistently that we considered it would be misleading to present them here.

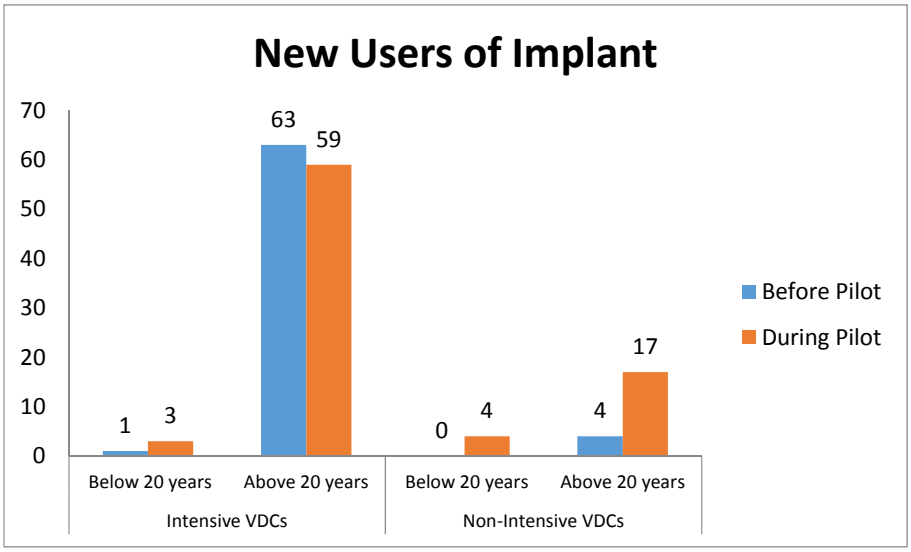
**Figure 3.1: Contraceptive uptake in the VDCs - charts**




New Users of Depo
400
350
300
250
200
150
100
50
0
25
12
362
239
25
41
266
235
Below 20 years
Above 20 years
Below 20 years
Above 20 years
Intensive VDCs
Non-Intensive VDCs
Before Pilot
During Pilot


New Users of IUCD
50
45
40
35
30
25
20
15
10
5
0
1
0
19
44
1
6
9
33
Below 20 years
Above 20 years
Below 20 years
Above 20 years
Intensive VDCs
Non-Intensive VDCs
Before Pilot
During Pilot




During pilot refers to the period Shrawan-Poush 2072 (July-December 2015)

Before pilot refers to the equivalent period in the previous year Shrawan-Poush 2071 (July-December 2014)

## 3.5 Limitations

The limitations of this evaluation are considerable, especially in terms of answering the question of whether the intervention led to an increase in family planning uptake. The samples were not representative in a statistical sense and as described above, the quantitative data reporting is unreliable, and the quantitative findings cannot be generalised because of the multiple sources of bias present. Nevertheless, we believe the insights from the qualitative findings could be transferable elsewhere.

We discovered some specific limitations to the quantitative data, which may also apply to other evaluations and analyses. All the services provided through a health facility and outreach clinics and FCHVs are recorded in the service specific HMIS registers at the health facility. The data from these registers is reported to the District Health Office (DHO) in a monthly reporting sheet (HMIS 9.3), where they are compiled and entered into standard software. Definitions and recording of uptake of FP was inconsistent between providers and over time. One specific example of this was that our discussions with service providers from different health facilities revealed that they used different definitions of new users of FP. One service provider said that before HC3 delivered the IPCC training to them, they had only considered clients using a specific form of FP for the first time to be new users. However, in the IPCC training they were told that they should also include returning users who had had a gap of a year or more in their use. It would be expected therefore that the IPCC training may have affected data collection practices and therefore that numbers before and after the IPCC training would not be comparable. In the case of new users, they are likely measuring different things between health facilities and so comparisons between facilities are likely to be unreliable, as well as the likely changes in measurement over the course of the

evaluation. The data on current users and on discontinuation rates were recorded even more inconsistently between facilities, to such a degree that we do not include this data in this report as we consider comparisons are likely to be misleading. Condom distribution is calculated based on stock each health facility receives and distributes, which includes batches distributed to FCHVs. Condoms from these batches may therefore be distributed to clients later than in the time period recorded in the HMIS or conceivably in some cases may not be distributed at all, depending on FCHV activity.

# 4. Conclusions and recommendations

## 4.1 Main conclusions: answering evaluation questions

*Do FCHVs deliver more FP services and approach more potential FP users using IPC training? Does FCHV exposure to IPC increase uptake of FP services? Does IPC increase knowledge, awareness, and willingness of FCHVs to deliver more FP information services?*

FCHVs seemed to enjoy the HC3 IPC training sessions and find them useful. Refresher training was something many said they value. Our survey results suggest that FCHVs receive refresher training from NGOs rather than government sources and we have no information about the quality of the training. The IPC orientation for FCHVs, according to the FCHVs themselves, helped refresh their memories and helped them think about how to communicate respectfully and politely with women in their wards.

As identified at the outset, it was not possible to collect key data, and so we could not address the question of whether numbers of users or number of services increased.

*What is the evidence that FCHVs are delivering the expected FP services in their communities?*

We found evidence that FCHVs are working hard to provide services for their communities. They use their own resources (time, cell phones) to contact clients and to provide help and advice. They refer clients to health services and accompany clients to help them obtain the services they need. Nevertheless their knowledge and skills are naturally limited: they often have limited formal education and limited subsequent training. We found evidence that in some cases they were providing inaccurate and even counter-productive family planning advice, such as advising women to discontinue oral contraceptive pills for fear of long-term side effects. FCHVs need more supervision and support, yet the FCHVs sometimes disliked the supervision of the HC3 supervisors because this created higher expectations of their work on the pilot, which meant they did not have time for other roles they had been asked to perform e.g. on other projects. They noted that they were not compensated in any way for this extra intensity of effort. Note that the work FCHVs were doing in this pilot was almost all within their existing scope of work e.g. mapping eligible clients and running HMGs, but not all were doing this work as a matter of routine.

*Are new WRA (with particular reference to post-partum mothers) being reached by FCHVs?*

Most FCHVs held health mothers groups near to their own homes and noted that can take a great deal of time to visit an entire ward. Some FCHVs described using cell phones – paying for this with their own money – to try to facilitate the follow-up process. The FCHVs tried to find out who was pregnant in their wards but at least one FCHV told us of a woman who successfully concealed her pregnancy until after the baby was born because she was

worried the FCHV would scold her for not having disclosed the pregnancy earlier. It is unclear what proportion of potential clients are reached by FCHVs because the denominator (i.e. how many there are in the first place) is unknown. Note that it is also unknown to services, who rely on FCHVs for this type of information. It seems likely that while FCHVs seem to know about many pregnancies in their wards, unwanted pregnancies may be concealed (and women may travel to terminate pregnancies elsewhere to avoid disclosure). Women with unmet need for family planning may sometimes be helped by FCHVs but we came across no accounts of FCHVs helping clients who were having extra- or pre-marital sexual relations. This is not to say that such clients were not helped, just that this was not mentioned as an activity directly to us.

### *What factors could increase the likelihood of FCHVs performing their tasks better?*

The supportive supervision that was added in the "intensive" intervention VDCs uncovered numerous areas where further support was needed for FCHVs to be able to carry out their roles. For instance, HC3 supervisors helped them form and run health mothers groups, which it was thought were already running and this took time. Supervisors also worked with FCHVs to show them how to make accurate records in the FCHV register – again, something that they were nominally already able to do. We have shown in our interviews that FCHVs may also lack important knowledge about family planning that means their advice to clients, while well meaning, may actually be counterproductive (such as the FCHV who strongly promoted withdrawal over OCPs). We checked the FCHV manual, and it does already contain the key basics that the FCHVs should know. Note that the lack of IEC materials such as leaflets about different contraceptive methods may also contribute to the lack of information because clients otherwise could read for themselves about the methods. Existing IEC materials were not available to the FCHVs for distribution.

We recommend as well that any future IEC materials be developed with participation from members of the target population to ensure that they are understandable for clients with low education levels and also contain the information clients need.

### *What do FCHVs think about the programme in the intensive VDCs? And what is the clients' perspective?*

FCHVs had mixed feelings about the programme: on the one hand, they liked the training and found it useful and inspiring. They also liked using referral slips – introduced within the pilot as part of the evaluation – which they felt gave them additional authority and helped to make their work more visible at the health services. On the other hand, they found the demands of the programme excessive, particularly the mapping exercises to identify potential clients which some said they did not use. Women told us they preferred women providers and would avoid male providers. This is consistent with some of the evaluation findings for the VSC+ pilot, which examined the effects of adding other contraceptive methods to the range available at 'sterilisation camps'. We do not have detailed information but the health facilities we visited as part of this evaluation had at least one female provider (ANM) and so for these facilities is possible that a client desiring a female provider would be able to return at a different time if she was not available when they first tried to obtain the service rather than having no access at all to a female provider.

*How long are results from the intensive intervention likely to last? Why? What would render results more durable/sustainable?*

Many interviewees emphasized the need for refresher training. Our observations of the FCHVs' sometimes patchy knowledge of family planning suggest that refresher training is essential to ensure that rumours are countered and that there is correct emphasis on the balance of risks and benefits of different methods. The need for reliable providers of contraception and abortion services is also clearly related to how sustainable it is to use FCHVs to deliver information and referrals. If an FCHV can refer to services where providers can supply a range of methods and information about these methods, her role is clearly marked out as primarily promotional: raising awareness of different methods and encouraging clients to go to services. If those services are very weak, however, our data show that the FCHV begins to take on the role that would more properly be held by a trained healthcare provider. In this case, she advises on side effects, counsels women to stop using particular methods, and so on. This latter role is one that should always be accompanied by referrals: she might for instance reassure a woman that bleeding is a known side effect of injectables, but that the woman should seek professional care. At present, the referral part of the process is not always there in part because the required services are not available, or are very limited in scope and quality.

## 4.2 Discussion

Our study has shown that there are gaps in family planning provision in Myagdi. The most serious gap is in lack of trained providers to give women accurate and timely information about contraceptive methods and to provide LARCs. The gap is being filled by FCHVs particularly with respect to sharing family planning related information with limited orientation, who are often (not always) trusted by local women who know them and seek their advice. LARCs are not always available, and are sometimes even withheld from women who request them without any alternative method being provided. Some FCHV tasks may be undermined by health system limitations. For instance, if FCHVs refer for LARCs but women are turned away when they seek these at the facility, the FCHV may lose credibility, or stop referring for LARCs at all. To help FCHVs to perform their tasks better that health posts need both the commodities and skilled staff required to provide a range of contraception and abortion services beyond the current condoms-pills-injectables trio that is often all that is available.

The more responsibilities the FCHVs are given, the more supervision they are likely to require to ensure that they know how to do their tasks correctly. However, some FCHVs said they did not like the supportive supervision because it meant that they had to give extra time to the intervention when they also needed to spend time on their other FCHV tasks, as well as doing their own daily household and economic activities. This was not because the scope of work had changed, rather that the supervision meant that tasks FCHVs had not always been doing routinely (such as mapping eligible clients, running health mothers groups) became part of the day-to-day workload.

FCHVs are currently expected to do a large number of diverse tasks without payment and which sometimes require out-of-pocket expenses as well, such as phone calls to follow up with clients. To do all the tasks adequately takes time and so some tasks are likely to be

done less frequently than is ideal, or perhaps skipped altogether. The FCHVs pointed out that when they cover a large geographical area it is very difficult to get to all households and so they rarely do it. FCHVs have excellent reach into even the most remote communities and with greater support their reach could potentially be extended even further.

FCHVs have played a vital role in the Nepal health system for many years, providing a bedrock for numerous interventions and carrying out a large number of duties to help the system run smoothly. Their role as health promoters has been expanding into areas of work more commonly associated with trained health providers, as we have shown in this report with respect to advice on family planning. FCHVs need to be supported by more trained healthcare workers who can help FCHVs to deliver services in the communities and who can provide technical advice.

FCHVs' roles as local community health promoters should be redefined and recognised with adequate support measures to advance their historic engagement in community health system strengthening.

## 4.3 Recommendations

1) *That FCHV support mechanisms be piloted to capitalise on and improve sustainability of FCHV work*

For instance, one option might be to train FCHV supervisors/outreach workers who are trained healthcare personnel tasked with working in the community. These workers could help to remove some of the excessive burden currently placed on FCHVs, and could also ensure that a) healthcare advice is available in places where women and families already are, rather than them having to travel to what is often a distant health facility; b) higher quality healthcare advice can be given than currently available from FCHVs; c) a trained provider will be able to spot health problems at an early stage and either address them immediately or refer to appropriate services, thus potentially avoiding emergency hospital visits. Another option that could also be investigated might be to train and pay FCHVs who show promise in certain ways e.g. who have higher levels of education or who have the skills needed for specific roles. A further option might be to develop a new cadre of community health workers to support the work done by the FCHVs. These options would need to be carefully thought through and piloted.

2) *That standard health service operating procedures for family planning be investigated and amended if necessary to ensure women are not incorrectly prevented from accessing the contraceptive services they seek.*

Supply side barriers to access to family planning need to be addressed. We found some evidence that healthcare providers are turning women away for apparently spurious reasons when they request services such as requiring women come back to the service a future date, depending on her menstrual cycle for methods that do not necessarily require this. Standard operating procedures for provision of injectables and pills should be examined to ensure they comply with latest guidelines to ensure that services can be delivered to the largest number of women possible who request them.. Better provision of LARCs should also be investigated.

***3) Privacy and confidentiality should be improved in the interface between FCHVs and health services.***

Quality of the advice is not the only issue with FCHV roles in the health sector. There is also a question about how patient confidentiality is being respected. At present, it seems as if there is a very porous boundary between the health facility staff and FCHVs in terms of information about clients, with FCHVs telling health staff about women in the community and vice versa. We speculate that lack of privacy may put women off seeking contraception from health facilities or force them to travel long distances to obtain services from facilities where they are not known. Regardless, health facility staff should not share information about clients outside the facility. If information sharing is considered potentially useful, the women most likely to be affected, services and FCHVs should be engaged in a dialogue about how best to achieve this without causing unintended harm.

***4) Emergency contraception should be provided and promoted.***

Emergency contraception options should be more readily available across Nepal to help prevent unintended pregnancies. Further research is required on the extent to which emergency contraception could be employed to greater effect in Nepal. From such studies the feasibility of FCHVs providing advice on, and even potentially distributing, emergency contraceptive pills could be further explored. This would require careful piloting to ensure it was done correctly and that women were not being encouraged to switch from more effective methods. Better access to emergency contraception could particularly benefit women whose husbands return unexpectedly from overseas and who therefore have not had time to obtain a more reliable method. Women who rely on other methods such as condoms should also have access to emergency contraception in case of method failure. Given that the method must be taken as soon as possible after unprotected intercourse, FCHVs appear to be an obvious source in remote areas or where clinics are not staffed full time.

***5) Any changes should be made with community participation throughout, including at the planning stage.***

Improvements in family planning services should be planned and carried out with full participation of clients in the process. For instance, local women may have ideas about how to tackle the issue of lack of female providers, which could help improve quality and attract additional clients to the service. Community participation has been shown to lead to innovative solutions previously in Nepal as well as other countries worldwide[6] and is at the heart of the new Global Strategy for Women's Children's and Adolescents' Health[7]. Nepal has shown leadership in this area, which should be built on to improve family planning provision. Current infrastructure lends itself to participatory approaches. For instance, health mothers groups might work with local healthcare providers to discuss what services would be most useful and how they should best be delivered. While we would advocate involving communities immediately, the best way to do it could also be subject to piloting to compare different approaches or techniques.

[6] Marston C, Hinton R, Kean S, Baral S, Ahuja A, Costello A, Portela A: **Community participation for transformative action on women's, children's and adolescents' health**. *Bull World Health Organ* 2016, **94**(5):376-382.
[7] http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

## 4.4 Conclusion

FCHV training and support is useful but not sufficient to create better family planning programmes. FCHVs can act as valuable champions of family planning, but they cannot work alone: they do not have the requisite skills or training to provide the healthcare support clients need.

For Nepal to achieve better healthcare coverage for all, FCHVs must be increasingly supported by healthcare professionals. FCHVs need a clearly defined role within the health system so that they are not simply asked to perform an increasingly complex collection of tasks. Our findings suggest that FCHVs would play a very valuable role in championing family planning at the community level. Their role as health promoters and not providers needs to be clarified and appropriate health provider support put in place to ensure FCHVs are not asked to go beyond their training and skill set but instead given the opportunity to play to their strengths: as community health promoters and health champions, in an evolving and improving health system.

# Annex 1 Evaluation Methodology

**Note from the evaluation team.** This annex **summarises** the methodology as it was planned at evaluation design stage. It is not meant as a complete methodological annex or to include all aspects considered during the evaluation design. In fact, the evaluation design included several documents that were shared with our clients (DFID and USAID) at different stages of the evaluation process and which our clients shared with other stakeholders in Nepal at their own discretion. These documents include the original M&E plan (3 March, 2015) and the mid-term progress report (November 2015). There were other interim, technical documents produced by the evaluation team along the way, including the data management plan that links evaluation questions to data collection tools and sources. These documents can be shared with interested parties upon request to the authors.

## Evaluation aims and questions

The specific needs of women targeted by this programme are not yet well understood. Existing literature from elsewhere overwhelmingly suggests that although information about FP options is clearly important, lack of information is not the only reason women do not use reliable modern methods when they do not want a pregnancy. In addition, it is not clear what training is proposed for the FCHVs and whether or not that training is evidence-based. Given that information is likely to be only part of the picture, it is important to assess how FCHVs might be in a position not only to provide information, but perhaps address other barriers to use. To do this, it is necessary to investigate three key levels: the individual (client or FCHV), the social interaction between the client and the FCHV, and the environment they are in.

**Individual**

**a. Clients**

- What are women's FP needs? What are their existing strategies for limiting childbirths (if any?)
- Why do they use or not use particular methods? What are the major barriers to their successfully limiting childbirths (e.g. knowledge? Service availability? Willingness to use FP?)
- How do they conceptualise their fertility and fertility strategies?
- What are their individual desires with respect to family size? Are these the same as those of members of their families or other key influencers?
- Do they use the existing services?
- What are their views on those services?
- Do women targeted by FCHVs find the intervention acceptable?
- Do women perceive FCHVs as suitable agents for FP? Have they ever approached FCHVs for specific advice before the intervention? During the intervention?

### b. FCHVs

- Does the intervention appear to have any effect on FCHV knowledge/ competence/ willingness to deliver FP information or counselling? Do existing FCHVs appear to be 'fit for purpose' as agents for FP information and counselling in terms of age, knowledge, attitudes? When did they receive the last refresher training? How do FCHVs rate their own work and effectiveness? What do they cite as enabling and constraining factors to perform the role they are expected to play? What is the typical routine of an FCHV during a week in terms of playing her role? How many hours does she report devoting to her role and how many women/couples does she appear to cover in a normal week? Does she receive regular supplies of FP commodities and IEC materials? Did the FCHV have any IEC materials before the intervention?
- How many women/households are mapped by the FCHVs? How many FP commodities and IEC materials are distributed by the FCHVs?
- Is there any evidence that the FCHVs are delivering FP information?
- What are the barriers to delivery of FP information? What could make FCHVs more able to do the work required? Is there any evidence of work overload or is the work easily added to the existing work?
- Are any new women reached or do the FCHVs tend to work with women they already know or work with during their other duties? How many contacts are made with women and women's groups? Are any of these new?
- What do FCHVs think about the intervention? Do they have suggestions for improvement?
- How do FCHVs perform their role in the community? Are the ways they see and perform their role congruent with the women's own needs as expressed in (1)?
- Are FCHV interventions likely to make a difference to FP uptake given these factors?

Is there any evidence of difference for FCHVs between the intensive and non-intensive version of the programme?

### c. Service providers

We will interview key informants involved in the pilot (DHO, FP supervisor, health facility in-charges, HFOMC member, HC3 staff and other informants as appropriate) as part of process documentation. We will also conduct semi-structured interviews with service providers in selected health facilities. We will ask:

- What preparatory processes are involved in mobilizing FCHVs to provide FP counselling and referral e.g. IPC training, workshops, logistics
- What is the resource allocation at local level? What supply-side factors can be identified (e.g. resourcing, HR allocation and management, local planning and implementation)
- What do key informants say are the facilitators and barriers of IPC through FCHVs?

### 2. Social interaction between client and FCHV

- What types of women interact with the FCHVs? How is the interaction? (Respectful? Didactic?) How are the groups facilitated? What other types of contacts do FCHVs have? If no interaction, why is that?

### 3. Environment

- What environmental factors might affect the intervention? e.g. terrain, weather, infrastructure, cultural norms or expectations, existing services.

- How feasible is this delivery model in the local context of the intervention?
- Are services (commodities plus providers) available? Are they accessible? Are there other demand-side factors that influence access to and use of services?
- What method mix is available in what places?
- Are abortions available? What types and where?
- Are long-term methods available? Who from?
- Is there any evidence that the intensive version of the intervention is better for clients?

## Evaluation design

Little is known about how FCHVs conduct their work, and how women respond, or what women's needs are. In addition, it is unclear to what extent it is possible to add extra tasks into the FCHV workload, or to what extent the FCHVs already provide FP advice. We consider that a good assessment of FCHV activity using qualitative data is essential, and will provide useful information for future programmes as well as for the current pilot. A qualitative approach will also provide a source of useful data given the serious methodological constraints on any quantitative data discussed above, and may allow some comparison between the two different types of site (i.e. intensive and non-intensive, or better but less likely to be possible, intensive and no intervention).

We propose to use a qualitative study design with mixed data collection methods. We will examine, qualitatively, two sites in depth: one VDC with the intensive focus intervention and one with the non-intensive version of the intervention. We will investigate one of each type of site in order ensure sufficient detail and analytical depth. With more sites, we would dilute our effort and only be able to provide very basic descriptive information, which would not answer the key research questions listed above. In order to provide additional data on the background to the intervention, we will also collect data from FCHV records from a sample of FCHVs across all 10 intensive focus sites, and from the one non-intensive site. The data from FCHV records will provide background descriptive information to supplement the main qualitative data.

## Qualitative approach

Qualitative data collection and analysis seeks to explore phenomena, and generate data, hypotheses and new understandings. While generalisability in the statistical sense will not be possible (because qualitative data are not numerical), this evaluation is likely to provide useful information for programme design, so data collected through the proposed means should be transferrable and useful. When the data and analysis are sufficiently in-depth, the findings will be relevant and transferable. The alternative of using more sites was considered but deemed unfeasible in the time and with the resources available, as it would probably spread available resources thinly, and prevent the depth of investigation required.

The selection of VDCs will be finalized in consultation with the implementing agency and DHO. We will select one 'intensive focus' VDC for the main qualitative data collection, and one VDC where either no intervention is taking place (ideal) or where the non-intensive version of the intervention is taking place (likely realistic scenario). We will choose the sites depending on the exact configuration of the final intervention, and in consultation with DHO and HC3.

We will collect data using participant observation and FCHV shadowing (where a fieldworker spends two or three days with an FCHV to see what her work involves first hand); focus group discussions with clients (e.g. mothers' groups); one-to-one interviews, and key informant interviews. We will also map local health facilities in the evaluation areas and visit a selection of them to understand where women would visit after a referral. If the opportunity arises, we will also travel with a woman to the facility when she takes up the referral to understand her views of the process.

In depth qualitative information will be collected from a variety of sources using the following methods:

i. Interviews with **key informants** (DHO, FP supervisor, FCHVs, health facility in-charges, FP service providers, members of mothers' group meetings, HFOMC members and other relevant informants). These will investigate perceptions of the pilot, facilitators and barriers to successful implementation of the pilot, and its sustainability and scalability. Interviews will be recorded where possible (with permission) and field notes taken before and after to record fieldworker impressions of the interview.

ii. Interviews with **clients counselled and referred by FCHVs**, ideally women from priority population groups if they can be identified. These will explore family planning needs, perceptions of the counselling/education provided by FCHVs, whether or not interaction with FCHVs has affected (in their opinion) their use of FP services or any other aspects of their fertility management practices. We will also collect reports from these referred women about the range of FP services offered to them and the quality of services received from the health facilities.

iii. Interviews with **women from the general population, ideally those from priority population groups** (not those referred to services by FCHVs). These will explore family planning needs, views about services, fertility strategies (e.g. preferences for different methods, experiences with different methods, views and perceptions of methods, and relevant practices).

iv. **Group interviews with local mothers' groups** to assess their views of FP and services, fertility beliefs, normative ideas about modern contraceptive methods, family size preferences etc.

v. **Observation** data: Fieldworkers will maintain a daily diary where they will write about their daily experiences, observations about the intervention, and the information that they have found informally. For example, they will write notes about how mothers groups are conducted in practice, details about interactions between FCHVs and clients, notes about terrain and barriers to access to services, observations about relevant practices within the communities that might affect family planning uptake such as availability of alternative FP methods (e.g. traditional methods) etc. Photographs may also be used to record particular events or scenes, with participant permission and subject to ethics committee approval.

## Quantitative FCHV record data

In addition to the qualitative data, we recognise that it might be useful for implementers to have a sense of the level of activity of the FCHVs as background information. Please note that as described above, it will not be possible to collect reliable, accurate quantitative data and so any data referred to in this section should be understood to be for basic background context only, and its limitations should be taken into account.

We will select a sample of 47 FCHVs from the 10 intensive-focus districts and examine their registers to attempt to enumerate the following, where possible:

- Number of households identified with target population
- Number of contacts made with women in the past 6 months
- Number of IEC materials distributed
- Number of self-reported referrals made to government services

We will seek 'comparison' data from the same FCHV records of the equivalent period in the previous year (i.e. the same calendar months as there are likely to be seasonal differences). However, such data may not be available and it is unclear to what extent it will be comparable with the data of interest in this evaluation. These issues will be assessed during baseline data collection, at which time, if data from an equivalent period in the previous year is not available, we will explore the possibility of measuring FCHV activity in the three months preceding the intervention.

As another way of comparing results linked to the intensive intervention VDCs we will also collect data from FCHVs we contact in the non-intensive site. The number of FCHVs to be included in this mini (non representative) sample will be confirmed at baseline depending on the site. Please note that the FCHV data are likely to present significant limitations:

- Records may not be reliable. It is unclear how well records are kept; it seems likely that different FCHVs will keep records with differing degrees of assiduousness. For instance, the time between conducting the activity and recording it might vary (which will likely affect accuracy); the women counted as 'referrals' might differ depending on what the FCHV considers to constitute 'referring'.
- The FCHVs are reporting on their own activities, and there is a significant incentive to over-report activities, both in general and in particular after the intervention where they will be encouraged to refer women to FP services and also to record these referrals.
- Participation in the intervention is likely to change reporting. Therefore if there are any relevant data prior to the intervention, any before-after comparison will be biased as it will measure both the effect of intervention on reporting, and also any changes in indicators measured, and it will not be possible to determine how much each contributes to the total change, if any is observed.

Because of the serious limitations of the FCHV records, we do not view the FCHV data as providing a 'quantitative measure' of the programme activity. Rather, these data provide useful additional contextual background to the qualitative data. We will also investigate as part of our examination of the FCHV records to what extent the limitations set out here do or do not appear to apply.

# Annex 2 Full tables of quantitative data obtained from structured interviews with FCHVs

**Table A2.1: IPC orientation training for FCHVs – timetable (translated from original in Nepali)**

**Schedule for the orientation program of IPC to the Female Community Health Volunteers**

Objectives:

- After the orientation, the participants will be able to contact and refer the clients of Family planning using inter-personal communication
- After the orientation, the participants will be able to tell the roles of IPC in behaviour change
- After the orientation, the participants will be able to properly use the IEC materials
- After the orientation, the participants will be able to tell the roles of FCHVs to contact and refer the FP clients.

## First Day

| Time | Topics | Methods | Facilitator |
|---|---|---|---|
| 10:00-10:15<br>10:15-10:30<br>10:30-10:45 | Introduction to the program:<br>• Registration and Welcome<br>• Introduction<br>• Objectives of the program | Participatory Method and Presentation | |
| 10:45- | Tea Break | | |

| Time | Topics | Methods | Facilitator |
|---|---|---|---|
| 11:00-12:00 | Information related to Family Planning<br>• What is family Planning?<br>• Advantages of family Planning<br>• Types of FP devices<br>• Discussions on the misconceptions of the various FP methods in the community and understanding the facts | Brain storming, Presentation and discussion | Health Facility In-charge |
| 12:00-12:45 | Interpersonal communication<br>• Meaning of communication<br>• Elements and types of communication<br>• Interpersonal communication and its importance | Brain storming, Presentation and discussion | |
| 12:45- | Lunch Break | | |
| 01:30-02:15 | Behaviour change<br>• Role of IPC in behaviour change<br>• Stages of behaviour change | Games, presentation and discussion | |
| 02:15-03:00 | Showing Video<br>• Skills required for IPC | Audio/Visual Aid and discussion | |
| 03:15-04:15 | • Stages of IPC<br>1. Establish good relations<br>2. Create a trust-worthy environment<br>3. Help to make informed choices of FP | Brain storming, Presentation and discussion | |
| 04:15-04:30 | Review of the day | Participatory | |

## Second day

| Time | Topics | Methods | Facilitator |
|---|---|---|---|
| 10:00-10:15 | Review of the first day | Participatory | |
| 10:15-10:30 | Tea Break | | |
| 10:30-11:30 | Skills required for IPC<br>• Active Listening<br>• Skills to ask the relevant questions | Brainstorming, | |
| 11:30-12:00 | Lunch Break | | |
| 12:00-01:00 | Showing Video<br>Meeting and discussions of Mother's Group | Audio/Visual Aid and discussion | |
| 01:00-01:30 | Role and importance of FCHVs for contact and referral of FP clients | Brainstorming, Group Presentations and Discussions | |
| 01:30-02:00 | Role of FCHVs to increase the uptake of FP services using the skills of IPC | Brainstorming, Group Presentations and Discussions | |
| 02:00-02:45 | Effective use of FP IEC materials | Demonstration and discussions | |
| 02:45-03:15 | FP Compliance | Presentations and discussions | HC3 |
| 03:15-03:45 | Recording and Reporting<br>• Problems in recording and reporting<br>• Solutions to the problems | Presentations and discussions | Health Facility In-charge |

| | | | |
|---|---|---|---|
| 03:45-<br>04:30 | Review of the whole day activities and closing session | Participatory | |
| 03:15-<br>04:15 | • Stages of IPC<br>4. Establish good relations<br>5. Create a trust-worthy environment<br>6. Help to make informed choices of FP | Brain storming, Presentation and discussion | |
| 04:15-<br>04:30 | Review of the day | Participatory | |

**Table A2.2: IPCC orientation training for health workers - timetable (translated from original in Nepali)**




**Schedule for the orientation program of IPCC to the health workers**

Objectives:

1. After the program, the participants will be able to tell about the inter-personal communication and skills.
2. After the program the participants will be able to tell about the role of IPC in behaviour change
3. After the program, the participants will be able to tell about counselling, its steps and will be able to provide counselling services
4. The participants will be able to effectively use the IEC materials required for IPCC

| Time | Topics | Methods | Facilitator |
|---|---|---|---|
| 10:00-10:15<br><br>10:15-10:45 | • Registration<br>• Welcome and introduction<br>• Objectives of the program | Participatory Method and Presentation | |
| 11:00- | Tea Break | | |
| 11:15-12-45 | • Pre-evaluation<br>• Interpersonal communication and its importance<br>• Meaning of interpersonal communication<br>• Stages of IPC<br>7. Establish good relations<br>8. Create a trust-worthy environment<br>9. Help to make informed choices of FP | Brain storming, Presentation and discussion | DHO |
| 12:45-01:30 | Lunch Break | | |
| 01:30-02:15 | Skills required for IPC<br><br>• Active Listening<br>• Skills to ask the relevant questions<br>• Observations | Brainstorming, Group Presentations and Discussions | |
| 02:15-03:00 | Behaviour change<br><br>• Role of IPC in behaviour change<br>• Stages of behaviour change | Games, presentation and discussion | |
| 03:00-03:15 | Tea-Break | | |
| 03:15-04:00 | Counselling<br><br>• Meaning of counselling<br>• Stages of counselling(Greeting) | Brainstorming, Group Presentations and Discussions | |

| Time | Topics | Methods | Facilitator |
|---|---|---|---|
| 04:00-04:45 | Video showing and discussions | Participatory | |
| 04:45-05:00 | Review of the day | | |
| Second day | | | |
| Time | Topics | Methods | Facilitator |
| 10:00-10:15 | Review of the first day | Participatory | |
| 10:15-11:00 | Proper use of BCC materials IEC materials | Demonstration | |
| 11:00- | Tea Break | | |
| 01:15-12:45 | Role Playing of Counselling (Abhibadan/ GATHER Approach) | | |
| 01:15- | Lunch Break | | |
| 01:30- | Role Playing of Counselling (Abhibadan/ | | |
| 02:30- | Tea-Break | | |
| 03:45-04:30 | Recording and Reporting | | |
| 04:30-04:45 | Review of the whole day activities | | |
| 04:45-5:00 | Closing session | | |

# Annex 3 Excel Tables: data from FCHV structured interviews and registers

**Table A3.1: Age distribution of FCHVs interviewed**

| | 21-30 years | 31-40 years | 41-50 years | 51-60 years | Total |
|---|---|---|---|---|---|
| **Singa** | 0 | 0 | 2 | 1 | 3 |
| **Jyamrukkot** | 1 | 3 | 0 | 0 | 4 |
| **Ratnechaur** | 0 | 2 | 0 | 0 | 2 |
| **Arman** | 1 | 1 | 3 | 0 | 5 |
| **Babiyachaur** | 0 | 1 | 1 | 0 | 2 |
| **Baranja** | 0 | 3 | 1 | 0 | 4 |
| **Bhakimli** | 1 | 1 | 2 | 0 | 4 |
| **Bima** | 0 | 2 | 2 | 0 | 4 |
| **Ghatan** | 0 | 2 | 1 | 0 | 3 |
| **Niskot** | 0 | 2 | 1 | 0 | 3 |
| **Okharbot** | 0 | 1 | 2 | 0 | 3 |
| **Ruma** | 0 | 3 | 0 | 1 | 4 |
| **Pulachaur** | 1 | 1 | 0 | 2 | 4 |
| **Darbang** | 0 | 2 | 1 | 0 | 3 |
| **Arthunge** | 0 | 1 | 1 | 0 | 2 |
| **Total intensive VDCs** | 4 | 25 | 17 | 4 | 50 |
| ***Rakhu Bhagwati*** | *1* | *3* | *0* | *1* | *5* |
| **Grand Total** | 5 | 28 | 17 | 5 | 55 |

*N=55

### Table A3.2: Caste/ethnicity of FCHVs interviewed

| | Dalit | Janajati | Madhesi | Muslim | Brahmin/Chhetri | Total |
|---|---|---|---|---|---|---|
| **Singa** | 0 | 2 | 0 | 0 | 1 | 3 |
| **Jyamrukkot** | 1 | 0 | 0 | 0 | 3 | 4 |
| **Ratnechaur** | 0 | 1 | 0 | 0 | 1 | 2 |
| **Arman** | 0 | 2 | 0 | 0 | 3 | 5 |
| **Babiyachaur** | 0 | 0 | 0 | 0 | 2 | 2 |
| **Baranja** | 0 | 3 | 0 | 0 | 1 | 4 |
| **Bhakimli** | 0 | 4 | 0 | 0 | 0 | 4 |
| **Bima** | 0 | 4 | 0 | 0 | 0 | 4 |
| **Ghatan** | 0 | 0 | 0 | 0 | 3 | 3 |
| **Niskot** | 0 | 2 | 0 | 0 | 1 | 3 |
| **Okharbot** | 0 | 2 | 0 | 0 | 1 | 3 |
| **Ruma** | 0 | 4 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 0 | 0 | 0 | 0 | 4 | 4 |
| **Darbang** | 0 | 3 | 0 | 0 | 0 | 3 |
| **Arthunge** | 0 | 2 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 1 | 29 | 0 | 0 | 20 | 50 |
| ***Rakhu Bhagwati*** | *0* | *0* | *0* | *0* | *5* | *5* |
| **Grand Total** | 1 | 29 | 0 | 0 | 25 | 55 |

*N=55

### Table A3.3: Total number of living children of FCHVs interviewed

| | 1 | 2 | 3 | 4 to 8 |
|---|---|---|---|---|
| **Singa** | 0 | 0 | 2 | 1 |
| **Jyamrukkot** | 0 | 3 | 1 | 0 |
| **Ratnechaur** | 1 | 0 | 1 | 0 |
| **Arman** | 2 | 2 | 1 | 0 |
| **Babiyachaur** | 0 | 1 | 1 | 0 |
| **Baranja** | 0 | 2 | 1 | 1 |
| **Bhakimli** | 0 | 3 | 0 | 1 |
| **Bima** | 0 | 0 | 3 | 1 |
| **Ghatan** | 0 | 1 | 0 | 2 |
| **Niskot** | 0 | 0 | 0 | 3 |
| **Okharbot** | 0 | 0 | 1 | 2 |
| **Ruma** | 1 | 0 | 2 | 1 |
| **Pulachaur** | 0 | 3 | 0 | 1 |
| **Darbang** | 0 | 1 | 2 | 0 |
| **Arthunge** | 0 | 2 | 0 | 0 |
| ***Rakhu Bhagwati*** | *0* | *3* | *2* | *0* |

### Table A3.4: Education level (highest grade completed) of FCHVs interviewed

| | Grade 5 or below | Grade 6 to SLC | Higher secondary | Bachelor degree and above | Non-formal education | Illiterate | Total |
|---|---|---|---|---|---|---|---|
| **Singa** | 2 | 1 | 0 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Ratnechaur** | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| **Arman** | 3 | 2 | 0 | 0 | 0 | 0 | 5 |
| **Babiyachaur** | 0 | 1 | 0 | 0 | 1 | 0 | 2 |
| **Baranja** | 1 | 3 | 0 | 0 | 0 | 0 | 4 |
| **Bhakimli** | 2 | 1 | 0 | 0 | 1 | 0 | 4 |
| **Bima** | 2 | 1 | 0 | 0 | 1 | 0 | 4 |
| **Ghatan** | 1 | 2 | 0 | 0 | 0 | 0 | 3 |
| **Niskot** | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| **Okharbot** | 1 | 1 | 0 | 0 | 1 | 0 | 3 |
| **Ruma** | 2 | 1 | 0 | 0 | 1 | 0 | 4 |
| **Pulachaur** | 1 | 1 | 0 | 0 | 2 | 0 | 4 |
| **Darbang** | 0 | 2 | 0 | 0 | 1 | 0 | 3 |
| **Arthunge** | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 19 | 23 | 0 | 0 | 8 | 0 | 50 |
| ***Rakhu Bhagwati*** | *1* | *2* | *0* | *1* | *1* | *0* | *5* |
| **Grand Total** | 20 | 25 | 0 | 1 | 9 | 0 | 55 |

*N=55

### Table A3.5 Major occupation of FCHVs interviewed

| | Housewife | Agriculture/animal husbandry | Daily wage job | Business | Service | Unemployed | Total |
|---|---|---|---|---|---|---|---|
| **Singa** | 1 | 2 | 0 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Ratnechaur** | 0 | 1 | 0 | 1 | 0 | 0 | 2 |
| **Arman** | 2 | 3 | 0 | 0 | 0 | 0 | 5 |
| **Babiyachaur** | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Baranja** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Bhakimli** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Bima** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Ghatan** | 0 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Niskot** | 0 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Okharbot** | 0 | 2 | 0 | 1 | 0 | 0 | 3 |
| **Ruma** | 0 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 2 | 2 | 0 | 0 | 0 | 0 | 4 |
| **Darbang** | 1 | 2 | 0 | 0 | 0 | 0 | 3 |
| **Arthunge** | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 6 | 42 | 0 | 2 | 0 | 0 | 50 |
| ***Rakhu Bhagwati*** | *0* | *3* | *0* | *0* | *2* | *0* | *5* |
| **Grand Total** | 6 | 45 | 0 | 2 | 2 | 0 | 55 |

*N=55

### Table A3.6: Number of years working as FCHV

| | 0-5 years | 6-10 years | 11-15 years | 16-20 years | 21-25 years | Total |
|---|---|---|---|---|---|---|
| **Singa** | 0 | 1 | 0 | 1 | 1 | 3 |
| **Jyamrukkot** | 1 | 1 | 2 | 0 | 0 | 4 |
| **Ratnechaur** | 1 | 0 | 1 | 0 | 0 | 2 |
| **Arman** | 1 | 0 | 2 | 2 | 0 | 5 |
| **Babiyachaur** | 0 | 0 | 0 | 2 | 0 | 2 |
| **Baranja** | 1 | 1 | 0 | 2 | 0 | 4 |
| **Bhakimli** | 1 | 0 | 0 | 3 | 0 | 4 |
| **Bima** | 2 | 0 | 0 | 2 | 0 | 4 |
| **Ghatan** | 0 | 1 | 0 | 2 | 0 | 3 |
| **Niskot** | 0 | 0 | 1 | 2 | 0 | 3 |
| **Okharbot** | 1 | 1 | 0 | 1 | 0 | 3 |
| **Ruma** | 1 | 0 | 2 | 1 | 0 | 4 |
| **Pulachaur** | 1 | 0 | 0 | 2 | 1 | 4 |
| **Darbang** | 0 | 2 | 0 | 1 | 0 | 3 |
| **Arthunge** | 0 | 0 | 1 | 1 | 0 | 2 |
| **Total intensive VDCs** | 10 | 7 | 9 | 22 | 2 | 50 |
| ***Rakhu Bhagwati*** | *1* | *2* | *0* | *2* | *0* | *5* |
| **Grand Total** | 11 | 9 | 9 | 24 | 2 | 55 |

*N=55

### Table A3.7: Received FP refresher training/information in any other integrated training from government sources

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 2 | 1 | 3 |
| **Jyamrukkot** | 3 | 1 | 4 |
| **Ratnechaur** | 1 | 1 | 2 |
| **Arman** | 1 | 4 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 2 | 2 | 4 |
| **Bhakimli** | 3 | 1 | 4 |
| **Bima** | 2 | 2 | 4 |
| **Ghatan** | 1 | 2 | 3 |
| **Niskot** | 2 | 1 | 3 |
| **Okharbot** | 2 | 1 | 3 |
| **Ruma** | 3 | 1 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 0 | 3 | 3 |
| **Arthunge** | 2 | 0 | 2 |
| **Total intensive VDCs** | 30 | 20 | 50 |
| ***Rakhu Bhagwati*** | *2* | *3* | *5* |
| **Grand Total** | 32 | 23 | 55 |

*N=55

### Table A3.8: How long ago do FCHVs report government family planning refresher training/information received

| | Less than a year | 1 to 5 years | 6 to 10 years | Total |
|---|---|---|---|---|
| **Singa** | 0 | 0 | 2 | 2 |
| **Jyamrukkot** | 0 | 0 | 3 | 3 |
| **Ratnechaur** | 0 | 0 | 1 | 1 |
| **Arman** | 0 | 1 | 0 | 1 |
| **Babiyachaur** | 0 | 0 | 2 | 2 |
| **Baranja** | 0 | 1 | 1 | 2 |
| **Bhakimli** | 0 | 1 | 2 | 3 |
| **Bima** | 0 | 1 | 1 | 2 |
| **Ghatan** | 0 | 1 | 0 | 1 |
| **Niskot** | 0 | 2 | 0 | 2 |
| **Okharbot** | 0 | 0 | 2 | 2 |
| **Ruma** | 0 | 0 | 3 | 3 |
| **Pulachaur** | 1 | 0 | 3 | 4 |
| **Darbang** | 0 | 0 | 0 | 0 |
| **Arthunge** | 0 | 0 | 2 | 2 |
| **Total intensive VDCs** | 1 | 7 | 22 | 30 |
| ***Rakhu Bhagwati*** | *0* | *0* | *2* | *2* |
| **Grand Total** | 1 | 7 | 24 | 32 |

***N=32

### Table A3.9: (Did you receive FP related training from any other sources?) Received FP related training from other sources

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 4 | 1 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 4 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 3 | 0 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 3 | 0 | 3 |
| **Arthunge** | 2 | 0 | 2 |
| **Total intensive VDCs** | 49 | 1 | 50 |
| ***Rakhu Bhagwati*** | *5* | *0* | *5* |
| **Grand Total** | 54 | 1 | 55 |

*N=55

### Table A3.10: (Who provided the training on FP other than government?) FP related training provided by

| | Suaahara program | IPAS program | Kadam Program | Plan Nepal | Sahamati Program | Mahila Bikash | Total |
|---|---|---|---|---|---|---|---|
| **Singa** | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 4 | 4 | 0 | 0 | 0 | 1 | 4 |
| **Ratnechaur** | 2 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Arman** | 4 | 2 | 0 | 0 | 0 | 0 | 4 |
| **Babiyachaur** | 2 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Baranja** | 4 | 4 | 0 | 1 | 0 | 0 | 4 |
| **Bhakimli** | 4 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Bima** | 4 | 3 | 0 | 0 | 0 | 0 | 4 |
| **Ghatan** | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Niskot** | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Okharbot** | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Ruma** | 4 | 4 | 0 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 4 | 3 | 1 | 0 | 0 | 0 | 4 |
| **Darbang** | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Arthunge** | 2 | 1 | 0 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 49 | 44 | 1 | 1 | 0 | 1 | 49 |
| ***Rakhu Bhagwati*** | *5* | *5* | *0* | *0* | *0* | *0* | *5* |
| **Grand Total** | 54 | 49 | 1 | 1 | 0 | 1 | 54 |

*Multiple response

*N=54

### Table A3.11: Participated in IPC training by HC3

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 4 | 1 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 3 | 1 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 2 | 1 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 3 | 0 | 3 |
| **Arthunge** | 2 | 0 | 2 |
| **Total intensive VDCs** | 47 | 3 | 50 |
| ***Rakhu Bhagwati*** | *5* | *0* | *5* |
| **Grand Total** | 52 | 3 | 55 |

*N=55

### Table A3.12: Total number of beneficiaries FCHVs report they mapped by priority group (Shrawan-Poush 2072)

| | Newly married couple (mapped) | Pregnant women (mapped) | Postnatal mothers (mapped) | 1000 days mothers (mapped) | Dalit women (mapped) | Migrants and their wives (mapped) | Total (MWRA (15-49 years) (mapped) |
|---|---|---|---|---|---|---|---|
| **Singa** | 4 | 5 | 2 | 29 | 54 | 100 | 207 |
| **Jyamrukkot** | 8 | 8 | 6 | 47 | 70 | 237 | 565 |
| **Ratnechaur** | 0 | 2 | 2 | 16 | 10 | 62 | 252 |
| **Arman** | 2 | 11 | 7 | 62 | 135 | 209 | 1070 |
| **Babiyachaur** | 2 | 7 | 8 | 35 | 63 | 50 | 95 |
| **Baranja** | 1 | 7 | 3 | 53 | 116 | 210 | 408 |
| **Bhakimli** | 2 | 6 | 1 | 44 | 99 | 210 | 265 |
| **Bima** | 2 | 9 | 1 | 34 | 37 | 59 | 437 |
| **Ghatan** | 9 | 3 | 1 | 22 | 68 | 93 | 340 |
| **Niskot** | 2 | 5 | 3 | 38 | 43 | 81 | 258 |
| **Okharbot** | 4 | 4 | 2 | 29 | 42 | 102 | 165 |
| **Ruma** | 1 | 16 | 4 | 77 | 161 | 226 | 772 |
| **Pulachaur** | 4 | 9 | 3 | 70 | 132 | 178 | 440 |
| **Darbang** | 2 | 6 | 1 | 22 | 12 | 34 | 325 |
| **Arthunge** | 1 | 2 | 1 | 19 | 34 | 85 | 205 |
| **Total intensive VDCs** | 44 | 100 | 45 | 597 | 1076 | 1936 | 5804 |
| ***Rakhu Bhagwati*** | *8* | *10* | *5* | *76* | *78* | *310* | *487* |
| **Grand Total** | 52 | 110 | 50 | 673 | 1154 | 2246 | 6291 |

***N=55

### Table A3.13: Beneficiaries contacted through home visits

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 2 | 1 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 0 | 2 | 2 |
| **Arman** | 3 | 2 | 5 |
| **Babiyachaur** | 1 | 1 | 2 |
| **Baranja** | 2 | 2 | 4 |
| **Bhakimli** | 3 | 1 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 1 | 2 | 3 |
| **Niskot** | 2 | 1 | 3 |
| **Okharbot** | 2 | 1 | 3 |
| **Ruma** | 3 | 1 | 4 |
| **Pulachaur** | 3 | 1 | 4 |
| **Darbang** | 3 | 0 | 3 |
| **Arthunge** | 1 | 1 | 2 |
| **Total intensive VDCs** | 34 | 16 | 50 |
| ***Rakhu Bhagwati*** | *3* | *2* | *5* |
| **Grand Total** | 37 | 18 | 55 |

*N=55

**Table A3.14: Total number of beneficiaries contacted through home visits (Shrawan-Poush 2072)**

| | Newly married couples | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | Total (MWRA (15-49 years) | Men | Unmarried/Adolescent | Woman aged over 50 | Total number of beneficiaries | Total no. of FCHVs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 0 | 0 | 1 | 7 | 4 | 3 | 8 | 3 | 0 | 0 | 11 | 2 |
| **Jyamrukkot** | 3 | 6 | 3 | 24 | 13 | 20 | 47 | 0 | 0 | 0 | 47 | 4 |
| **Ratnechaur** | | | | | | | | | | | | 0 |
| **Arman** | 0 | 1 | 5 | 12 | 9 | 10 | 19 | 0 | 0 | 0 | 19 | 3 |
| **Babiyachaur** | 0 | 1 | 0 | 4 | 3 | 1 | 7 | 0 | 0 | 0 | 7 | 1 |
| **Baranja** | 0 | 0 | 0 | 0 | 8 | 8 | 16 | 10 | 0 | 0 | 26 | 2 |
| **Bhakimli** | 1 | 0 | 0 | 14 | 5 | 3 | 17 | 0 | 0 | 0 | 17 | 3 |
| **Bima** | 0 | 0 | 0 | 8 | 7 | 4 | 18 | 0 | 0 | 0 | 18 | 4 |
| **Ghatan** | 1 | 0 | 1 | 3 | 9 | 0 | 13 | 0 | 0 | 0 | 13 | 1 |
| **Niskot** | 1 | 3 | 0 | 12 | 8 | 10 | 16 | 0 | 0 | 0 | 16 | 2 |
| **Okharbot** | 0 | 0 | 2 | 7 | 5 | 4 | 21 | 0 | 0 | 0 | 21 | 2 |
| **Ruma** | 0 | 2 | 3 | 8 | 9 | 10 | 20 | 0 | 0 | 0 | 20 | 3 |
| **Pulachaur** | 1 | 7 | 3 | 24 | 30 | 17 | 38 | 3 | 0 | 0 | 41 | 3 |
| **Darbang** | 0 | 2 | 1 | 6 | 1 | 1 | 8 | 0 | 0 | 0 | 8 | 3 |
| **Arthunge** | 0 | 0 | 0 | 3 | 3 | 0 | 3 | 0 | 0 | 0 | 3 | 1 |
| **Total intensive VDCs** | 7 | 22 | 19 | 132 | 114 | 91 | 251 | 16 | 0 | 0 | 267 | 34 |
| ***Rakhu Bhagwati*** | *0* | *0* | *0* | *14* | *9* | *6* | *35* | *0* | *0* | *0* | *35* | *3* |
| **Grand Total** | 7 | 22 | 19 | 146 | 123 | 97 | 286 | 16 | 0 | 0 | 302 | 37 |

*N=37

### Table A3.15: Beneficiaries contacted through other means

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 5 | 0 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 4 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 3 | 0 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 3 | 0 | 3 |
| **Arthunge** | 1 | 1 | 2 |
| **Total intensive VDCs** | 49 | 1 | 50 |
| ***Rakhu Bhagwati*** | *5* | *0* | *5* |
| **Grand Total** | 54 | 1 | 55 |

*N=55

**Table A3.16: Total number of beneficiaries contacted through other means (Shrawan-Poush 2072)**

| | Newly married couples | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | MWRA (15-49 years) | Unmarried people | Total number of beneficiaries | Total (N) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 2 | 2 | 0 | 18 | 11 | 21 | 40 | 0 | 40 | 3 |
| **Jyamrukkot** | 0 | 2 | 2 | 12 | 15 | 31 | 100 | 0 | 100 | 4 |
| **Ratnechaur** | 0 | 2 | 0 | 7 | 1 | 6 | 51 | 0 | 51 | 2 |
| **Arman** | 0 | 4 | 0 | 19 | 26 | 31 | 81 | 0 | 81 | 5 |
| **Babiyachaur** | 0 | 1 | 0 | 6 | 8 | 11 | 43 | 0 | 43 | 2 |
| **Baranja** | 0 | 4 | 3 | 33 | 19 | 31 | 61 | 16 | 77 | 4 |
| **Bhakimli** | 1 | 3 | 0 | 17 | 10 | 27 | 75 | 0 | 75 | 4 |
| **Bima** | 0 | 2 | 0 | 17 | 29 | 29 | 79 | 0 | 79 | 4 |
| **Ghatan** | 0 | 1 | 0 | 7 | 7 | 31 | 51 | 0 | 51 | 3 |
| **Niskot** | 3 | 3 | 2 | 37 | 24 | 55 | 80 | 0 | 80 | 3 |
| **Okharbot** | 0 | 4 | 2 | 25 | 16 | 16 | 65 | 0 | 65 | 3 |
| **Ruma** | 1 | 9 | 0 | 24 | 24 | 25 | 62 | 0 | 62 | 4 |
| **Pulachaur** | 1 | 3 | 0 | 15 | 47 | 38 | 67 | 0 | 67 | 4 |
| **Darbang** | 0 | 3 | 0 | 11 | 2 | 34 | 47 | 0 | 47 | 3 |
| **Arthunge** | 0 | 0 | 0 | 0 | 10 | 6 | 24 | 0 | 24 | 1 |
| **Total intensive VDCs** | 8 | 43 | 9 | 248 | 249 | 392 | 926 | 16 | 942 | 49 |
| ***Rakhu Bhagwati*** | *1* | *4* | *3* | *31* | *21* | *57* | *80* | *0* | *80* | *5* |
| **Grand Total** | 9 | 47 | 12 | 279 | 270 | 449 | 1006 | 16 | 1022 | 54 |

*N=54

### Table A3.17: Methods FCHVs named as those they mostly used to make contact with eligible beneficiaries

| | First common way | Second common way | Third common way | Fourth common way | Fifth common way | No contacts | Total |
|---|---|---|---|---|---|---|---|
| **Home visits** | 5 | 24 | 12 | 8 | 4 | 0 | 53 |
| **HMG** | 46 | 5 | 2 | 0 | 0 | 0 | 53 |
| **Health Facility** | 0 | 1 | 7 | 22 | 20 | 0 | 50 |
| **Phone calls** | 2 | 13 | 26 | 9 | 3 | 0 | 53 |
| **Meeting at public places** | 1 | 11 | 7 | 11 | 0 | 0 | 30 |
| **No contacts** | 0 | 0 | 0 | 0 | 0 | 1 | 1 |

*N=55

*ranking

### Table A3.18: FCHV reports a mothers' group meeting is conducted in her ward

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 4 | 1 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 4 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 3 | 0 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 2 | 1 | 3 |
| **Arthunge** | 1 | 1 | 2 |
| **Total intensive VDCs** | 47 | 3 | 50 |
| ***Rakhu Bhagwati*** | *4* | *1* | *5* |
| **Grand Total** | 51 | 4 | 55 |

*N=55

**Table A3.19: Health topics FCHVs report are discussed in health mother's group meetings**

| | Safe motherhood | Nutrition | Hygiene and sanitation | Infectious diseases | Family Plannning | Immunization | Safe Abortion | No health topics discussed | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 3 | 3 | 3 | 2 | 3 | 0 | 1 | 0 | 3 |
| **Jyamrukkot** | 1 | 4 | 3 | 0 | 3 | 0 | 2 | 0 | 4 |
| **Ratnechaur** | 2 | 1 | 2 | 1 | 2 | 2 | 1 | 0 | 2 |
| **Arman** | 1 | 4 | 3 | 1 | 3 | 0 | 0 | 0 | 4 |
| **Babiyachaur** | 2 | 2 | 1 | 0 | 2 | 1 | 0 | 0 | 2 |
| **Baranja** | 3 | 4 | 1 | 0 | 4 | 2 | 1 | 0 | 4 |
| **Bhakimli** | 2 | 4 | 3 | 1 | 4 | 0 | 0 | 0 | 4 |
| **Bima** | 2 | 4 | 3 | 2 | 4 | 0 | 0 | 0 | 4 |
| **Ghatan** | 2 | 3 | 3 | 1 | 3 | 2 | 2 | 0 | 3 |
| **Niskot** | 0 | 3 | 3 | 0 | 3 | 0 | 0 | 0 | 3 |
| **Okharbot** | 1 | 2 | 2 | 1 | 3 | 1 | 0 | 0 | 3 |
| **Ruma** | 1 | 4 | 4 | 0 | 4 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 0 | 1 | 4 | 2 | 3 | 1 | 1 | 0 | 4 |
| **Darbang** | 1 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 2 |
| **Arthunge** | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 |
| **Total intensive VDCs** | 22 | 42 | 37 | 12 | 43 | 10 | 8 | 0 | 47 |
| ***Rakhu Bhagwati*** | *3* | *4* | *2* | *3* | *2* | *3* | *2* | *0* | *4* |
| **Grand Total** | 25 | 46 | 39 | 15 | 45 | 13 | 10 | 0 | 51 |

*N=51

### Table A3.20: Frequency of health mothers group meetings conducted in the ward

| | One meeting per month | Total |
|---|---|---|
| **Singa** | 3 | 3 |
| **Jyamrukkot** | 4 | 4 |
| **Ratnechaur** | 2 | 2 |
| **Arman** | 4 | 4 |
| **Babiyachaur** | 2 | 2 |
| **Baranja** | 4 | 4 |
| **Bhakimli** | 4 | 4 |
| **Bima** | 4 | 4 |
| **Ghatan** | 3 | 3 |
| **Niskot** | 3 | 3 |
| **Okharbot** | 3 | 3 |
| **Ruma** | 4 | 4 |
| **Pulachaur** | 4 | 4 |
| **Darbang** | 2 | 2 |
| **Arthunge** | 1 | 1 |
| **Total intensive VDCs** | 47 | 47 |
| ***Rakhu Bhagwati*** | *4* | *4* |
| **Grand Total** | 51 | 51 |

*N=51

### Table A3.21: Distance in walking time reported by FCHVs from their house to the health mothers' group meeting venue

| | 10 minutes or less | 11-30 minutes | 31 minutes-1 hour | More than 1 hour | Total |
|---|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 3 | 1 | 0 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 0 | 0 | 2 |
| **Arman** | 3 | 1 | 0 | 0 | 4 |
| **Babiyachaur** | 1 | 1 | 0 | 0 | 2 |
| **Baranja** | 3 | 1 | 0 | 0 | 4 |
| **Bhakimli** | 2 | 2 | 0 | 0 | 4 |
| **Bima** | 2 | 2 | 0 | 0 | 4 |
| **Ghatan** | 2 | 1 | 0 | 0 | 3 |
| **Niskot** | 1 | 1 | 0 | 1 | 3 |
| **Okharbot** | 2 | 1 | 0 | 0 | 3 |
| **Ruma** | 3 | 1 | 0 | 0 | 4 |
| **Pulachaur** | 3 | 1 | 0 | 0 | 4 |
| **Darbang** | 2 | 0 | 0 | 0 | 2 |
| **Arthunge** | 1 | 0 | 0 | 0 | 1 |
| **Total intensive VDCs** | 33 | 13 | 0 | 1 | 47 |
| ***Rakhu Bhagwati*** | *3* | *0* | *1* | *0* | *4* |
| **Grand Total** | 36 | 13 | 1 | 1 | 51 |

*N=51

**Table A3.22: Number of individuals FCHVs report are members of their health mothers groups**

| | 11 to 20 members | 21 to 30 members | 31 to 40 members | 41 to 50 members | Total |
|---|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 0 | 1 | 1 | 2 | 4 |
| **Ratnechaur** | 1 | 0 | 1 | 0 | 2 |
| **Arman** | 3 | 1 | 0 | 0 | 4 |
| **Babiyachaur** | 1 | 1 | 0 | 0 | 2 |
| **Baranja** | 2 | 1 | 1 | 0 | 4 |
| **Bhakimli** | 1 | 3 | 0 | 0 | 4 |
| **Bima** | 0 | 3 | 1 | 0 | 4 |
| **Ghatan** | 3 | 0 | 0 | 0 | 3 |
| **Niskot** | 1 | 1 | 1 | 0 | 3 |
| **Okharbot** | 2 | 0 | 1 | 0 | 3 |
| **Ruma** | 2 | 1 | 1 | 0 | 4 |
| **Pulachaur** | 2 | 1 | 1 | 0 | 4 |
| **Darbang** | 2 | 0 | 0 | 0 | 2 |
| **Arthunge** | 0 | 1 | 0 | 0 | 1 |
| **Total intensive VDCs** | 23 | 14 | 8 | 2 | 47 |
| ***Rakhu Bhagwati*** | *3* | *1* | *0* | *0* | *4* |
| **Grand Total** | 26 | 15 | 8 | 2 | 51 |

*N=51

**Table A3.23: FCHV reports of composition of the health mother's groups they organise**

| | Newly married couple | Pregnant women | Postnatal mothers | 1000 days mothers | Dalit women | Migrants and their wives | Total MWRA (15-49 years) | Male | Adolescents/unmarried | Women aged over 50 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 2 | 2 | 0 | 21 | 25 | 12 | 43 | 0 | 0 | 1 | 44 |
| **Jyamrukkot** | 0 | 8 | 4 | 22 | 52 | 19 | 155 | 3 | 0 | 3 | 161 |
| **Ratnechaur** | 0 | 2 | 0 | 4 | 33 | 1 | 51 | 0 | 0 | 5 | 56 |
| **Arman** | 0 | 5 | 5 | 26 | 25 | 23 | 74 | 0 | 0 | 0 | 74 |
| **Babiyachaur** | 0 | 1 | 0 | 3 | 9 | 6 | 39 | 0 | 0 | 1 | 40 |
| **Baranja** | 0 | 4 | 3 | 33 | 31 | 19 | 76 | 2 | 1 | 3 | 82 |
| **Bhakimli** | 1 | 3 | 0 | 23 | 22 | 6 | 71 | 3 | 0 | 17 | 91 |
| **Bima** | 0 | 2 | 0 | 23 | 32 | 32 | 94 | 2 | 0 | 14 | 110 |
| **Ghatan** | 0 | 1 | 0 | 7 | 29 | 3 | 50 | 0 | 0 | 0 | 50 |
| **Niskot** | 3 | 3 | 2 | 35 | 52 | 24 | 76 | 0 | 0 | 3 | 79 |
| **Okharbot** | 0 | 4 | 2 | 23 | 15 | 14 | 59 | 0 | 0 | 2 | 61 |
| **Ruma** | 1 | 6 | 3 | 24 | 30 | 21 | 86 | 5 | 0 | 10 | 101 |
| **Pulachaur** | 0 | 3 | 1 | 8 | 32 | 18 | 73 | 2 | 3 | 1 | 79 |
| **Darbang** | 0 | 1 | 0 | 4 | 16 | 1 | 40 | 0 | 0 | 0 | 40 |
| **Arthunge** | 0 | 0 | 0 | 0 | 6 | 10 | 24 | 0 | 0 | 6 | 30 |
| **Total intensive VDCs** | 7 | 45 | 20 | 256 | 409 | 209 | 1011 | 17 | 4 | 66 | 1098 |
| ***Rakhu Bhagwati*** | *1* | *4* | *3* | *39* | *51* | *8* | *77* | *0* | *0* | *3* | *80* |
| **Grand Total** | 8 | 49 | 23 | 295 | 460 | 217 | 1088 | 17 | 4 | 69 | 1178 |

*N=51

### Table A3.24: Data for 2072 (Shrawan-Poush) available for inspection in FCHV register

| | Complete data available | Complete data not available | Data not recorded | Total |
|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 3 |
| **Jyamrukkot** | 1 | 3 | 0 | 4 |
| **Ratnechaur** | 1 | 1 | 0 | 2 |
| **Arman** | 1 | 0 | 4 | 5 |
| **Babiyachaur** | 0 | 1 | 1 | 2 |
| **Baranja** | 2 | 2 | 0 | 4 |
| **Bhakimli** | 2 | 2 | 0 | 4 |
| **Bima** | 1 | 3 | 0 | 4 |
| **Ghatan** | 1 | 1 | 1 | 3 |
| **Niskot** | 2 | 0 | 1 | 3 |
| **Okharbot** | 1 | 2 | 0 | 3 |
| **Ruma** | 3 | 1 | 0 | 4 |
| **Pulachaur** | 2 | 2 | 0 | 4 |
| **Darbang** | 2 | 0 | 1 | 3 |
| **Arthunge** | 0 | 2 | 0 | 2 |
| **Total intensive VDCs** | 22 | 20 | 8 | 50 |
| ***Rakhu Bhagwati*** | *1* | *4* | *0* | *5* |
| **Grand Total** | 23 | 24 | 8 | 55 |

*N=55

### Table A3.25: Data for 2071 (Shrawan-Poush) available for inspection in FCHV register

| | Complete data available | Register not available with FCHV at the time of interview | Data not recorded | Total |
|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 3 |
| **Jyamrukkot** | 2 | 2 | 0 | 4 |
| **Ratnechaur** | 1 | 1 | 0 | 2 |
| **Arman** | 0 | 5 | 0 | 5 |
| **Babiyachaur** | 0 | 2 | 0 | 2 |
| **Baranja** | 2 | 2 | 0 | 4 |
| **Bhakimli** | 1 | 3 | 0 | 4 |
| **Bima** | 2 | 2 | 0 | 4 |
| **Ghatan** | 2 | 1 | 0 | 3 |
| **Niskot** | 0 | 3 | 0 | 3 |
| **Okharbot** | 1 | 2 | 0 | 3 |
| **Ruma** | 2 | 2 | 0 | 4 |
| **Pulachaur** | 3 | 1 | 0 | 4 |
| **Darbang** | 0 | 3 | 0 | 3 |
| **Arthunge** | 0 | 2 | 0 | 2 |
| **Total intensive VDCs** | 19 | 31 | 0 | 50 |
| ***Rakhu Bhagwati*** | *2* | *3* | *0* | *5* |
| **Grand Total** | 21 | 34 | 0 | 55 |

*N=55

### Table A3.26: Number of beneficiaries receiving contraceptive methods from FCHVs in Shrawan-Poush 2072 (from registers with complete data only)

| | Total number of people who received condoms | Total number of condoms distributed | Total number of people who received pills | Total number of pills cycles distributed |
|---|---|---|---|---|
| **Singa** | 1 | 20 | 21 | 21 |
| **Jyamrukkot** | 10 | 300 | 4 | 4 |
| **Ratnechaur** | 6 | 85 | 14 | 14 |
| **Arman** | 4 | 50 | 3 | 3 |
| **Babiyachaur** | 0 | 0 | 0 | 0 |
| **Baranja** | 115 | 1150 | 8 | 8 |
| **Bhakimli** | 21 | 268 | 15 | 17 |
| **Bima** | 8 | 147 | 11 | 18 |
| **Ghatan** | 10 | 200 | 0 | 0 |
| **Niskot** | 10 | 60 | 2 | 2 |
| **Okharbot** | 1 | 30 | 9 | 9 |
| **Ruma** | 5 | 90 | 1 | 1 |
| **Pulachaur** | 2 | 15 | 8 | 8 |
| **Darbang** | 19 | 225 | 5 | 5 |
| **Arthunge** | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 212 | 2640 | 101 | 110 |
| ***Rakhu Bhagwati*** | *4* | *40* | *3* | *3* |
| **Grand Total** | 216 | 2680 | 104 | 113 |

*N=23

### Table A3.27: Number of beneficiaries receiving contraceptive methods from FCHVs in Shrawan-Poush 2071 (from registers with complete data only)

| | Total number of people who received condoms | Total number of condoms distributed | Total number of people who received pills | Total number of pills cycles distributed |
|---|---|---|---|---|
| **Singa** | 0 | 0 | 29 | 29 |
| **Jyamrukkot** | 8 | 100 | 23 | 23 |
| **Ratnechaur** | 8 | 320 | 3 | 3 |
| **Arman** | 0 | 0 | 0 | 0 |
| **Babiyachaur** | 0 | 0 | 0 | 0 |
| **Baranja** | 75 | 750 | 27 | 27 |
| **Bhakimli** | 13 | 145 | 13 | 20 |
| **Bima** | 9 | 54 | 6 | 6 |
| **Ghatan** | 11 | 220 | 0 | 0 |
| **Niskot** | 0 | 0 | 0 | 0 |
| **Okharbot** | 4 | 59 | 4 | 4 |
| **Ruma** | 6 | 85 | 7 | 7 |
| **Pulachaur** | 20 | 945 | 6 | 6 |
| **Darbang** | 0 | 0 | 0 | 0 |
| **Arthunge** | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 154 | 2678 | 118 | 125 |
| ***Rakhu Bhagwati*** | *3* | *40* | *7* | *7* |
| **Grand Total** | 157 | 2718 | 125 | 132 |

*N= 21

### Table A3.28: FCHVs who report receiving referral slips from HC3

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 3 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 5 | 0 | 5 |
| **Babiyachaur** | 2 | 0 | 2 |
| **Baranja** | 4 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 3 | 0 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 2 | 0 | 3 |
| **Arthunge** | 2 | 0 | 2 |
| **Total intensive VDCs** | 48 | 0 | 50 |
| ***Rakhu Bhagwati*** | *0* | *5* | *5* |
| **Grand Total** | 50 | 5 | 55 |

*N=55

### Table A3.29: When FCHVs report receiving referral slips

| | Baisakh (2072) | Jestha (2072) | Ashad (2072) | Shrawan (2072) | Bhadra (2072) | Asoj (2072) | Do not remember | Total |
|---|---|---|---|---|---|---|---|---|
| **Singa** | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 0 | 0 | 0 | 1 | 0 | 2 | 1 | 4 |
| **Ratnechaur** | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 |
| **Arman** | 0 | 0 | 0 | 0 | 5 | 0 | 0 | 5 |
| **Babiyachaur** | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| **Baranja** | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 4 |
| **Bhakimli** | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 4 |
| **Bima** | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 4 |
| **Ghatan** | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 |
| **Niskot** | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 3 |
| **Okharbot** | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 3 |
| **Ruma** | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 4 |
| **Pulachaur** | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 4 |
| **Darbang** | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 3 |
| **Arthunge** | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 2 | 4 | 3 | 9 | 24 | 6 | 2 | 50 |
| ***Rakhu Bhagwati*** | *0* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
| **Grand Total** | 2 | 4 | 3 | 9 | 24 | 6 | 2 | 50 |

*N=50

**Table A3.30: FCHV reports referring women to health facilities for family planning services (either verbally or through referral slip)**

| | Yes, reports referrals | No, does not report referrals | Total |
|---|---|---|---|
| **Singa** | 2 | 1 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 4 | 1 | 5 |
| **Babiyachaur** | 1 | 1 | 2 |
| **Baranja** | 1 | 3 | 4 |
| **Bhakimli** | 3 | 1 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 1 | 2 | 3 |
| **Niskot** | 2 | 1 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 2 | 1 | 3 |
| **Arthunge** | 0 | 2 | 2 |
| **Total intensive VDCs** | 37 | 13 | 50 |
| ***Rakhu Bhagwati*** | *3* | *2* | *5* |
| **Grand Total** | 40 | 15 | 55 |

*N=55

**Table A3.31: Number of referrals FCHVs report making verbally for FP services (Shrawan-Poush 2072)**

| | FP counselling | Condoms | Pills | Depo | Implant | IUCD | Sterilisation | Other FP services | Total number of people referred | Total number of respondents (FCHVs) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 4 | 1 |
| **Jyamrukkot** | 0 | 0 | 0 | 6 | 0 | 0 | 5 | 0 | 11 | 3 |
| **Ratnechaur** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| **Arman** | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 3 |
| **Babiyachaur** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 |
| **Baranja** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Bhakimli** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Bima** | 0 | 0 | 0 | 3 | 0 | 0 | 7 | 0 | 10 | 3 |
| **Ghatan** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Niskot** | 0 | 0 | 0 | 6 | 1 | 0 | 0 | 0 | 7 | 2 |
| **Okharbot** | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 0 | 15 | 1 |
| **Ruma** | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 2 |
| **Pulachaur** | 4 | 0 | 1 | 3 | 0 | 0 | 7 | 0 | 15 | 4 |
| **Darbang** | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | 1 |
| **Arthunge** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 6 | 0 | 4 | 23 | 2 | 0 | 36 | 0 | 71 | 22 |
| ***Rakhu Bhagwati*** | *0* | *0* | *2* | *2* | *0* | *0* | *24* | *0* | *28* | *3* |
| **Grand Total** | 6 | 0 | 6 | 25 | 2 | 0 | 60 | 0 | 99 | 25 |

*N= 25

*Multiple response

**Table A3.32: Number of referrals FCHVs report making for FP services using referral slips (Shrawan-Poush 2072)**

| | FP counselling | Condoms | Pills | Depo | Implant | IUCD | Sterilisation | Total number of people referred | Total number of respondents (FCHVs) |
|---|---|---|---|---|---|---|---|---|---|
| **Singa** | 0 | 0 | 2 | 3 | 0 | 0 | 4 | 9 | 2 |
| **Jyamrukkot** | 5 | 0 | 1 | 11 | 2 | 0 | 0 | 19 | 2 |
| **Ratnechaur** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 |
| **Arman** | 3 | 0 | 0 | 2 | 0 | 1 | 5 | 11 | 3 |
| **Babiyachaur** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 |
| **Baranja** | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 3 | 1 |
| **Bhakimli** | 0 | 2 | 1 | 3 | 0 | 0 | 0 | 6 | 3 |
| **Bima** | 0 | 5 | 4 | 2 | 7 | 0 | 2 | 20 | 3 |
| **Ghatan** | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 |
| **Niskot** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 |
| **Okharbot** | 0 | 0 | 4 | 3 | 0 | 0 | 0 | 7 | 3 |
| **Ruma** | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 4 | 2 |
| **Pulachaur** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 |
| **Darbang** | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | 1 |
| **Arthunge** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 9 | 9 | 17 | 29 | 10 | 1 | 12 | 87 | 25 |
| ***Rakhu Bhagwati*** | *0* | *0* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
| **Grand Total** | 9 | 9 | 17 | 29 | 10 | 1 | 12 | 87 | 25 |

*N=25

*Multiple response

### Table A3.33: Facility where most referrals made to

| | HP/SHP/PHCC | Hospital | Private organization/NGO/INGO | Pharmacies | Total no of respondents (FCHVs) |
|---|---|---|---|---|---|
| **Singa** | 2 | 0 | 0 | 0 | 2 |
| **Jyamrukkot** | 3 | 1 | 0 | 0 | 4 |
| **Ratnechaur** | 1 | 2 | 0 | 0 | 2 |
| **Arman** | 4 | 0 | 0 | 0 | 4 |
| **Babiyachaur** | 0 | 1 | 0 | 0 | 1 |
| **Baranja** | 1 | 0 | 0 | 0 | 1 |
| **Bhakimli** | 3 | 0 | 0 | 0 | 3 |
| **Bima** | 4 | 1 | 0 | 0 | 4 |
| **Ghatan** | 0 | 1 | 0 | 0 | 1 |
| **Niskot** | 2 | 0 | 0 | 0 | 2 |
| **Okharbot** | 3 | 0 | 0 | 0 | 3 |
| **Ruma** | 4 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 4 | 3 | 0 | 0 | 4 |
| **Darbang** | 2 | 0 | 0 | 0 | 2 |
| **Arthunge** | 0 | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 33 | 9 | 0 | 0 | 37 |
| ***Rakhu Bhagwati*** | *3* | *3* | *0* | *0* | *3* |
| **Grand Total** | 36 | 12 | 0 | 0 | 40 |

*Multiple responses possible per FCHV

*N=40

### Table A3.34: Number of clients FCHVs report they followed up (Shrawan-Poush 2072)

| | Number of clients referred who were followed up (2072) | Total no. of respondents (FCHVs) |
|---|---|---|
| **Singa** | 12 | 2 |
| **Jyamrukkot** | 14 | 3 |
| **Ratnechaur** | 2 | 2 |
| **Arman** | 12 | 3 |
| **Babiyachaur** | 2 | 1 |
| **Baranja** | 3 | 1 |
| **Bhakimli** | 6 | 3 |
| **Bima** | 28 | 4 |
| **Ghatan** | 2 | 1 |
| **Niskot** | 7 | 2 |
| **Okharbot** | 7 | 3 |
| **Ruma** | 6 | 4 |
| **Pulachaur** | 8 | 4 |
| **Darbang** | 4 | 2 |
| **Arthunge** | | 0 |
| **Total intensive VDCs** | 113 | 35 |
| ***Rakhu Bhagwati*** | *18* | *3* |
| **Grand Total** | 131 | 38 |

*N=38

**Table A3.35: Total number of referred clients followed up who FCHV reports received family planning services**

| | Clients who received Condoms | Clients who received Pills | Clients who received Depo | Clients who received Implant | Clients who received IUCD | Clients who received Sterilisation | Clients who received other FP services | Total no. of FCHVs |
|---|---|---|---|---|---|---|---|---|
| **Singa** | 0 | 4 | 4 | 0 | 0 | 0 | 0 | 2 |
| **Jyamrukkot** | 1 | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Ratnechaur** | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 2 |
| **Arman** | 1 | 1 | 3 | 0 | 0 | 3 | 0 | 3 |
| **Babiyachaur** | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 |
| **Baranja** | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |
| **Bhakimli** | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 3 |
| **Bima** | 5 | 4 | 3 | 7 | 0 | 6 | 0 | 4 |
| **Ghatan** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Niskot** | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 2 |
| **Okharbot** | 1 | 3 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Ruma** | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 0 | 2 | 4 | 1 | 0 | 0 | 0 | 4 |
| **Darbang** | 1 | 1 | 2 | 0 | 0 | 0 | 0 | 2 |
| **Arthunge** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 13 | 23 | 33 | 10 | 0 | 10 | 1 | 35 |
| ***Rakhu Bhagwati*** | *0* | *2* | *2* | *0* | *1* | *2* | *0* | *3* |
| **Grand Total** | 13 | 25 | 35 | 10 | 1 | 12 | 1 | 38 |

*N=38

### Table A3.36: Maximum number of follow ups of referred clients, according to FCHVs doing the follow up (Shrawan-Poush 2072)

| | Not followed up | Once | Twice | Thrice | Not required, all referred clients received FP service | Total |
|---|---|---|---|---|---|---|
| **Singa** | 0 | 1 | 0 | 0 | 1 | 2 |
| **Jyamrukkot** | 0 | 1 | 1 | 0 | 1 | 3 |
| **Ratnechaur** | 0 | 0 | 0 | 0 | 2 | 2 |
| **Arman** | 0 | 2 | 0 | 0 | 2 | 3 |
| **Babiyachaur** | 0 | 0 | 0 | 0 | 1 | 1 |
| **Baranja** | 0 | 0 | 0 | 0 | 1 | 1 |
| **Bhakimli** | 0 | 0 | 0 | 0 | 3 | 3 |
| **Bima** | 0 | 2 | 0 | 0 | 2 | 4 |
| **Ghatan** | 0 | 0 | 0 | 0 | 1 | 1 |
| **Niskot** | 0 | 2 | 0 | 0 | 0 | 2 |
| **Okharbot** | 0 | 1 | 0 | 0 | 2 | 3 |
| **Ruma** | 0 | 1 | 0 | 1 | 2 | 4 |
| **Pulachaur** | 0 | 1 | 0 | 0 | 3 | 4 |
| **Darbang** | 0 | 0 | 0 | 0 | 2 | 2 |
| **Arthunge** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total intensive VDCs** | 0 | 11 | 1 | 1 | 23 | 35 |
| ***Rakhu Bhagwati*** | *1* | *2* | *0* | *0* | *0* | *3* |
| **Grand Total** | 1 | 12 | 1 | 1 | 23 | 38 |

*N=38

### Table A3.37: Records of IEC /leaflets distributed in the community available (calendar year 2072)

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 0 | 3 | 3 |
| **Jyamrukkot** | 0 | 4 | 4 |
| **Ratnechaur** | 0 | 2 | 2 |
| **Arman** | 0 | 5 | 5 |
| **Babiyachaur** | 0 | 2 | 2 |
| **Baranja** | 0 | 4 | 4 |
| **Bhakimli** | 0 | 4 | 4 |
| **Bima** | 0 | 4 | 4 |
| **Ghatan** | 0 | 3 | 3 |
| **Niskot** | 0 | 3 | 3 |
| **Okharbot** | 0 | 3 | 3 |
| **Ruma** | 0 | 4 | 4 |
| **Pulachaur** | 0 | 4 | 4 |
| **Darbang** | 0 | 3 | 3 |
| **Arthunge** | 0 | 2 | 2 |
| **Total intensive VDCs** | 0 | 50 | 50 |
| ***Rakhu Bhagwati*** | *0* | *5* | *5* |
| **Grand Total** | 0 | 55 | 55 |

*N=55

### Table A3.38: No. of times and how supervisors from HC3 met with FCHVs

| | Through home visits | Through mother's group meeting | Through monthly FCHVs meeting | On the way | Through WaterAID program |
|---|---|---|---|---|---|
| **Singa** | 10 | 5 | 7 | 1 | 0 |
| **Jyamrukkot** | 13 | 2 | 12 | 0 | 0 |
| **Ratnechaur** | 3 | 2 | 7 | 0 | 0 |
| **Arman** | 16 | 6 | 9 | 0 | 0 |
| **Babiyachaur** | 4 | 2 | 3 | 0 | 0 |
| **Baranja** | 10 | 4 | 1 | 0 | 0 |
| **Bhakimli** | 6 | 4 | 0 | 0 | 0 |
| **Bima** | 10 | 3 | 8 | 1 | 0 |
| **Ghatan** | 3 | 0 | 6 | 0 | 0 |
| **Niskot** | 8 | 5 | 9 | 0 | 0 |
| **Okharbot** | 7 | 3 | 9 | 0 | 0 |
| **Ruma** | 7 | 2 | 12 | 0 | 0 |
| **Pulachaur** | 13 | 4 | 12 | 0 | 0 |
| **Darbang** | 6 | 0 | 6 | 0 | 0 |
| **Arthunge** | 5 | 0 | 3 | 0 | 0 |
| **Total intensive VDCs** | 121 | 42 | 104 | 2 | 0 |
| ***Rakhu Bhagwati*** | *0* | *0* | *0* | *0* | *0* |
| **Grand Total** | 121 | 42 | 104 | 2 | 0 |

*N=55

### Table A3.39: FCHV reports having ever received training on recording in HMIS register

| | Yes | No | Total |
|---|---|---|---|
| **Singa** | 3 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 2 |
| **Arman** | 5 | 0 | 5 |
| **Babiyachaur** | 1 | 1 | 2 |
| **Baranja** | 4 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 4 |
| **Bima** | 4 | 0 | 4 |
| **Ghatan** | 3 | 0 | 3 |
| **Niskot** | 3 | 0 | 3 |
| **Okharbot** | 3 | 0 | 3 |
| **Ruma** | 4 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 4 |
| **Darbang** | 3 | 0 | 3 |
| **Arthunge** | 2 | 0 | 2 |
| **Total intensive VDCs** | 49 | 1 | 50 |
| ***Rakhu Bhagwati*** | *5* | *0* | *5* |
| **Grand Total** | 54 | 1 | 55 |

*N=55

### Table A3.40: How long ago does the FCHV report receiving any training on HMIS

| | Less than 6 months ago | 6 months to 1 year ago | More than a year ago | Total |
|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 3 |
| **Jyamrukkot** | 2 | 0 | 2 | 4 |
| **Ratnechaur** | 2 | 0 | 0 | 2 |
| **Arman** | 3 | 0 | 2 | 5 |
| **Babiyachaur** | 1 | 0 | 0 | 1 |
| **Baranja** | 4 | 0 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 0 | 4 |
| **Bima** | 4 | 0 | 0 | 4 |
| **Ghatan** | 2 | 1 | 0 | 3 |
| **Niskot** | 3 | 0 | 0 | 3 |
| **Okharbot** | 3 | 0 | 0 | 3 |
| **Ruma** | 4 | 0 | 0 | 4 |
| **Pulachaur** | 3 | 0 | 1 | 4 |
| **Darbang** | 1 | 1 | 1 | 3 |
| **Arthunge** | 2 | 0 | 0 | 2 |
| **Total intensive VDCs** | 41 | 2 | 6 | 49 |
| ***Rakhu Bhagwati*** | *5* | *0* | *0* | *5* |
| **Grand Total** | 46 | 2 | 6 | 54 |

*N=54

### Table A3.41: Where FCHV says she records FP services she delivers that she then reports to health facility

| | In ward register | In piece of paper | Do not record | Total |
|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 0 | 2 |
| **Arman** | 4 | 1 | 0 | 5 |
| **Babiyachaur** | 1 | 0 | 1 | 2 |
| **Baranja** | 3 | 1 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 0 | 4 |
| **Bima** | 4 | 0 | 0 | 4 |
| **Ghatan** | 3 | 0 | 0 | 3 |
| **Niskot** | 3 | 0 | 0 | 3 |
| **Okharbot** | 3 | 0 | 0 | 3 |
| **Ruma** | 4 | 0 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 0 | 4 |
| **Darbang** | 3 | 0 | 0 | 3 |
| **Arthunge** | 2 | 0 | 0 | 2 |
| **Total intensive VDCs** | 47 | 2 | 1 | 50 |
| ***Rakhu Bhagwati*** | *5* | *0* | *0* | *5* |
| **Grand Total** | 52 | 2 | 1 | 55 |

*N=55

### Table A3.42: FCHV reports of whether they needed help recording the services delivered

| | Reports doing it by herself | Reports help from family members | Reports help from health facility staff | Reports help from fellow FCHVs | Total |
|---|---|---|---|---|---|
| **Singa** | 2 | 0 | 1 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 0 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 0 | 0 | 2 |
| **Arman** | 5 | 0 | 0 | 0 | 5 |
| **Babiyachaur** | 1 | 0 | 0 | 0 | 1 |
| **Baranja** | 4 | 0 | 0 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 0 | 0 | 4 |
| **Bima** | 3 | 1 | 0 | 0 | 4 |
| **Ghatan** | 3 | 0 | 0 | 0 | 3 |
| **Niskot** | 3 | 0 | 0 | 0 | 3 |
| **Okharbot** | 3 | 0 | 0 | 0 | 3 |
| **Ruma** | 4 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 2 | 2 | 0 | 0 | 4 |
| **Darbang** | 3 | 0 | 0 | 0 | 3 |
| **Arthunge** | 2 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 45 | 3 | 1 | 0 | 49 |
| ***Rakhu Bhagwati*** | *4* | *1* | *0* | *0* | *5* |
| **Grand Total** | 49 | 4 | 1 | 0 | 54 |

*N=54

### Table A3.43: How often FCHVs say they report to the health facility

| | Monthly | Bi-monthly | Quarterly | Do not report | Total |
|---|---|---|---|---|---|
| **Singa** | 3 | 0 | 0 | 0 | 3 |
| **Jyamrukkot** | 4 | 0 | 0 | 0 | 4 |
| **Ratnechaur** | 2 | 0 | 0 | 0 | 2 |
| **Arman** | 5 | 0 | 0 | 0 | 5 |
| **Babiyachaur** | 1 | 0 | 0 | 0 | 1 |
| **Baranja** | 4 | 0 | 0 | 0 | 4 |
| **Bhakimli** | 4 | 0 | 0 | 0 | 4 |
| **Bima** | 4 | 0 | 0 | 0 | 4 |
| **Ghatan** | 3 | 0 | 0 | 0 | 3 |
| **Niskot** | 3 | 0 | 0 | 0 | 3 |
| **Okharbot** | 3 | 0 | 0 | 0 | 3 |
| **Ruma** | 4 | 0 | 0 | 0 | 4 |
| **Pulachaur** | 4 | 0 | 0 | 0 | 4 |
| **Darbang** | 2 | 1 | 0 | 0 | 3 |
| **Arthunge** | 2 | 0 | 0 | 0 | 2 |
| **Total intensive VDCs** | 48 | 1 | 0 | 0 | 49 |
| ***Rakhu Bhagwati*** | *5* | *0* | *0* | *0* | *5* |
| **Grand Total** | 53 | 1 | 0 | 0 | 54 |

*N=54