Nepal Family Health Program BCC Formative Research and Evaluation

(Findings on FCHV client interactions and Exit interviews)

(Final Report)

By **Valley Research Group (VaRG)**
Post Box 4112
Kathmandu, Nepal

June, 2004

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of NFHP II and and do not necessarily reflect the views of USAID or the United States Government.

Contents

			Page
Preface			
List of tables and figure			
Study team			
Abbreviations			
Chapter 1	**Introduction**		**3**
	1.1	Background	3
	1.2	Objectives of the study	4
	1.3	Methodology	4
	1.4	Field organization and data collection	4
	1.5	Data cleaning and analysis	5
	1.6	Limitations of the Study	5
Chapter 2	**Characteristics of the Respondents**		**6**
	2.1	Characteristics of FCHVs, their supervisors and health facility management committee members	6
	2.2	Characteristics of clients	6
Chapter 3	**Findings of the Study**		**8**
	3.1	Supervisor-FCHV interaction	8
	3.2	FCHV-clients interaction	12
	3.3	Findings on exit interview	16
	3.4	Findings on health facility management committees	20
Chapter 4	**Summary and Conclusions**		**24**
	4.1	Summary of findings	24
	4.2	Conclusions	30

List of Tables and Figures

		Page
Table 1.1	Respondent type and sample size for client provider interaction by district	4
Table 2.1	Percent distribution of clients by ethnicity	6
Table 2.2	Percent distribution of respondents by age group	7
Table 2.3	Percent distribution of respondents by level of education	7
Table 2.4	Percent distribution of respondents by number of living children	7
Table 3.1	Greetings each other and listening to the FCHVs concerns	9
Table 3.2	Informing and providing material support to FCHVs	10
Table 3.3	Reporting and problem solving	11
Table 3.4	Knowledge transfer and ensuring understanding	11
Table 3.5	Percent distribution of clients by purpose of visiting FCHV based on field staff observations	12
Table 3.6	Greetings client and problem identification	13
Table 3.7	Referral to clients	13
Table 3.8	Listening and referring	14
Table 3.9	Use and distribution of BCC materials to the clients	14
Table 3.10	Use and distribution of BCC materials to the clients	15
Table 3.11	Encouraging to ask questions and aiding for decision making	15
Table 3.12	Encouraging to ask questions and aiding for decision making	16
Table 3.13	Percent distribution of respondents by purpose of visit to the FCHVs	16
Table 3.14	Percent distribution of respondents by satisfaction with the services of FCHVs	17
Table 3.15	Percent distribution of respondents by opinion regarding the FCHV's behavior	17
Table 3.16	Percent distribution of respondents by comfortability in asking questions in various issues with FCHVs	18
Table 3.17	Percent distribution of respondents reporting the types of BCC materials used by FCHVs during interaction	18
Table 3.18	Percent distribution of respondents reporting the types of BCC materials used by FCHVs during interaction	19
Figure 3.1	Percent distribution of respondents by frequency of visit to the FCHV or by the FCHV	19

Chapter 1

Introduction

1.1 Background

Nepal continues to experience high levels of population growth. Preliminary results of the 2001 Census estimate that the population is growing at a rate of 2.27 per annum. The total fertility rate, estimated at 4.1 births per woman, is still high. One of the direct implications of high population growth is on the health delivery system. After the New National Health Policy of 1991, His Majesty's Government is focusing its efforts on meeting basic health needs through the implementation of primary health care programs. Provision of basic health services to the maximum number of rural people and an increase in accessibility to services and their delivery with people's participation, particularly women, are the principal aims of the present national health policy.

Due to the efforts made by the government and international donor agencies, the health of women and children in Nepal has improved considerably over the past three decades. While these gains are encouraging, health indicators continue to lag behind desired levels. For instance, while contraceptive prevalence has risen dramatically over the past three decades, over one-quarter of married women still have an unmet need for family planning (MOH, 2001). This is a clear indication that there is much room for improving the family planning situation in the country.

With regard to MCH services, about 51% of pregnant women in Nepal still do not seek any antenatal services from health facilities or health workers. Assistance during delivery from trained health personnel is quite low (10.8% from a doctor or nurse) and only friends and relatives attend more than half of all deliveries. The child immunization coverage is still low, with only 65% of the children aged 12-23 months were fully immunized. The infant mortality rate is estimated at 64.2 per 1,000 live births (MOH, 2001).

In response to the continued high fertility; high infant, child, and maternal mortality; and low levels of health service utilization, the Female Community Health Volunteer (FCHV) Program was introduced in 2045/46 B.S. to expand the coverage of the basic primary health care services, including family planning. By now, more than 45,000 FCHVs are working throughout the country. The role of FCHVs is focused mainly on the motivation and education of local mothers and community members for safe motherhood, childcare, immunization, family planning, nutrition, sanitation, and control of communicable diseases. One study observed that FCHVs are highly desired by rural communities for their ability to provide primary health and minor medical care to the people along with being information, education and communication services agents. However, the study also found that people do not perceive them as a credible source for consultation during times of medical need. This is an indication that the role of FCHVs should be further strengthened for delivering counseling and primary health services at the community level.

1.2 Objectives of the study

The overall objective of this study is to collect baseline information from the program areas of the Nepal Family Health Program (NFHP) to inform the national FP/MCH BCC strategy and assist in the design of the radio health programs. The specific objective of this study is to determine the knowledge, attitudes, and skills of FCHVs and the perceptions of FCHVs among community members and community leaders. The findings will contribute to assessments of the effect of NFHP BCC activities.

1.3 Methodology

The study was conducted in five of the 17 districts covered by the Nepal Family Health Program (NFHP): Siraha, Bara, Nawalparasi, Banke and Kailali. Within each of the sampled districts, one VDC was selected to serve as the study site. The selected VDCs were *Padariya* in Siraha, *Khutawa Jabadi* in Bara, *Pragatinagar* in Nawalparasi, *Indrapur* in Banke and *Beladevipur* in Kailali district.

Data were collected from four types of respondents, including: FCHVs, their supervisors (VHWs), Health Facility Management Committees (HFMC) officials, and clients of FCHVs. In total, 15 FCHVs, 15 supervisors, and 8 health management committee officials were interviewed. For each FCHV, five interactions with clients were observed, with an exit interview conducted with each client following the observed interaction. The total number of respondents by type is given in Table 1.1.

Table 1.1 Respondent type and sample size for client provider interaction by district

Respondent type	Siraha	Bara	Nawal-parasi	Banke	Kailali	Total
FCHV	3	3	3	3	3	15
Supervisor (interaction with FCHVs)	3	3	3	3	3	15
Health facility management committee member	2	2	1	1	2	8
Clients	15	15	15	15	15	75
Total	**23**	**23**	**21**	**21**	**23**	**113**

Separate questionnaires were developed jointly by JHU/CCP, NFHP and VaRG for use with each of type of respondent.

1.4 Field organization and data collection

The study was carried out under the overall supervision of the senior members of the study team. Three teams, each consisting of one supervisor and 2 female interviewers, were mobilized to collect information from the study areas. The field teams were trained in interviewing and observation techniques at the VaRG office prior to the fieldwork. The data were collected in March 2003.

1.5 Data cleaning and analysis

All the completed questionnaires were checked and edited by trained data editors and coders at the VaRG office before they were entered into the computer. The edited questionnaire was coded for computer entry, entered and validated by a computer processing team consisting of a computer programmer and data entry personnel. The data processing was done in FoxPro software to generate a "cleaned" data set. Data was then transferred to SPSS PC+ and an SPSS system file was prepared. Data analysis was done using simple frequency tables.

1.6 Limitations of the Study

A major limitation of this study is that it does not actually reflect the full client-provider interaction as there are 34 cases where assessments were based on role-playing. Also, these interactions were observed in mostly accessible areas.

Chapter 2

Characteristics of the Respondents

This chapter presents the characteristics of FCHVs, their supervisors (VHWs), health facility management committee (HFMC) members, and clients of FCHVs included in the study.

2.1 Characteristics of FCHVs, their supervisors and health facility management committee members

Of the 15 FCHVs included in the study, 3 were Brahmin, 4 were Chhetri and others were Tharu, Kalawar, Mahato, Kami, Chamar and Newar. About three-fifths of the FCHV's supervisors were VHWs and the rest were MCHWs. Similarly, of the 8 health facility management committee members interviewed, 2 were Brahmin, 2 Tharu, one was Chhetri and the rest (N=3) were of other castes. One of the respondents was the chairperson and the rest (N=7) were members of the HFMC.

2.2 Characteristics of clients

A total of 75 FCHV client interactions were observed (15 from each district) during the study. Of the 75 observations, 41 cases were observed in real situations and the rest (N=34) were observed in role-play settings. All clients were interviewed immediately after they received counseling and other services from the FCHV. Table 2.1 shows the ethnic composition of the clients. Overall, 28% of the clients were Tharu and 36% were of Terai origin. Brahmin and Chhetri clients each comprised 13% of the total.

Table 2.1 Percent distribution of clients by ethnicity

Caste or ethnicity	Real	Role-play	Total
Brahmin	9.8	17.6	13.3
Chhetri	4.9	23.5	13.3
Tharu/Chaudhari/Rana Tharu	31.7	23.5	28.0
Thakur/Giri/Teli/ Kumhar/ Mandal/Kalwar/ Mahato/ Kushawaha/Dhimal	41.5	29.4	36.0
Other (Khatun/Muslim/ Newar/Magar/Chamar/Kami)	12.2	5.4	9.3
Total	**41**	**34**	**75**

Over half (53.3%) of the respondents were between 20-29 years old, and one-third (33.3%) were between 30-39 years of age. One in every 10 respondents was 40 years of age or older. A very small proportion (2.7%) was between 15-19 years old. The mean age of the respondents was 29.1 years.

Table 2.2 Percent distribution of respondents by age group

Age of the respondent (in completed years)	Real	Role-play	Total
15-19	2.4	2.9	2.7
20-24	22.0	26.5	24.0
25-29	29.3	29.4	29.3
30-34	24.4	17.6	21.3
35-39	9.8	14.7	12.0
40-44	2.4	2.9	2.7
45-49	9.8	5.9	8.0
Mean	**29.3**	**29.0**	**29.1**
SD	**7.8**	**7.3**	**7.6**
Total	**41**	**34**	**75**

Table 2.3 shows the educational status of the respondents. Slightly over half (50.7%) of the respondents were illiterate and about 15% were marginally literate (i.e. could read and write but had no formal schooling). Only 8% of the respondents had an educational level of SLC or greater. Clients observed in real situations were more likely to be illiterate than the clients in the role-play situations.

Table 2.3 Percent distribution of respondents by level of education

Grade completed	Real	Role-play	Total
Illiterate	61.0	38.2	50.7
Just literate	14.6	14.7	14.7
Primary	7.3	5.9	6.7
Lower secondary	7.3	11.8	9.3
Secondary	7.3	14.7	10.7
SLC and above	2.4	14.7	8.0
Total	**41**	**34**	**75**

Forty-four percent of the respondents had 1-2 living children, 29% had 3-4 and 19% had 5 or more living children. Eight percent of the respondents had no living children. The mean number of living children was 2.8, with a standard deviation of 1.9 (Table 2.4).

Table 2.4 Percent distribution of respondents by number of living children

Number of living children	Real	Role-play	Total
0	9.8	5.9	8.0
1	14.6	20.6	17.3
2	26.8	26.5	26.7
3	14.6	20.6	17.3
4	14.6	8.8	12.0
5+	19.5	17.6	18.7
Mean	**3.0**	**2.7**	**2.8**
SD	**2.2**	**1.6**	**1.9**
Total	**41**	**34**	**75**

Chapter 3

Findings of the Study

Data obtained through supervisor-FCHV interaction, FCHV-client interaction, exit interview with clients and health facility management committee members are discussed in this chapter. The first section presents results on supervisor-FCHV interaction, followed by FCHV-client interaction and exit interview with clients. The last section presents findings obtained from health facility management committee members.

3.1 Supervisor-FCHV interaction

Of the 15 supervisor-FCHV interactions that were observed, 3 were in real situations and the rest (N=12) were in role-play situations. Most of the interactions were related to reproductive heath (N=13), family planning (N=9), general health issues ((N=7) and safe motherhood (N=6). Observers were asked to record eight aspects of the interaction between supervisors and FCHVs, including:

a) Greeting each other
b) Listening to FCHVs' concerns
c) Informing FCHVs about new things
d) Material support
e) Reporting
f) Problem solving
g) Knowledge transfer
h) Ensuring understanding

Data presented in Table 3.1 reveal that in real situations, almost all the supervisors were attentive, expressed their own concerns and took notes on the concerns of the FCHVs. Of the three supervisors, one supervisor did not probe when it was necessary. In the role-play situations, one quarter of the supervisors did not probe when necessary .

Table 3.1 Greetings each other and listening to the FCHVs concerns

Description	Real			Role-play			Total
	Yes	No	Total	Yes	No	Total	% yes
Greets							
FCHV and supervisor greet one another	100.0	-	3	75.0	25.0	12	80.0
Supervisor is attentive	100.0	-	3	100.0	-	12	100.0
Supervisor expresses concern/caring	100.0	-	3	83.3	16.7	12	86.7
Listens							
Takes note of all of the FCHV's concerns	100.0	-	3	100.0	-	12	100.0
Supervisor repeats the issues back to the FCHV	100.0	-	3	91.7	8.3	12	93.3
Supervisor makes "listening noises – hmm"	100.0	-	3	100.0	-	12	100.0
Supervisor probes when necessary	66.7	33.3	3	75.0	25.0	12	73.3

Data presented in Table 3.2 reveal that almost all the supervisors in both the real situations and role-playing explained logistics, materials and information, and provided FCHVs with information concerning where to get medicines and materials. However, only 50 percent of supervisors updated the FCHVs on new materials and trainings. A higher proportion of supervisors in the real situation were updated the FCHVs on new materials and training, compared to the cases observed in the role-play situations.

Table 3.2 Informing and providing material support to FCHVs

Description	Real			Role-play			Total
	Yes	No	Total	Yes	No	Total	% yes
Informs							
Supervisor explains logistics to the FCHV	100.0	-	3	100.0	-	12	100.0
Supervisor explains materials and information to the FCHV	100.0	-	3	91.7	8.3	12	93.3
Supervisor updates the FCHV on new materials received	66.7	33.3	3	50.0	50.0	12	53.3
Supervisor updates the FCHV on training to be held	66.7	33.3	3	41.7	58.3	12	46.7
Supervisor provides information on action – where to get medicines, materials, who to see	100.0	-	3	100.0	-	12	100.0
Material support							
Supervisor checks materials including IEC materials	100.0	-	3	91.7	8.3	12	93.3
Supervisor checks supplies of FCHV	100.0	-	3	66.7	33.3	12	73.3
Provides materials							
Supervisor provides IEC materials or gives a time/place where they can be obtained, if necessary	100.0	-	3	91.7	8.3	12	93.3
Supervisor provides supplies FP, medicines, first aid, etc. or gives a time/ place where they can be obtained, if necessary	100.0	-	3	83.3	16.7	12	86.7

All the supervisors in the real situations checked the materials and supplies, provided IEC materials or gave a time for it or informed the FCHVs where they could obtain the materials, and supplied family planning methods, medicine, first aids, etc. However, in the role-play situation some supervisors did not check the materials and supplies, did not provide IEC materials and did not supply family planning methods, medicines, first aids etc.

Table 3.3 shows data on the reporting and problem-solving aspects of the interaction. During the real situations, all the supervisors asked the FCHVs to show their records, but only two supervisors went through the records with FCHVs and supported FCHVs in record-keeping and reporting. Similarly, all the supervisors in the real situations probed FCHV for actions undertaken and probed about the problems and constraints they encountered. However, one out of three supervisors did not probe for solutions or actions that the FCHV had implemented. In the role-play situations, over half of the supervisors asked the FCHVs to show records and about 86% went through records with the FCHVs and supported them in record-keeping and reporting. Likewise, all the supervisors probed FCHVs for action undertaken, and 9 in every 10 supervisors probed FCHVs for problems or constraints they encountered and for solutions or actions the FCHVs had implemented.

Table 3.3 Reporting and problem solving

Description	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
Reporting							
Supervisor asks to see records	100.0	-	3	58.3	41.7	12	66.7
Supervisor goes through the records with the FCHV	66.7	33.3	3	85.7	14.7	7	80.0
Supervisor supports her in record keeping/reporting	66.7	33.3	3	85.7	14.3	7	80.0
Problem solves							
Supervisor probes FCHV for actions undertaken	100.0	-	3	100.0	-	12	100.0
Supervisor probes FCHV for problems/constraints encountered	100.0	-	3	91.7	8.3	12	93.3
Supervisor probes FCHV solutions or actions which the FCHV has implemented	66.7	33.3	3	83.3	16.7	12	80.0

All the supervisors in both the real and role-play situations assisted FCHVs with their problems, assisted with information and provided correct information. However, one supervisor in a real situation did not probe the FCHV for questions on any topic, and in the role-play situations about a quarter of the supervisors did not ensure that FCHVs had understood the information (Table 3.4).

Table 3.4 Knowledge transfer and ensuring understanding

Description	Real			Role-play			Total
	Yes	No	Total	Yes	No	Total	% yes
Knowledge transfer							
Supervisor assists the FCHV with problems they are currently facing	100.0	-	3	100.0	-	12	100.0
Supervisor probes for FCHV questions on any topic	66.7	33.3	3	100.0	-	12	93.3
Supervisor assists the FCHV with information	100.0	-	3	100.0	-	12	100.0
Supervisors provide correct information	100.0	-	3	100.0	-	12	100.0
Ensures understanding							
Supervisor checks to ensure that the FCHV understands the information	100.0	-	3	75.0	25.0	12	60.0

Excluding one interaction in a role-play situation, both the supervisors and the FCHVs were comfortable during the interactions. Neither the supervisors nor the FCHVs appeared to dominate the interactions. There were some interruptions in two of the interactions (both in real situations), which were caused by children and other family members (Table not shown).

The observers were also instructed to note any general observations during the interaction sessions, if any. Most of the observers (N=11) noted that both the FCHVs and supervisors talked openly during the interaction sessions. About one-third of the observers noted that supervisors enquired about the problems and concerns of the FCHVs, asked FCHVs to take medicines if needed and assured FCHVs that they would provide assistance to them in their work (such as giving them information about family planning, safe motherhood and diarrhea in the community).

3.2 FCHV-clients interaction

A total of 75 FCHV-client observations were made during the study. Of the 75 observations, 41 observations were in real situations and another 34 observations were role-play. Table 3.5 reveals the reasons for clients' visits to FCHVs. Based on the field staff observations, the main purpose of the clients' visits to FCHVs was for receiving child health services (56.0%) followed by safe motherhood (30.7%), family planning (25.3%) and general health (25.3%). About 12% of clients visited for reproductive health services. This finding is also consistent with the results of the earlier study (NFHP Baseline Survey), in which most respondents (73.3%) indicated that they had discussed child survival during their last meeting with an FCHV.

Table 3.5 Percent distribution of clients by purpose of visiting FCHV based on field staff observations

Purpose of visit	Real	Role-play	Total
Child health	56.1	55.9	56.0
Safe motherhood	29.3	32.4	30.7
Family planning	17.1	35.3	25.3
General health	36.6	11.8	25.3
Reproductive health	4.9	20.6	12.0
Total	**41**	**34**	**75**

As in the case of supervisor-FCHV interactions, 7 aspects were observed during the interaction between FCHVs and clients. The aspects observed were:

a) Greetings and problem identification
b) Referral
c) Listening and exploring
d) Use of IEC materials
e) Providing options and checking understanding
f) Encouraging questions and aiding in decision making
g) Providing information and materials

All the FCHVs (in both the real situations and role-play) listened to clients' concerns attentively and in a friendly manner. Similarly, all FCHVs identified clients' problems and provided correct information to the clients. The majority (>95%) of the FCHVs discussed options to deal with clients' problems and about three-quarters repeated issues back to the clients. However, only about a quarter of the FCHVs were observed to greet the clients who visited them (Table 3.6).

Table 3.6 Greetings client and problem identification

Description	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
Interaction							
FCHV greets client	24.4	75.6	41	29.4	70.6	34	26.7
FCHV listens to client's concern	100.0	-	41	100.0	-	34	100.0
FCHV is attentive and friendly	100.0	-	41	100.0	-	34	100.0
Problem identification							
FCHV identifies a problem	100.0	-	41	100.0	-	34	100.0
FCHV discuses options – more than one way to deal with the problem	95.1	4.9	41	100.0	-	34	97.3
FCHV provides correct information to solve the problem	100.0	-	41	100.0	-	34	100.0
FCHV repeats issue back to the client	75.6	24.4	41	73.5	26.5	34	74.7

Over 80% of the FCHVs talked about the health conditions that need to be referred to a higher level of health care. Among those FCHVs who did talk about the needs of referral, more than 90% (in both the real and role-play situation) also talked about where the client should go for a referral and who the client should see (Table 3.7).

Table 3.7 Referral to clients

Referral	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
FCHV talks about what needs to be referred	82.9	17.1	41	79.4	20.6	34	81.3
FCHV talks about where to go for referral, and who to see	91.2	8.8	34	92.6	7.4	27	91.8

Data presented in Table 3.8 indicate that all the FCHVs explored clients' feelings, needs and expectations in both the real situations and role-play settings. Similarly, almost all the FCHVs (97.6%) in the real situations and all in the role-play listened to the clients' concerns and used non-verbal gestures to encourage clients to speak. About three-quarters of the FCHVs also probed clients when necessary in both the real situations and role-play settings. It seems that there is no significant difference in the real and role-play situations.

Table 3.8 Listening and referring

Listens and explores	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
FCHV explores the client's feelings, needs and expectations	100.0	-	41	100.0	-	34	100.0
FCHV used non-verbal communication to indicate she is listening	97.6	2.4	41	100.0	-	34	98.7
FCHV probes when necessary	73.2	26.8	41	67.6	32.4	34	70.7

Only about half of the FCHVs used BCC materials during interaction with their clients. However, about 90% of the FCHVs who used BCC materials allowed the clients to see or touch the BCC materials. A very small proportion of the FCHVs provided BCC materials to their clients. The above information indicates that use of BCC materials is quite low during the interaction between the FCHVs and their clients.

Table 3.9 Use and distribution of BCC materials to the clients

BCC materials	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
FCHV uses BCC materials	51.2	48.8	41	41.2	58.8	34	46.7
FCHV allows the client to see/touch the BCC materials	90.5	9.5	21	78.6	21.4	14	85.7
FCHV gives BCC materials to the client	19.0	81.0	21	50.0	50.0	14	31.4

The majority (over 85%) of the FCHVs in both the real and role-play situations clearly listed the options available to their client, including the choice of no action, and referred them elsewhere for more information (Table 3.10). Similarly, more than 90% of the FCHVs explained the advantages and disadvantages of each of these options. However, only half of the FCHVs checked to ensure that the clients understood the information they had been given, indicating the need for orienting FCHVs in this aspect as it is a very crucial aspect in the FCHV-client interaction.

Table 3.10 Use and distribution of BCC materials to the clients

Description	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
Options							
FCHV clearly lists options including choice of no action and referral for more information	87.8	12.2	41	85.3	14.7	34	86.7
FCHV explains the pro's and con's of each choice of treatment/ action (FP)	91.7	8.3	36	89.7	10.3	29	90.8
Checks understanding							
FCHV checks to ensure that the client understands the information	53.7	46.3	41	70.6	29.4	34	61.3

All the FCHVs in real interactions and more than 90% during role-play situations provided opportunities for clients to ask questions and probed for additional information. In the real interactions, nine in every 10 FCHVs asked clients open-ended questions and aided them in their decision, while in case of role-play situations, all the FCHVs did so (Table 3.11).

Table 3.11 Encouraged clients to ask questions and aided in decision making

Description	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
Encourages questions							
FCHV provides opportunity for client to ask questions – probes for questions	100.0	-	41	97.1	2.9	34	98.7
Q120: FCHV probes for questions	100.0	-	41	91.2	8.8	34	96.0
FCHV asks open-ended questions	90.2	9.8	41	100.0	-	34	94.7
Aids decision making							
FCHV aids the client in his/her decision	90.2	9.8	41	100.0	-	34	94.7

During the interaction sessions, more than 85% of the FCHVs in both the real and role-play situations provided materials such as FP devices, medicines, first aids, etc. to the clients. However, only about one-third of the FCHVs discussed or scheduled a follow-up visits (Table 3.12).

Table 3.12 Providing information and materials

Provides information/materials	Real			Role play			Total
	Yes	No	Total	Yes	No	Total	% yes
FCHV provides materials (FP devices, medicines, first aids, etc.)	85.4	14.6	41	88.2	11.8	34	86.7
FCHV discusses/schedules a follow-up visit	29.3	70.7	41	41.2	58.8	34	34.7

During the interaction session, it was observed that both the FCHVs and clients were comfortable and neither dominated the other. In 9 interaction sessions, children or other family members interrupted the interaction sessions. Thus there is a need for FCHVs to be aware of the importance of confidentiality and an uninterrupted session.

In most of the interactions, both the FCHVs and clients discussed freely despite some interruption. In 5 sessions the FCHVs provided counseling using Jeevan Surakshya flip chart. The FCHVs (N=10) also provided Jeevan Jal to the clients and explained about the ways of preparing Jeevan Jal. Twenty-one clients were referred to the health facility for consultation and check-ups. Most of the field staff observed no obstacles during interaction sessions.

3.3 Findings on exit interview

After the interaction sessions all the clients were interviewed to get their opinion regarding the services provided by the FCHVs on that particular day. The results are discussed in this section.

a) Purpose of visit

Nearly half (45.3%) of the clients visited the FCHVs to get child health services followed by safe motherhood (21.3%) and family planning (18.7%). Some respondents visited for information and services on reproductive health and general health (Table 3.13).

Table 3.13 Percent distribution of respondents by purpose of visit to the FCHVs

Purpose of visit to the FCHV today	Real	Role play	Total
Child health	46.3	44.1	45.3
Safe motherhood	24.4	17.6	21.3
Family planning	12.2	26.5	18.7
General health	12.2	2.9	8.0
Reproductive health	4.9	8.8	6.7
Total	**41**	**34**	**75**

When further asked about other reasons for visiting FCHVs, the majority (70.7%) of the clients said that FCHVs are always available and about three-fifths thought that they provide good services (Table not shown). Other reasons mentioned by the clients were:

- Good behavior (42.7%)
- Provide medicines (38.7%)
- Health facility too far (17.3%)

b) Opinion regarding the services of FCHVs

Almost all the clients were satisfied with the overall quality of the FCHVs' services and behavior. Similarly, more than 95% of the clients were satisfied with the information and counseling provided by FCHVs. However, a comparatively lower percentage (74.7%) was satisfied with the availability of supplies (Table 3.14).

Table 3.14 Percent distribution of respondents by satisfaction with the services of FCHVs

Satisfaction with the services of FCHV (% yes only)	Real	Role play	Total
The overall quality of services	97.6	100.0	98.7
The way you were treated by the FCHV	100.0	100.0	100.0
The availability of supplies	85.4	61.8	74.7
The information given to you	95.1	97.1	96.0
The type of counseling you received	97.6	94.1	96.0
Total	**41**	**34**	**75**

When further asked whether they were satisfied with the services received from the FCHV, almost all (97.7%; N=73) of the clients responded affirmatively (Table not shown). The most frequently cited reasons for satisfaction were good services (78.1%) and availability when needed (72.6%). The other reasons for satisfaction mentioned by the respondents were:

- Good behavior (54.8%)
- Provides medicines (49.3%)
- Knowledgeable (2.7%)

Only two of the clients were not satisfied with the FCHVs' services. The reasons given by these clients were that they did not provide medicines, they were not always available when needed, and they lacked adequate knowledge (Table not shown).

All the clients said that FCHVs are attentive and friendly, and that they listen to their concerns. Nearly 9 in every 10 clients said that FCHVs encourage them to ask questions. However, only 56% and 39% of the respondents respectively said that FCHVs allow them to see or touch the BCC materials and greet them in a friendly manner (Table 3.15).

Table 3.15 Percent distribution of respondents by opinion regarding the FCHV's behavior

Opinion regarding the FCHV behavior (% yes only)	Real	Role play	Total
Greet you in a friendly manner	39.0	35.3	37.3
Listen to your concern	100.0	100.0	100.0
Attentive and friendly	100.0	100.0	100.0
Encourage you to ask questions	87.8	91.2	89.3
Allow you to see/touch the BCC materials	56.1	41.2	49.3
Total	**41**	**34**	**75**

All the respondents were asked whether they would feel comfortable in asking questions related to health and family planning with FCHVs. The results are presented in Table 3.16. Almost all the respondents said that they would feel comfortable in asking questions related to health and family planning.

Table 3.16 Percent distribution of respondents comfortable asking questions about various issues with FCHVs

Did you feel that you could…. (% yes only)	Real	Role play	Total

Ask the FCHV for more health information	100.0	100.0	100.0
Ask for clarification if you did not understand	100.0	100.0	100.0
Ask for the FCHV's opinion or advice	97.6	100.0	98.7
Tell the FCHV about your concerns or worries	100.0	100.0	100.0
Ask the questions about the health and family planning	100.0	100.0	100.0
Make personal remarks	90.2	85.3	88.0
Answer the FCHV questions	97.6	100.0	98.7
Seek FCHV advice	100.0	100.0	100.0
Seek FCHV opinion	97.6	100.0	98.7
Understand the language that the FCHV used	97.6	100.0	98.7
Express your disagreement with something she said	100.0	100.0	100.0
Total	**41**	**41**	**75**

c) Use of BCC materials during interaction

The clients were also asked whether the FCHV used any BCC materials during the interaction. In response, nearly half (46.7%; N=35) of them responded in the affirmative. Of those who said that the FCHV had used a BCC material, nearly 9 in every 10 clients said that the FCHV used a poster, followed by a pamphlet (28.6%). The other BCC materials used by a few FCHVs were flip charts and the *Jeevan Surakshya* package (Table 3. 17).

Table 3.17 Percent distribution of respondents reporting the types of BCC materials used by FCHVs during interaction

Types of BCC materials used	Real	Role play	Total
Poster	80.0	100.0	88.6
Pamphlet	25.0	33.3	28.6
Flip chart	20.0	6.7	14.3
Jeevan Surakshya	20.0	-	11.4
Other	10.0	-	5.7
Total	**20**	**15**	**35**

All the clients said that these BCC materials were useful. Posters were reported as more useful to the majority (82.9%) of the clients, followed by pamphlets (20.0%) and flip charts (11.4%). Less than 5% of the responds found Jeevan Surakshya useful (Table not shown).

d) Visit to an FCHV or an FCHV's visit to a client

Almost all (97.3%) of the clients said that they had either visited an FCHV or that an FCHV had visited them in the last six months (besides the visit on the interview date). Over 45% of the respondents had visited an FCHV in the month prior to the survey. About one-third mentioned a visit in the last 1-3 months and another 22% had visited them 3 months ago (Table 3.18).

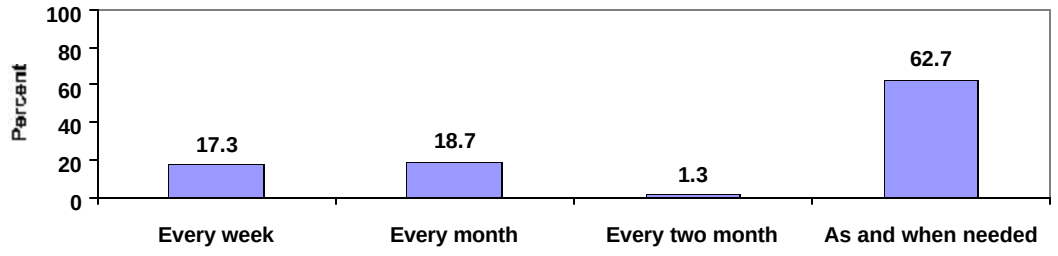
Table 3.18 Interaction with FCHVs prior to current visit

Description	Real	Role play	Total
Whether visited FCHV or the FCHV visited you at any			

time in the last 6 months besides today's visit			
Yes	97.6	97.1	97.3
No	2.4	2.9	2.7
Total	**41**	**34**	**75**
Last time visited			
<1 months	62.5	24.2	45.2
1-2 months	12.5	18.2	15.1
2-3 months	15.0	21.2	17.8
3 months +	10.0	36.4	21.9
Total	**40**	**33**	**73**

When further asked how frequently they visit the FCHV or the FCHV visits them, the majority (62.7%) of respondents said that they visit the FCHV when needed (Figure 3.1). About one-fifth of the respondents said that they interact with an FCHV every month and another 17% mentioned every week. It is interesting to note that the findings of the earlier study (NHFP Baseline Survey) indicate that about 79% of the respondents had contacted an FCHV within the month prior to the survey.

Figure 3.1 Percent distribution of respondents by frequency of visit to the FCHV or by the FCHV



e) Strengths and weaknesses of the FCHV

The clients were also asked to mention the strengths and weaknesses of FCHVs. The most frequently cited strengths of the FCHVs, as perceived by the respondents, were that they are able to create awareness on health issues in the community (88.0%) and they are available in the community (70.7%). A few of the clients said that they are knowledgeable and available whenever needed (Table not shown).

Regarding the weaknesses of FCHVs, nearly half of the clients said that FCHVs are not knowledgeable and have no adequate logistics support. About 30% of the clients said that they could not give adequate time to a client because they had to cover too many households in the community. About one-fifth (17.6%) of the clients thought that FCHVs lacked proper training (Table not shown).

f) Perceptions on FCHV as a person and as an FCHV

All the clients were also asked to describe the FCHV as a person and as an FCHV. With regard to the FCHV as a person, about two-fifths of the clients described the FCHV as a friend or neighbor and another one-third described her as a village sister (Table not shown). About a quarter of the

clients described the FCHV as a friendly and helpful woman in the community. Some of the clients described the FCHV as a person in the following ways:

- Person having good behavior (16.0%)
- Disciplined and laborious woman (8.0%)
- Person who knows many things about health issues (6.7%)
- Person having good character and honest (5.3%)

When asked to describe the FCHV as an FCHV, over 40% of the clients described her as a person who provides information and services in the community and is available any time (Table not shown). Over a quarter of the clients described the FCHV as a cooperative (30.7%) and honest (25.3%) woman. Some of the clients described the FCHV as a person who creates awareness in the community. Clients also described the FCHV as an FCHV in the following ways:

- Health worker (18.7%)
- Person who can provide good counseling (13.3%)
- Person having positive aptitude/ person who treats the community people equally (12.0%)
- Person having adequate knowledge (12.0%)
- Educated woman (6.7%)

3.4 Findings on health facility management committees

a) Meeting with FCHVs

Altogether 8 chairperson/members of the health facility management committee were included in the study. Two of the respondents were involved in the committee for less than 3 years and the rest (N=6) were involved for 3 or more years. All the respondents reported that they had known the FCHVs working in their areas. Five out of 8 respondents meet the FCHV every month and 3 meet the FCHV more than once a month. Most said that they meet the FCHVs at their homes/village (62.5%) or at the health facility (50.0%). Two respondents said they meet the FCHVs during mothers' group meetings. Three respondents said that they met the FCHVs during *Immunization Day* or *Vitamin A Day* activities. All the respondents agreed that FCHVs attend the health post coordination meetings. About half of the respondents said that they attend every month and 38% said that they attend the meeting whenever there is an issue.

When further asked what types of issues FCHVs frequently raised to the HFMC, the majority of the respondents said that FCHVs ask for supplies and medicines (87.5%) and financial support (75.0%).

b) Knowledge about the roles of FCHVs

All the respondents were aware of at least one role of the FCHVs. The majority (87.5%) of the respondents said that FCHVs provide help on health issues in general. The other roles of FCHVs as mentioned by the respondents were:

- Provide family planning information (62.5%)
- Prepare for delivery (62.5%)
- Provide immunization (37.5%)
- Distribute Vitamin A capsules (75.0%)
- Assist during special events such as Immunization Day, Condom Day and Vitamin A Day (50.0%)

c) FCHV in the community

Most of the respondents (87.5%) thought that FCHV are very popular in their community and another 13% said that they are *to some extent popular*. When further asked about the good things about the FCHV program. over three-quarters each of the respondents said that they are close to the community and provide health-related information and education. The other aspects they considered good in the FCHV program were:

- Help with immunization (50.0%)
- Provide medicines and supplies (50.0%)
- Help with vitamin A (37.5%)
- Help with family planning program (25.0%)
- Provide counseling and information on pneumonia (12.5%)

The respondents were also asked about the problems or issues faced by them in the FCHV program. In response to this, the majority of the respondents complained that FCHVs are illiterate (75.0%) and that they ask for allowances (75.0%). The other problems or constraints mentioned by the respondents were:

- Lack of budget to assist the FCHVs (50.0%)
- Lack of time to support them (25.0%)
- Lack of materials to share with them (25.0%)
- FCHVs are untrained (12.5%)
- FCHVs are not motivated (12.5%)

When further asked about the types of support that the HFMC provides to the FCHVs, more than three-fifths of the respondents said they assist FCHV during Vitamin A Day. Similarly, slightly over one-third (37.5%) of the respondents said that they provide financial support (allowances) and assist during mothers' group meetings. About a quarter of the respondents also said they provide materials, medicines and arrange training for FCHVs.

All the respondents thought that FCHVs require further training to improve their work performance. The respondents suggested providing training in:

- Environment and sanitation (50.0%)
- Refresher training on pneumonia/ARI (37.5%)
- Treatment of diarrhea (37.5%)
- ANC/safe motherhood (37.5%)
- Family planning (25.0%)

When asked to list good ways for FCHVs to learn new things, five out of 8 respondents thought that the radio is a good way for FCHV to learn. Reasons in support of radio included: that it is easy to access (100.0%), convenient for FCHVs (40.0%), FCHVs like radio (40.0%) and it is cost-effective (20.0%) (Table not shown). Only 3 respondents were not in favor of using the radio as a means of training FCHVs. These respondents mentioned that FCHVs cannot remember all the information that would be presented at one time, they are too busy in their work, and it is difficult to teach.

d) Availability and use of BCC materials

The HFMC members included in the study were asked about the types of BCC materials provided to the FCHVs. In response, all the respondents said that FCHVs were provided posters and another 63% each said they were provided pamphlets and flipcharts. Only 13% of the respondents said that booklets were provided to the FCHVs. The source of supply of these BCC materials were the health posts (100.0%) followed by the DHO (50.0%) and a NGO or INGO (12.5%). All the respondents opined that these BCC materials were useful to FCHVs for their work.

When further asked about how the FCHVs use these BCC materials in the community, about half of the respondents stated that they distribute these materials. Similarly, about half of the respondents said that they use materials explaining the illustrations. About a quarter of the respondents said FCHV use the materials explaining the contents. Four out of 8 respondents opined that they should be provided with additional materials to be used for pregnant women and new mothers.

Respondents' opinion regarding the types of materials needed for FCHVs was also sought during the study. Nearly 90% of the respondents suggested providing more BCC materials and about half suggested providing necessary medicines (Table not shown). The other materials suggested by the respondents were:

- First aid supplies (25.0%)
- Radio (25.0%)
- Uniform (25.0%)
- Bicycle (25.0%)

Some of the respondents suggested providing financial support and allowances to the FCHVs to motivate them to work as FCHVs.

e) Assistance to the FCHVs by the HFMC

All the respondents were asked a question, *if you could do anything to assist your local FCHVs with their work, what would you do?* In response, about half of the respondents said they would provide more medicines or supplies and allowances. Similarly, nearly 40% of the respondents said that they would provide more training, supervision and BCC materials.

When further asked about the constraints they have faced in providing the above-mentioned assistance, over 60% of the respondents mentioned the lack of funds. Another half of the respondents opined that there was a lack of motivation among the health committee members. The other constraints mentioned were:

- Lack of support from DHO (12.5%)
- Lack of support from regional office (25.0%)
- Lack of support from NGO/INGO (25.0%)
- Lack of time (25.0%)

Chapter 4

Summary and Conclusions

4.1 Summary of Findings

a) Introduction

The overall objective of the study is to collect the baseline information from the program areas of the Nepal Family Health Program (NFHP) in order to provide input for national FP/MCH BCC strategy for NHEICC as well as for the design of radio health programs. The specific objective of this study is to determine changes in FP/MCH knowledge, attitudes, behaviors, perceptions, interpersonal communication and counseling (IPC/C) skills, self-image and biases among FCHVs as a result of NFHP BCC activities.

The study was conducted in five districts out of a total of 17 districts covered by the NFHP: Siraha, Bara, Nawalparasi, Banke and Kailali. A total of five VDCs (one from each district) were selected to collect information related to the client provider interactions. Four types of respondents (FCHVs, their supervisors (VHWs), health facility management committee officials and clients of FCHVs) were selected for interview. In total 15 FCHVs, 15 supervisors, and 8 health management committee officials were selected. Similarly, 5 clients of each FCHVs were identified to observe FCHV client interactions and for an exit interview. Three teams consisting of one supervisor and 2 female interviewers in each team were mobilized to collect information from the study areas. The data collection activity was carried out during March 2003.

One of the major limitations of this study is that it does not actually reflect the full client provider interaction as there are 34 cases where assessment were based on role-playing. Also these interactions were observed in mostly accessible areas.

b) Characteristics of the Respondents

Of the 15 FCHVs included in the study, 3 were Brahmin, 4 were Chhetri and others were Tharu, Kalawar, Mahato, Kami, Chamar and Newar. About three-fifths of the FCHV's supervisors were VHW and the rest were MCHWs. Similarly, of the 8 health facility management committee members interviewed, 2 each were Brahmin and Tharu, one was Chhetri and the rest (N=3) were of other castes.

A total of 75 FCHV client interactions were observed (15 from each district) during the study. Of the 75 observations, 41 cases were observed in real situations and the rest (N=34) were observed in role-play settings. All these respondents were interviewed immediately after they received counseling and other services from the FCHV. Overall, 28% of the clients were Tharu and 36% were of Terai origin. Thirteen percent were Brahmin and 13% were Chhetri.

The mean age of the respondents was 29.1 years. Nearly half (49.3%) of the respondents were literate. The mean number of living children was 2.8.

c) Findings of the Study

i) Supervisor-FCHV interaction

Of the 15 supervisor-FCHV observation made 3 were in real situations and the rest (N=12) were role-play situations. Most of the interactions were related to reproductive heath (N=13), family planning (N=9), general health issues ((N=7) and safe motherhood (N=6).

In the real situations, almost all of the supervisors were attentive, expressed their own concerns and took notes on the FCHVs' concerns. Almost all of the supervisors in both the real and role play situations explained logistics, materials and information, and provided information on action, such as where to get medicines and materials. However, the proportion of supervisors updating the FCHVs on new materials and trainings was about 50%. Higher proportions of supervisors in the real situations were found to be updating the FCHVs on new materials and training as compared to the cases observed in role-play.

All the supervisors in the real situations checked the materials and supplies, provided IEC materials or gave time for it or informed them of a place where they could obtain supplies, and supplied family planning methods, medicine, first aids, etc. However, in the role-play situations some supervisors did not check the materials and supplies, did not provide IEC materials and did not supply family planning methods, medicines, first aids, etc.

During the real situations, all the supervisors asked the FCHVs to show their records, but only two supervisors went through the records with FCHVs and supported FCHVs in record-keeping and reporting. Similarly, all the supervisors in the real situations probed FCHV for actions undertaken and probed them about the problems and constraints they encountered.

All the supervisors in both the real and role-play situations assisted FCHVs with their problems, assisted with information and provided correct information. However, one supervisor in the real situation did not probe the FCHV for questions on any topic, and in role-play situations about a quarter of the supervisors did not ensure that FCHVs had understood the information.

Except in one interaction (role-play situation) both the supervisors and FCHVs were comfortable during the interaction. Neither the supervisor nor the FCHV dominated during the interaction. There was some interruption in two interactions (both in real situations), created mainly by children and other family members.

ii) FCHV-clients interaction

All the FCHVs (in both the real situations and role-play) had listened to clients' concerns attentively and in a friendly manner. Similarly, all FCHVs identified clients' problems and provided correct information to the clients. The majority (>95%) of the FCHVs discussed options to deal with the problems and about three-quarters repeated issues back to the clients. However, only about a quarter of the FCHVs greeted their clients when they visited them to obtain information and services.

Over 80% of the FCHVs talked about referral to higher health facilities in both the real interaction and role-play settings. Among those FCHVs who talked about the referral, more than 90% also talked about where the client should go for referral and who the client should see.

All the FCHVs explored clients' feelings, needs and expectations in both the real situations and role-play settings. Similarly, almost all the FCHVs (97.6%) in the real situations and all in the role-play listened to the clients' concerns and used non-verbal communication to encourage clients. About three-quarters of the FCHVs also probed clients whenever necessary in both the real situations and role-play settings.

Only about half of the FCHVs used BCC materials during interactions with their clients. A very small proportion of the FCHVs provided BCC materials to their clients. The above information indicates that use of BCC materials is quite low during the interaction between the FCHVs and their clients.

The majority (over 85%) of the FCHVs in both the real and role-play situations clearly listed the options including choice of no action and referral for more information. Similarly, more than 90% of the FCHVs explained pro's and con's of each choice of treatment and actions to their clients. However, slightly over half of the FCHVs checked to ensure that the clients understood the information they had been given, indicating the need for orienting FCHVs in this aspect as it is a very crucial aspect in the FCHV-Client interaction.

The great majority of the FCHVs provided opportunity to clients to ask questions and probed for questions. In the real interactions nine in every 10 FCHVs asked open-ended questions and aided the clients in their decision, while in the case of role-play situations all the FCHVs did so.

During the interaction sessions more than 85% of the FCHVs in both the real and role-play situations provided materials to the clients such as FP devices, medicines, first aids, etc. However, only about one-third of the FCHVs discussed or scheduled a follow-up visit.

During the interaction session it was observed that both the FCHVs and clients were comfortable and neither group dominated the other. In 9 interaction sessions there was some interruption. Children and other family members interrupted the interaction sessions. Thus there is a need for FCHVs to be aware of the importance of the confidentiality and an uninterrupted session.

iii) Findings on exit interview

Purpose of visit

Nearly half (45.3%) of the clients visited the FCHVs for child health services followed by safe motherhood (21.3%) and family planning (18.7%). Some respondents visited for information and services on reproductive health and general health. The reasons for visiting FCHV, other than that they were the local health workers, were that FCHVs are always available and provide good services.

Opinion regarding the services of FCHVs

Almost all the respondents were satisfied with the overall quality of FCHV's services and behavior. Similarly, more than 95% of the respondents were satisfied with the information and counseling provided by FCHVs. However, a comparatively lower percentage (74.7%) was satisfied with the availability of supplies.

When further asked whether they were satisfied with the services received from the FCHV, almost all (97.7%) of the respondents responded affirmatively. The most frequently cited reasons for satisfaction were good services (78.1%) and availability when needed (72.6%).

All the respondents opined that FCHVs are attentive and friendly, and they listened to their concerns. Nearly 9 in every 10 respondents expressed that FCHVs encouraged them to ask questions. Likewise, almost all the respondents said that they would feel comfortable asking questions related to health and family planning.

Use of BCC materials during interaction

Nearly half of the respondents said that FCHV used BCC materials, mainly posters and pamphlets, during the interaction. All the respondents found these BCC materials useful. Posters were reported as more useful to the majority (82.9%) of the respondents followed by pamphlets (20.0%) and flip charts (11.4%).

Visit to FCHV or FCHV's visit to clients

Almost all (97.3%) of the respondents said that either they visited the FCHV or the FCHV visited them in the last six months (besides the visit on the interview date). Over 45% of the respondents had visited an FCHV in the last month from the date of survey. About one-third had visited in the last 1-3 months and another 22% had visited them 3 months ago or more.

Strengths and weaknesses of the FCHV

The respondents were also asked to mention about the strengths and weaknesses of FCHV. The most frequently cited strengths of the FCHV as perceived by the respondents were that they are able to create awareness on the health issues in the community (88.0%) and they are available in the community (70.7%). A few of the respondents said that they are knowledgeable and available whenever needed.

Regarding the weaknesses of FCHVs, nearly half of the respondents said that FCHVs are not knowledgeable and have no adequate logistics support. About 30% of the respondents said that they could not give adequate time because they had to cover many households in the community. About one-fifth (17.6%) of the respondents noticed that they lacked proper training.

Perceptions on FCHV as a person and as an FCHV

All the respondents were also asked to describe the FCHV as a person and as an FCHV. With regard to the FCHV as a person, about two-fifths of the respondents described the FCHV as a friend or neighbor and another one-third described her as a village sister. About a quarter of the respondents described the FCHV as a friendly and helpful woman in the community.

When asked to describe the FCHV as an FCHV, over 40% of the respondents described her as a person who provides information and services in the community and who is available any time. Over a quarter of the respondents described the FCHV as a cooperative (30.7%) and honest (25.3%) woman. Some of the respondents described the FCHV as a person who creates awareness in the community.

iv) Findings on health facility management committees

Meeting with FCHVs

Altogether 8 chairperson/members of the health facility management committee were included in the study. All the respondents reported that they had known the FCHVs working in their areas. Five out of 8 respondents meet the FCHV every month and 3 meet more than once a month. Mostly they meet the FCHVs either at their homes/village (62.5%) or at the health facility (50.0%).

When asked what types of issues FCHVs frequently raised to the HFMC, the majority of the respondents said that they ask for supplies and medicines (87.5%) and financial support (75.0%).

Knowledge about the roles of FCHVs

All the respondents were aware of at least one role of the FCHVs. The majority (87.5%) of the respondents said that FCHVs provide help on general health issues. About three-quarters of the respondents said that they distribute Vitamin A capsules, and over 60% each said they provide FP information and prepare for delivery.

FCHV in the community

Most of the respondents (87.5%) opined that FCHVs are very popular in their communities and another 13% said that they are *to some extent popular*. When further asked about the good qualities of the FCHV program over three-quarters each said that they are close to the community and provide health-related information and education.

The respondents were also asked about the problems or issues faced by them in the FCHV program. In response to this, the majority of the respondents complained that FCHVs are illiterate (75.0%) and they ask for allowances (75.0%). The other problems or constraints mentioned by the respondents were lack of budget to assist the FCHVs, and lack of time and materials to support them.

When further asked about the types of support the HFMC provide the FCHVs, more than three-fifths of the respondents said they assist FCHVs during Vitamin A Day. Similarly, slightly over one-third (37.5%) of the respondents said that they provide financial support (allowances) and assist during mothers group meetings. About a quarter each also said they provide materials, provide medicines, and arrange training for FCHVs.
All the respondents opined that FCHVs require further training on different aspects such as environment and sanitation, ARI, diarrhea, ANC/safe motherhood and family planning to improve their work performance.

When further asked about the good ways for FCHVs to learn new things, five out of 8 respondents opined that radio is a good way for FCHVs to learn, giving the reasons that it easy to access

(100.0%), convenient for FCHVs (40.0%), FCHVs like radio (40.0%) and it is cost-effective (20.0%).

Availability and use of BCC materials

All the HFMC members said that FCHVs were provided posters and another 63% each said they were provided pamphlets and flipcharts. Only 13% of the respondents said that booklets were provided to the FCHVs. The source of supply of these BCC materials were health post staff (100.0%) followed by DHO (50.0%) and NGO or INGO (12.5%). All the respondents opined that these BCC materials were useful to FCHVs for their work.

Respondents' opinion regarding the types of materials needed for FCHVs was also sought during the study. Nearly 90% of the respondents suggested providing more BCC materials and about half suggested providing necessary medicines.

4.2 Conclusions

1) Overall, the study findings reveal the smooth and friendly interaction between the supervisors and FCHVs. However, some of the aspects such as updating the FCHVs on new materials, checking records maintained by FCHVs and providing support to FCHVs in record keeping and reporting is still low. Therefore, these aspects need to be taken into consideration by the program.

2) The study findings reveal that the use of BCC materials by FCHVs during interactions with clients is quite low. Similarly, a very small proportion of the clients reported that FCHVs used pamphlets or posters during the interactions. Hence, efforts should be made to encourage FCHVs to use BCC materials during interactions.

3) The survey results show that nearly half of the FCHVs did not check to ensure that the clients understood the information they had been given, indicating the need for orienting FCHVs in this aspect as it is a very crucial aspect in the interaction.

4) The exit interview results reveal that more than a quarter of the clients were not satisfied with the availability of supplies. Hence, this aspect needs to be taken into consideration.

5) A higher proportion of the clients said that FCHVs are not knowledgeable and lack adequate logistics support. The HFMC also suggested further training for the FCHVs in order to increase their skills. Therefore, efforts should be made to provide additional or refresher training to FCHV on a regular basis.