Mobilizing Men in Rural Nepal to Support Safer Motherhood and Reproductive Health Services

– Mid Term Evaluation –

EngenderHealth/Nepal Family Health Program
Sanepa, Lalitpur

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
DHO	District Health Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FP	Family Planning
HFMC	Health Facility Management Committee
HIV	Human Immuno Deficienc y Virus
HP	Health Post
IEC	Information Education and Communication
IUD	Intra Uterine Device
MAP	Men As Partners
MCH	Maternal and Child Health
MOH	Ministry of Health
NFHP	Nepal Family Health Program
PE	Peer Educator
PHC	Primary Health Care Center
PNC	Post Natal Care
RH	Reproductive Health
SHP	Sub Health Post
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VDC	Village Development Committee

EXECUTIVE SUMMARY

There has been increased focus on the importance of men' s constructive role in reproductive health (RH) since the last decade. EngenderHealth's Men as Partners (MAP) program has been playing a key role in increasing men's access to family planning and their role in reproductive health. With the success of a MAP program in many countries, especially in Pakistan, a two-year MAP pilot project was initiated in the four Village Development Committees (VDCs) of Nawalparasi district of western Nepal in November 2002. The goal of the Nepal MAP project is to demonstrate the utility and effectiveness of male involvement in improving the reproductive health of both men and women. The project is a joint collaboration between the Ministry of Health, Family Health Division, and USAID supported Nepal Family Health Program (NFHP), of which EngenderHealth is a partner.

The project included several interventions: MAP orientations for health facility staff, Health Facility Management Committee (HFMC) members and Female Community Health Volunteers (FCHVs), and a MAP Peer Educators' training. These preparatory interventions were carried out over a seven-month period (December 2002-May 2003) before the initiation of the Peer Educator outreach activities. Peer Educators who are the volunteers, have been active in their communities since June 2003. Peer educators' roles in the communities are to provide outreach information to men and women in their communities with key reproductive health messages about family planning, STI/HIV, safe motherhood, and men's constructive involvement in RH and to distribute condoms. Peer educators are followed up and monitored every two months by the MAP Program officer.

The objective of this mid-term evaluation was to assess if the MAP project has contributed to improved reproductive health outcomes in the four intervention areas, and to assess the attitude and perception of key stakeholders in the community (i.e., women and men, service providers, health management committee members) toward the MAP project. The evaluation was carried out using both qualitative and quantitative methods, which included analysis of service statistics, interviews with service providers, FCHVs, peer educators and community people, and focus group discussions with HFMC members.

Seven indicators for the mid-term evaluation were identified from the service statistics: number of condoms distributed, number of men accepting vasectomy, number of women accepting pill and Depo-Provera, number of women coming for antenatal check-up (ANC) visits, number of women delivering at health facilities or at home by a skilled attendant, and the number of male STI clients seeking services from the health facility. We collected information on these 7 indicators for the period January to December 2002 to serve as baseline data. Based on the service statistics information and the interviews with key stakeholders, the findings are quite encouraging. An increase has been noted for all the seven indicators between 2002 and 2003 from service statistic records. The most notable increase was in the number of condoms distributed, which increased from 20,620 pieces in 2002 to 56,477 pieces in 2003.

The evaluation also indicated that after the MAP project began, more husbands are accompanying their wives to seek health services. Health facility data indicate that the number of men coming with their wives for (ANC) services has increased significantly in all the VDCs where the program has been implemented. For example, in the first quarter of 2003, 60 men visited a clinic with their wives in Jaganathpur health facility. During the

fourth quarter of the same year, this number increased to more than 150. Increased male participation in ANC services was also reported during the interviews with various groups of respondents

In addition to accompanying wives for ANC services, husbands are providing care and support in other aspects of safe motherhood after the MAP project. Women are encouraged by their husbands to have nutritious food during pregnancy, take rest and have ANC check-ups, and are offering increased support in household activities etc.

Respondents reported that there has been increase in the knowledge of reproductive health issues, including STI/AIDS among the community people. This has brought some changes in their health status and health seeking behavior. Community people feel that the quality of health services has improved at the health facilities-staff are more polite, responsive and encouraging men to visit the clinic with their wives. After the MAP training, health facility staff and FCHVs have realized why men's role in reproductive health is important. They feel that their work is supported by the Peer Educators (MAP project) and feel that the project should be continued, strengthened and expanded.

There are some improvements to be made in the project as well. There is need for more collaborative work between the FCHVs and the male peer educators since they are serving the same communities. Although services in many reproductive health issues have increased after the MAP project, men and women are not seeking STIs services at local health facilities.

Based on this mid-term evaluation findings the following recommendations have been developed:

- Strengthen the linkages between Peer Educators and FCHVs,
- Conduct orientation and refresher trainings to Peer Educators and health facility staff on STI prevention, and emphasize the use of condoms for dual protection,
- Conduct interpersonal communication training for the peer educators,
- Strengthen couple counseling during ANC check ups, in order to address issues such as increasing women’s awareness in about danger signs during pregnancy and child birth, and precautions to be taken,
- Expand the program in other areas in a cost-effective way, and
- Continue monitoring the project.

1.0 BACKGROUND

Over the past decade there has been an increased focus on the importance of men's constructive involvement in reproductive health (RH). EngenderHealth's Men As Partners (MAP) Program has played a key leadership role in this international movement. To date, EngenderHealth has supported male involvement work in over 20 countries worldwide. In 2001, EngenderHealth completed a successful project in Pakistan (funded by the Nippon Foundation of Japan). The project was important because it demonstrated significant increases in men's access to family planning and reproductive health services in the communities where the MAP project was implemented. The Nepal project was designed using some of the lessons learned from the Pakistan MAP project.

The Nepal MAP project is currently piloting a strategy in four communities, namely, Kolhua, Narayani, Jamuniya and Somani Village Development Committees (VDCs)[1] in the Nawalparasi district of western Nepal. This project is the first pilot intervention of its kind in Nepal. It is designed to demonstrate the positive impact of male involvement in reproductive health (RH) and offer an effective and cost efficient mode for male involvement programming that can be replicated throughout the country. This project is a joint partnership between the Ministry of Health, Family Health Division (FHD), and the Nepal Family Health Program[2], of which EngenderHealth is a partner.

The goal of the Nepal Men As Partners Project is to demonstrate the utility and effectiveness of male involvement programming strategies as a means to improve the reproductive health status of men and women. The specific program objectives are:

1. To improve the quality of men's reproductive health services offered at the primary health care center, health post, and sub-health post of four VDCs within one district,

2. To provide men's reproductive health information and promote men's reproductive health services in four VDCs within one district,

3. To improve RH outcomes for both men and women, and

4. To evaluate the effectiveness of the program interventions in meeting program objectives.

The evaluation component of the project is very important. In Nepal there has been a small number of 'men as partners' projects however few have been well evaluated.[3] Project activities began in November 2002 with the preparatory activities, discussed below. The Peer Educators were trained in May 2003. Funding for project activities continues through December 2004.

[1] VDCs are government administrative areas in districts. Each VDC is further divided into 9 wards. Each VDC has a government health facility (either a sub health post, a health post or a primary health center).
[2] The Nepal Family Health Program (NFHP) is a 5-year program funded by USAID/Nepal.
[3] EngenderHealth. Men as Partners in Reproductive Health in Nepal. 2003, Kathmandu, Nepal.

2.0 PROGRAM DESIGN

This project includes several interventions designed to strengthen male participation in reproductive health. Several key activities were conducted prior to the initiation of the peer educator outreach activities over a 7-month period (November 2002 through May 2003).

2.1 Community Selection

In consultation with the MOH, FHD, Nawalparasi district was selected for the pilot project. This district is in the western region of the country, consisting of 73 VDCs and one municipality. Four VDCs and their associated health facilities were selected as per the decision made in an initial meeting with the District Health Office (DHO) staff. The following criteria were used for selection of VDCs: located in rural area; technical assistance interventions are needed to improve services; and they were easily accessible for close monitoring of program. Following selection of the sites, the four health facilities were visited to brief the staff about the project and ask about their interest in participating in the project. Staff at all four health facilities expressed enthusiasm about the project. See Table 1 for information about the four selected VDCs

Table 1: Estimated Target Population of Pilot MAP Sites[4]:

Name of VDCs	Total Population	Married women of 15-49 yrs (MWRA)	Annual number of expected pregnancies	Type of Health Facility available
Jamuniya	12,607	2,462	537	PHC
Kolhua	8,993	1,756	383	HP
Narayani	10,340	2,019	440	SHP
Somani	9,363	1,828	399	SHP

PHC - Primary Health Care Center; HP - Health Post; SHP - Sub-Health Post

2.2 Development of a MAP Training Curriculum and Reference Manual

Using the EngenderHealth MAP curriculum *(Introduction to Men's Reproductive Health Curriculum)* we adapted this manual for the Nepali context. This new Nepali version of the MAP curriculum was used for training service providers and Peer Educators. During the training, health facilities staff wanted more information about men's roles in reproductive health. Based on this request and felt need, a Nepali language reference manual entitled *Role of Men in Reproductive Health* was also developed

2.3 Workshop for Health Facility Staff

Two three-day workshop program in January 2003 for 26 staff from the 4 participating health facilities. The purpose of the workshop was to develop their skills for providing male friendly services. On the last day of workshop,

[4] Data from the MOH/HMIS system.

the service providers developed action plans for how to improve their facilities to better serve the men and women in their community. Action items included: ensuring the clinic was clean and welcoming, providing IEC materials in the waiting area, putting furniture in the waiting area, inviting men to accompany their wives for ANC visits and counseling, placing a box with condoms in the reception room and increasing awareness about role of men in RH.

2.4 Orientation for Health Facility Management Committee (HFMC) Members

Each health facility has a management committee, composed of 10-14 members. We conducted four one-day orientation sessions for these committees in order to orient them to the MAP project and gain their support for the project so they would develop a sense of ownership for the project. The HFMC members made a commitment to the program and agreed to advocate about the importance of male involvement in their communities.

2.5 Orientation for Female Community Health Volunteers (FCHVs)

In February and March 2003, a one-day orientation was conducted for 36 FCHVs and 12 traditional birth attendants (TBAs) assigned to the four health facilities in the MAP pilot VDCs. Several of the FCHVs and TBAs thought the male peer educator program was a good approach to reaching men as they often feel some hesitation in speaking to men about reproductive health issues. As one FCHV said during the orientation:

"In the past, we Female Community Health Volunteers were only providing health education on RH issues to community men and women. Some men would listen to us, but some men were very stubborn. We found that these men listen to male Peer Educators. Female are also satisfied because male are supporting for them in RH issues. So we are hoping that there will be improvement in RH status of both men and women of this community. "

FCHV of Narayani VDC with a MAP bag

2.6 Selection and Training of Peer Educators

Why Peer Educators? Nepal has a history of using community volunteers for health related activities, most notably the Female Community Health Volunteer (FCHV) program. Because of this history, in consultation with the MOH partners, we chose a strategy of using men from the community as Peer Educators who were ready to work on volunteer basis. In addition, studies have also shown that the peer education approach is an effective way for sharing RH information with difficult to reach populations (e.g., youth).[5]

The Peer Educators are expected to inform their peers about reproductive health including family planning, safe motherhood, STI/AIDS, and role of men in improving the reproductive health status of the community people. These changes were to be brought by various activities such as formal and informal group discussions, home visits, and distribution of IEC

[5] AIDSCAP Project,… , "How to Create an Effective Peer Education Project"

materials. They also distribute condoms and refer community members to the health facilities for family planning and other reproductive health services.

Selection of Peer Educators

A total of 200 men, 50 from each VDC, were selected by community members to serve as Peer Educators. Criteria for the selection of Peer Educators included:

- Interested to work as a volunteer
- Preferably married
- Teachers[6]
- Interested in the goals of the MAP program
- Respected and trusted by friends;
- Some education;
- Preferably using a family planning method;
- Interest in helping others;
- Good communication skills; and
- Likelihood of not migrating from the community in the next year.

There has been some attrition since the project began, a few men have moved away from their communities. Peer educators are on average 34 years of age (they range in age from 18 to 66 years; see Table 2.) The majority of the Peer Educators are married.

Table 2: Number of Peer Educators and Average Age, by VDC

	Total	Somani	Jamuniya	Kolhua	Narayani
Number of Peer Educators	194	50	47	50	47
Average Age (yrs.)	34.1	30.5	33.4	38.8	33.3
Age Range (yrs.)	18-66	20-55	22-48	18-66	20-50

Training

Between April and May 2003, 16 basic training sessions for the Peer Educators (12-14 trainees per session) were conducted; each event was held over a three -day period. The focus of the training was on increasing their knowledge about and skills for communicating about family planning (FP), safe motherhood, STI and HIV/AIDS prevention and treatment, promotion of male responsible behaviors and safe sexual behaviors such as abstinence, one sexual partner, use of condoms. Pre and post test scores showed significant increase in knowledge following the training.

Peer Educators with bag, cap, t-shirt

Peer Educators were given bags, caps and t-shirts, which identify them as community educators; they were also given a supply of condoms and IEC materials (flip chart, pamphlets about family planning and STIs). In addition they were taught how to keep a record of their activities in a standard logbook.

[6] 10% of the peer educators selected from each VDC are teachers (n=5 per each VDC).

2.7 Monitoring and Supervision

A MAP program officer conducts follow up meetings with the Peer Educators bi-monthly. These follow up meetings provide an opportunity to provide refresher training on particular topics, answer questions, and provide general support to the men and develop work plan for upcoming activities. The MAP program officer also conducts bi- monthly follow up visits with the health facility staff. The purpose of these meetings is to review progress, action plan, question and answer issues and develop action plan for future.

At the start of the project, we identified 7 indicators that would be monitor during the two-year project. These indicators were chosen because they are part of the current reporting system in the health facilities. These indicators are collected from the four health facilities bi-monthly. Data was collected data for each of these indicators for the year preceding the program interventions in order to document changes in service utilization. The seven indicators are:

1. Number of condoms distributed by the health facility,
2. Number of men accepting vasectomy in the VDC,
3. Number of new pill acceptors at VDC health facilities,
4. Number of new Depo-Provera users at VDC health facilities,
5. Number of women completing 4 ANC visits,
6. Number of women delivering at the health facility or with at home by a skilled birth attendant,
7. Number of male STI clients seeking services at the health facility.

2.8 Other Activities in Support of the MAP Project

In addition to above-mentioned activities, a street drama was conducted with a focus on male responsibility. A total of 8 shows were organized in four VDCs in May 2003, drawing nearly 7,000 persons.

Snapshot of artists & spectators of street theatre "Daitwa"

3.0 PURPOSE AND METHOD FOR EVALUATION

3.1 Purpose

The aim of this mid term evaluation is to assess the results on reproductive health services provided by four health facilities of project areas (mainly the seven key indicators) and attitude and practices of community people on the role of men in reproductive health services. In addition suggestions from key stakeholders on how to improve the MAP project activities was also collected.

The specific objectives of the evaluation were:

1. To identify changes in reproductive health outcomes at the health facilities in the four intervention areas since the MAP project began,

2. To examine service providers' attitudes and practices about providing services in their health facilities,

3. To obtain feedback from the Peer Educators about their work,

4. To assess the views of male and female clients, community male and female residents, and HFMC members about MAP project activities, and

5. To obtain suggestions from the service providers, Peer Educators, community members and HFMC members on how the MAP project could be improved.

3.2 Methodology

This mid term evaluation of the MAP project includes a range of data collection activities in order to obtain a cross section review of the activities to date. This assessment combines both qualitative and quantitative data. Service statistics for 7 key indicators, mentioned above, as well as other service statistics were collected from each of the 4 health facilities in the pilot district. In-depth interviews and focus group discussions with a range of stakeholders was also conducted.

A team of EngenderHealth staff from Nepal, New York and Bangkok office developed the questionnaires and discussion guides. In order to gather information at the field level four persons (two males and two females) with experience in conducting qualitative evaluation research were recruited. In January 2004, the interviewers participated in a three-day training program designed to orient them to the MAP project, objectives of the evaluation, in-depth interview questionnaires and focus group guides. Role-plays were used during the training to clarify issues of terminology and to clarify how to make the questions simple and comprehensible for the respondents.

3.3 Types of Respondents

Respondents for this evaluation included:

- **Peer Educators:** Ten Peer Educators from each of the project VDCs were selected using systematic random sampling methods.
- **Clients:** It was determined that the ANC service day at each site was the ideal time to collect information from clients at the health facilities since these days are the busiest days in the clinics and researchers would therefore be able to interview sufficient number of clients in a short period of time. Trained interviewers conducted in-depth, exit interviews with clients who received reproductive health related services on the day of interview or within past six months. Interviewers visited the health facilities over a three-day period to interview clients about the type of services they received in the health facility; all clients who received RH related services were interviewed. The desired sample size was not fixed; that is it was decided to interview the maximum number of clients as possible during the 3-day visit. Both male and female interviewers conducted these interviews.

- **Community men and women respondents:** Married men between the ages of 15 to 59 years and married women, aged 15 to 49 were selected for interviews (respondents were not married to each other). One community in each VDC was selected for these interviews. The selection of these villages was done in the following manner: Standing in front of the health facility a pencil was spun on the ground; we walked in the direction of the pointed pencil to the next nearest village that had at least 20 houses (it was not intended to interview respondents residing in the same village as the health facility). Once the interviewers arrived in the village, they used the same method (spinning pencil) to identify households: the interviewers went into the center of each village and rotated a pencil or pen. The male interviewer went in the direction of the pointed pencil and the female interviewer went in the opposite direction. Interviewers went to the first 10 houses to select a respondent. If the first 10 houses did not have a man or woman within the desired age group, they proceeded to the next cluster of houses until the desired sample was reached. Male and female interviewers conducted interviews with members of the same sex to make respondents feel more comfortable talking about RH issues. Respondents were selected in the following manner:

- **Female Community Health Volunteers (FCHVs):** FCHVs were randomly selected using the list of Peer Educators, organized by VDC.

- **Service Providers:** All cadres of service providers working in the four health facilities were interviewed.

- **Health Facility Management Committee (HFMC):** One focus group discussion with each VDC's health management committee was conducted.

Focus group discussions were tape-recorded and transcriptions of the discussion were prepared in Nepali and then translated into English. Open- ended responses from the in-depth interviews were transcribed and then translated into English for analysis. Data collection was carried out between January 18 to February 3, 2004 and analysis in February 2004. See Table 3 for a summary of data collection methods by stakeholder group, and number of respondents per VDC.

Table 3: Data Sources and Sample Size

Data Source	Methodology	Sample Size per VDC				
		Total	Somani	Jamuniya	Kolhua	Narayani
Peer Educators	In-depth interviews	40	10	10	10	10
Clients at health facility	Structured & open-ended questionnaire	95	20	31	27	17
Community men	In-depth interview	40	10	10	10	10
Community women	In-depth interview	40	10	10	10	10
FCHVs	In-depth interview	21	6	5	5	5
Health facility staff	In-depth interviews	19	3	8	6	2
Health Committees	Focus groups	4	1	1	1	1

4.0 STUDY FINDINGS

4.1 Services at Health Facilities

As mentioned above, data was collected from the four participating health facilities on 7 indicators. As shown in Table 4, overall there are increases for each of the 7 indicators from 2002 to 2003. For example, the distribution of condoms increased from 20,620 in 2002 to 56,477 in 2003 (an increase by 174%) and number of women completing four antenatal visits increased from 342 to 519 during the same period.

Table 4: Monitoring and Evaluation Indicators

Indicators	2002	2003	% Increase
Number of condoms distributed	20,620	56,477	174
Number of men accepting vasectomy	4	14	250
Number of new pill acceptors	21	50	138
Number of new Depo-Provera users	170	185	9
Number of women completing 4 ANC visits	342	519	52
Number women delivering at the health facility or with at home by a skilled birth attendant	149	178	19
Number of male STI clients seeking services at the health facility	8	31	288

In addition to these 7 key indicators, service facilities began keeping records of the number of men coming for services with their wives. Table 5 shows the number of men coming with their partners for family planning and ANC services. Service statistics indicate that there has been increase in the number of men coming to the health facilities with their spouses for ANC services during one-year period. The most notable increase has been in the Nawalpur and Jaganathpur health facilities (Figure 1). For example, during the first quarter of 2003, 66 women visited the Jaganathpur health facility with their husbands; during the last quarters of the year, this increased to approximately 159. Numbers of husbands coming with their wives for ANC care is higher in both Jaganathpur and Nawalpur compared to the other two sites, as these are larger health facilities having more range of services than in SHP (a primary health center and a health post, respectively).

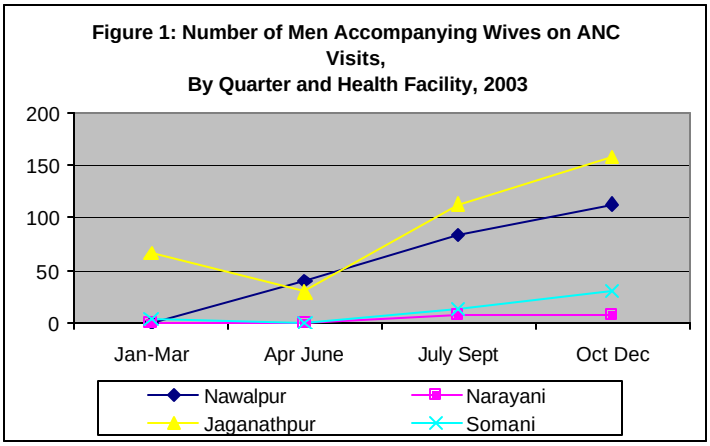


Table 5: Number of Couples Coming for RH Services by Health Facility, January – December 2003

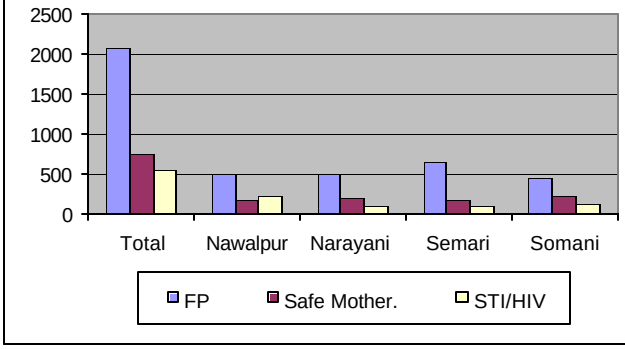
	Total	Somani SHP	Jaganathpur PHC	Nawalpur HP	Narayani SHP
Number of Couples coming for FP services	29	15	0	10	4
Number of Husbands coming with Wife for ANC	667	47	368	236	16

Note: The catchment areas of Jaganathpur PHC and Nawalpur HP are Jamuniya and Kolhua VDCs, respectively.

4.2 Peer Educators' Activities

The Peer Educators' activities began after their training ended in May 2003. Peer Educators keep a logbook to record their activities, including all home visits and topics discussed. After their training, as shown below in Figure 2 the Peer Educators reported that between June and November 2003, they have reached more than 2,000 persons with family planning information, over 500 persons were reached with safe motherhood and STI/HIV issues.

Figure 2: Number of Persons Informed about Specific Health Topics by VDC, June- November 2003



Profile of Peer Educators

Peer Educators who were interviewed were on average 36 years of age, have some secondary education and are for the most part working as farmers; most are married.[7] Peer Educators interviewed from the Kolhua VDC are significantly older than their peers from other three VDCs (mean age is 42 years) and those from Jamuniya VDC are younger (mean age 33 years). Almost all Peer Educators had formal schooling, with about two-thirds secondary level of education. Agriculture was the occupation for 3 out of 5 Peer Educators (Table 6).

Table 6: Characteristics of Peer Educators

Age (in years)	6	15.0
20-24	6	15.0
25-29	8	20.0
30-34	4	10.0
40+	16	40.0
Mean age	36	
Education		
Illiterate	2	5.0
Some Primary	5	12.5
Some Secondary	26	65.0
Post Secondary	7	17.5
Occupation		
Agriculture	24	60.0
Service job	10	25.0
Other	6	15.0
Total	**40**	**100.0**

[7] 90% of all peer educators are married.

Views on MAP Training Received

Peer Educators gave a variety of reasons about why they decided to take on this role (in order of frequency mentioned):

Energetic MAP Peer Educators of Narayani VDC, Nawalparasi with white T-shirts and bags provided by MAP program

- To learn and teach about FP/RH in order to increase public awareness about their importance;
- Interest in working with the community;
- To learn about STI and teach others about safe sexual behavior;
- To help reduce negative rumors about RH;
- Feeling that they could influence men about RH issues more easily than a female community health volunteer; and
- To inform community about the equal treatment of sons and daughters.

Respondents gave many examples of how they helped their communities working as a peer educator: they said that because they have gained new knowledge about RH issues, this has provided them with the opportunity to inform and serve their communities about these issues and they are less shy talking about RH; in addition, a few Peer Educators mentioned that they have now become recognized community leaders, they have more knowledge about HIV/AIDS, STI and the importance of using condoms; they have started using FP and are informing other men to use FP; and they have increased their knowledge about safe motherhood issues.

When asked about challenges they faced working as Peer Educators in their community, about one fifth of the Peer Educators said they did not face any challenges. The remaining indicated that the biggest challenge they face is talking to women about RH issues followed by convincing community men to use condoms (according to the peer educators, men don't like to use condoms). Other challenges they face include: lacking effective interpersonal communication skills to be able to speak with conservative community members who are opposed to FP. Four PEs (2 from Jamuniya and 2 from Somani) mentioned they need more support in their work from the health facilities.

Respondents were asked what advice they would give other Peer Educators about overcoming challenges. The most commonly mentioned suggestions was were to provide information in group meetings more often, maintain your patience if community members don't listen, don't feel shy when talking about RH, keep a supply of condoms with you and educate men how to properly store and use them, utilize posters to announce community gatherings and use street theater and songs for health education events.

As mentioned above, we conducted pre and post-test assessments of the Peer Educator's knowledge and attitudes about reproductive health issues during the 3-day training course. In this mid term evaluation the Peer Educators were asked what aspects of the training they found useful now that they had worked as Peer Educators for more than 6 months. All respondents said the training was very useful or useful. The *most useful* aspect of the training was learning about the advantages and disadvantages of family planning methods, followed

by prevention of STI, HIV/AIDS, importance of maternity care and the important role men can play in maternity care (and other RH issues). Two men mentioned the importance of gender equity especially in relationship to how one treats their sons and daughters. The *most important* thing the respondents said they learned in the training was the importance of prevention for reducing STI and HIV/AIDS infections, followed by family planning, male involvement in FP and maternity care, maternity care, RH care for both men and women, and male RH care. One respondent mentioned the importance of adolescent RH issues. When asked what they want to learn more about in the future, the most frequently cited response was the need for more information about transmission and prevention of STIs, HIV/AIDS (mentioned by about a one third of the respondents), followed by maternal and child health care information, family planning, women's reproductive health, child immunization and other general health issues (e.g., abortion, first aid).

Community Activities and Community Reactions

The five most important activities these PEs have carried out in their communities include:

1. Distribution of condoms and education about how to use them (mentioned by all respondents);
2. Education about maternity care to men and women;
3. Education about family planning methods and importance of birth spacing to community men and women;
4. Conducting group meetings for men and women about reproductive health, including use of street drama and song contests;
5. Education about STI, HIV/AIDS to community people

A few PEs mentioned they had provided information about RH to youth, and helped a few people get access to sterilization services.

MAP PE in an enter-edutainment activity

Peer Educators were asked about the topics they discussed during their outreach activities. All the Peer Educators reported they spoke about family planning, mother's health, STI/HIV prevention and control, and male RH. About half said they have talked about child health, and less than half reported discussing specifically about gonorrhea.

Based on the activities the Peer Educators have carried out, they report they have seen changes in RH of men and women in their communities. Specifically, they report the biggest change has been more positive involvement of men in RH and MCH issues (e.g., better communication between husband and wife, more men going to ANC care with wives, mentioned by 9 out of 10 respondents), followed by increased use of FP among both men and women, an increase in the number of women seeking ANC, less hesitation and shyness talking about sex and RH issues, more awareness about importance of birth spacing, more women going to the health facility for delivery, and an improvement in women's health due to better nutrition. A few respondents mentioned other noticeable changes such as increase in

child immunization. A few Peer Educators also noted that some daughters and sons are being treated more equitably, increased communication between men and women, and decreased belief in traditional healers.

Peer Educators were asked what kind of reaction they have received from the people in their communities about their activities. The overall reaction has been positive – people appreciate the information that has been shared and good advice; they have learned a lot about RH issues. Other reactions have included:

- Good to have condoms distributed;
- Youths are less shy and are asking for information and condoms;
- Women are positive about the idea of their husbands accompanying them to ANC visits; and
- Peer Educators are recognized as doing good work (social service) and as leaders in community.

All but one Peer Educator said they have been to their local health facility in the last year in specific regard to the MAP project. The primary purpose of their visits were to get a new supply of condoms, to attend meetings about outreach activities, to bring women from their communities for ANC care or FP services and/or to take their wife or child for care, to ask providers for more information about STI services. The reporting of PEs with regard to the visit to the health facility during last year is consistent with reporting of service providers. Most of the service providers during interview also reported that PEs have visited the health facilities with regard to the above-mentioned services (see section 4.6 for details).

Recommendations from Peer Educators

When asked to the Peer Educators how this project could help men in the community become more interested in reproductive health issues and to suggest specific activities to engage men. Their recommendations include:

- Conducting street drama once a month (mentioned by half of the respondents);
- Conducting more community information giving activities for both men and women (e.g. use market days to distribute condoms and hold community meetings; use sporting events to conduct sessions); conducting these activities more frequently, including door to door visit once a month;
- Make more temporary methods of FP available; provide more information about ease of vasectomy compared to female sterilization.

One respondent suggested using educated and respected men from the community to help inform about men's role in RH. Other suggestions for strengthening the program include: conducting refresher training at frequent intervals; providing more supervision support to Peer Educators; and including more interaction/exchanges with other Peer Educators.

4.3 Client Interviews

Profile of Clients

Clients attending the health facility were interviewed during over a period of three days immediately following their appointments. Three men were interviewed; the remaining

respondents were women (Table 7). Although more men were expected to be interviewed during the study design, however the reality is that few men seek RH services at these facilities. Two of the male clients and 95% of the female clients were married (4 women from the Narayani SHP were unmarried).

Table 7: Number of Male and Female Client Respondents by Health Facility

Sex	Somani SHP		Jaganathpur PHC		Nawalpur HP		Narayani SHP		Total	
	N	%	N	%	N	%	N	%	N	%
Male	0	0.0	1	3.2	1	3.7	1	5.9	3	3.2
Female	20	100.0	30	96.8	26	96.3	16	94.1	92	96.8
Total	**20**	**100.0**	**31**	**100.0**	**27**	**100.0**	**17**	**100.0**	**95**	**100.0**

Table 8 presents characteristics of female clients only. Their age distribution indicates that they were quite young; seven in ten clients were between the age group 15 to 19 years, with overall mean age being 23 years. About 45% were illiterate, and 95% were married.

Table 8: Characteristics of Female Clients

	N	%
Age (in years)		
15-19	65	70.7
20-24	17	18.5
25-29	7	7.6
30-34	3	3.3
Mean age	23	
Education		
Illiterate	42	44.6
Literate	2	2.2
Some primary	19	20.7
Some secondary or above	30	32.6
Marital Status		
Married	87	94.6
Unmarried	5	5.4
Total	**92**	**100.0**

More than half of the female clients said the primary reason for their visit was for ANC while about a quarter had visited to immunize their children. More than one in ten female clients visited the health facility for family planning services. Table 9 provides list of reasons for clients' visit to the health facility.

Table 9: Purpose of Visit to the Health Facility, Female Clients only

Services	N	%
Antenatal care	52	56.5
Immunization	24	26.1
Family Planning	11	11.9
Child Health	3	3.3
STI management	3	3.3
Other RH (antenatal, infertility)	2	2.2
Other non RH services	16	17.4

Multiple responses allowed, therefore percentages exceed 100.

Clients are aware of a range of reproductive health services that are available at the health facilities and all have visited the clinic in the last 6 months (with or without their spouse) prior to the interview. All clients mentioned ANC was available. Other services mentioned by clients, in order of frequency included: immunizations, child health, family planning, delivery services, postnatal check ups, reproductive heath check ups, STI management, postabortion check up and infertility check up. Clients know about these services through a variety of

Table 10: Source of Knowledge about Services, All Clients

Source	N=95 %
Friends	81.1
Family Members	69.5
FCHVs	68.4
Service Providers	30.5
Peer Educators	23.2
Radio	22.1
Community Members	4.2
Newspapers	1.1
Other	17.9

Multiple responses allowed; percentages exceed 100.

sources: friends, family members, FCHVs, service providers, peer educators, radio, and other sources; see table 10.

Views Toward the Services

Respondents reported having visited the clinic on average three times during the last six months (clients at the Narayani sub health post visited on average nearly four times in the last six months). Only two female clients (from Jaganathpur) said they were not happy with the service they received on the day of the interview. Clients who were not happy said it was because they have to return since they were not able to get the care they needed and the provider was rude. Clients said they were satisfied with the services they received because providers:

- Gave advice about next follow up visit, medicines to take,
- Listened, diagnosed and treated client's problems using clinical tools (e.g., stethoscope, BP instrument);
- Advised to eat nutritious foods for better health;
- Gave immunization to child, informed about other immunizations needed and did not scold me or the child when she cried;
- Distributed iron tablets free of charge;
- Were friendly and cooperative;
- Gave good counseling before giving family planning method;
- Gave tetanus toxoid (TT) shots free of charge.

A few other clients said they received the services quickly and were satisfied because the provider asked her husband to come into the exam room (spontaneously mentioned by at least one client at each health facility with the exception of Nawalpur HP).

Thirteen of the female clients (14%) were at the clinic on the day of the interview with their spouse; another 13 reported they had been to the clinic at least once in the last 6 months with their husband. One male client was at the facility with his wife for family planning. Overall, nearly three in ten clients had visited the health facility with their spouse during the past six months. Two men were there alone for child immunization services.

When asked female clients who were there with their spouse on the day of the interview or had been to the clinic in the last six months with their spouse why they brought their husbands along on these visits. Respondents said they came with their spouses because it would be easier to make a decision about care based on the providers' suggestions with her husband present; having spouse present makes it easier to discuss issues/feels more confidence with husband present; because the service providers recommended she bring her husband; easier to go together on bicycle; and mother in law recommended the couple go together. A few clients mentioned they need their husbands along since they do not speak the same Nepali language as the providers (mentioned by at least one respondent from each clinic except, Narayani SHP).

How did the service providers treat clients who came with spouses? Half of the respondents said the men had to wait outside the exam room; one third said their husband was allowed to be present during the exam. Other comments about how the men were treated included: providers talked to husbands about giving his wife nutritious foods, vitamins, iron tablets; and provided overall good suggestions about her care.

Those clients who had never been to the clinic with their spouse (N=56) were asked if they would consider coming with their partner sometime in the future. The majority of female clients (82%) responded yes (one man who had never been with his wife also replied yes). Clients said they would come with their partners because their partners would be able to understand the providers' suggestions about her health care needs and her condition; husband would be able to purchase the required medicines; she would feel more comfortable and confident with her husband.

The majority of all clients (70%) reported they had noted changes in the health facility in how clients are treated. These changes include:

- Providers started suggesting that women should bring their husbands for the ANC visits; husbands being advised to provide nutritious food for wives;
- Privacy is better-curtains have been up in exam area;
- Waiting area has furniture;
- Facility is cleaner; and
- Better care (as noted by use of stethoscope and blood pressure machines), providers ask questions.

Clients made a few suggestions for improving services: provide medicines free of charge, provide referrals to other health facilities in timely manner; provide services 24 hours per day for essential/emergency services; provide information about the correct use of medicines; provide wider range of medicines; better behavior by providers—"*Questions asked by patient should be understood properly and answered without getting angry"*.

4.4 Interviews with Community Men and Women

Profile of Community Men and Women

A total of 40 men and 40 women in the community were interviewed. Men ranged in age from 19 to 58 years, and were on average 30 years of age (there were some differences in age between the VDCs: men in Jamuniya were on average 34 years of age, while those from Somani and Narayani were 28 and 27 years, respectively. Men in Kolhua were on average 32.5 years of age. Half work as farmers, one quarter are employed in service job and the reminder have their own small business

Women interviewed ranged in ages between 17 and 37 years, and were on average 25 years old (women living in Narayani VDC were on average younger: 22 years). Just over half of all women have some secondary education; all of the women respondents in Somani VDC had no schooling—8 out of 10 were illiterate; the remaining were literate. All were mothers, with majority having a 12 to 24 months' youngest child (Table 11). Three quarters of the women report they do not work outside the home (data not presented).

Table 11: Profile of Male and Female Respondents from the Community

Characteristics	Men		Women	
	N	%	N	%
Mean Age (years)	30.5		25	
Education				
Illiterate	4	10.0	8	20.0
Literate	3	7.5	4	10.0
Some primary	11	27.5	5	12.5
Some secondary or above	22	55.0	23	57.5
Age of youngest child (months)				
< 12	13	32.5	11	27.5
12 – 24	15	37.5	17	42.5
25-36	12	30.0	3	7.5
36 +	0	0.0	9	22.5
Mean age	40	25	40	28
Total	**40**	**100.0**	**40**	**100.0**

Opinions about Male Support in Reproductive Health

Both men and women were asked nine specific questions about whether husbands helped their wives with health care issues related to family planning, antenatal care, post natal care, child health, and general health issues. See Table 12 for results for men and women. As shown in this table, men were more likely to report positive behaviors for each question compared to what women reported. Differences were noted among respondents from the 4 VDCs: both men and women in Kolhua reported more positive male behaviors compared to respondents from the other VDCs: all men responded affirmatively to all of the 9 questions and 80-90% of women responded positively to 7 of the 9 questions. It is likely that since the questions are related to the support provided by husbands to their wives on reproductive health issues, husbands could be over reporting in order to indicate themselves as caregivers to their wives. Instead wives' reporting could be more reliable since they are the direct recipients of the care from their husbands.

Table 12: Percentage of Men and Women who Responded Positively about Male Behavior and Support

Questions	Men		Women	
	N	%	N	%
Discuss number of children to have	38	95.0	34	85.0
Husband suggested wife get checkup when not well	38	95.0	35	87.5
Discuss whether to use FP	37	92.5	32	80.0
Husband suggested ANC	37	92.5	34	85.0
Husband helped with wife's work during pregnancy*	37	92.5	25	62.5
Husband supported wife with household work in postpartum period*	37	92.5	27	67.5
Husband helped taking children for immunization*	36	90.0	19	47.5
Husband discussed possible problems and solutions about delivery*	34	85.0	21	52.5
Husband accompanied wife for ANC visit*	33	82.5	20	50.0

* Difference between male and female responses is significant at 5 % level.

All female respondents were further asked if there are other ways men could help their wives. Eight out of ten respondents said men could ensure women have nutritious food and take vitamins and help her with hard work around the home. Other responses from the men include: providing more support with child care, thinking more about her health, and taking her for health care. Women reported similar positive behaviors: over half said their husbands provide vitamins and nutritious foods and help with the housework. Almost half of the women also reported their husbands help with childcare. Other ways men could help include: supports her use of family planning and take care of her when she is sick and/or during and after pregnancy.

Women were also asked if there was anything else they wished their husbands were doing to support them. They want men to take care of them when they are sick (e.g., buy medicine, take to health facility, buy nutritious food), men could use a family planning method (temporary or permanent methods), help with child care, provide more help with household chores (e.g., cooking) and be more loving and caring. Four women from Kolhua said men should not be involved in sexual activities outside the home (one specifically said if he does engage in sexual activities then he should use protection.)

All respondents were asked if they had noticed any changes in men's interest in their families in the last year. Nine out of 10 men noted changes—three quarters of male respondents said husbands are more interested in ANC and both husband and wife are going to health facility for ANC checkups; half mentioned that men are more interested in child health (e.g., immunizations), more men are helping with work at the house, use of family planning, including vasectomy has increased, men are more interested in nutritious foods and vitamins

for their wives, more interest in safe motherhood, men are giving wives time to rest, and increased awareness and knowledge about birth spacing.

About 8 of 10 women responded they had noted changes in the husbands in their community—half said they have noticed men are more supportive of family planning (either the wife's use or men's use), followed by more supportive during pregnancy (pre and post natal periods) and in general are more supportive of wife's health. Men and women gave specific recommendations about other ways that men can help to improve the health of women in their communities—the number one response from men was that men can provide more nutritious foods and vitamins and help reduce women's work load by giving her time to rest. The most frequently mentioned response among the women we interviewed was men could be more supportive of family planning, including men's use of a method.

Men made several other suggestions: men should take their wives to the health clinic for ANC and other RH services; help women with house work when they are pregnant; and men can use family planning and increase their interest in family planning. A few mentioned that men should reduce the amount of quarreling with their spouse.

Women respondents' other suggestions included:

- Men can provide support during pregnancy (e.g., take wife to health facility for care, encourage eating nutritious food, help with hard work in the home);
- Pay attention/support her during illness (e.g., buy her medicines, provide nutritious foods);
- Help with household work;
- Less gambling and drinking;
- Less extramarital sex;

Three women mentioned there should be more understanding about gender equity regarding children (e.g., don't focus only on sons); and two women mentioned there should be less violence against women.

Awareness of Peer Educators and Opinions about their Activities

All but one of the men interviewed said they knew who the Peer Educators in their community are while only 60% (24 out of 40 respondents) of the women said they knew who the Peer Educator was (women from Kolhua and Narayani were less likely to say they recognized these men). Of the total 80 respondents half of them said the Peer Educator had visited their home in the last 6 months to discuss health issues. Both men and women reported that the Peer Educator talked about family planning, pregnancy care (pre and post natal), child health and other general health issues. One male respondent mentioned male involvement in RH.

Among the men and women who reported they had had interactions with the Peer Educators, most said they were doing a good job; a few men and women had no opinion. Only one male respondent (from Somani) said he did not like his work—he said the Peer Educator was not providing the RH information he should be doing. Men said the work of the of Peer Educators was good because they were:

- Distributing condoms and teaching men how to use them,

- Teaching about the benefits of family planning,
- Providing information about pregnancy care,
- Providing information about RH (including the use of traditional songs and street drama to deliver messages),
- Creating awareness about health and nutrition,
- Providing information about child immunization.

The above responses from the community men indicate that Peer Educators were fully fulfilling their tasks they were supposed to perform.

Women gave similar responses about why they like the Peer Educators' work. Peer educators:

- Teach about family planning and distribute condoms;
- Discuss maternal and child health issues;
- Discuss STIs and sexuality issues;
- Provide information about RH.

The male and female respondents gave several examples of the type of activities the Peer Educators are carrying out: distributing condoms and teaching men how to use them; using street theater and song competitions to inform about RH; providing information about FP and importance of birth spacing, suggesting men go with their wives for ANC visits and providing information about safe motherhood and child health issues (e.g., immunizations). Three men (2 from Somani and 1 from Kolhua) said the Peer Educators were also talking about STIs.

Male and female respondents provided specific suggestions about other activities the Peer Educators could do to improve the health of their communities: the most frequently mentioned suggestion by both men and women is that the Peer Educators should be discussing more about family planning and its benefits. Other suggestions include: more outreach, including out reach to more villages, use of more street theater and song competitions, distribute more materials about RH; help organize and/or provide other health services (e.g., distribute other temporary family planning methods, distribute cough medicines, arrange for blood tests, organize for sterilization camps). Three men mentioned the need to talk more about gender equity, i.e., treating sons and daughters equally.

Nine out of 10 women said they have visited the health facility in their community in the last year; the 3 women who have not visited said it was because they don't trust the services that are provided in Jaganathpur PHC (Jamuniya VDC) or prefer to go to other hospital. Eight out of 10 male respondents said they have not used the local health facility in the last year because there has been no need for services.

4.5 Interviews with Female Community Health Volunteers (FCHVs)

Orientation to MAP Project

All of the FCHVs interviewed had attended a one-day orientation to the MAP project in March 2003; all of the respondents said the orientation was very useful or useful (two thirds, one third, respectively). The FCHVs said the orientation was useful because of the focus on male involvement on such issues as antenatal care, family planning and why it is important to involve men in these issues. Other topics they found useful included a discussion about STIs,

importance of talking to youth about reproductive health and family planning; a few respondents said they learned some new things about ANC and gained a better understanding about a range of reproductive health issues.

Opinions about MAP Activities

All FCHVs were asked if the MAP program had helped to improve male and female reproductive health in their community and how it had been helpful. The most frequent response was that more men and women are using FP, and there is clear perception that more men are using condoms for both pregnancy and disease prevention. FCHVs also report that there is more positive male involvement, especially in regard to ANC care—more men seem to accompanying their wives to the clinic for ANC checkups, and service providers at the clinics are encouraging women to bring their husbands for the ANC visits. Other important changes the FCHVs noticed include greater awareness in the communities about RH issues and child immunization.

The FCHVs said they had noticed positive changes in the behavior of men and their roles in reproductive health in the community following the initiation of the MAP program. The most frequently cited changes they noted is men are more involved in taking their wives for ANC care, ensuring they have nutritious food to eat during pregnancy, followed by greater use of condoms and support of FP use in general. A few FCHVs mentioned that some men have had a vasectomy and others have expressed interest in getting a vasectomy. The third biggest change they have noticed is their overall positive support of women, for example with household chores, making sure they see a provider when sick. A few FCHVs also mentioned that men seem to be practicing safe sex by using condoms more frequently.

All of the FCHVs interviewed said they knew the MAP Peer Educators in their community. They were aware of many of the activities that the Peer Educators have undertaken; specifically they mentioned that they distribute condoms, conduct community education programs for both men and women about a range of health issues (e.g., antenatal care, FP, childhood immunizations, nutrition), talk about how to properly use a condom, refer women to health facility for ANC care. One FCHV mentioned she had observed a Peer Educator talking about gender equity issues—treat sons and daughters equally. Another FCHV mentioned that she noticed positive behavior changes in the Peer Educators themselves—they are being more supportive of their wives and helping with the household work.

All FCHVs were asked if there were any effect on their work as a result of having the Peer Educators in their communities. The most frequently cited change was that these men have helped promote men's use of condoms and their support of family planning in general; because the Peer Educators are distributing condoms there is perception that more men are using condoms. A few FCHVs mentioned that their work load is easier now that they have the Peer Educators: there are now more people to educate the community; it is easier for the Peer Educators to talk to men—'*men would not listen to our advice but now they listen to peer educators advice on family planning methods and sterilization.'* And ' *earlier it was difficult for us to talk to them and they would also hesitate.'*

Several of the FCHVs also mentioned that the Peer Educators have been very helpful in supporting the immunization and vitamin A capsule distribution programs.

Most of the FCHVs said they have conducted joint activities with the Peer Educators (15 out of the 21 respondents). The most frequently mentioned type of activity was working together on the immunization program, followed by community education activities to discuss family planning, ANC and RH issues. Two FCHVs said they also conducted folk song competitions and a street drama program together. The FCHVs said the impact of working together with the Peer Educators has been an increase in use of FP, more participation of both men and women in the community, increased knowledge among men in the community about RH issues. Two FCHVs said the Peer Educators make their work easier as they are supporting them on the same issues.

FCHVs were also asked for suggestions about what other activities the Peer Educators could do to strengthen male involvement in RH. Some FCHVs said PE should encourage men to be more involved in pregnancy care—to provide nutritious food during pregnancy, and allow wife to rest during her pregnancy. Other suggestions include: PE should attend more community gatherings about health issues, in particular one FCHV recommended that PE attend monthly mothers group meeting. A few of the FHCVs also mentioned that there should be more coordination between the two groups since they are working on the same issues. Other suggestions included: the Peer Educators need to be more active in their communities, Peer Educators need supervision, FCHVs should be involved in the Peer Educators' follow up meetings, use videos for community education, conduct activities in the local language (Tharu).

FCHVs also made several suggestions about other ways to improve the program: provide more training to the FCHVs on the same issues (‘*One-day orientation was not enough. Should provide training for us to learn more of the RH issues.*’), conduct more joint Peer Educator and FCHV meetings to discuss issues and how to take the activities forward; conduct regular publicity about the program; increase the number of FCHVs in each ward; and periodically evaluate the performance of the Peer Educators.

4.6 Interviews with Service Providers

Usefulness of the MAP Project

All the service providers working in the four health facilities were interviewed. They included Auxiliary nurse midwife (n=4), village health worker (n= 4), community medical assistant (n=6), public health inspector (n=1), one maternal child health worker, one health assistant, one lab assistant and one administrator. Fourteen of the respondents were men, 5 women.

All but three of the respondents said they attended the orientation workshop on MAP in 2003; all of the respondents said the workshop was useful. The most frequently mentioned response about the usefulness of the workshop was that these providers learned new things about reproductive health in general, and specifically received new information about STIs and safe motherhood. The second most important thing they found useful was the importance of male involvement in family planning and safe motherhood care. A few respondents said they also increased their knowledge about family planning. One respondent said that the presentation about gender equity issues was very useful. The most important things these respondents said they learned about was safe motherhood care—danger signs of pregnancy, care during pregnancy and post delivery; the second area respondents mentioned as important was about transmission of STI, HIV/AIDS and how clients can protect themselves. The third most

frequently cited area they thought was important was the role of men in reproductive heath, including safe motherhood and family planning. Three respondents said gender equity was also important. A few respondents also mentioned they learned how to publicize health activities and why it is important to talk about different health issues in group meetings. Service providers said they would like to learn more about safe motherhood issues (four respondents specifically mentioned about delivery related procedures) and STIs, HIV/AIDS, and more technical information about RH issues. Two respondents requested more information about IUDs.

All but one of the respondents reported they have shared information about their training with their colleagues; in addition, several respondents said they have shared information with local teachers and others in their communities. They have shared information about general RH issues, family planning, STIs, antenatal care, male involvement in RH, and gender equity.

Perceived Changes after the MAP Project

These service providers were asked a series of questions about any positive changes they have noticed after the initiation of the MAP project—changes at the health care facility and changes in the communities they serve.

- **Changes at the health facility**: The most frequently mentioned change is providers are now asking men to accompany their wives for ANC visits and that there are now more women coming for ANC care and the providers themselves are ensuring pregnant women are getting TT vaccine, vitamin A and iron tablets and are informed about danger signs of pregnancy. The next most frequently mentioned change is that the physical structure has improved—furniture added for sitting, partitions put up for privacy, information has been posted about hours of services, type of services provides, and costs; storeroom re organized, etc. Other positive changes noted include more women coming for deliveries at the health facility and improved care during delivery (delivery beds now in place); increase in use of family planning (condoms, pills, Depo). The majority of respondents said they did not face any constraints in making these changes. A few providers faced constraints such as staff shortages and lack of funds for facility renovations, and one provider said it was difficult getting the community to utilize the health facility for deliveries. Providers are working with district level heath authorities to address infrastructure and staffing issues. Providers are conducting more outreach efforts to educate the community about safe motherhood issues, which is slowly having a positive effect (i.e., more women coming to the health facility for delivery).

- **Male clients reactions to changes**: Providers say that men's reactions have been positive, especially related to ANC—they seem interested in the health of their wives; they now know how frequently she should have check ups. Men are now coming for condoms, bringing their wives for FP services and understand that they are also responsible for family planning. Providers report that several men have noticed the changes in the facility and like the fact there is a place for them to sit when they accompany their wives.

- **Female clients reactions to changes**: The most frequently mentioned change providers say women have reacted to is they seem happy coming to the health facility with their husbands and that providers are providing information to husbands about

pregnancy care and her health status; in addition women feel good about the kind of ANC care they are getting (e.g., TT vaccine, iron tablets). Some women clients have noted the changes in the physical space (furniture, fans, etc).

- **Reactions from the community**: The overall reaction from the community has been positive-- community is more aware of reproductive health issues; the community is glad husbands are accompanying their wives to the heath facilities for ANC visits; and it is good to have peer educators distributing condoms. A couple provider said there have been some negative reactions from mothers-in-laws –they did not have the ANC when they were pregnant, why do these women need the care *("..Now these women need to go for regular check ups, which is not needed and is all fuss."*)

- **Service improvement at the facility**: The most frequently mentioned change in service delivery is there is an increase in FP users, particularly condom use, followed by increase in ANC visits, and limited increase in the number of deliveries. A few providers mentioned that the quality of the service they are providing for ANC has improved: *"confidence developed to talk to women during ANC and no hesitation in front of men."*

Service providers were also asked how their communities have benefited from the MAP Peer Educators' work. The most frequently cited benefits include: increase in knowledge and use of FP (several respondents noted that more men are using condoms), increase in referrals for ANC care, increased awareness about safe sex, STI transmission, and overall increased awareness about reproductive health.

All but three of the providers reported that the MAP Peer Educators had visited their health facility seeking information about reproductive health issues. The Peer Educators came to the facilities most frequently to discuss FP issues and to get a re-supply of condoms for community distribution. The Peer Educators also came seeking information about they could help with the child immunization program, information about ANC and safe delivery, to discuss how to make more progress with the program (e.g., how to organize folk song competitions, discuss how to conduct street theater program). Providers made several suggestions for strengthening male involvement in RH in their communities:

- Provide regular supervision and evaluation of the program;
- Conduct follow up meetings more frequently between service providers and PEs;
- Conduct more training/refresher training for service providers;
- Publicize the program through posters, pamphlets and FM radio, and involve women in the program (select female peer educators in each ward);
- Provide rewards to Peer Educators;
- Involve FCHVs in MAP program;
- Use more street dramas (use local artists in these productions); and
- Expand the program to other VDCs.

4.7 Health Management Committee Members' Views

One focus group discussion was conducted for each of the VDC health facility management committees to get their feedback and opinions on the MAP Program. Participants in these discussions support many of the findings from the other people interviewed.

Changes in the health facility: The participants in these groups were very appreciative of the minor inputs the program made to the facility to improve the services and the infrastructure.

Participants from Jaganathpur PHC noted:

> *"Previously there were also different rooms available to provide different services for clients, e.g., dispensary room, registration room, ANC room,…but there were no signs to recognize these rooms for patients. At that time it was difficult for clients to know where to go for services. Where as after MAP, we put signboard in front of all rooms. Now clients can read and get service easily."*

From Nawalpur Health Post:

> *"It has become more comfortable for both visitors/clients and service providers because the program has done the renovation, provided with equipment and furniture, information boards, ceiling fan, etc. "*

In addition to the physical changes, participants also noted changes in how the facilities are managed:

- *" records are kept properly of ANC checkups and of male partners coming together"*, Nawalpur HP;
- *"recording and reporting of ANC/PNC cases .. is done systematically…"* Narayani SHP.

Participants from all four groups also noted behavior changes in the service providers: they are spending more time counseling clients; are giving couple counseling; giving messages about ANC care and support to women's relatives (i.e., mothers-in-laws, husbands,); more deliveries by skilled service providers; and providers *"provide services without getting irritated"*.

Opinions about the MAP program: The participants in all groups had positive opinions of the program: they said the program is being accepted by the community and the residents in these communities appreciate the work of the peer educators; having men provide information about RH has resulted in a perceived increase use of condoms and more men are attending ANC visits with their wives. Participants in Narayani SHP also noted that the Peer Educators in their community are participating in other community social work activities such as digging drains, maintaining roads, etc. thereby contributing to the overall development of the community. These participants also said having information about why men should be involved in RH is good and is having a positive effect.

How the program has improved the health of men and women in the community: All the groups cited positive results of this program. Like other respondents whose opinion was sought for this evaluation, the management committee members have noticed that more women are attending ANC visits, men are being more attentive to their wives, ensuring wives are getting nutritious food and helping with the care of children. Members from Jaganthpur PHC said there are now reduced misconceptions about vasectomy resulting in an increased

acceptance of the method. From Nawalpur HP, participants noted that more men are seeking treatment for STIs.

Suggested improvements for the program: Participants from all four groups said there should be more regular monitoring and supervision of the peer educators; one person suggested that the program should hire a local supervisor; another person suggested making one Peer Educator in an area the coordinator for up to 5 fellow Peer Educators to coordinate activities. Other suggestions included: more street theater on a regular basis in the local dialect; and involving the FCHVs in the Peer Educators' meetings.

Overall the health management committees are happy with the program and very supportive of its efforts. Though they do not have funds to contribute to any of the activities, they are willing to provide other support by advocating for the program at community meetings, serve as mediator, if necessary between the program and the community, and help health facilities solve problems.

5.0 DISCUSSIONS

The findings presented above from the multiple informants, and the service statistics, clearly show that the MAP project is having a positive effect on the men and women living in these four rural communities in western Nepal. There is widespread support for the role of a male Peer Educator in helping to improve communities' health. There is an agreement by all respondents that there is more positive male involvement in these communities for RH care: men are concerned about family planning, maternity care, and child health issues. Specifically we note the following trends:

- An increase in the number of women seeking maternity care—ANC and post natal services;
- Increase in interest and support among men about women's health, especially pregnancy related care;
- An increased awareness about family planning and the benefits of child spacing;
- Increase in the number of condoms distributed by the four health facilities in the year since the program started, while increase in distribution of other temporary methods has not been as dramatic. Although we do not have data about changes in contraceptive use, there is a clear perception that FP use has increased, especially condom use.
- Increased awareness about STIs and demand for more information about STI prevention. Although there is increased awareness, men and women in these communities are not seeking services at the four health facilities for information or treatment. Traditionally clients rely on the private sector for treatment and care for STIs.

Based on the findings from this evaluation, the following activities have been proposed for implementation between April and December 2004:

1. Strengthen the linkages between the Peer Educators and FCHVs by:
    - Encouraging male Peer Educators to occasionally attend the mothers' group meetings.
    - Conducting joint home visits.
    - Conducting health education session jointly

2. Conduct orientation and refresher training on STI prevention for Peer Educators and health facility staff, and emphasize dual protection issues regarding condom use,

3. Conduct training for Peer Educators in effective interpersonal communication skills,

4. Continue to monitor the activities of the Peer Educators to strengthen MAP project,

5. Begin a dialogue with the FHD about how to take this project to scale in a cost effective manner, and

6. Work with health facility providers to strengthen couple counseling during ANC check up; women like their husbands to be informed about nutritious food, rest and preparation for delivery.