

A Study on Radio Listeners' Group

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Preface

Since the beginning of NFHP, we have used an approach in which weekly radio drama-serial broadcasts, focusing on MCH/FP content, are supplemented by facilitated discussions among groups of village women. We refer to these as radio listeners groups.

During phase I (2004-2005), 135 such groups were formed, across 3 districts (and with over 3,800 women participating). The study we are reporting on here has taken a detailed look at living circumstances and health-related knowledge, attitudes and practices of these participants as well as of non-participant members from the same and other communities.

Because these groups are not comparable with regard to demographic, socio-economic and other factors (and because we do not have baseline data from the study-respondents), we cannot directly measure impact. However, the study gives a very informative picture of typical rural Nepali women engaging in day-to-day life challenges, applying what they know to help improve the health of their families. This information is very useful, giving us a better idea of the factors impinging on household decisions about protecting health, caring for sick family members and seeking health-care services. And it gives us a detailed picture of health-related information available to women.

In many instances we see encouragingly high levels of awareness and active discussion of health issues with family members and friends. Generally, levels of awareness are higher in RLG members than in the two comparison groups. In some instances this seems clearly related to exposure to the drama serial content (although in other cases, differences may be attributable to baseline differences between those who ended up as RLG participants and those who did not). In most cases, non-RLG participants drawn from the VDCs where RLGs were conducted had higher levels of awareness than controls from non-intervention VDCs. This may be attributable in part to a 'halo effect', with information having diffused in the community, originating from RLG participants.

This report reflects a carefully conducted study and rigorous analysis. We commend Valley Research Group, Bharat Ban and others involved in its conduct, and particularly thank Marc Boulay (JHUCCP/ Baltimore) for his expert technical assistance.

Dr. Stephen Hodgins
Chief of the Party
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Abbreviations

ADRA	ADRA Nepal
AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Assistant Nurse Mid-wife
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BPP	Birth Preparedness Package
CARE	CARE Nepal
CBO	Community Based Organization
DE	Distance Education
DS	Drama Serial
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FP	Family Planning
FP/MCH	Family Planning and Maternal and Child Health
HA	Health Assistant
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HP	Health Post
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow Inc.
KAP	Knowledge, Attitude and Practice
MASS	Management Support Services
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
M&E	Monitoring and Evaluation
MOHP	Ministry of Health and Population
NFCC	Nepal Fertility Care Center
NFHP	Nepal Family Health Program
NGO	Non-Governmental Organization
NHEICC	National Health Education Information and Communication Center
NHTC	National Health Training Center
NTAG	Nepal Technical Assistance Group
ORS	Oral Rehydration Solution
PHCC	Primary Health Care Center
RCP	Radio Communication Program
RHP	Radio Health Program
RLG	Radio Listeners Group
SAVE/US	Save the Children US
SBA	Skilled Birth Attendant
SD	Standard Deviation
SES	Socio-Economic Status
SHP	Subhealth Post
SM	Safe Motherhood
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TV	Television
USAID	United States Agency for International Development
VaRG	Valley Research Group
VDC	Village Development Committee
VHW	Village Health Worker
WEI	World Education Inc.

Executive Summary

1) Summary of findings

a) Introduction

The Radio Health Programs (RHP) of Nepal Family Health Program (NFHP) were designed, written and produced with technical support and management of the Behavior Change Communication (BCC) Team of NFHP in close coordination with National Health Education Information and Communication Center (NHEICC), Family Health Division (FHD) and National Health Training Center (NHTC) and other partner organizations. Both programs were launched in March 2004 and, since then, have been broadcast nationally on Radio Nepal as MOHP programs.

The overall objective of the study was to assess the added-value of the radio listeners' groups to the Radio Health Program (RHP). The study was conducted in 3 districts namely Siraha, Dhanusha and Mahottari using a 30-cluster sampling design technique. Structured interviews and focus group discussion techniques were used to collect information from the Radio Listeners Group (RLG) members, non-RLG members and the respondents of control areas. A total of 1,367 currently married women aged 15-49 years were included in the study. Of which 467 were the RLG members, 450 non-members from the RLG wards and 450 residents of non-RLG wards. In addition, 12 focus group discussions (6 among RLG members, 3 each among non-members residing RLG wards and women of non-RLG wards) were conducted. Fieldwork was conducted during January - February 2006.

Data processing and analysis was done using FOXPRO and SPSS software. The analysis for this report focused on comparisons between RLG members, Non-RLG members of the RLG wards, and women living in non-RLG wards. In addition, multivariate regression analyses were used to examine the relationship between the RLG status and selected outcome indicators related to family planning, safe motherhood, child health, and HIV/AIDS.

b) Respondents and Community Characteristics

The mean age of the respondents of all three categories remained the same at 31 years indicating insignificant difference on the age composition among the respondents of three categories. The largest percentage (37%-49%) of the respondents from all three categories represented from *other terai ethnic* group followed by about a quarter (21%-29%) in Tibeto-Burman caste. A sizeable percentage (14%-21%) of the respondents were *Dalit*. Slightly a higher percentage of the RLG members (24%) compared to the non-RLG members (22%) and the respondents of the control areas (18%) were reported to be literate.

The percentage of the respondents possessing radio and television sets in their households was much higher among RLG members compared to other two categories. Almost all the respondents, except for 1% each of RLG and non-RLG member, have access to established drinking water supply system. Very small percentage (8%-17%) of the respondents of all three categories reported having toilet facility in their houses.

Nearly half (47%) of the RLG members followed by 30% non-RLG members and 22% respondents of the control areas reported that mothers groups in their areas are in existence. More than half of the RLG and non-RLG members and about one-third of the respondents from the control areas reported that they have access to the health facility within a distance of less than half an hour.

All the RLG members and about three-quarters of the respondents of other two categories reported to have listened to the radio. Over 60% of the RLG members compared to 41% non-RLG members and 34% those from the control areas reported to have watched television. About 50% of the RLG members followed by 45% of the non-RLG members and 33% respondents of control areas found the reception of the Radio Nepal very good and clear.

The mean number of children ever born among the responding women was 3.2 and children currently living were 2.9. The mean number of children ever born and currently living was slightly higher among the women of the control areas and lower among the RLG members.

c) Findings on RLG

Most of the RLG members reported that they joined the RLG with the expectation of learning new topics (84%) and health related matters (74%) from it. Nearly half (47%) of the respondents reported that their friends, neighbors or relatives encouraged them to join the RLG and nearly two-fifths (38%) were encouraged by FCHVs. About a quarter of the respondents were encouraged by their husbands (25%) and other family members (24%) indicating the good support of the family in joining the radio listening groups.

The very large majority (95%) of the respondents reported that their listening groups meet every week, and most of them said that the radio listening session mostly lasted for 30-60 minutes. The average number of persons usually attend in each session of RLG meeting was recorded to be 18.

Almost all (97%) the respondents reported that their groups organize discussion sessions every time after listening to the radio drama serial. Most of the respondents reported that they discuss the contents of the *Gyan Nai Shakti Ho* radio drama serial with their group members and non-members outside the group meetings. Over half of the respondents reported that they discussed about the radio serial once or twice a week.

Slightly over one-fifth (22%) of the respondents reported that FCHVs mostly facilitate the radio listeners group sessions. Over three-quarters (78%) mentioned social workers, NGOs and other persons who mostly get involved in facilitating the groups. All the respondents appreciated the facilitation skills of their facilitators.

About 66% of the respondents expressed that such listening groups have made positive changes in their community *a lot*. Nearly three-quarters (72%) of the respondents also felt that their participation in the radio listeners group have made *a lot of changes* in their personal life.

Knowledge of RLG and interaction with RLG members

Over 80% of the non-RLG members and 3% respondents of control areas were aware about the existence of RLG in their areas. Almost the same percentage of the respondents (79% non-RLG members and 2% from control areas) also reported knowing the persons who belonged to RLG.

d) Exposure to Radio Health Program

Exposure to radio health program

All the RLG members followed by 22% of the non-RLG members and 6% of the respondents of the control areas reported to have listened to either of the *Gyan Nai Shakti Ho* (in Nepali) or *Gyane Shakti Hai* (in Maithili) radio drama serial. The great majority (89%) of the RLG members compared to only 29% non-RLG members and 8% of the respondents of control areas reported that they had been listening to the drama serial for more than 18 months.

The majority of the respondents with a higher percentage of the respondents of control areas (89%) than those of non-RLG members (79%) and RLG members (65%) felt that the dialogue spoken by the characters in the drama serial was *easy to understand*. More than half of the RLG members and the respondents of control areas found the duration of broadcast time of the radio drama serial shorter. The majority of the respondents (59%-78%) with a higher percentage of the RLG members opined that the radio drama serial was both entertaining and educational.

Over 90% of the RLG members compared to 73% of the non-RLG members and 65% of the respondents from control areas reported that they had discussed about the drama serial with others – mostly with their friends, neighbors and female members in the family.

Thirteen percent of the RLG members, 3% non-RLG members and 2% of the respondents of the control areas had heard about *Sewa Nai Dharma Ho*, a distance education radio program in the past one-year. About 30% of the RLG members and 10% each of the non-RLG members and the respondents from control areas reported that they listened to the radio program called *Jana Swastha Karyakram*.

Exposure to other health related television programs

Among those who had ever watched television, about 61% of the RLG members compared to 46% non-RLG members and 43% respondents of control areas reported to have watched health or family planning program on television during last year. Over a quarter of the RLG members and 10% each of the non-RLG members and those of control areas also reported that they had watched the *Asal Logne* tele-film.

Exposure to other materials and printed BCC materials

A large percentage of the respondents of all three categories (98% RLG members, 85% non-RLG members and 78% from control areas) reported to have seen posters on health or family planning in the past one year.

e) Family Planning

Knowledge and use

All the RLG members and almost all the non-RLG members (99%) and the respondents of control areas (98%) were found to be aware of at least one method of family planning. Spontaneous knowledge of respondents about different family planning methods was much higher among RLG members compared to the respondents of other two categories.

The proportion of the respondents who were currently using any FP method at the time of survey was much higher among RLG members (58%) compared to the non-RLG members (49%) and the respondents of control areas (48%). The higher parentage of the respondents of all three categories were currently using female sterilization (28%-35%), and the second and third most commonly used methods were Depo Provera (11%-14%) and oral pills (3%-4%) respectively. The percentage of respondents using other contraceptive methods remained at less than 2% among all three categories of the respondents. Multivariate regression analysis indicates that RLG members were 1.4 times more likely than women in the comparison community to report currently using a modern contraceptive method.

Among those who were not using any FP methods at the time of survey, about three quarters of the respondents of all three categories reported that they would use FP methods to delay or avoid pregnancy in the future.

Interpersonal communication on FP

About 40% of the RLG members followed by slightly over one-third of the non-RLG members and less than one-third of the respondents from control areas reported that they discussed about their desired number of children and on FP/contraceptives use with their husbands in the past 6 months prior to the survey. Multivariate regression analysis further show that RLG members were 1.5 times more likely and non-members were 1.3 times more likely than women in the control communities to have discussed family size or contraceptive methods with their spouse in the past six months.

Nearly 80% of the RLG members compared to 52% non-RLG members and 48% of the respondents of the control areas reported to have discussed about family planning methods with their friends, neighbors or relatives in the past 6 months.

f) Safe Motherhood

Knowledge and attitudes towards antenatal care

About 96% of the RLG members compared to 88% non-RLG members and 77% respondents in control areas perceived it to be very important for receiving clinic check ups during pregnancy.

Just over half (52%) of the RLG members followed by 49% non-RLG members and 38% respondents from control areas correctly mentioned that a woman should first receive antenatal services between 3-4 moths of pregnancy. Likewise, 73% of the RLG members compared to only 57% of the non-RLG members and 52% respondents of control areas correctly mentioned that a woman should receive pregnancy check ups at least four times.

Almost all the RLG members (98%) and more than 90% of the non-RLG members and the respondents of control areas reported that they have heard about iron/folic tablets. Almost all (99%) the RLG members and 97% each of the non-RLG members and the respondents of the control areas reported to have heard about immunization against tetanus.

The higher percentages of the respondents of all the three categories were found to be aware of three dangers signs such as vaginal bleeding (56%-85%), severe lower abdominal pain (79%-82%) and severe headache (48%-60%) that may appear during pregnancy. The average number of danger signs or symptoms mentioned by the RLG members was significantly higher (3.0) than their respective counterparts non-RLG members (2.5) and the respondents of control areas (2.2).

Knowledge and attitudes towards delivery services

All the RLG members followed by 98% of the non-RLG members and 91% of the respondents of the control areas opined that it is important to attend the delivery by the skilled health workers such as staff nurse, ANM, doctor, etc.

Almost all (99%) of the RLG members followed by 96% non-RLG members and 88% respondents of the control areas were able to mention at least one specific plans or preparations to be made in advance to ensure the safe delivery. The most frequently cited plans and preparations mentioned by the respondents were making arrangements of money (73%-92%), clean delivery kits or clean blade and thread (30%-50%), foods (30%-36%), identifying nearest health facility (14%-31%) and skilled providers (9%-29%). Multivariate regression analysis further explains that both the RLG members and non-RLG members have greater knowledge on birth preparedness package compared to the respondents of control areas.

About 6 in every 10 RLG members followed by more than half of the non-RLG members and over 40% of the respondents of control areas considered doctor and nurse or ANM as important sources for receiving assistance during delivery. About 4 in every 10 respondents with the higher percentage of those from control areas considered TBA as the suitable person for receiving assistance during delivery. The adjusted odds ratio show that RLG members were 5.5 times and non-RLG members were 2.8 times more likely to be aware of skilled birth attendants than the respondents of the control areas indicating the effect of the program intervention to impart knowledge about it to the people of the community. Similarly, RLG members were also more likely to be informed about the skilled birth attendants than the non-RLG members living in their community.

The higher percentage (44%-62%) of the respondents of all the three categories with a higher proportion of RLG members considered district hospital as the best place for giving birth to a child.

Almost all (97%) the RLG members followed by 82% non-RLG members and 74% respondents of control areas were found to be aware of the clean delivery kits. The higher percentage of the respondents of all the three categories mentioned blade (70%-79%) and surface (63%-74%) that need to be kept clean during childbirth. However, knowledge of respondents about the need of keeping other four things (such as hands, thread, nails and perineum) clean was relatively low.

The most commonly cited danger signs that could occur during labor or deliver by the respondents of all three categories were: appearance of baby's leg first (56%-79%), labor longer than 12 hours (74%-79%), excessive bleeding before or after delivery (49%-76%) and appearance of baby's hand first (51%-74%). Knowledge of respondents of all the three categories on danger signs such as appearance of baby's umbilical cord first and convulsion was found to be quite low.

Knowledge and attitudes towards postpartum services

Almost all the RLG members (99%) followed by 96% of the non-RLG members and 86% of those from control areas perceived it to be either very important or somewhat important in receiving postpartum check ups from the clinics or health facility.

Knowledge of respondents of all the three categories regarding the timing of receiving first check up services after the delivery was found to be low as only 30% of the RLG members, 20% non-RLG members and 12% of the respondents of control areas said that a woman should receive first check up services within 3 days after the delivery.

Almost all the women of three categories opined that it is necessary to provide more care and support by the family members after the delivery. About 9 in every 10 respondents with slightly a higher percentage of RLG members viewed that a woman should be given more nutritious foods. Likewise, over 85% of the RLG members followed by 75% non-RLG members and 69% of those from the control areas mentioned *giving advise for more rest*. Over 80% of the respondents (80%-89%) of all three categories opined that husbands and mothers-in-law should provide care and supports to the postpartum women.

Almost all (98%) of the RLG members followed by 95% non-RLG members and 88% of the respondents of control areas were able to mention at least one danger sign that may appear within first four weeks after the delivery. The most frequently cited danger signs were heavy bleeding, foul discharge and lower abdominal pain and high fever. Those mentioning convulsion and mastitis as the danger signs was relatively low (9%-23%) among all three categories of the respondents. Knowledge about various types of danger sings or symptoms that could occur during the first four weeks after the delivery was significantly higher among RLG members compared to the non-RLG members and the respondents of control areas.

Interpersonal communication on safe motherhood

The great majority (88%) of the RLG members compared to those of non-RLG members (66%) and respondents of control areas (58%) reported that they had talked to other people about safe mother issues like antenatal care or delivery. The majority (70%-86%) of the respondents of all three categories with a higher percentage of the RLG members reported discussing safe motherhood issues with their friends and neighbors.

Both the RLG members and non-RLG members have greater knowledge on safe motherhood compared to the respondents of control areas. The mean adjusted safe motherhood scores among RLG members were 1.50 units higher than among women in the control communities and mean safe motherhood knowledge among non-RLG members was 0.50 units higher than the respondents of the control areas. The survey results also further show that RLG members have significantly greater knowledge about safe motherhood compared to the non-RLG members of the study areas.

g) Child Health

Knowledge about newborn care

The level of knowledge about different types of danger signs or symptoms related with newborn was found to be much higher among the RLG members than the respondents of other two categories. On average, RLG members were able to mention 2.2 types of danger signs or symptoms while this figure was 1.9 among non-RLG members and 1.8 among the respondents of control areas. The most frequently cited danger signs were fast or difficult breathing, poor sucking or feeding and hypothermia.

Almost all the RLG and non-RLG members and about 95% of the respondents of control areas reported that one should use new or sterilized blade to cut the cord of the newborn. Over 60% of the respondents of all three categories with a higher percentage of the non-RLG members opined that any kinds of substances should be applied on the stump after cutting the newborn's cord.

Slightly over half (53%) of the RLG members followed by 42% non-RLG members and 38% of the respondents of control areas correctly mentioned that the newborn should be dried and wrapped before the placenta is delivered. Over 95% of the respondents of all three categories mentioned *clean dry cloth* to be used in wrapping the newborn.

About 50% of the RLG members compared to only 26% non-RLG members and 18% respondents of control areas correctly mentioned that the baby should be given bath *24 hours after the birth*.

The great majority (78%-95%) of the respondents of all three categories opined that a child should be given colostrums. Only about one-third of the RLG members and about 22% of the respondents of other two categories correctly reported that the baby should be first put to the breast immediately after the birth.

The great majority (88.9%-99.6%) of the respondents of all three categories with a higher percentage of the RLG members considered it to be important in getting health check ups by the newborn immediately after the birth. The majority of the respondents of all the three categories (50.5%-76.0%) with the higher percentage of those from control areas considered 8-42 days as the appropriate time for receiving health check ups by the newborn. Nearly one-third of the RLG members followed by about 22% of the non-RLG members and 14% of the respondents of control areas mentioned within 3 days after birth for receiving health check ups.

Both the RLG members and non-RLG members have greater knowledge on newborn care and child health compared to the respondents of control areas. The mean adjusted newborn care scores among RLG members were 0.97 units higher than among women in the control communities and mean newborn care among non-RLG members was 0.29 units higher than the respondents of the control areas. Similarly, the level of knowledge about child health was higher by 1.11 units among RLG members and 0.28 units among non-RLG members compared to the respondents of control areas. The survey results also further show that RLG members have significantly greater knowledge about newborn care and child health compared to the non-RLG members of the study areas.

Diarrhea and its treatment

The program has promoted three home care strategies namely, giving more fluids than usual, giving more foods than usual and continue breastfeeding to be adopted during diarrhea. Nearly two-fifths (37%) of the RLG members compared to 23% of the non-RLG members and 19% of the respondents of control areas were able to mention at least two of the above mentioned three home care strategies.

Among those respondents whose child below 5 years of age had suffered from diarrhea in the last two months preceding the survey, over 76% of the RLG members followed by 55% non-RLG members and 38% those from the control areas reported that they consulted FCHVs during the last diarrheal episode.

More than 9 in every 10 RLG members compared to about two-thirds of the non-RLG members and the respondents of control areas reported that they provided more liquid items during diarrhea than usual. Likewise, about 62% of the RLG members compared to 53% non-RLG members and 45% respondents of the control areas reported that they fed more food than usual.

ARI and its treatment

Almost all the RLG members and 98% of the non-RLG members and 96% of the respondents of control areas were found to be aware about at least one symptoms associated with serious respiratory illness. Considerably, a higher percentage of the RLG members compared to the respondents of other two categories were found to be aware of various symptoms associated with such illness.

When asked about how they would treat to their child during cough, cold or pneumonia at home, the higher percentage of the respondents of all three categories reported that they would keep the child warm (73%-79%), look for chest indrawing (19%-36%), look for fast or difficult breathing (22%-35%) and give more fluid than usual (15%-31%). The mean number of home care strategies – that are promoted by the program -- mentioned was significantly higher among RLG members (2.2) compared to the non-RLG members (1.8) and the respondents of the control areas (1.5).

Over 60% of the RLG members compared to only 27% non-RLG members and 17% those of control areas reported that they consulted FCHVs when their child below five years of age was suffering from cough, cold or pneumonia in the last 2 months preceding the survey. About 60% of the respondents of all the three categories (59%-63%) also said that they provided traditional treatment at homes. Nearly half of the RLG members and one-third each of the non-RLG members and the respondents of control areas reported taking their child to the subhealth post, health post or pharmacy for treatment.

Malnutrition and Vitamin A

About 96% of the RLG members followed by 91% respondents of the control areas and 87% non-RLG members knew about symptoms of malnutrition among children. The most frequently cited symptoms were failure to gain weight or weight loss (48%-66%), thin face, shoulders or buttocks (44%-55%) and constant crying and irritability (38%-53%).

The great majority (96%-98%) of the respondents reported that their children aged 6-59 months were given Vitamin A capsule during the distribution campaign in 2062 Kartik BS (October/November 2005).

The adjusted odds ratio reveal that RLG members were nearly 2.5 times more likely to have spoken with FCHVs regarding newborn and child health than the respondents of the control areas. Similarly,

RLG members were also more likely to have discussed with FCHVs than the non-RLG members living in their community. However, non-RLG members were not more likely to have discussed with FCHVs than respondents in the control areas.

h) Knowledge about HIV/AIDS

Almost all (97%) the RLG members compared to 71% of the non-RLG members and 65% of the respondents of control areas reported that they have heard about HIV or AIDS. Among those who reported having heard about HIV or AIDS, the higher percentage of the respondents of all three categories spontaneously mentioned that HIV could be transmitted through multiple sexual relationships (68%-89%), sexual intercourse with infected persons (61%-77%), sharing needles used by HIV infected person (27%-51%) and infected blood transfusion (23%-37%). The percentage of respondents of all three categories mentioning different modes of HIV transmission stood very high (81%-100%) after probing each of the possible modes.

The adjusted odds ratios reveal that RLG members were 3.9 times more likely to have knowledge about three or more modes of transmission of HIV/AIDS compared to the respondents of control areas. The odds ratios obtained from logistics regression further show that RLG members were also more likely to be aware of three or more modes of transmission compared to the non-RLG members of the study areas. Non-RLG members, however, were not more likely to know about at least three modes of transmission of HIV/AIDS than the respondents of control areas.

Quite a high percentage of the respondents have misconception regarding the modes of transmission of HIV or AIDS. Considerably a higher percentage of the respondents of all three categories reported that HIV/AIDS could be transmitted through mosquito bites (69%-74%), using dishes (30%-41%) or sharing meals (29%-42%) or working together (28%-40%) with HIV/AIDS infected person.

Radio, neighbors, and FCHVs were the major sources of information about HIV/AIDS for the majority of the respondents of all three categories. About 87% of the RLG members also reported that they heard about HIV/AIDS from radio listeners group.

i) Female Community Health Volunteers

Familiarity with FCHVs and their services

Almost all (>97%) the respondents of all three categories reported that they have known the FCHVs of their areas. Among those who had heard of family planning more than 93% of the RLG members compared to 77% non-RLG members and 73% respondents of control areas reported that FCHVs in their areas provide information and services related to family planning. Likewise, the higher percentages of the respondents reported that FCHVs provide information on TT vaccines (58%-70%), provide iron tablets (44%-59%), advise to give vitamin A to children (54%-55%), about child immunization (54%-55%), advise to visit health facility for ANC (49%-53%) and provide counseling during pregnancy, delivery and postpartum (28%-44%).

The majority of the respondents with a higher percentage of RLG members were aware that FCHVs of their areas provide information on immunization (71%-88%) and on vitamin A (78%-82%). More than three-quarters of the respondents of control areas and nearly three quarters of the RLG members and non-RLG members also reported that FCHVs distribute vitamin A capsules. More than two-fifths of the RLG members (44%-46%) and about a quarter (25%-30%) of the non-RLG members and the respondents of control areas were also aware that FCHVs of their area provide information and treatment services of diarrhea.

About three quarters (74%) of the RLG members followed by 40% non-RLG members and 35% respondents of control areas reported that FCHVs of their areas provide information and services related to HIV/AIDS.

Interaction with FCHVs

Over 90% of the RLG members followed by 88% respondents of control areas and 85% non-RLG members reported that they had met FCHVs to seek health related information and services. About half of the respondents (45%-54%) of all three categories with a higher proportion of RLG members reported to have met the FCHVs within 7 days prior to the survey. A higher percentage (40%-55%) of the respondents of all categories reported that they discussed with FCHVs about child health during their last visit. Relatively a smaller percentages of the respondents reported discussing on issues related to family planning (5%-21%), safe motherhood (6%-17%) and STIs and HIV/AIDS (0.3%-2.1%).

2.0 Recommendations

Based on the study findings following recommendations are made:

On radio health program and RLG

- 1) About half of the respondents of all three categories reported that they could not understand Nepali language easily. In order to capture these types of population the program should also broadcast radio drama serial in local languages.
- 2) The survey findings reveal the less representation (<3%) of Muslim people in the Radio Listeners Group. Hence, the RLG program should also reach this section of population to deliver health messages.
- 3) Although the great majority of the respondents had exposure to the radio, over half of them had no radio set in their houses. Therefore, the RLG activities need to expand group members to reach the population not having radio by establishing RLG in different parts of the study districts.
- 4) The survey results show that about 22% of the RLG members discussed about the content of the radio drama serials less than once in a month and about 14% had rarely or never discussed about it. Therefore, the program should encourage them to share/discuss whatever they have learned from RLG with the community fellow women so that non-members of the community would also be benefited from the RLG initiatives.
- 5) About half of the respondents of all three categories perceived the broadcast duration of drama serial as shorter. Therefore, this aspect needs to be taken into consideration while designing program in the future.
- 6) The survey results reveal that a sizeable percentage of the respondents of all three categories (12%-35%) felt somewhat difficult to understand the dialogue spoken by the characters in the drama serial. Hence, efforts should be made to use simple, common and easily understandable words and phrases as far as possible.
- 7) The great majority of the respondents of all three categories find the radio drama serial both entertaining and educational implying that the program is quite useful in creating interest as well as

disseminating information on FP/SM/CH and HIV/AIDS. This type of radio drama serial with entertaining and educational (enter educate) approach could also be initiated for other types of health issues.

- 8) Only less than half of the respondents of all three categories found the reception of the Radio Nepal “very good and clear” while the rest found it fair and poor. This finding suggests the need for broadcasting the drama serial from regional as well as local radio stations.
- 9) The survey results show that only 22% of the non-RLG members and 6% respondents of the control areas had listened to the radio drama serial *Gyan Nai Shakti Ho* in the past. The average number of drama episodes listened by the non-RLG members and the respondents of the control areas in the last three months was found to be quite low indicating irregular listenership of the serial. Therefore, the program should make its efforts to a) increase the listeners of radio drama serial at community level, and b) encourage community for regular listenership.

On family planning

- 1) Although the contraceptive prevalence rate is high among the respondents of all three categories compared to the national average, the current use of oral pills, condoms, Norplant and male sterilization remained still low. Hence, the program should inform the target audience about the relative advantages of these contraceptives through radio health program and during discussions in RLG meetings in order to encourage them in using these contraceptives.
- 2) Spousal communication on the desired number of children and contraceptive use was found to be relatively low among the respondents of all three categories in the study areas indicating the need of emphasizing community to discuss on these matters by informing them about the advantages of having such communications between spouses.

On safe motherhood

- 1) The survey results reveal that only about half of the RLG members and non-RLG members and 38% of the respondents from control areas had correct knowledge (between 3-4 moths of pregnancy) on the timing of receiving first antenatal check up services during pregnancy. Therefore, dissemination of information on these aspects should be continued.
- 2) A sizeable percentage of the respondents of all three categories were found to be unaware about the most frequently occurring danger signs or symptoms during pregnancy, delivery and postpartum periods. It is therefore, necessary to impart knowledge about various types of danger signs or symptoms associated with pregnancy, delivery and postpartum to the community people.
- 3) Knowledge of respondents of all three categories regarding the specific plans and preparations to be made to ensure the safe delivery is still low. The program has promoted 6 specific plans and preparations in its birth preparedness package. However, the average number of such preparations known by the respondents of all three categories ranged from 1.2 –2.0. Therefore, the program should continue its efforts to inform people through radio health program about the things that need to be prepared in advance to ensure the safe delivery.
- 4) The survey findings reveal that knowledge of respondents of all three categories regarding the timing of receiving first health check up after the birth was low as only 30% of the RLG members, 20% non-RLG members and 12% respondents of control areas reported that a woman should receive such checkups within three days after the birth. Hence, dissemination of information through radio

health program should be continued to increase the level of knowledge of the community about it.

- 5) Considerably a smaller percentage of the respondents of all three categories opined that a woman should receive postnatal services from a nurse, ANM, MCHW, or HA/AHW. Hence, it is necessary to inform people about the availability of postnatal services from these cadres of health service providers.

On child health

- 1) The survey results reveal that knowledge of respondents of all three categories about various danger signs that may occur to the newborn was relatively low. Hence, it is suggested to impart knowledge to the people thorough radio health program on various kinds of danger signs that may occur among newborn.
- 2) Correct knowledge of respondents regarding the basic newborn care such as timing of drying and wrapping, and bathing was relatively low. This finding suggests for imparting knowledge to the community about the appropriate timing of receiving basic newborn cares.
- 3) Knowledge of respondents regarding the home care strategies that has to be adopted during diarrhea and cough, cold or pneumonia was found to be low among all three categories of the respondents. Likewise, their knowledge about signs and symptoms related to ARI and malnutrition was also found to be low. Hence, the program should further disseminate information on these aspects.

On HIV/AIDS

- 1) Although quite a high percentage of the respondents of all three categories reported to have heard about HIV/AIDS, considerably a higher percentage of the respondents have misconception (such as transmission of HIV/AIDS through mosquito bites, sharing dishes or meal or working together with infect person) regarding the modes of transmission of HIV/AIDS. Therefore, there is a need of giving more information about the correct modes of transmission of HIV/AIDS to the community through radio health program.

On FCHV and mothers' group

- 1) Most of the respondents had known the FCHVs of their areas. However, knowledge of respondents regarding types of information and services provided by FCHVs in the areas of family planning, pregnancy and child birth, child health and HIV/AIDS is still low. Therefore, the program should inform to the community about the information and services that are available from their FCHVs.
- 2) The survey results show that woman in both the program and control areas are less aware about the existence of mothers' group in their community. This indicates the need of creating awareness among the community about it including benefits of participating in mothers' group meetings.

Chapter 1

Introduction

1.1 Background

The Nepal Family Health Program (NFHP), funded by United States Agency for International Development (USAID) Nepal, is a consortium of cooperating agencies namely JSI, JHU/CCP, JHPIEGO and Engender Health. In addition NFHP has also included other organizations that are working as collaborating partners including: CARE, SAVE/US, MASS, NFCC, NTAG, ADRA, WEI. The NFHP Program has aimed to assist the Ministry of Health and Population (MOHP) in implementing specific activities that strengthen delivery and use of high impact FP/MCH services at the household and community levels. At present 17 districts are covered by NFHP. This research activity studies the effect of using radio listeners groups linked with national radio broadcast implemented by the NFHP.

NFHP has aimed to improve family planning and maternal child health services in Nepal through *Information, Education, Communication and Behavior Change Interventions*. The main BCC activities of NFHP has been focused on *strengthening the capacity of the community level providers* particularly FCHVs to deliver FP/MCH services and promoting key FP/MCH behavior change through community based communication, health education and training interventions. In order to empower the FCHVs and upgrade their knowledge and communication skills NFHP has designed and implemented the Radio Health Program (RHP). The RHP consists of two complementary radio programs designed to promote key behaviors related to Family Planning and Maternal Child Health (FP MCH). *Sewa Nai Dharma Ho 'Service is Religion'* is a weekly radio distance education (DE) program for Female Community Health Volunteers (FCHVs) to strengthen their knowledge of FP and MCH, improve their interpersonal counseling skills, and increase their motivation and self-esteem. *Gyan Nai Shakti Ho 'Knowledge is Power'* is a drama serial (DS) program for the general public to improve the household management of health, encourage men and women to seek assistance from the FCHV in their community, and increase the respect shown to FCHVs for their work and commitment.

The programs were designed, written and produced with technical support and management of the Behavior Change Communication (BCC) Team of NFHP in close coordination with National Health Education Information and Communication Center (NHEICC), Family Health Division (FHD) and National Health Training Center (NHTC) and other partner organizations. Both programs were launched in March 2004 and, since then, have been broadcast nationally on Radio Nepal as MOHP programs.

Radio listeners' groups (RLGs) were formed to complement the radio broadcasts of the DS program. These groups meet weekly at the time of the DS broadcast to review the previous week's messages, listen to the program, and then discuss the issues that arose during the current episode. During the first phase of the RLG activity (2004-5), 135 RLGs were formed with a total of 3,810 participants in Siraha, Dhanusha and Mahottari districts, with the average of 28 members in each RLG. The RLGs have been formed in 111 wards of 31 VDCs and one municipality in these three districts. With the support of World Education, the RLGs have been extended to Bara and Parsa districts in 2005-6. The DS program is broadcast every Sunday between 2:15-2:30 pm.

These RLGs may extend both the reach and effectiveness of the drama serial program. RLGs provide the opportunity to tailor program messages into local languages. Discussions during RLGs provide the opportunity to address questions and concerns related to program messages and allow women to learn from the experiences of their peers. Participants may also discuss program messages with friends and neighbors outside of the RLG, extending the reach of the program.

As the RLG is formed in the selected districts of the NFHP core program areas since 2004, it is timely to assess the contribution of RLG in enhancing knowledge, attitudes and practice of the community people on family planning and health matters. In view of this, the assessment study was carried out for NFHP by VaRG.

Prior studies have shown the benefits of Radio Listeners Group to impart knowledge to the community related to FP/MCH. A 2001 study conducted in Phulbari VDC of Chitwan district revealed that the radio listener group members exposed to Radio Communication Program (RCP) implemented by the MOHP and the Johns Hopkins University/Population Communication Services (JHU/PCS) helped to enhance the knowledge and increase use of family planning health services available in the community¹. The study, conducted in both the program and control areas in order to assess the contribution made by the program intervention, revealed that most of the dependent variables odds ratio for respondents with full exposure to RCP was greater than one and were statistically significant. The study also revealed that most of the adjusted and unadjusted odds ratio of attitude and advocacy variables for the full exposure group were significantly greater than one. The survey findings concluded that RCP was instrumental for achieving its goal in the Phulbari areas. Another study conducted among the radio listeners group of Digital Broadcasting Initiatives in two different time span in the selected districts of the terai showed the increased knowledge of the radio listeners' group members on the causes and preventive measures against the transmission of STIs and HIV/AIDS². The current research will add to the body of knowledge and evidence about facilitated radio listeners groups.

1.2 Objectives of the study

The overall objective of the study was to assess the added-value of the radio listeners' groups to the Radio Health Program.

The specific objectives of the study were as follows:

- a) To assess the effect of participation in RLG on FP/MCH knowledge, attitudes, and practice, relative to individuals exposed to the DS independently or not exposed;
- b) To identify whether the effects of the RLG on FP/MCH knowledge, attitudes and practice (KAP) diffuse beyond participants to other members of their community; and
- c) To understand the RLG participants' and non-participants' attitude and perceptions related to the drama serial and the radio listeners' groups.

¹ *Radio Communication Program: An Impact Study in Phulbari Site of Chitwan District (2001), conducted by Valley Research Group (VaRG) for Johns Hopkins University/Population Communication Services, USA and Ministry of Health, Kathmandu.*

² *Digital Broadcast Initiative –Endline Survey Document: Nepal (2004). UNDP/Equal Access/VaRG.*

1.3 Methodology

Both the quantitative as well as qualitative methods were used to collect information from the program areas. Information required for the purposes of the study was collected from both the Radio Listeners' Group members and non-members. The study was conducted in 3 districts, namely Siraha, Dhanusha and Mahottari, using a 30-cluster sampling design technique. A total of 1,367 currently married women between 15-49 years of age were included in the study, of which 467 were the RLG members, 450 non-members from the RLG wards and 450 residents of non-RLG wards. In addition, 12 focus group discussions were conducted in the study districts of which 6 groups were among the RLG members and another 6 groups among the non-members residing RLG wards (3 groups) and women living in non-RLG wards (3 groups). Verbal consent was obtained from the responding women prior to interviewing them.

a) Selection of clusters/ wards

Selection of intervention areas

The initial sampling frame consisted of the wards or clusters of wards in Siraha, Dhanusha and Mahottari districts in which RLGs program have been implemented over the past year. For this purpose, information regarding the name and number of RLGs located in each ward together with the number of RLG members in each group was obtained from the NFHP. Based on the available information, the RLG wards were combined into clusters to ensure that sufficient RLG members were available in each location to satisfy sample size requirements. Then, 30 RLG clusters were selected randomly in order to interview the members of the radio listeners groups.

Selection of control areas

For comparison purposes the control areas were also selected. A total of 15 wards were selected from the three program districts with the ratio of 1:2 between control and intervention ward.

To increase the comparability with the intervention areas while also minimizing the diffusion of the program effect from the intervention areas, the wards for comparison purposes were selected from a list of all the wards that are one-step removed from the intervention areas (i.e. one ward separates the selected wards from the intervention ward). Wards adjacent to the intervention areas were excluded as far as possible for the selection of comparison areas to remove the possibility of spill over effects. Prior to selecting the control wards from each area, a list of alike to program wards in terms of their ethnic composition, distance to health facility and other factors was prepared in consultation with the local key informants. From the list of non-adjacent wards, a comparison ward was selected based on its similarity to the matched intervention ward in terms of ethnic composition, distance to health facility and distance to the nearest road head. The selection of control ward was done at the time of the data collection in the program ward of that locality.

b) Selection of respondents

In intervention areas

After selecting the intervention areas, the field team prepared a sketch map of each of the sampled clusters prior to proceeding for the data collection activity on consultation with knowledgeable

persons of each locality. After preparing a map of the clusters, the team identified the RLG members households and marked on the map.

The field teams prepared a list of all the RLG members together with their age, sex, marital status and number of days of their attendance in the RLG meetings during the past one-year prior to the survey week. The eligible RLG members for the present study was the currently married women aged 15-49 years who have participated in more than 20% of the RLG meetings in the past year. Based on these information the RLG members were further categorized into three broad categories:

- a) Frequent RLG member households (who have participated in at least 75% of RLG meetings in the past year)
- b) Infrequent RLG members households (who have participated in 20-74% of RLG meetings in the past year)
- c) Non-RLG member households or non-members (who have participated fewer than 20% of RLG meeting or none in the past year).

In each RLG cluster, 16 households with a RLG member (frequent and infrequent members) were selected. In doing so, eight households from the list of households in which a frequent RLG member resides and eight households from the list of households in which an infrequent RLG member resides were randomly selected. In wards with eight or less households in which a frequent RLG member resides, all frequent RLG member households were included and the number of infrequent RLG member households were increased to maintain the total number of RLG households selected in the ward at 16. In addition, 15 households were randomly selected from the list of households in which non-RLG members reside.

After completing the interviews with the RLG members, they were classified into three broad age groups i.e. 15-24, 25-34 and 35-49 years before selecting the non-RLG members within the RLG wards for interview. This was the basis for the selection of the non-RLG members of the specific age group from the RLG wards. Based on this information the same age group of non-RLG members from the RLG ward were selected for interview to avoid the age confounding effects. The required number of respondents were selected randomly. The “*screening questionnaire*” was administered to the head of households to identify the eligible respondents for the purpose of the study. The interview was continued until the required number of women of specific age groups were interviewed from each cluster. Only one eligible woman was interviewed from each of the sampled household. In case of more than one eligible woman residing in the sampled household only one woman was selected randomly. It was planned to interview 31 currently married women of reproductive (16 RLG members and 15 non-RLG members) from each of the RLG wards. However, 13 RLG members could not be interviewed from few clusters due to the unavailability of the members in those clusters. Thus a total of 467 RLG members and 450 non-members from the RLG wards were successfully interviewed from three study districts (Table 1.1).

Table 1.1 Distribution of sample population by type and district

S. No.	Respondent type	Siraha	Dhanusha	Mahottari	Total
1	In program areas				
	Number of clusters	15	9	6	30
	Number of RLG members	232	139	96	467
	Non-RLG members	225	135	90	450
2	In control areas				
	Number of clusters	8	4	3	15
	Number of respondents	240	120	90	450

ii) In control areas

The selection of respondents from the control areas was made following the same methods used for the selection of non-RLG members of the RLG wards. The same proportion of the women of the specific age group (i.e. 15-24, 25-34 and 35-49 years) interviewed in the RLG cluster were selected for interview in the control areas to minimize the age confounding effects. A total of 30 currently married women between 15-49 years old were selected from each of the non-RLG wards. Thus, a total of 450 women from 15 control areas were included in the study.

As in the case of program areas, the field team prepared a sketch map of each sampled clusters in consultation with local key persons prior to proceeding for the data collection activity. Based on the information obtained from the map and household list form, the field team randomly selected one settlement in order to identify an *index house* to start the interview in the sampled ward. The index household was identified by using the *spin the bottle* method. In order to identify the eligible respondents for the purpose of the study the “*screening questionnaire*” was administered to the head of households especially developed for the purpose of the proposed study. The interview was continued until the required number of women of specific age groups were interviewed from each cluster. Only one eligible woman was interviewed from each of the sampled household. In case of more than one eligible woman residing in the sampled household only one woman was selected randomly.

c) Focus group discussions

Twelve focus group discussions (FGDs) were conducted among the currently married women aged 15-49 years of age, separately among the RLG members, non-members of RLG wards and women of non-RLG wards in the study areas. Of the 12 FGDs, 6 were conducted among the RLG participants, and 3 FGDs among the non-members of the RLG wards and another 3 FGDs among the women living in the non-RLG wards.

1.4 Instruments development and pre-testing

The study used both structured and semi-structured interviews. The survey instruments (interview schedule and FGD guidelines) were jointly prepared by NFHP and VaRG (See [Annex # 2](#)). The final draft of the survey instruments was translated into Nepali and pre-tested among the radio listeners’ group members and non-members in Bara district before administering them in the field.

1.5 Field organization and data collection

The study was conducted under the overall supervision of the senior team members. The field staff was selected from among those who have previous knowledge and experiences in field survey. There were a total of 7 teams. Each team consisted of one supervisor and 2-3 female interviewers. They were given training for 8 days before mobilizing them to the field. Field work was conducted during January - February 2006.

1.6 Data processing and analysis

Data generated through interviews were coded for computer entry, data were validated by a computer processing team consisting of computer programmer and data entry personnel. After data entry and their checking, the printout of raw data was generated and verified with the questionnaires for detecting errors in data entry. In the second stage, machine editing of the data were done, by developing a computer program in FOXPRO software. Then, the cleaned data set was transferred to SPSS for output generation.

Data are presented in the form of tables and graphs. Initial data analysis involved simple frequency tables and cross tabulations. The analysis for this report focused on comparisons between RLG members, Non-RLG members of the RLG wards, and women living in non-RLG wards. Differences in knowledge, attitudes, and behaviors between RLG members and others provide some evidence of an effect of participation in the RLGs, while differences between non-members and women in non-RLG wards suggest a diffusion of the program beyond the RLG and into the wider community.

In addition, multivariate regression analyses were used to examine the relationship between the RLG status and selected outcome indicators related to family planning, safe motherhood, child health, and HIV/AIDS. These analyses were used to account for the underlying differences across the three study groups and remove the possibility that associations between RLG status and outcome indicators reflected these underlying differences across groups. The results of the multivariate analyses are presented in the respective chapters. For the logistical and linear regression analysis a number of control and dependent variables were identified based on the bi-variant analysis results. These variables were further recoded in three different categories such as dichotomous variables, categorical variables and continuous variables. Information regarding the control and dependent variables used in multivariate regression analysis is presented in [Annex # 1](#). Information collected through focus group discussions was transcribed, processed and analyzed manually and are presented in the relevant chapters of the report.

Chapter 2

Respondents and Community Characteristics

This study covered a total of 1,367 respondents of different categories. Of which, 467 were the members of the Radio Listeners Group (RLG), 450 were the non-RLG members of the RLG wards and the rest (n=450) were the respondents from the control areas. This chapter presents the socio-economic and demographic characteristics of the respondents of all three categories. The first section discusses on the age and ethnic composition of the respondents followed by literacy status and household possession and housing characteristics in the second and third sections. Knowledge about the existence of the mothers group is discussed in the fourth section and data on access to health facility in the fifth section. The sixth section presents data on marriage and fertility. Characteristics of the FGD participants are presented in the last section.

2.1 Age and ethnic composition

The survey results reveal that about a quarter of the respondents of all three categories (RLG members, non-RLG members and residence of control areas) were between 25-29 years and another one-fifth each were between 20-24 and 30-34 years (Table not shown). The mean age of the respondents of all three categories remained the same at 31 years indicating insignificant difference on the age composition among the respondents of three categories. It is to be noted that in the present study the same age categories of the respondents of non-RLG group and control areas as that of RLG group was purposively selected in order to minimize the age confounding effects.

Table 2.1 shows the ethnic composition of the respondents included in the study. The largest percentage (37.1%-49.3%) of the respondents from all three categories represented from *other terai ethnic* group followed by about a quarter (21.1%-28.5%) in Tibeto-Burman caste. Slightly a higher percentage of the non-RLG members compared to other categories of the respondents were from *other terai groups*. Considerably a higher percentage of the respondents from control areas (21.3%) represented from Dalit caste than the respondents of other two categories (16.1% RLG members and 14.4% non-RLG members).

Table 2.1 Percent distribution of respondents by ethnicity

Ethnicity	RLG member	Non-RLG member	Control area
Brahmin/Chhetri	8.8	9.1	12.9
Tibeto-Burman	28.5	21.1	25.8
Tharu	0.4	1.1	0.4
Dalit	16.1	14.4	21.3
Muslim	2.8	4.2	1.3
Other terai±	41.5	49.3	37.1
Other	1.9	0.7	1.1
Total (n)	467	450	450

± Other terai includes: Yadav; Kumhar; Rajbhar; Baniya; Kanu; Kurmi; Sudi; Kalwar; Teli; Kushuhawa.

2.2 Literacy

Table 2.2 shows the literacy status of the responding women of three categories and the level of education of their husbands. Those respondents who have completed primary level of education or able to read Nepali language fluently were defined as the literates in the present study. Slightly a higher percentage of the RLG members (23.8%) compared to the non-RLG members

(21.8%) and the respondents of the control areas (17.6%) were reported to be literate. Over 80% of the women of all three categories with the higher percentage of those from control areas had never attended schooling. About 7% each of the respondents had attained some primary and some secondary level of education while only about 4% had completed SLC and above level of education.

Table 2.2 Percent distribution of respondents by their literacy status and level of education, and their husband's level of education

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Percent literate	23.8	21.8	17.6
Level of education of respondents			
No schooling	80.1	80.4	84.0
Some primary	7.9	7.3	6.9
Some secondary	8.4	7.8	6.4
SLC or above	3.6	4.4	2.7
Husband's level of education			
No schooling	36.0	47.3	45.8
Some primary	19.9	13.8	16.7
Some secondary	24.2	19.8	21.1
SLC or above	19.7	18.7	16.4
Do not know	0.2	0.4	-

Considerably a higher percentage (64.0%) of the RLG members compared to the non-RLG members (52.7%) and the respondents of the control areas (54.2%) reported that their husbands have attended schools mostly attaining either some primary or secondary level of education. Nearly one-fifth of the RLG and non-RLG members and 16% of the respondents from control areas reported that their husbands have completed SLC or above level (Table 2.2).

When asked about the language(s) they usually speak at homes, the majority (62.7%-73.6%) of the respondents of all three categories mentioned Maithili that they usually speak at their homes. Nearly half (45.4%) of the RLG members and about 36% each of the non-RLG members and the respondents from control areas also reported that they usually speak Nepali at their homes. Most of the respondents of all three categories reported that they could understand Maithili language easily. By respondent types, over 80% of the non-RLG members and the respondents from control areas compared to 73% RLG members claimed that they could understand Maithili easily. Only 53% of the RLG members and about 43% each of the non-RLG members and the respondents of control areas affirmed that they could understand Nepali language easily (Table 2.3).

Table 2.3 Percent distribution of respondents by languages they usually speak at home and who can understand Nepali and Maithili languages

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Language spoken at home			
Maithili	62.7	73.6	66.0
Nepali	45.4	35.6	36.4
Magar	13.1	8.7	12.9
Tamang/Lama	7.9	6.9	5.8
Other (Hindi/Churaute/ Muslim/ Bhojpuri/ Tharu)	3.4	2.6	0.7
Understand Maithili language			
Yes, easily	73.2	80.7	81.6
Yes, with some difficulty	16.9	13.1	10.2
No	9.9	6.2	8.2
Understand Nepali language			
Yes, easily	53.3	43.3	42.9
Yes, with some difficulty	33.0	24.2	20.4
No	13.7	32.4	36.7

2.3 Household possession and housing characteristics

About three-fifths (57.8%-63.1%) of the respondents of all three categories reported having bicycle in their households. The percentage of the respondents possessing radio and television sets in their households was much higher among RLG members compared to other two categories of the respondents (Table 2.4). Access to electricity facility was also found to be much higher among RLG members (48.6%) than the non-RLG members (41.6%) and those of control areas (31.8%).

Table 2.4 Percent distribution of respondents having bicycle, TV and radio in their households (% yes only)

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Bicycle	62.7	63.1	57.8
Radio	53.5	45.8	44.4
TV set	27.4	22.9	18.2
Electricity facility	48.6	41.6	31.8

The source of drinking water for the majority of the respondents was reported to private or public tube well (55.9%-67.1%) followed by private or public well (15.3%-37.3%) and public or private tap (4.7%-17.6%). Almost all the respondents, except for 1% each of RLG and non-RLG member, have access to established water supply system (Table not shown).

Very small percentage of the respondents of all three categories reported having toilet facility in their houses. Respondent wise comparison indicates that the percentage of respondents having toilet facility in their houses was slightly higher among RLG members (16.7%) and non-RLG members (15.1%) than the respondents of control areas (7.7%) (Table not shown).

The majority (71.1%-78.2%) of the respondents of all three categories included in the study had houses roofed with tiles or *khapada* followed by thatched ones (15.8%-24.7%). Less than 5% of

the respondents had metal or cement roof in their houses. Regarding main materials of the wall, most of the respondents (82.7%-89.1%) said that the walls of their houses are bamboo plastered with clay. About 10% of the houses were with the walls of cement or bricks or cement blocks (Table not shown). No much difference was observed on the use of materials in the houses across the respondents' category.

Based on the information collected in the survey the socio-economic status (SES) index of the responding women has been calculated for the analysis purposes. The SES of the respondents was calculated by considering specific variables such as source of drinking water, toilet facility, roofing and wall of house, and possession of household (electricity, bicycle, TV and radio). While calculating the index each item was first given specific scores, which was based on the definition used in the previous studies carried out at national or international levels. The SES index was calculated by giving the scores for each of the following items of the sampled households:

Household items	Scores
Main material of the roof	4 for cement; 2 for metal or tiles/Khapada; 0 for other
Main material of the wall	4 for cement or cement blocks; 2 for bricks or wood planks; 1 for bamboo with cement; 0 for other
Type of toilet facility	4 for flush toilet; 3 for ventilated improved pit latrine; 2 for traditional pit latrine; 0 for other
Main source of drinking water	2 for piped, tube well or well in house/yard/plot; 1 for public or neighbors' tap, tube well or well; 0 for other
Household possession	2 for TV; 1 for radio; 1 for bicycle; 1 for electricity

Based on the total scores of each individual the SES index calculated using NTILES (rank transformation) containing in SPSS software where SES scores of the selected variables are converted into three ranks i.e. low, medium and high status. As presented in Table 2.5, nearly half of the respondents (43.8%-48.4%) with the higher percentage of those residing in control areas belonged to medium level SES. Over 30% of the respondents from control areas followed by 27% non-RLG members and 22% RLG members belonged to low SES. Considerably a higher percentage of the RLG members in comparison with non-RLG members and the respondents of control areas were found to be high SES.

Table 2.5 Percent distribution of respondents by their socio-economic status index

SES Index	RLG member	Non-RLG member	Control area
Low	21.6	26.7	30.2
Medium	44.3	43.8	48.4
High	34.0	29.6	21.3
Total (n)	467	450	450

2.4 Existence of mothers group

All the respondents were asked if mothers' groups in their areas existed or not. In response, nearly half (47.3%) of the RLG members followed by 30% non-RLG members and 22% respondents of the control areas reported that mothers groups in their areas are in existence. The above findings indicate that women in the study areas are less aware about the existence of mother's group in their areas. Those respondents who were aware about the existence of mothers group in their areas were further asked if they had participated in the mothers' group meetings

within 6 months prior to the survey. Over 60% of the RLG members compared to only one-third of the respondents from the control areas and 10% of the non-RLG members reported participating in the mothers' group meeting during that time (Table 2.6).

Table 2.6 Percent distribution of respondents by awareness about the existence of mothers' group in their areas and participation in the mothers' group meeting

Description	RLG member	Non-RLG member	Control area
Existence of mothers' group			
Yes	47.3	30.0	22.4
No/ do not know	52.7	70.0	77.6
Total (n)	467	450	450
Ever participated in the mothers' group meeting in the past 6 months			
Yes	63.3	10.4	33.7
No	36.7	89.6	66.3
Total (n)	221	135	101

Among those who reported participating in the mothers' group meetings were further asked whether there was discussions on issues related to family planning, safe motherhood, child health and HIV/AIDS. The great majority (>93%) of respondents of all three categories reported that they had discussion on issues related to family planning, safe motherhood and child health during the meetings. Relatively a smaller percentage of the respondents of all three categories reported discussing issues on HIV/AIDS during mothers' group meetings. For instance, 84% of the RLG members followed by 68% of the respondents from control areas and 64% non-RLG members reported discussing HIV/AIDS during mothers' group meeting (Table 2.7).

Table 2.7 Percent distribution of respondents reporting the issues discussed during mothers' group meetings, among those who reported participating in the mothers' group meeting within 6 months prior to the survey (% yes only)

Discussed on	RLG member (n=140)	Non-RLG member (n=14)	Control area (n=34)
Family planning	95.7	100.0	94.1
Safe motherhood (antenatal, delivery and PP care)	95.7	92.9	97.1
Child health (ARI, Diarrhea, Malnutrition, immunization, etc.)	96.4	100.0	100.0
HIV/AIDS	84.3	64.3	67.6

The respondents were also asked if they were affiliated with any of the community-based organizations (CBOs) in their areas. Data presented in Table 2.8 shows that a higher percentage of the respondents of all three categories were found to be affiliated with the savings or credit groups which is followed by mothers' group and literacy class group. Respondent wise comparison shows that the percentage of respondents who were involved in such groups was much higher among RLG members than the respondents of other two categories.

Table 2.8 Percent distribution of respondents by their affiliation with CBOs of their areas

Whether belonged to any of the following groups in locality	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Mothers' group	25.9	2.9	7.3
Literacy Class Group	9.0	1.3	1.6
Saving/Credit Group	36.2	19.8	16.7
Chairperson or member of RLG	27.2	-	-
Other±	3.9	2.0	1.6

± Other includes: Garibi Nibaran Bisheshwar Karyakram; Indreni Sewa Samaj; Garibi Nibarn Samuha; Subhealth post management committee; treasurer of Child Development Center; Chhimeki Samuha; Raj Devi Samuha; Mahila Sada Sanstha; Forest Group; Himal Mahila Samuha; Self Help Group; Kopila Sahakari Sanstha; Mahila Sahakari Sanstha; Poverty Alleviation Group; Janaki Mahila Samuha; Buddha Mahila Samuha.

2.5 Access to health facility and service utilization

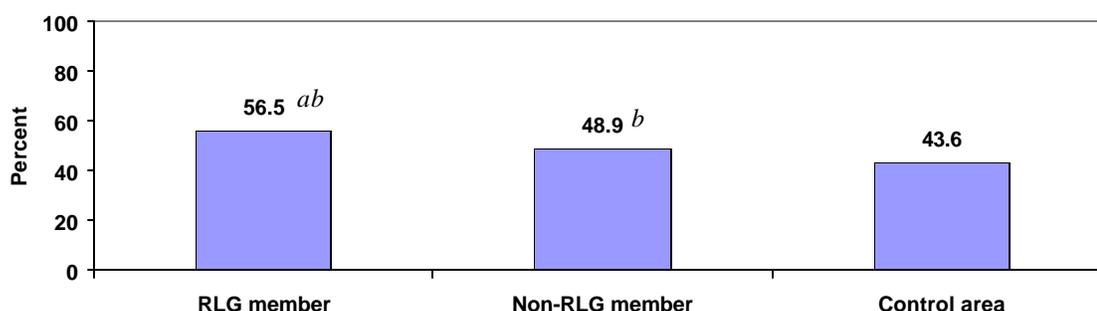
Information regarding the access to the health facility among the respondents of the study areas was sought during survey. More than half of the RLG and non-RLG members and 34% of the respondents from control areas reported that they have access to the health facility within a distance of less than half an hour and the rest had to spend more than half an hour to reach the nearest health facility from their residence. The mean travel time to reach the nearest health facility was more than 31 minutes for the respondents of control areas and about 25 minutes for RLG members and non-RLG members (Table 2.9).

Table 2.9 Percent distribution of respondents reporting the time required to reach the health facility

Walking distance to the nearest health facility	RLG member	Non-RLG member	Control area
<15 minutes	32.5	25.3	10.0
15-29 minutes	19.3	24.9	23.6
30-44 minutes	34.5	35.6	47.6
45-59 minutes	2.8	2.7	5.8
60 minutes +	10.7	11.6	13.1
Do not know	0.2	-	-
Mean (minutes)	24.6	25.5	31.4
SD	17.9	17.1	17.4
Total (n)	467	450	450

The respondents were also asked whether they had visited the health facility for seeking services in the past 6 months preceding the survey date. A significantly higher percentage of the RLG members than the other two categories of the respondents reported to have visited health facilities for seeking services ($p < .05$). For instance, about 57% of the RLG members in comparison to 49% non-RLG members and 44% respondents of control areas reported visiting the health facility for seeking health services in the past 6 months prior to the survey (Figure 2.1).

Figure 2.1 Percent distribution of respondents who visited the health facility for any type of services in the past 6 months prior to the survey date



n= 467 RLG members, 450 each of non-RLG members and the respondents of control areas
 Statistical tests: ^a – comparison with Non-RLG ($p<0.05$); ^b – Comparison with Control ($p<0.05$)

Of the respondents who had visited the health facility in the past 6 months preceding the survey, the majority (56.1%-62.2%) of the respondents of all three categories reported visiting the health facility for child health followed by 19% for safe motherhood. About 18% each of the RLG and non-RLG members and 10% respondents from control areas had also visited health facility for family planning services. About one in every 10 respondents had visited to get services for general illness (Table 2.10).

Table 2.10 Percent distribution of respondents by purpose of visiting the health facility in the past 6 months prior to the survey date, among those who had visited the health facility

Purposes of visiting the health facility (Multiple Responses)	RLG member	Non-RLG member	Control area
Child health	56.1	56.4	62.2
Safe motherhood	19.3	19.1	19.4
Family planning	18.2	17.7	9.7
Illness (self or family member)	13.3	8.2	9.7
Other [±]	8.7	7.3	6.6
Total (n)	264	220	196

[±] Other includes: headache; stomach pain; chest pain, infection or wound; tuberculosis; back pain; to get medicines; dental problem; ear problem; pain in hand; diarrhea; dysentery; urinary problem; skin problem.

2.6 Exposure to the electronic media

All the respondents, irrespective of their ownership status of radio and television, were asked how frequently they listened to the radio and watched television. All the RLG members and about three quarters of non-RLG members (74.2%) as well as the respondents of control areas (76.4%) had exposure to the radio (Table 2.11). The percentage of respondents listening to the radio either almost every day or at least once a week was much higher (87.1%) among RLG members compared to the non-RLG members (40.5%) and those of the control wards (38.9%). Considerably a higher percentage of the RLG members than other two categories of the respondents were found to have been exposed to television. For instance, over 60% of the RLG members compared to 41% non-RLG members and 34% those from the control areas reported to have watched television. With respect to the frequency of watching television, quite a small percentage (8.4%-16.3%) of the respondents of all three categories reported that they watched television almost every day (Table 2.11).

Table 2.11 Percent distribution of respondents by frequency of listening to radio and watching television

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Frequency of listening to radio			
Almost everyday	30.8	16.9	20.0
At least once a week	56.3	23.6	18.9
Less than once a week	12.8	33.8	37.6
Not at all	-	25.8	23.6
Frequency of watching television			
Almost everyday	16.3	11.1	8.4
At least once a week	17.8	10.9	7.8
Less than once a week	26.6	19.1	18.2
Not at all	39.4	58.9	65.6

Ownership of radio or television was found to be much higher among the RLG members than those of other two categories of the respondents. About 63% of the RLG members compared to 52% non-RLG members and 50% of the respondents from control areas reported to have either radio or television in their houses. About one in every 10 respondents of all three categories reported that they have a radio set only (Table 2.12).

Table 2.12 Percent distribution of respondents by ownership of radio and television

Ownership of media	RLG member	Non-RLG member	Control area
None	37.5	47.8	50.2
Radio only	35.1	29.3	31.6
TV only	9.0	6.4	5.3
Both radio and TV	18.4	16.4	12.9
Total	467	450	450

Those respondents who reported having a radio set or television or both sets were asked to what extent they got opportunity to choose their desired programs on the radio and television in their houses. Their responses are presented in Table 2.13. The survey results reveal that RLG members have more opportunity to choose their desired programs on radio and television than the respondents of other two categories. Nearly half (49.2%) of the RLG members compared to only 27% non-RLG members and 31% of the respondents of control areas reported that they could choose their desired program on the radio always or often. Considerably a higher percentage (53.9%) of the RLG members compared to other two categories (about 38%) of the respondents reported that they get opportunity to choose their desired television programs always or often in their households.

Table 2.13 Percent distribution of respondents by opportunity to choose the desired program on the radio and TV

Description	RLG member	Non-RLG member	Control area
How often do you get to choose what is listened to on the radio in your house			
Always	34.4	14.6	14.5
Often	14.8	12.6	16.0
Sometimes	42.4	53.9	54.5
Rarely	7.6	16.0	12.5
Never	0.8	2.9	2.5
Total	250	206	200
How often do you get to choose what is watched on the television in your house			
Always	40.6	28.2	20.7
Often	13.3	10.7	17.1
Sometimes	33.6	46.6	42.7
Rarely	9.4	13.6	17.1
Never	3.1	1.0	2.4
Total	128	103	82

The respondents were also enquired about the clarity of the Radio Nepal broadcast in their areas. On the question “*how well are you able to hear programs on Radio Nepal?*” nearly half (49.9%) of the RLG members followed by 45% of the non-RLG members and 33% respondents of control areas found the reception of the Radio Nepal very good and clear. A higher percentage of respondents of control areas than other two categories of respondents felt that the reception of the Radio Nepal was just fair. About one in every six respondents of all three categories felt its reception poor (Table 2.14).

Table 2.14 Percent distribution of respondents mentioning the extent of clarity of the Radio Nepal broadcast

Clarity of Radio Nepal	RLG member	Non-RLG member	Control area
Very good and clear	49.9	44.9	32.6
Fair	35.8	38.0	49.1
Poor	14.3	17.1	18.3
Total	467	334	344

The FGD participants of all three categories were also enquired about the radio listening habits of the people of their community. The FGD results reveal that most of the people in their community, irrespective of their age, sex and castes, listened to radio. A few of the participants, however, mentioned that people with low-income group and marginalized ones such as *Chamar, Dom, Mushar*, etc. do not listen to radio most frequently due to lack of radio set in their houses and time constraints or they have to go to the field most of the time for work. A few participants also viewed that access to television programs in their areas has also motivated them to watch television than to listen the radio. A 30 years old RLG member belonged to Mushar caste from Mahottari further added, “*Children, youth every body listens to radio programs. Particularly, upper caste people and youth listen to the radio more often. People from upper caste are often educated and they understand programs. Lower caste people are illiterate and they do not understand programs therefore they listen less often.*”

On the query about the time of the year people in their community listen to the radio most often and less often, almost all the participants included in the focus group discussions reported that during the cropping season in July/August (*Ashad* and *Shrawan*) people in their community listened to the radio less often. According to the participants winter season is the best time for radio listening to the community people of the study areas. The participants also noticed the increasing trend of people listening to the radio giving the reasons that these days radio is available in cheaper price, and people have access to informative, entertaining and educational programs from different radio stations. Some participants mostly the RLG members also reported that people in their community listened to the radio to know current political events. However, a few participants opined that TV program has reduced radio listening time.

Most of the FGD participants reported that people in their community mostly listen to the radio at 6-8 am, 12 noon – 2 pm, 4-5 pm and 7-9 pm. According to them housewives mostly listened to radio during food preparation time in the morning and evening. The participants also said that both the males and females listened to radio in the afternoon when they are free from their agriculture work.

The majority of the FGD participants of all three categories reported that people in their community mostly listened to Radio Nepal and Kantipur FM. Some participants also mentioned Image FM, and Birgunj FM. A few participants (one in every 10) also reported that people in their community listened to Indian radio stations such as All India, Aakaswani, Lucknow. Most of the participants found the programs aired from these Nepali radio stations interesting and entertaining. They also appreciated songs, and health related programs broadcast from these radio stations. During the discussions, the participants also suggested to broadcast programs in local (Maithili) language so that everyone could understand easily.

2.7 Marriage and fertility

More than two-thirds of the respondents of all three categories reported that they got married at less than 17 years of age. About one-fifth (17.6%-20.6%) of the respondents were married at the age of 17-18 years and another 15% after the age of 19 years. The mean age of marriage among the RLG members and those residing in the control areas was slightly higher (16.0 years) than the non-RLG members (Table not shown).

The mean number of children ever born and currently living by sex among the respondents of three different categories was calculated, and the results are presented in Table 2.15. The mean number of children ever born among the responding women was 3.16 and children currently living were 2.89 indicating that about 9% of the children born to the women had died. The mean number of children ever born and currently living was slightly higher among the women of the control areas and lower among the RLG members.

Table 2.15 Mean number of children ever born and currently living

Respondent type	Children ever born			Children currently living		
	Sons	Daughter	Total	Sons	Daughter	Total
RLG member	1.64	1.45	3.09	1.51	1.34	2.85
Non-RLG member	1.57	1.60	3.17	1.42	1.45	2.87
Control area	1.61	1.61	3.22	1.46	1.47	2.93
Total	1.61	1.56	3.16	1.47	1.42	2.89

2.8 General characteristics of FGD participants

Twelve focus group discussions (FGDs) were conducted among the currently married women aged 15-49 years of age. Of the 12 FGDs, 6 FGDs was conducted among the RLG participants, and another 3 each among the non-RLG members and the women of the control areas. A total of 94 women (47 RLG participants, 22 non-RLG participants and 25 from control areas) participated in the FGDs with the average number of 7-8 persons per FGD.

Table 2.16 presents the ethnic composition, and literacy status of the participants included in the FGDs. As in the quantitative survey most of the participants of all three categories were of terai origin (such as Yadav, Shah, Mandal, Mahato, Mushahar, etc.) followed by Tibeto-Burman castes (such as Magar, Lama, Tamang) and *Dalit*. Almost half of the RLG members and about three quarters of the participants from control areas were illiterate while nearly three quarters of the non-RLG members participated in the FGDs were reported to be literate.

Table 2.16 Percent distribution of FGD participants by their selected background characteristics

Description	RLG members (n=47)	Non-RLG members (n=22)	Participants of control areas (n=25)
Ethnicity			
Tibeto-Burman	25.5	27.3	50.0
Dalit	40.4	36.4	4.0
Other terai castes	31.9	31.8	46.0
Other	2.1	4.6	-
Literacy			
Literate	48.9	72.7	28.0
Illiterate	51.1	27.3	72.0

Chapter 3

Findings on RLG

This chapter presents data on knowledge about the existence of radio listeners' groups (RLG) in their areas among the non-RLG members and the respondents of the control areas. Likewise information about the radio listeners group collected from the RLG members such as motivating factors for joining RLG, frequency and duration of group meetings and discussions, opinion on program facilitators and influence of the RLG are also discussed.

3.1 Motivating factors in joining RLG

As mentioned in chapter one, there was a total of 467 RLG members included in the study from three study districts namely Mahottari, Dhanusha and Siraha. Data presented in Table 3.1 shows that the great majority (95.1%) of the respondents were affiliated with the RLG for more than one year and the rest (4.9%) for less than one year. Most of the respondents reported that they joined the RLG with the expectation of learning new topics and issues (84.4%) and health related matters (73.9%). The other reasons mentioned by a sizeable percentage of the respondents were that they got advice from other people (26.1% by FCHV and 22.1% by friends) and found the program entertaining (26.3%).

Table 3.1 Percent distribution of RLG members by their duration of involvement in RLG and reasons for joining the RLG

Description	%	No.
Duration of involvement in RLG		
<12 months	4.9	23
12-23 months	95.1	444
Total	100.0	467
Main reasons for joining the listening group (Multiple Response)		
Can learn new topics and issues	84.4	394
Can learn health related matters	73.9	345
It is entertaining	26.3	123
FCHV advised	26.1	122
Friends advised	22.1	103
NGO advised	8.1	38
Other (advised by daughter/ advised by facilitator)	5.6	26
Total	-	467

The respondents were also asked if any of their family members belonged to their radio listeners' group. About one-fifth (19.9%) of the respondents reported that their family members also belonged to their group, mostly the female members (Table 3.2).

Table 3.2 Percent distribution of RLG members by family members belonging to the RLG

Whether any family member belong to this group (Multiple Response)	%	No.
Sister-in law	13.7	64
Mother-in-law	2.6	12
Other family members (daughter, daughter-in-law, husband, brother-in-law, aunt)	5.6	26
None	80.1	374
Total	-	467

When enquired about the persons who encouraged them to join the RLG, nearly half (46.5%) of the respondents reported that their friends, neighbors or relatives encouraged them to join the RLG (Table 3.3). Nearly two-fifths (37.9%) of the respondents also mentioned that they were encouraged by FCHVs. About a quarter of the respondents also mentioned that they were encouraged by husbands (25.3%) and other family members (23.6%) indicating the good support of the family in joining the radio listening groups. These findings are consistent with the results obtained from the FGD participants of RLG. During the discussion, most of the RLG members reported that they became member of their radio listeners group with the suggestion of FCHVs, friends and family member.

Table 3.3 Percent distribution of RLG members who were encouraged to join the RLG

Persons encouraging to join the RLG group (Multiple Response)	%	No.
Friend/neighbor/relative	46.5	217
FCHV	37.9	177
Husband	25.3	118
Other family member	23.6	110
NGO staff	15.8	74
Mother-in-law	6.9	32
Facilitator	3.6	17
Father-in-law	1.3	6
Other (social worker)	2.1	10
No one/self	2.1	10
Total (n)	-	467

The respondents were also asked whether they themselves had encouraged any other people of their community to join the RLG. Over 9 in every 10 respondents affirmed that they had encouraged others to join the RLG. Only 8% of the respondents reported that they had not encouraged others (Table not shown).

One day FCHV Didi gave me a book and told me to join the radio listeners group. Seeing some naked pictures in the book, my husband forbade me to join the group. However, after reading the book, our daughter-in-law explained us that RLG group is for good purpose only after then he (husband) recommended me to join the group.”

A 42 years old Dalit RLG member from Siraha district

3.2 Frequency and duration of group meetings and discussions

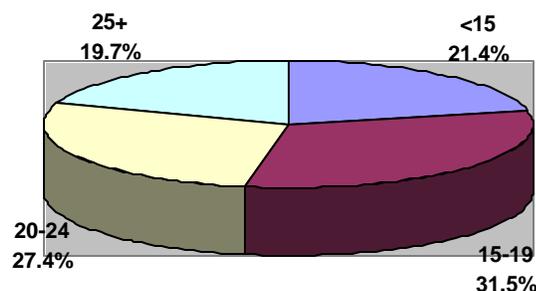
The large majority (95.1%) of the respondents reported that their listening groups meet every week. In principle, each of the radio listening session should be organized from 45-60 minutes. In this context, the respondents were asked about the duration of their radio listening group session. In response, about 7 in every 10 respondents said that the radio listening session mostly lasted for 30-60 minutes. About one-fifth (19.9%) of the respondents also said that the meeting lasted for less than half an hour and another 10% mentioned more than one hour (Table 3.4).

Table 3.4 Percent distribution of RLG members reporting the frequency and duration of radio listening group meeting

Description	%	No.
Frequency of organizing listening group meeting		
Once a week	95.1	444
Twice a week	1.9	9
Once every fifteen days	2.1	10
Other (once a month)	0.9	4
Total	100.0	467
Duration of a typical listening group session		
<30 minutes	19.9	93
30-45 minutes	32.5	152
46-60 minutes	37.5	175
61 minutes or more	10.1	47
Total	100.0	467

The higher percentage (58.9%) of the respondents reported that usually 15-24 people attend in each of the radio listeners' group meeting. Over 21% of the respondents mentioned less than 15 persons who usually attend and another 20% said that more than 25 persons participate in each of the group meeting. The average number of persons usually present in each session of RLG meeting was recorded to be 18 (Figure 3.1). The FGD results revealed that except a few participants most of them reported that they mostly attend the RLG meetings regularly. According to the participants, they missed some RLG meetings during peak agricultural seasons, when they were ill and while visiting parents home (*Maitee*) or other relative's homes. A 30 years old Musahar woman gave the reason for not attending the meetings regularly, "Sometimes I miss the group meeting, as there is no one at home to take care of my 4 young children."

Figure 3.1 Percent distribution of RLG members by number of persons participating in each session of the radio listeners' group



Mean: 18.2 person; SD= 5.4
N= 467

Almost all (97.2%) the respondents reported that their groups organize discussion sessions every time after listening the drama serial. Only about 3% of the respondents said that their groups do not organize such discussions in every meeting (Table not shown). In the FGD, almost all the RLG members reported that they actively took part in the discussion after listening to the radio program. According to them, only a few members did not take part actively due to shyness and being not conversant in Nepalese language that make them difficult to express their views during the discussion sessions.

Even if I know the subject matter better, I feel awkward to express in front of others. I lose confidence and feel that what I am telling is wrong.

A 40 years old Tamang woman from Siraha district

I do not understand the program completely due to my language problem. I do always fear that what others will react with me if I do speak in the group.

A 25 years old Kumal woman from Dhanusa district

The members of the RLG who participated in the FGD were also asked to give their opinion regarding differences on listening to the radio program in the “group settings” and “alone” at home. The FGD participants found it completely different. More than half of the participants mentioned that in the groups they could discuss on the related topics and ask their peers if they do not understand anything. Likewise, more than half of the participants also opined that group listening is more interactive and enjoyable than listening to the program at home.

It is very useful to listen in a group. We can ask to friends whenever we do not understand. If someone misses a program in a particular week, she can know the message of the program in the next week group discussion and discussion helps us to remember for long.

A 32 years old Magar woman from Mahottari district

Before I used to be quiet, very shy and could not talk with other persons. Now, I can speak in front of others and discuss among the group.

A 40 years old Tamang woman from Siraha district

Most of the respondents reported that they discuss the contents of the *Gyan Nai Shakti Ho* radio serials with their group members and non-members outside the group meetings (Table 3.5). Over half of the respondents reported that they discussed about the radio serial once or twice a week (58.7% with group members and 51.2% with non-members). About one in every 10 respondents also reported to have discussed more than twice a week.

The RLG members participated in the FGDs also reported discussing and sharing matters they learned from the group meetings with their family members, relatives and friends particularly about the importance of seeking antenatal services, danger signs and symptoms during pregnancy and delivery, importance of using family planning methods and appropriate birth spacing. Some participants also reported that after learning from the RLG meetings they have advised others for seeking antenatal services, taking adequate rest and eating nutritious foods during pregnancy, giving *Jeevan Jal* (ORS) during diarrhea, maintaining environment clean, etc. The above information clearly reveals that most of the RLG members shared information they have learned from the RLG with others.

Table 3.5 Percent distribution of RLG members reporting the frequency and duration of radio listening group session

Description	%	No.
Frequency of discussing the content of the Gyan Nai Shakti Ho episodes with group members outside the group meetings		
Five to six times a week	0.6	3
Three to five times a week	9.9	46
Once or twice a week	58.7	274
Once a month	17.3	81
Rarely/ never	13.5	63
Total	100.0	467
Frequency of discussing the content of the Gyan Nai Shakti Ho episodes with non-members		
More than five times a week	0.4	2
Between three to four times a week	12.4	58
About two times a week	51.2	239
Less than once in a month	22.1	103
Rarely/ never	13.9	65
Total	100.0	467

3.3 Opinion on program facilitator

Slightly over one-fifth (21.6%) of the respondents reported that FCHVs mostly facilitate the radio listeners' group sessions. Over three-quarters (78.4%) mentioned social workers, NGOs and other persons who mostly get involved in facilitating the groups (Table not shown).

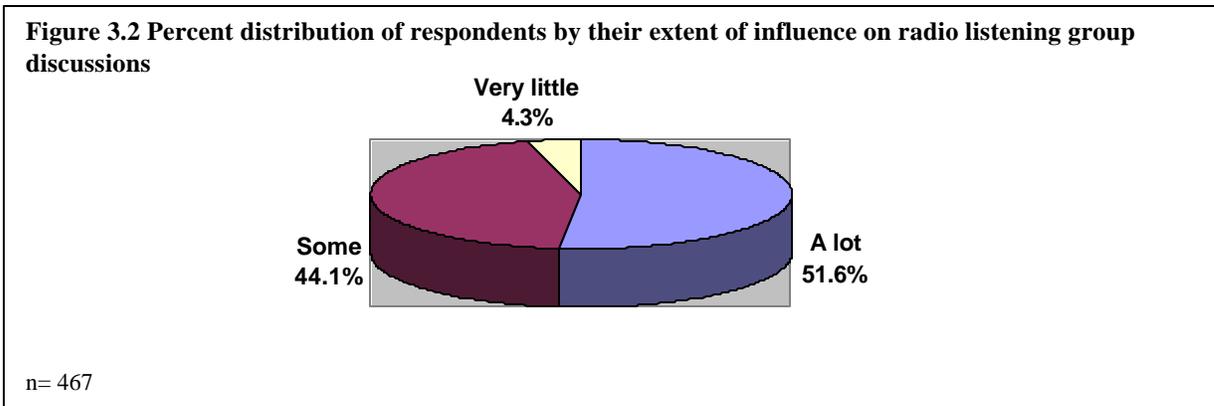
Opinion of the RLG members on the facilitation skills of their facilitators was also sought during the study. All the respondents appreciated the facilitation skills of their facilitators with respect to ensuring every member to participate in the discussion, summarizing messages of the drama serial and main points made during the discussions. About two-thirds (65.1%-66.6%) agreed that they handled the above-mentioned aspects *very well* and the rest opined that they did *well* (Table 3.6)

Table 3.6 Percent distribution of RLG members by their opinion on the facilitation skills of their facilitators

Facilitation skills of the facilitator	Very well	Well
Ensures that every member participates in the discussion	65.1	34.9
Summarizes the messages in the drama serial	66.6	33.4
Summarizes the main points made during the discussion	66.2	33.8

3.4 Influence of the program

Information regarding the extent of influence of the respondents on the listeners' group discussions was also sought during the survey. Data presented in Figure 3.2 show that over half (51.6%) of the respondents have *a lot* of influence followed by 44% have *some* 4% have *a very little* influence on listening group sessions.



Majority of the respondents observed the positive influence of the radio listeners’ group session in making changes in their community. Nearly two-thirds (66.4%) of the respondents expressed that such listening groups have made positive changes in their community *a lot* and another 30% opined that it has brought *some or a little* changes in their community. Quite a small percentage the respondents did not observe any influence of the listeners’ group in their community (Table 3.7). On the question “*to what extent has participation in the listening group made changes in your life?*” nearly three-quarters (71.5%) of the respondents felt that their participation in the radio listening group have made *a lot of changes* in their personal life. About a quarter of the respondents felt *some changes* while only 3% felt very little changes in their personal life.

Table 3.7 Percent distribution of RLG members who observed changes in their community and felt changes in their life styles as a result of participation in the RLG

Description	%	No.
To what extent is the listening group able to make changes in the community?		
A lot	66.4	310
Some	30.2	141
Very little	2.6	12
None	-	-
Do not know	0.9	4
Total	100.0	467
To what extent has participation in the listening group made changes in your life?		
A lot	71.5	334
Some	24.6	115
Very little	3.2	15
None	0.6	3
Do not know	-	-
Total	100.0	467

Similar question was also put forward to the RLG members who participated in the FGDs. Most of the FGD participants acknowledged that the RLG provided them opportunity to learn many information related to health, safe motherhood and family planning. Most of the participants mentioned that they learned about the importance of receiving antenatal and delivery services, advantages of feeding colostrums to newborn, importance of green vegetables to the pregnant women, washing hands with soap, causes of pneumonia, delaying marriage, diarrhea and its treatment, HIV/AIDS, etc. by joining the radio listeners group. Some of the notable expressions made by the participants during FGDs were:

I knew what a pregnant woman has to do and not to do during her pregnancy. When and where a pregnant woman has to go for her check up. I also knew that we need to feed nutritious food to pregnant women and allow her rest from hard work.

A 32 years old Magar woman from Siraha district

We have started to keep our houses and yard clean and asked our children to wash their hands before taking meal. We learned that baby should feed some extra food than breast milk.

A 23 years old Musahar woman from Mahottari district

We have already changed our practice by arranging a clean room with enough light and air for the delivery keeping pregnant woman clean during delivery.

A 45 years old Magar woman from Mahottari

The overall findings reveal that the radio listening group sessions have been instrumental in bringing positive changes among the community people in various aspects of their life.

The respondents were also asked to give the reasons why people of their community do not join the radio listeners groups. Lack of time, poverty and busy with the household works were the main reasons for not joining the radio listeners group as reported by over four-fifths of the respondents. Nearly one-fifth of the respondents reflected that people in their community lack of knowledge about the importance of such radio programs. Restrictions by family members and lack of awareness or illiteracy as reasons for not joining the group was mentioned by about 10% each of the respondents (Table 3.8). The above findings were also found to be consistent with the FGD results. A typical reason for not joining the RLG group mentioned by a 28 years old Teli Non-RLG member was “Some people of our community mentioned that the RLG members discuss about vulgar topics (in her words discussion on reproductive organs, condom use, etc.) in the group meetings, therefore, I did not join the group.”

Table 3.8 Percent distribution of RLG members by their opinion regarding the reasons for not joining by other people of their community in the radio listeners groups

Reasons for not joining RLG by other people in the community	%	No.
Busy with household work/ lack of time/ poverty/ should take care of children	81.8	382
Lack of knowledge about the importance of the program/ do not care about the program	17.1	80
Family members, mothers-in-law, husbands do not allow	11.6	54
Lack of awareness/ due to illiteracy	10.3	48
Did not feel it necessary to go/ not interested to attend or join the meeting	7.5	35
Language problems/ difficult to understand Nepali language	3.6	17
Other±	9.6	45
Do not know	1.3	6
Total (n)	-	467

± Other includes: broadcast time inappropriate; no new membership issued; young daughters and daughter-in-law are not allowed to go outside; no monetary benefit; did not like the program; religious reason; they have radio set in their own house; because of low caste people; too old women do not join the group; poor behavior of facilitator.

3.5 Knowledge of RLG and interaction with RLG members

All the non-RLG members and the respondents of the control areas were asked if they were aware about the existence of the Radio Listeners Group in their areas. In response, over 80% of the non-RLG members and 3% respondents of control areas affirmed that they are aware about the existence of RLG in their areas. Almost the same percentage of the respondents (79.1% non-RLG members and 2.2% from control areas) also reported knowing the persons who belonged to RLG (Table 3.9).

Table 3.9 Percent distribution of non-RLG members and the respondents of control areas who know about RLG or any persons belonging to RLG in their areas

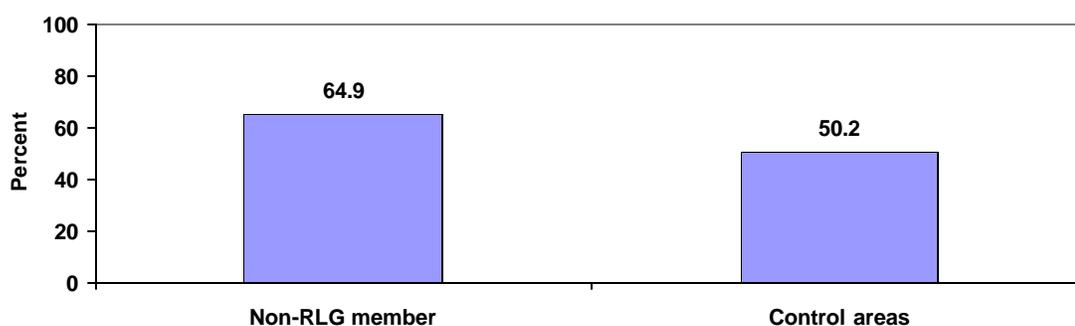
Description	Non-RLG member (n=450)	Control areas (n=450)
Percent who know about the RLG	80.4 ^b	2.7
Percent who know any one who belongs to RLG member	79.1 ^b	2.2

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Regarding the existence of radio listeners group, a similar result was observed from FGD participants (non-RLG members and the participants of control areas). All the non-RLG members included in the FGD had knowledge about the existence of radio listeners group in their areas. However, not a single participant of control group knew the existence of such groups. When enquired to the participants of the control areas about their interest in participating in such radio listening groups, all the FGD participants of the control group expressed their willingness to participate in such program in their community. In this respect a FGD group of the control areas in Siraha district said, “Please do start ‘GYAN NAI SHAKTI HO’ and other program in our area also. We are very interested to join the group.”

Both the non-RLG members and the respondents of the control areas were asked if any one had talked to them about family planning, safe motherhood, child health or STI/HIV/AIDS matters in the past one year. In response, 65% (n=292) of the non-RLG members and 50% (n=226) of the respondents of control areas reported that some one else had talked to them on the above mentioned issues in the last one year prior to the survey date (Figure 3.3).

Figure 3.3 Percent distribution of non-RLG members and respondents of control wards receiving information from some one else about family planning, safe motherhood, child health or STI/HIV/AIDS matters in the past one-year



N= 450 each of non-RLG members and the respondents of control wards

As discussed in Chapter 3 (see Table 3.5), a sizeable percentage of the RLG members reported discussing various health issues with both the members of the RLG and non-RLG members of their community. To further explore the diffusion of the health information outside the RLG, Table 3.10 presents the percent of non-RLG members and women living in control areas who reported discussing health issues with others in the last one year prior to the survey. A higher percentage of the respondents of both categories (51.8% non-RLG members and 41.3% respondents of control areas) reported that they had discussed at least one issues related to child health. Likewise, about one-third of the non-RLG members and about 23% respondents of control areas mentioned issues related to family planning and spousal communication. About one-fifth of the respondents of both categories reported that someone had discussed with them on safe motherhood issues. The percentage of respondents of both categories mentioning aspects such as FCHVs roles and STIs and HIV/AIDS was quite low (Table 3.10).

Table 3.10 Percent distribution of non-RLG members and the respondents of control areas mentioning at least one topics on different issues they were discussed by some one in the last one year

What issues did s/he discuss with you?	Non-RLG member (n=450)	Control areas (n=450)
Safe motherhood±	22.2	17.1
FP and spousal communication§	33.6	22.9
Child health‡	51.8	41.3
FCHV's roles	2.9	3.1
About STIs and HIV/AIDS	0.4	1.3

± *Safe motherhood: danger signs during pregnancy; danger signs during delivery; care during delivery and birth preparedness.*

§*FP and spousal communication: Contraceptive methods; well-planned family; spousal communication.*

‡*Child health: Vitamin A; Immunization; diarrhea and three home rules; nutrition; cough/cold and home based treatment; neonatal care; recognizing signs and symptoms of pneumonia and home based care; new born danger signs; breast feeding and supplemental food.*

Chapter 4

Exposure to the Radio Health Program

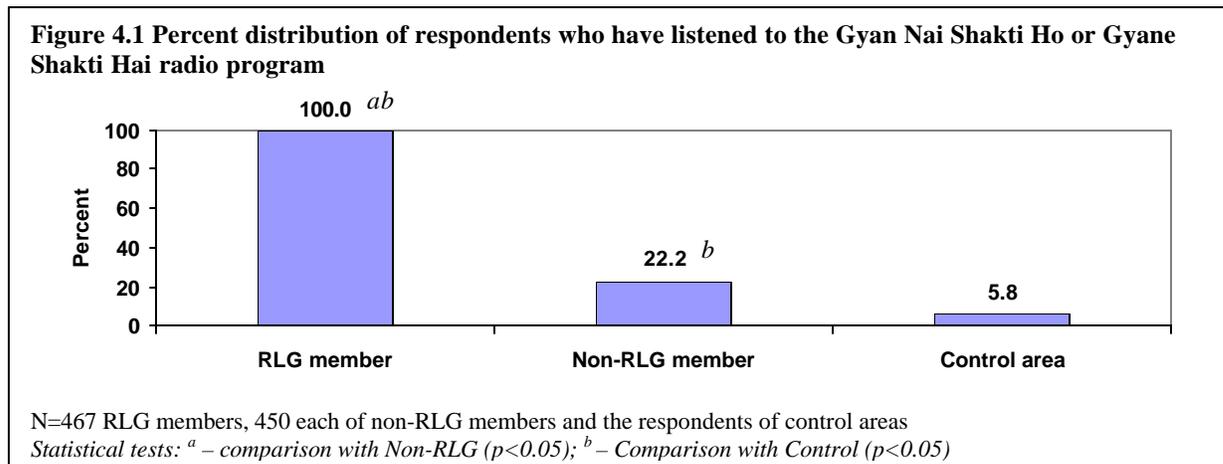
This chapter presents information regarding the exposure of respondents to electronic media, radio health programs, print media including types of health related messages they listened from these media was collected from all three categories of the respondents included in the study.

4.1 Exposure to radio health program

Respondents' level of exposure to the radio health programs namely, *Gyan Nai Shakti Ho* and *Sewa Nai Dharma Ho* are discussed in this section.

a) Exposure to *Gyan Nai Shakti Ho*

All the RLG members followed by 22% of the non-RLG members and 6% of the respondents of the control areas reported to have listened to the *Gyan Nai Shakti Ho* (in Nepali) or *Gyane Shakti Hai* (in Maithili) radio health programs (Figure 4.1). The above findings further reinforces that exposure to the drama serial was much higher among non-RLG members compared to the respondents of control areas ($p < .05$). Likewise, 36% of the RLG members compared to only 7% non-RLG members and 4% of those from control areas reported to have listened to the *Gyane Shakti Hai* radio program aired in Maithili language (Table not shown).



FGD findings also reveal that very few participants of non-RLG and control groups had listened *Gyan Nai Shakti Ho*. When asked about the reasons for not listening to this radio health program, most of the FGD participants (non-RLG members and those of control areas) reported that they have not heard about the program. Some participants, mostly the non-RLG members mentioned that they did not know about the program and time of airing. Few non-RLG participants from Dhanusha district informed about the difficulty in understanding program in Nepali language. The above findings suggest the need for informing the community people about the program broadcasting time and schedule.

Findings of the FGD indicate that in RLG area *Gyan Nai Shakti Ho* is very popular followed by *Sathi Sanga Manko Kura*. Some of the reasons for the popularity of the radio program were full of health information and knowledge gaining program. They appreciated receiving health

information on child health and immunization, pregnancy care, feeding nutritious foods to pregnant women, making small family by using family planning methods, etc. provided by these radio programs. However, in the non-RLG and control group area *Sathi Sanga Manka Kura* and *Hello Mithila* programs were reported to be more popular. Some other programs mentioned by the participants were *Sewa Nai Dharma Ho*, *Jana Swastha Karyakram*, *Desh Pardesh*, and *No Tension*.

When does the program broadcast we do not know. We do not know any thing about the program and we do not understand the program in Nepali language.
A 30 years old non-RLG member from Dhanusha District

Gyan Nai Shakti Ho is very popular in our area. It tells us how to find out dangers signs and symptoms during pregnancy, it tells us about methods of family planning, and teaches us how to care an infant.
A 30 years old Dalit RLG member from Siraha district

Hello Mithila is popular in our area because it is in Maithili language and we all understand it clearly.
A 20 years old Teli woman of Non-RLG from Siraha district

Among those who had listened to the *Gyan Nai Shakti Ho* or *Gyane Shakti Hai* radio health programs were further asked about the frequency of listening to these programs. Data presented in Table 4.1 indicate that a very few of the respondents who are not affiliated with radio listening groups have listened to the radio health programs regularly. For instance, over 60% of the RLG members compared to less than 10% of the non-RLG members and the respondents of control areas reported to have listened to the radio program every week. Likewise, about one-third of the RLG members and non-RLG members and 23% of the respondents from control areas reported listening to the radio program a couple of times in a month. The percentage of respondents who had listened to the radio programs only once or twice was quite high among the non-RLG members (23.0%) and the respondents of control areas (34.6%) as compared with the RLG members.

Table 4.1 Percent distribution of respondents by frequency of listening to Gyan Nai Shakti Ho or Gyane Shakti Hai radio health programs

Frequency of listening to Gyan Nai Shakti Ho	RLG member	Non-RLG member	Control area
Every week	63.0	9.0	7.7
A couple of times a month	33.2	35.0	23.1
Once a month	2.1	22.0	15.4
Less than once a month	0.9	11.0	19.2
Only listened once or twice	0.9	23.0	34.6
Total (n)	467	100	26

Those respondents (18 RLG members, 56 non-RLG members and 18 respondents of control areas) who reported listening to the radio health programs less frequently (such as once a month, less than once a month or once or twice) were again asked about reasons for not listening to the radio programs more often. The large majority (83.9%-94.4%) of the respondents of all three categories gave the reason as the *lack of time*. About one-fifth of the non-RLG members and 6% each of the RLG members and the respondents of control areas mentioned *inconvenient broadcast time* as the reason for not listening to the radio program. Few of the respondents also cited lack of radio set, no knowledge about broadcast time, and language difficulty for not

listening to the radio program more often (Table not shown). The findings also indicate lack of awareness of the people as the reason for not listening to the program. About one-third of the RLG members included in the FGDs also reported that they have been listening to every episode of *Gyaan Nai Shakti Ho*. However, about two-thirds of the participants reported that they have missed some episodes due to their household and farm work.

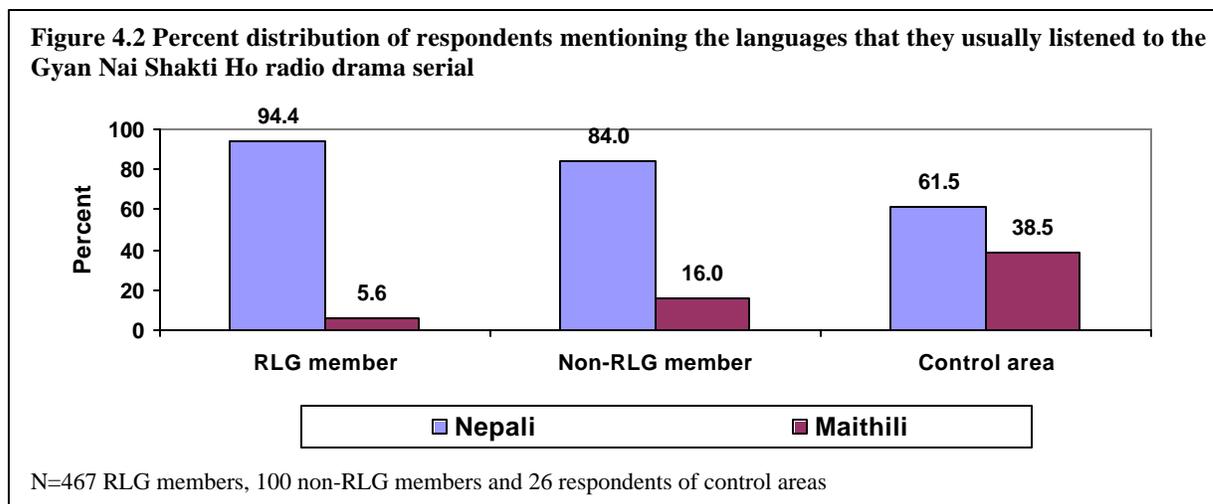
When further enquired about the duration of listening to the radio health program, the great majority (88.9%) of the RLG members compared to only 29% non-RLG members and 8% of the respondents of control areas reported that they had been listening to the program for more than 18 months. More than half of the non-RLG members and the respondents of control areas as against only 4% of the RLG members had been listening to the *Gyan Nai Shakti Ho* radio health program for less than one year. The mean duration of listening to the radio program was quite high (20.5 months) among RLG members compared to non-RLG members (11.9 months) and the respondents of control areas (8.1 months). The respondents were also enquired about the number of episodes of *Gyan Nai Shakti Ho* they have listened in the last three months prior to the survey date. As expected, quite a higher percentage of the RLG members compared to the non-RLG members and the respondents of the control areas reported to have listened to more than 8 episodes during the last three months period. The mean number of radio episodes listened by the RLG members was 8 followed by 4 episodes among non-RLG members and 2 episodes among the respondents of the control areas (Table 4.2).

Table 4.2 Percent distribution of respondents listening to the Gyan Nai Shakti Ho radio program by duration and number of episodes

Description	RLG member (n=467)	Non-RLG member (n=100)	Control area (n=26)
Duration of listening to the "Gyan Nai Shakti Ho" radio drama serial (in months)			
<6	-	16.0	23.1
6-11	4.7	35.0	26.9
12-17	6.4	8.0	7.7
18 +	88.9	29.0	7.7
Do not know	-	12.0	34.6
Mean	20.5	11.9	8.1
SD	3.3	6.8	6.0
Number of episodes of "Gyan Nai Shakti Ho" radio drama serial listened in the last 3 months			
None	9.0	22.0	30.8
1-4	10.3	40.0	53.8
5-8	24.4	20.0	15.4
9-12	55.9	16.0	-
Do not know	0.4	2.0	-
Mean	8.1	4.0	2.2
SD	3.8	3.7	2.0

On the question “*How often would you listen to Gyan Nai Shakti Ho if you were not a member of a group?*” almost all the RLG members participated in the FGD reported that they would not have listened to the programs regularly as they would not have been aware about the program itself and also on the timetable of the program broadcast. They felt that participation in the RLG have encouraged them to listen to the program regularly.

The respondents were also asked in what languages they usually listened to the *Gyan Nai Shakti Ho* radio drama serial. Over 94% of the RLG members followed by 84% non-RLG members and 62% of the respondents of the control areas reported that they usually listened to the radio serial in Nepali language. The percentage of the respondents who usually listened to the radio serial in Maithili was higher among the respondents of the control areas (Figure 4.2).



Opinion of respondents regarding the language or dialogue spoken by the characters in the drama and broadcast duration of the program was also sought during the study. Majority of the respondents with a higher percentage of the respondents of control areas (88.5%) than those of non-RLG members (79.0%) and RLG members (65.1%) felt that the dialogue spoken by the characters in the drama serials was *easy to understand*. Nearly 30% of the RLG members followed by 17% non-RLG members and 12% respondents of the control areas find it somewhat difficult to understand. When asked to give their opinion on the duration of broadcast time of the radio drama serial, more than half of the RLG members and the respondents of control areas find it to be short. Half of the non-RLG members followed by 46% of the RLG members and 39% of the respondents of control areas felt the duration of broadcast time to be just right. Quite a small percentage (<4%) of the respondents find the broadcast duration of the drama serial to be too long (Table 4.3).

Table 4.3 Percent distribution of respondents by their opinion regarding the language, and broadcast duration of the *Gyan Nai Shakti Ho* radio drama serial

Description	RLG member (n=467)	Non-RLG member (n=100)	Control area (n=26)
How easy it is to understand the dialogue spoken by the characters in the drama?			
Easy to understand	65.1	79.0	88.5
With some difficulty	29.3	17.0	11.5
Do not understand at all	5.6	4.0	-
Opinion regarding the broadcast duration of "Gyan Nai Shakti Ho" radio drama serial			
Short	52.0	49.0	57.7
Just right	46.3	50.0	38.5
Long	1.5	1.0	3.8
Do not know	0.2	-	-

When asked to give their impression on the radio dram serial *Gyan Nai Shakti Ho*, majority of the respondents (59.0%-77.9%) with a higher percentage of the RLG members opined that the radio drama serial was both entertaining and educational. Over one-third (34.6%) of the respondents from control areas followed by 26% non-RLG members and 14% RLG members find it more entertaining, and 15% of the non-RLG members and 8% of the RLG members find the drama serial more educational (Table 4.4). The FGD participants voiced that *Gyaan Nai Shakti Ho* is a good radio program, which satisfied them utmost. They further mentioned that the program has been able to inform them about issues related to child health, pregnancy, general hygiene, immunization, etc.

Table 4.4 Percent distribution of respondents by their impression on the *Gyan Nai Shakti Ho* radio program

Main impression about "Gyan Nai Shakti Ho" radio drama serial	RLG member	Non-RLG member	Control area
It is more entertaining	14.1	26.0	34.6
It is more educational	7.9	15.0	-
It is entertaining and educational as well	77.9	59.0	65.4
Total (n)	467	100	26

More than three-quarters of the RLG members and non-RLG members included in the FGD expressed that the *Gyan Nai Shakti Ho* radio health program reflected the real situation of their own community. The participants felt that the job description of their FCHV and Janaki Didi were same. Inter-caste marriage discussed in the program is also taking place in their communities. Drinking and wife beating habit of some male member in their communities and the husband of Ita Kumari also reflected similar situation in their communities.

The FCHV Didi of our area is the same as Janaki Didi in the drama. Like Janaki Didi, our FCHV Didi also distributes condoms, pills, provides suggestions for health check up for pregnant woman, and worked in immunization.
A 40 years old Musahar woman of RLG from Siraha district

When Ita Kumari was pregnant, her husband used to return home drinking alcohol and start giving bad names and fight with her. This situation is as same as mine.
A 30 years old Yadav woman of RLG from Dhanusha district

Those respondents who had exposure to the radio drama serial were also asked whether they had discussed about the contents with any one in the past 6 months. Data presented in Table 4.5 indicates that RLG members are more likely to discuss about the radio drama serial than other two categories of the respondents ($p < .05$). For instance, over 90% of the RLG members compared to 73% of the non-RLG members and 65% of the respondents from control areas reported that they had discussed about it with others. An overwhelming majority (86.3%-88.2%) of the respondents of all three categories reported that they had discussed about the radio drama serial with their friends and neighbors. Likewise more than three-quarters of the respondents from the control areas and over 60% of the RLG members and non-RLG members had discussed with their sisters-in-law. Over 40% each of the RLG and non-RLG members and more than half of the respondents of the control areas also reported that they had discussed with their sisters. Relatively a higher percentage of the RLG members compared to the non-RLG members and the respondents of the control areas had discussed about the drama serials with their husbands.

Table 4.5 Percent distribution of respondents by discussion on Gyan Nai Shakti Ho radio drama serial with others in the past 6 months

Description	RLG member	Non-RLG member	Control area
Whether discussed the "Gyan Nai Shakti Ho" radio drama serial with any of your friends, neighbors or relatives in the past 6 months	<i>ab</i>	<i>b</i>	
Yes	91.6	73.0	65.4
No	8.4	27.0	34.6
Total (n)	467	100	26
With whom did you discuss? (Multiple Response)			
Friend/neighbor	87.1	86.3	88.2
Sister-in-law	65.4	63.0	76.5
Sister	44.4	41.1	52.9
Husband	37.4	20.5	5.9
Mother-in-law	21.0	11.0	5.9
Daughter/son	14.7	6.8	5.9
Mother	10.5	4.1	5.9
Daughter-in-law/ brother-in-law/ sister-in-law/ niece/ nephew	4.7	2.7	5.9
Father-in-law, father, brother, FCHV	5.4	-	-
Total (n)	428	73	17

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Those respondents who reported to have listened to the radio drama serial *Gyan Nai Shakti Ho* were further asked to mention some of the names of characters of the serial that they could remember. Table 4.6 shows data on percentage of respondents who could mention six main characters of the drama serial. Higher percentages of the respondents of all three categories were able to mention the names of *Tara*, *Kamalesh*, *Janaki* and *Abdul*. Characters such as *Madho Babo* and *Chapa* was also mentioned by a sizeable percentages of the RLG and non-RLG members. The average number of characters known by the RLG members was significantly higher (6.5) than those of non-RLG members (4.0) and the respondents of control areas (2.7). When further asked to give the name of their most favorite character, over two-thirds of the respondents of control areas and about half each of the RLG and non-RLG members mentioned *Janaki* as their most favorite character. The second and third favorite characters were reported to be *Tara* and *Kamalesh*.

Opinion of the participants regarding various characters of the drama serial was also sought during FGDs. Almost every participants of the FGD mentioned that all characters of the program were nice and they liked all. Majority of the FGD participants enjoyed the good work and the health education given by Janaki Didi. Many participants also expressed that they liked the love affairs between Tara and Kamalesh. Some FGD members of non-RLG also liked the health education given by Janaki Didi and comedian role of Abdul.

Table 4.6 Percent distribution of respondents mentioning the names of main 6 characters and most favorite character in radio drama serial

Description	RLG member	Non-RLG member	Control area
Names of the of main 6 characters remembered (Multiple Response)			
Tara	91.0	72.0	65.4
Kamalesh	90.6	71.0	69.2
Janaki	82.9	57.0	57.7
Abdul	69.0	41.0	26.9
Madho Babu	50.1	22.0	7.7
Champa	48.0	24.0	11.5
Mean number of characters known	6.5^{ab}	4.0	2.7
Total (n)	467	100	26
Name of the most favorite character			
Janaki	46.4	47.7	68.2
Tara	19.3	19.8	4.5
Kamalesh	11.7	11.6	9.1
Abdul	10.8	7.0	4.5
Champa	3.3	2.3	-
Other±	8.4	11.7	13.5
Total (n)	461	86	22

± Other includes: It Kumari, Madho Babu, Soniya, Jeevan, Mukhendra; Ramala; Nirmala; Begam; Rasida; Parbati; Ramesh; Sumitra; Gauri; Toyaram; Rama; Pandit Baje; Phoolmati; Mukesh; Tuppiwala; Toyanath; Dinesh; Nagendar; Mukhiya Ba; Naina; Lahuni; Phool Kumari; Dulari.

Note: Other responses mentioned by the respondents were excluded from the table but included in the calculation for average number of characters known.

Statistical tests: A – comparison with Non-RLG ($p < 0.05$); B – Comparison with Control ($p < 0.05$)

Almost all the participants of RLG reported that they liked every aspect of *Gyaan Nai Shakti Ho*. The most frequently cited preferences were: love affairs between Tara and Kamalesh, health information provide by Janaki Didi, Abdul playing *Damaru* while selling ice cream, It Kumari giving pickles (Achar) prepared by herself to other village people, health related information discussed by various artists, support given by the husband of It Kumari during her pregnancy, etc. However, some of them did not like the sad parts such as theft of Abdul’s box, Kamalesh in Jail and Madho Babu being alone.

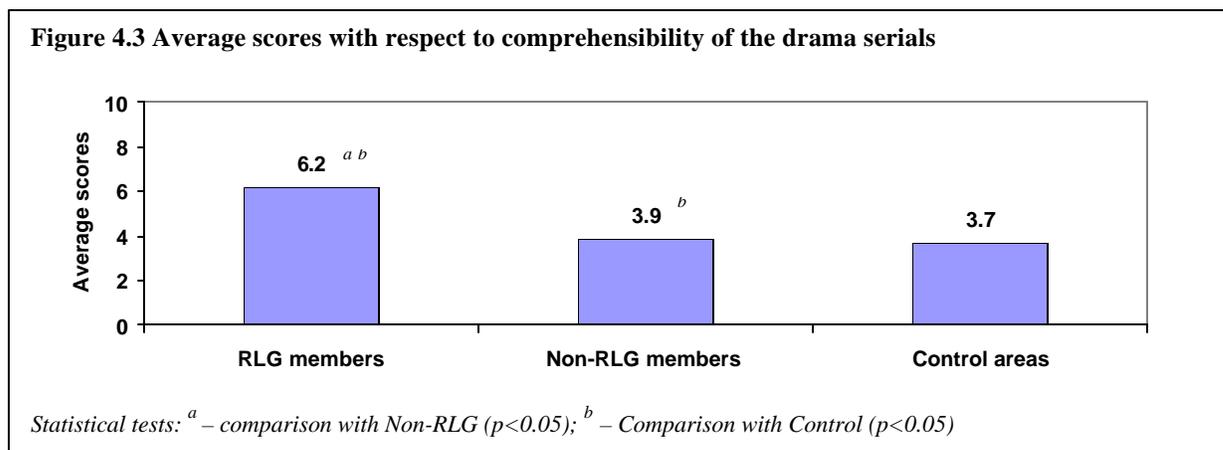
I liked all the characters of the drama. The most I liked was Janaki Didi. She taught everybody about family planning, taught what to do and what not to do during pregnancy.

A 30 years old Tamang RLG member from Mahottari

Among all the episodes they listened, pregnancy related episode, STI and HIV/AIDS related episode, marriage between Kamalesh and Tara, and Janaki Didi’s information were very memorable for all the FGD participants. The episode of Kamalesh in the Jail and the pickle making of It Kumari were also memorable for some FGD participants.

In order to assess the comprehensibility of the drama serial, nine questions related to the main characters, their activities in the serials, various events described in the serials, etc. were asked to the respondents of all three categories who reported having heard of the serial “*Gyan Nai Sakti Ho*”. Based on their responses comprehension scores has been calculated by assigning one score for each of the right answer given by the respondents; thus ranging from 0 to 9 scores. The

results are presented in Figure 4.3. The level of comprehension was found to be significantly higher among RLG members compared to the respondents of other two categories. For instance, the RLG members obtained the average scores of 6.2 followed by 3.9 by the non-RLG members and 3.7 by the respondents of the control areas.



b) Exposure to *Sewa Nai Dharma Ho*

The survey results reveal that 13% (n=62) of the RLG members, 3% (n=14) non-RLG members and 2% (n=7) of the respondents of the control areas had heard about *Sewa Nai Dharma Ho* distance education radio program in the past one-year (Table not shown). These respondents were asked about the frequency of listening to this radio program. About one-fifth of the RLG members and non-members reported to have listened the radio program every week while none of the respondents from control areas reported to be doing so. About 39% of the RLG members followed by 36% non-RLG members and 29% respondents of control areas reported listening to the program a couple of times in a month (Table 4.7). The percentage of respondents listening to the radio program less frequently (i.e. once a month or less) was much higher (71.5%) among the respondents of control areas than their respective counterparts (41.9% RLG members and 42.9% non-RLG members).

Table 4.7 Percent distribution of respondents by frequency of listening to the *Sewa Nai Dharma Ho* radio program

Frequency of listening to <i>Sewa Nai Dharma Ho</i>	RLG member	Non-RLG member	Control area
Every week	19.4	21.4	-
A couple of times a month	38.7	35.7	28.6
Once a month	16.1	-	14.3
Less than once a month	4.8	14.3	42.9
Only listened once or twice	21.0	28.6	14.3
Total (n)	62	14	7

Among those who were exposed to the *Sewa Nai Dharma Ho* radio program were further asked about the number of episodes they have listened in the last 3 months prior to the survey date. Data presented in Table 4.8 show that a higher percentage of the RLG members compared to those of non-RLG members and the respondents of the control areas have listened to more number of episodes. For instance, over half (51.6%) of the RLG members followed by 43% of the non-RLG members and 14% respondents of control areas reported to have listened to more than 4 radio episodes in the last 3 months. The mean number of episodes listened during that period was 5.5

among RLG members whereas it was 4.5 among non-RLG members and 2.7 among the respondents of the control areas.

Table 4.8 Percent distribution of respondents by number of episodes of Sewa Nai Dharma Ho radio drama listened to in the last three months, among those who were exposed to the radio program

Number of episodes of "Sewa Nai Dharma Ho" listened in the last 3 months	RLG member	Non-RLG member	Control area
None	12.9	14.3	14.3
1-4	35.5	42.9	71.4
5-8	21.0	28.6	14.3
9-12	30.6	14.3	-
Mean	5.5	4.5	2.7
SD	4.2	4.1	1.9
Total	62	14	7

c) Types of messages or topics heard from radio health program

Those respondents who were exposed to the radio health programs (either of Gyan Nai Shakti Ho, Gyane Shakti Hai or Sewa Nai Dharma Ho) were asked about types of health related topics they have heard from these radio health programs. There were more than 20 listed health related topics included in the survey questions. The responses given by the respondents have been further categorized into five broad categories for the analysis purposes namely safe motherhood, family planning and spousal communication, child health, FCHV's roles and STIs or HIV/AIDS. The percentages of the RLG members who spontaneously mentioned various types of health related topics that they heard from radio program was much higher than those of non-RLG members and the respondents of the control areas (Table 4.9). For instance, about 64% of the RLG members compared to 52% respondents of control areas and 48% non-RLG members reported to have heard of safe motherhood. Likewise, about three quarters of the RLG members as against 68% non-RLG members and 56% respondents of control areas mentioned family planning and spousal communication. About 87% of the RLG members compared to about 70% of the respondents of other two categories reported that they heard about child health from the radio health programs. The percentage of respondents who reported hearing about FCHVs roles and STIs or HIV/AIDS from radio health programs was slightly higher among the respondents of control areas than those of other two categories.

Table 4.9 Percent distribution of respondents mentioning the types of topics they heard from Gyan Nai Shakti Ho or Sewa Nai Dharma Ho radio health program

Health topics heard while listening to Gyan Nai Shakti Ho or Sewa Nai Dharma Ho	RLG member (n=467)	Non-RLG member (n=103)	Control area (n=27)
Safe motherhood±	63.8	47.6	51.9
Family planning and spousal communication§	74.3	68.0	55.6
Child health‡	86.9	69.9	70.4
FCHV's roles	9.4	7.8	14.8
About STIs and HIV/AIDS	10.3	3.9	18.5

± *Safe motherhood: danger signs during pregnancy; danger signs during delivery; care during delivery and birth preparedness.*

§ *FP and spousal communication: Contraceptive methods; well-planned family; spousal communication.*

‡ *Child health: Vitamin A; Immunization; diarrhea and three home rules; nutrition; cough/cold and home based treatment; neonatal care; recognizing signs and symptoms of pneumonia and home based care; new born danger signs; breast feeding and supplemental food.*

During the FGDs, the participants reported that they listened to many useful information on immunization of children, family planning, care of pregnant women including need of seeking pregnancy check ups and TT vaccines, adolescent health, delaying marriage, HIV/AIDS and practice of hygienic home environment from the *Gyaan Nai Shakti Ho* radio program. They pointed out that the program has covered similar problems of their own communities. During the discussion, some of the participants also suggested adding other health related issues such as epilepsy, asthma, gastritis, leprosy, malaria, tuberculosis, and disadvantages of irrational drug use in the radio program.

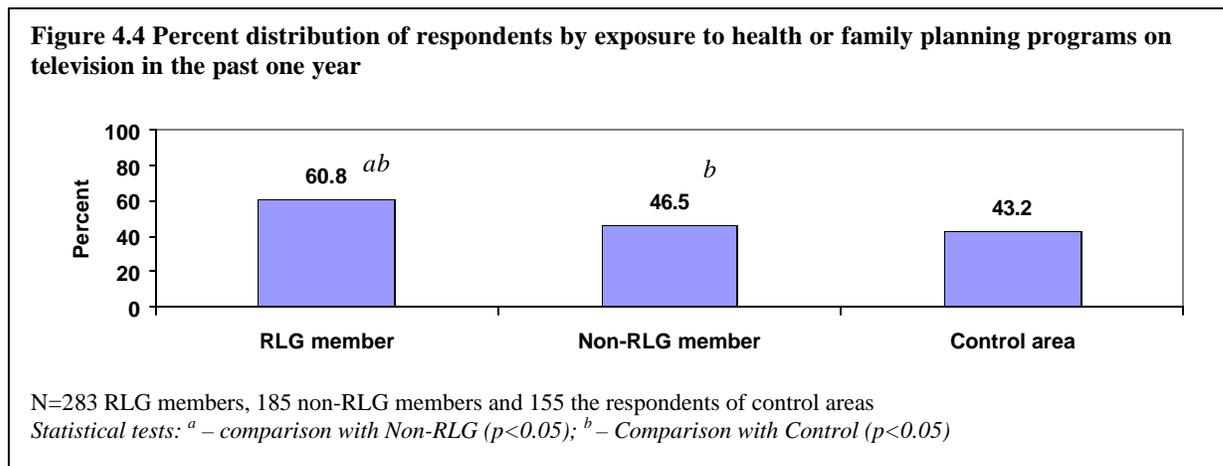
I knew from the radio program Jeevan Jal should be taken during diarrhea, pregnant women should eat nutritious food in their pregnancy and rest from work, and not to have many children.

A 35 years old RLG member from Dhanusha

4.2 Exposure to other health related television and radio programs

Television

Among those respondents who reported to have watched television were asked if they had watched any health or family planning programs during last year. Data presented in Figure 4.4 show that exposure to health or family planning program on television was found to be much higher among RLG members (60.8%) than those of non-RLG members (46.5%) and respondents of control wards (43.2%). The observed difference was found to be statistically significant ($p < .05$).

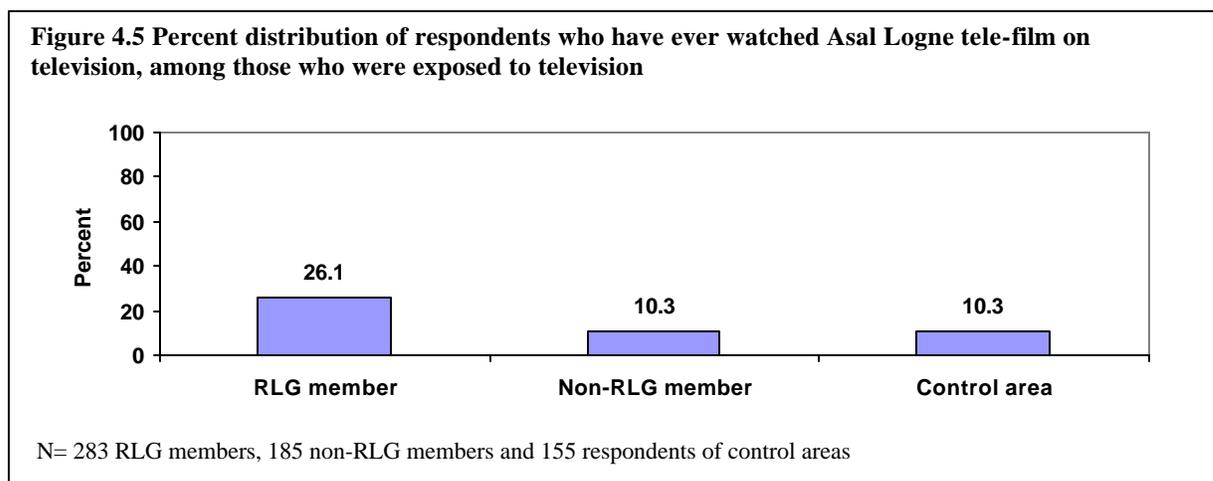


Among those who have been exposed to health or family planning programs on the television during the last one-year prior to the survey were further asked to recall messages of the program they watched. Comparatively a higher percentage of the RLG members than other two categories of the respondents were able to mention different types of messages (Table not shown). The top five messages recalled by the respondents were as follows:

- FP methods for spacing birth; delaying birth and about different family planning methods (18.6%-29.9%)
- Message on need of using family planning after having two children; advantages of family planning (9.0%-20.9%)
- Information about HIV/AIDS; giving love and care to HIV infected person (9.3%-29.9%)
- Not to have many children; have only two children; small family is happy family (6.0%-14.5%)

- Feeding Jeevan Jal/ Nun-Chini-Pani during diarrhea; feeding beans soup during diarrhea; use of latrine to prevent from diarrhea (8.1%-13.4%)

The Ministry of Health and Population aired a tele-film called *Asal Logne* (good husband) nationally through Nepal Television with the objectives of promoting images of caring husbands to their pregnant wives. In order to examine the exposure of the respondents, those respondents who had been exposed to television were asked if they had ever watched the *Asal Logne* telefilm. In response, over a quarter of the RLG members compared to only 10% each of the non-RLG members and those of control areas reported that they had watched this tele-film (Figure 4.5).



Radio

Information regarding the exposure of respondents to other radio programs related to health or family planning on the radio was sought during the survey. Data presented in Table 4.10 show that a higher percentage RLG members than the non-RLG members and the respondents of control areas had been exposed to *Jana Swastha Karyakram*. About 30% of the RLG members and 10% each of the non-RLG members and the respondents from control areas reported that they had heard about *Jana Swastha Karyakram*.

Table 4.10 Percent distribution of respondents who have heard of Jana Swastha Karyakram on the radio in the past one year

Respondent type	Spontaneous yes	After probing yes	Spontaneous and after probing yes	Total (n)
RLG member	3.9	26.6	30.5	467
Non-RLG member	2.2	8.2	10.4	450
Control area	1.1	10.0	11.1	450

4.3 Exposure to other materials and printed BCC materials

All the respondents were asked if they had seen or heard any of the health related messages from the newspaper, magazine, cinema, community group meeting and festival or community events in the past one-year prior to the survey. Relatively a higher percentage of the respondents of all three categories reported that they have seen or heard health related messages during community group meetings and festival or other community events. However, only a small percentage (1.1%-8.6%) of the respondents of all three categories mentioned other sources such as

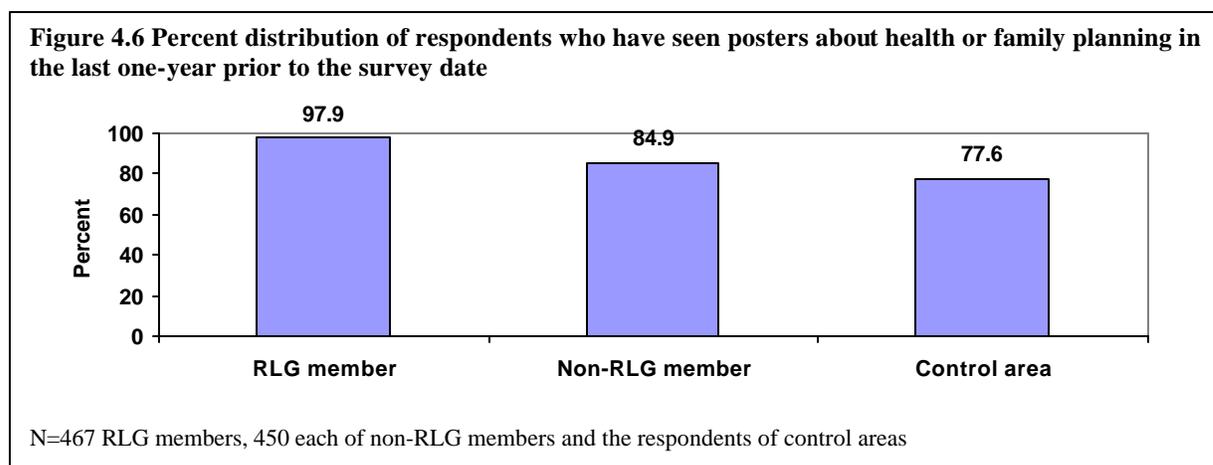
newspaper, magazine and cinema from which they got health related messages Considerably a higher percentage of the RLG members compared to the non-RLG members and the respondents of the control areas reported that they had seen or heard about the health related messages from the above mentioned sources (Table 4.11).

Table 4.11 Percent distribution of respondents mentioning sources from which they got health related messages in the last one year

Seen or heard any health messages from the following	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
In the newspaper	8.6	5.8	2.7
In a magazine	7.7	5.6	3.8
While at the cinema	6.0	1.3	1.1
During a community group meeting	45.6	7.1	5.6
During a festival or other community event	35.1	16.2	9.8

All the respondents were asked if they had seen any posters related to health or family planning in the last one year preceding the survey date. The survey results reveal that a large percentage of the respondents of all three categories reported to have seen posters on health or family planning in the past one year. Comparatively a higher percentage of the RLG members compared to the respondents of other two categories had seen posters on it. For instance, about 98% of the RLG members compared to 85% non-RLG members and 78% of the respondents of control areas reported that they had seen posters on health or family planning in the last one year (Figure 4.6).

Figure 4.6 Percent distribution of respondents who have seen posters about health or family planning in the last one-year prior to the survey date



Those respondents who had seen any type of health or family planning posters in the past one year were asked to mention about types of posters they have seen during that time. The percentage of respondents who had seen different types of posters on health or family planning was much higher among RLG members than other two categories of the respondents. More than 94% of the RLG members reported that they had seen posters on danger sign, Sumata, five types of FP methods and family planning. The percentages of respondents who had seen these posters ranged between 77%-91% among non-RLG members and 76%-87% among the respondents of control areas (Table 4.12). Considerably a higher proportion of the RLG members (88.8%) compared to 73% non-RLG members and 69% of the respondents in control areas reported they had seen *Abhibadan* poster in the past one year prior to survey date.

Table 4.12 Percent distribution of respondents by types of health or family planning posters seen in the past one year

Type of posters seen	RLG member (n=457)			Non-RLG member (n=382)			Control area (n=349)		
	Spont	Prob	Total	Spont	Prob	Total	Spont	Prob	Total
Danger sign poster	51.2	47.0	98.2	36.6	54.2	90.8	31.5	55.9	87.4
Sumata poster	44.9	51.6	96.5	27.0	57.1	84.1	16.3	65.3	81.6
Poster showing 5 types of methods	38.5	56.0	94.5	24.9	57.1	82.0	23.5	52.4	75.9
FP Poster	40.0	54.3	94.3	25.9	50.8	76.7	29.2	48.4	77.6
Abhibadan Poster	19.5	69.1	88.6	7.3	65.4	72.7	4.3	65.0	69.3
Other±	2.8	-	2.8	2.1	-	2.8	4.9	-	5.6

± Other includes: about permanent FP method; Number One condom; poster on small family; poster on small family and happy family; poster showing a person cutting the cord; poster on Jeevan Jal; a pregnant woman eating green vegetable; on iodized salt; on immunization; on leprosy; a women receiving pregnancy check up services.

Chapter 5

Family Planning

This chapter presents findings on knowledge and use of family planning methods among the respondents of different categories included in the study. In addition, aspects relating to interpersonal communication on family planning issues are also dealt in the chapter. The first section presents findings on knowledge of respondents on different family planning methods followed by their FP use status in the second section and interpersonal communication in the third section. Multivariate analysis for the selected family planning indicators have been made in the last section.

5.1 Knowledge of family planning methods

All the RLG members and almost all the non-RLG members (99.1%) and the respondents of control areas (98.0%) were found to be aware of at least one method of family planning. Only 3 out of 450 RLG members and 9 respondents in control areas were found to be unaware about family planning (Table not shown). Table 5.1 presents data on knowledge (according to their spontaneous responses and after probing) of respondents about different family planning methods. The level of knowledge about different family planning methods was higher among the RLG members than those of the non-RLG members and the respondents of control areas. Almost all the RLG members reported that they have heard of all modern family methods. The percentage of non-RLG members who were aware of different modern family planning methods ranged from 84%-98% and 77%-97% among the respondents of the control areas. Knowledge of natural methods such as periodic abstinence and withdrawal was relatively lower among all three categories of the respondents. The overall results indicate no significant difference on the level of knowledge about different family planning methods among the respondents of different categories. However, the spontaneous knowledge on different family planning methods was very high among RLG members compared to other two categories of the respondents.

Table 5.1 Percent distribution of respondents by knowledge of different family planning methods

Heard of different family planning methods	RLG member (n=467)			Non-RLG member (n=450)			Control ward (n=450)		
	Spontaneous yes	After probing yes	Total	Spontaneous yes	After probing yes	Total	Spontaneous yes	After probing yes	Total
Oral pills	88.0	11.3	99.4	81.1	15.1	96.2	75.6	18.4	94.0
IUD	65.5	31.0	96.6	29.8	54.7	84.5	26.9	50.4	77.3
Injection (Depo Provera)	93.4	6.6	100.0	85.1	12.4	97.5	82.4	14.0	96.4
Condom	71.3	28.5	99.8	45.8	49.6	95.4	38.0	56.0	94.0
Norplant	72.2	27.2	99.4	36.9	53.1	90.0	30.0	57.1	87.1
Female sterilization	71.7	28.1	99.8	59.1	38.7	97.8	56.0	41.3	97.3
Male sterilization	57.4	41.3	98.7	41.6	53.1	94.7	40.7	48.7	89.4
Periodic abstinence	3.4	64.0	67.5	1.1	37.3	38.4	2.0	32.0	34.0
Withdrawal	2.4	42.6	45.0	0.7	23.6	24.3	0.2	15.6	15.8

5.2 Use of family planning methods

Ever and current use of family planning methods

Data on ever use and current use status of the contraceptives by the respondents of three different categories are presented in Table 5.2. The percentage of the respondents who had ever used any family planning (FP) method was very high among RLG members (71.3%) and lower among the respondents of control areas (56.2%). More than 62% of the non-RLG members reported to have ever used any method of FP. The proportion of respondents who were currently using any FP method at the time of survey was also very high among RLG members (58.0%) compared to the non-RLG members (49.3%) and the respondents of control areas (47.8%). The higher percentage of the respondents of all three categories were currently using female sterilization (27.6%-34.9%), and the second and third most commonly used methods were Depo Provera (11.3%-13.7%) and oral pills (2.7%-4.1%) respectively. The percentage of respondents using other contraceptive methods remained at less than 2% among all three categories of the respondents indicating the need of motivating couples to use other spacing as well as permanent methods of FP.

Table 5.2 Percent distribution of respondents by ever and current use of family planning methods

Contraceptive methods	RLG member (n=467)		Non-RLG member (n=450)		Control area (n=450)	
	Ever use	Current use	Ever use	Current use	Ever use	Current use
Oral pills	12.4	4.1	10.0	2.7	5.8	3.1
IUD	0.9	0.2	1.8	0.7	0.4	-
Injection (Depo Provera)	31.0	13.7	24.4	11.6	22.9	11.3
Condom	9.6	1.9	6.7	1.8	3.3	0.2
Norplant	0.9	0.2	0.9	0.2	1.3	0.9
Female sterilization	34.9	34.9	28.7	28.7	27.6	27.6
Male sterilization	0.9	0.9	0.7	0.7	2.0	2.0
Periodic abstinence	2.4	1.3	2.9	1.3	2.4	1.1
Withdrawal	1.5	0.9	2.0	1.8	1.6	1.6
None	28.7	42.0	37.8	50.7	43.8	52.2
Any modern method	-	55.8	-	46.2	-	45.1
Any method	71.3	58.0	62.2	49.3	56.2	47.8

Reasons for not using family planning methods

Among those who had heard of family planning, 42% (n=196) of the RLG members, 51% (n=225) non-RLG members and 44% (n=226) of the respondents from control areas were not using any FP methods at the time of survey. These respondents were asked about the reasons for non-use of FP methods. The results are presented in Table 5.3. The main reason for not using contraceptives by the respondents of all three categories was associated with *reproductive health cycle issues* such as desire for children, no resumption of menses, menopausal/hysterectomy and currently pregnant. Likewise, the second most frequently cited reason for not using contraceptives was related to *spousal issues* such as husband away from home, infrequent sex and husband's disapproval. About one in every 10 respondents also gave reasons related to *method dissatisfaction or health issues* such as health or fertility concern, side effects, confusion on methods, etc as reasons for not using family planning methods. Reasons associated with

unavailability of methods, religion and disapproval from family members for not using FP methods was mentioned by quite a small percentage of respondents of all three categories.

Table 5.3 Percent distribution of respondents by reasons for not using any family planning methods at the time of survey, among those who had heard of FP

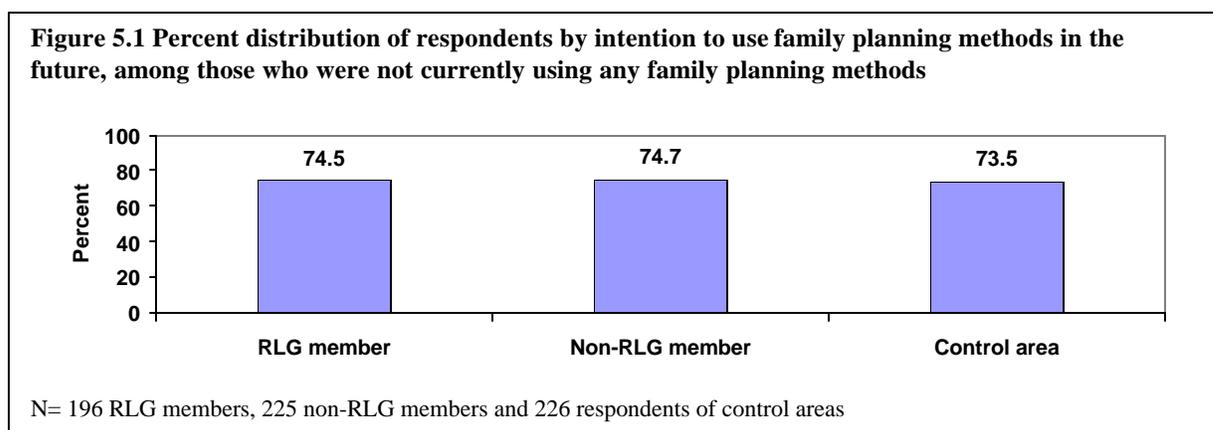
Reasons for not currently using a FP method (Multiple Response)	RLG member	Non-RLG member	Control area
Reproductive health cycle issues			
Want more children/want son/want daughter	19.4	17.8	24.3
No resumption of menses/ recently delivered a child/child is too small	14.3	15.6	25.7
Menopausal/hysterectomy	12.8	8.9	7.5
Currently pregnant	5.6	9.8	6.6
Spousal issues			
Husband away from home	35.2	24.0	26.1
Husband did not like	3.1	3.6	1.3
Infrequent sex	2.6	4.4	4.0
Method dissatisfaction or health issues			
Health/fertility concerns	9.7	10.7	9.3
Confused about method	3.6	2.7	2.2
Other health related±	3.0	5.6	2.9
Other than health related§	2.5	7.5	3.9
Total (n)	196	225	226

± Other includes: excessive bleeding; difficult to get pregnant; inconvenient to use; not satisfied; stomach pain; headache; dizziness; feverish; eyes turned weak; irregular menses; IUD makes pain; weakness.

§ Other includes: religion; unavailability; family members opposed; felt not necessary; bad health of husband; was not able to conceive; prevented conception by using herbs; believed self not able to conceive anymore; lack of money; thought breast milk will dry up; too old; suffering from tuberculosis.

Intention to use family planning methods

Those respondents who reported not using any family planning methods at the time of survey were also asked about their intention to use family planning methods in the future. On the question “Do you think you will use a method to delay or avoid pregnancy at any time in future?” about three quarters (73.5%-74.7%) of the respondents of all three categories reported that they would use family planning methods to delay or avoid pregnancy in the future (Figure 5.1).



All the current users were asked to mention the sources from where they obtained their current methods last time. Similarly, the non-users were also asked to mention the sources from where one could get family planning methods. The responses given by both the current users and non-users are presented in Table 5.4. Majority of the current users of all three categories mentioned government hospital (44.2%-49.8%) from where they obtained their current methods last time followed by subhealth post (14.2%-16.3%) as the most second important source and the family planning camp (9.9%-13.0%) as their third important source. Less than 10% of the respondents of all three categories mentioned health post, NGO clinics, FCHVs, primary health care centers and outreach clinics from where they obtained their current methods. Among the non-users, the higher percentage of the respondents of all three categories were aware that contraceptives are available from subhealth post (30.6%-41.6%), government hospitals (23.9%-29.7%), and health post (12.2%-23.8%). Very small percentage of the non-users of all three categories were found to be aware about the availability of the family planning methods from primary health care centers, outreach clinics, and FCHVs indicating the need for making them aware about the places where family planning methods are available in the community.

Table 5.4 Percent distribution of current FP users by their source of supply of family planning and non-users by knowledge about the source of supply of family planning

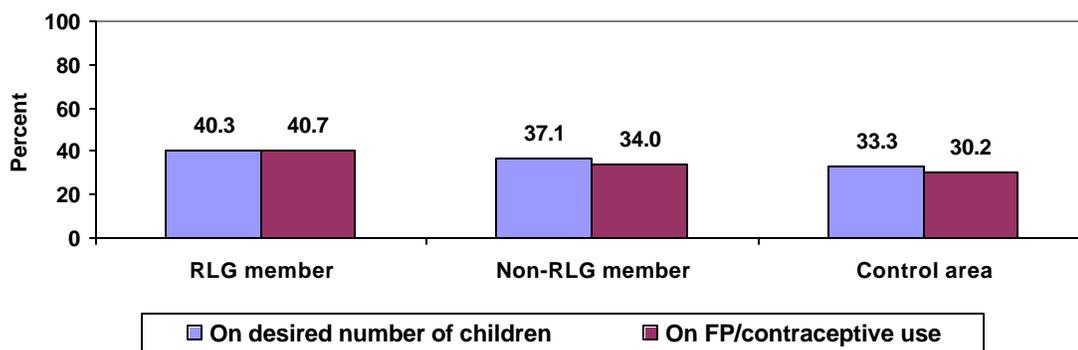
Source of supply or knowledge about supply source of FP methods	RLG member		Non-RLG member		Control area	
	Current users	Non users	Current users	Non users	Current users	Non users
Government hospital	46.0	29.6	44.2	29.7	49.8	23.9
SHP	14.2	30.6	16.3	31.4	16.3	41.6
FP camp	13.0	1.0	10.1	0.4	9.9	-
Health post	9.6	23.8	11.1	20.9	4.4	12.2
NGO clinic	5.7	1.9	6.3	-	1.5	2.9
FCHV	5.4	2.9	1.9	2.1	3.0	1.7
PHCC	2.7	2.4	1.0	2.1	2.5	1.3
Outreach clinic	1.5	-	4.8	-	3.9	-
Other±	1.6	2.9	3.8	2.1	8.4	7.6
Currently using withdrawal or periodic abstinence technique	-	4.9	-	5.9	-	5.0
Do not know	0.4	-	0.5	5.4	0.5	3.8
Total (n)	261	206	208	239	203	238

± Other includes: Mobile clinic; pharmacy or chemist; private hospital or clinic; VHW; MCHW.

5.3 Interpersonal communication on family planning

Those respondents who were aware of family planning were further asked if they had discussed with their husbands about their desired number of children and on FP/contraceptives use over the past 6 months from the survey date. Data presented in Figure 5.2 indicate that spousal discussion on the matters related to desired number of children and family planning use was less common among the respondents of control areas compared to other two categories of respondents. For instance, about 40% of the RLG members followed by slightly over one-third of the non-RLG members and less than one-third of the respondents from control areas reported that they discussed about the above issues with their husbands in the past 6 months prior to the survey.

Figure 5.2 Percent distribution of respondent who discussed with their husbands about desired number of children and family planning in the past 6 months preceding the survey, among those who have heard of family planning methods



N= 467 RLG members, 447 non-RLG members and 441 respondents of control areas

Those respondents who have heard of family planning methods were further asked if they had discussed family planning with their friends, neighbors or relatives in the past 6 months preceding the survey date. The results are presented in Table 5.5. Quite a high percentage of the RLG members (79.9%) than the non-RLG members (52.1%) and the respondents of the control areas (48.1%) affirmed to have discussed with their friends, neighbors or relatives in the past 6 months ($p < .05$). The majority of the respondents of all three categories reported that they had discussed about family planning with friends or neighbors (76.4%-89.8%), sisters-in-law (57.1%-66.0%) and sister (37.3%-40.6%).

Table 5.5 Percent distribution of respondents who have discussed family planning with their friends, neighbors or relatives in the past 6 months

Description	RLG member	Non-RLG member	Control area
Whether discussed FP with any of your friends, neighbors or relatives in the past 6 months			
Yes	79.9	52.1	48.1
No	19.9	45.9	51.7
Do not know	0.2	2.0	0.2
Total (n)	467	447	441
With whom did you discuss? (Multiple Response)			
Friends/neighbors	89.8	83.3	76.4
Sister-in-law	66.0	57.1	64.2
Sister	40.2	37.3	40.6
Mother-in-law	13.4	9.4	12.3
Other±	13.9	15.9	11.2
Total (n)	373	233	212

± Other includes: mother; daughter; husband; daughter-in-law, FCHV; brother's sister; niece.
 Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

5.4 Multivariate analysis for selected family planning indicators

Multivariate regression models were used to examine the relationship between RLG membership status and three family planning indicators: spousal communication about family planning, intentions to use family planning among non-users, and current use of a modern contraceptive method. These models included several characteristics that differed across the RLG membership

categories and, therefore, may confound the association between family planning and RLG membership status. By including these characteristics, these models remove the possibility that the differences in these characteristics across the groups may explain the association between RLG membership and family planning behaviors.

Both RLG members and non-RLG members were more likely than women in the control communities to have discussed family planning with their spouse, suggesting that the effect of the RLGs on spousal communication may extend beyond those women directly participating in the groups. Adjusting for the differences between these groups, RLG members were 1.5 times more likely and non-members were 1.3 times more likely than women in the control communities to have discussed family size or contraceptive methods with their spouse in the past six months. RLG members were not more likely than non-RLG members to have discussed family planning with their spouse in the past six months (Table 5.6).

Table 5.6 Unadjusted and adjusted odds ratios from logistic regression models predicting spousal communication about family planning, intentions to use a FP method in the future, and current use of a modern contraceptive method

Respondent Type	Spoke to husband in past 6 months about FP		Intention to use a FP method, among non-users		Current use of a modern FP method	
	Odds Ratio		Odds Ratio		Odds Ratio	
	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹
RLG Member	1.5***	1.5**	1.1	0.9	1.5*** [^]	1.4*** [^]
Non-RLG member	1.2	1.3*	1.1	1.0	1.0	1.0
N	1367		1367		1367	
¹ Adjusting for age, literacy, ethnic group, number of living children, socioeconomic status, husband education, fluency in Nepali, distance to nearest health facility, frequent television use, frequent radio use, participation in other community groups, recent interaction with the FCHV Comparisons with Control group: *p<0.10; **p<0.05; ***p<0.01 [^] RLG members differ from non-RLG members: p<0.05						

The effects of the RLGs on contraceptive use appeared to be limited to the participants. RLG members were more likely to be currently using a modern contraceptive method than either non-RLG members or women living in the control communities. Adjusting for the differences between the groups, RLG members were 1.4 times more likely than women in the comparison community to report currently using a modern contraceptive method. Non-members were not more likely to be using a contraceptive method than women in the control communities. RLG members were also significantly more likely to be using a contraceptive method than non-RLG members living in their own community.

RLG membership status was not associated with intentions to use a contraceptive method in the future.

Chapter 6

Safe Motherhood

In order to assess the level of knowledge of respondents regarding safe motherhood services a series of questions related to antenatal, delivery and postnatal services were put forward to all the three categories of the respondents (RLG members, non-RLG members and the respondents of control areas) included in the study. In addition, attitudinal questions related to these aspects were also asked to the respondents. This chapter presents findings on these aspects.

6.1 Opinion on age at marriage, pregnancy and birth spacing

The respondents were asked to give their opinion regarding the appropriate age of marriage for girls and boys. The results are presented in Table 6.1. Majority (61.6%- 83.5%) of the respondents with a higher percentage of the RLG members considered 19-20 years as the ideal age of marriage for girls (Table not shown). The mean ideal age of marriage for girls suggested by the respondents was slightly higher (20.0 years) among RLG members than the respondents of other two categories (19.5 years by RLG members and 19.2 years by the respondents of control areas). With respect to the ideal age of marriage for a boy, more than two-thirds (67.5%) of the RLG members, 60% non-RLG members and 57% respondents from control areas considered 25 years or above as the appropriate age of marriage for boys (Table not shown). The recommended mean age of marriage for boys was slightly higher among RLG members (24.5 years) than non-RLG members (24.1 years) and the respondents of the control areas (24.0 years).

Table 6.1 Percent distribution of respondents by their opinion regarding the ideal age of marriage for girls and boys, for a woman to become pregnant and birth spacing

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Mean ideal age of marriage for girls (in years)	20.0 (1.0)	19.5 (1.6)	19.2 (1.9)
Mean ideal age of marriage for a boy (in years)	24.5 (2.7)	24.1 (3.2)	24.0 (3.3)
Mean ideal age for a woman to first become pregnant (in years)	21.6 (1.6)	21.2 (1.8)	20.7 (2.0)
Mean ideal birth spacing/gap between two children (in years)	4.3 (1.0)	3.9 (1.1)	3.9 (1.1)

Note: Figures in parentheses indicate standard deviation.

The survey results reveal that majority of the respondents of all three categories are in favor of late pregnancy. For instance, about 80% of the RLG members followed by 69% non-RLG members and 60% of the respondents from control areas considered 21 years or more as the best age of a woman for the first pregnancy (Table not shown). The mean ideal age for a woman to be pregnant for the first time was mentioned as 21.6 years by RLG members, 21.2 years by non-RLG members and 20.7 years by the respondents from control areas (Table 6.1). With respect to the ideal birth spacing, over 60% of the RLG members followed by 45% respondents in control areas and 42% non-RLG members considered 5 years or more as the ideal interval between two births. The mean ideal years of birth spacing was considerably higher among RLG members (4.3 years) than those of non-RLG members (3.9 years) and the respondents of control areas (3.9 years).

6.2 Knowledge and attitudes towards antenatal care

A series of questions related to knowledge and attitudes towards antenatal services were asked to all the respondents. This section presents findings on these.

a) Opinion regarding need of receiving ANC

When asked about the importance of receiving antenatal services, except a few respondents in control areas almost all the respondents perceived the importance of getting clinical check ups during pregnancy. Respondents wise data show that the great majority (96.1%) of the RLG members compared to 88% non-RLG members and 77% respondents in control areas perceived it to be very important (Table 6.2).

Table 6.2 Percent distribution of respondents by their opinion regarding the importance of getting clinic check-ups during pregnancy

Description	RLG member	Non-RLG member	Control area
Opinion regarding the importance of getting clinic check-ups during pregnancy			
Very important	96.1	88.4	77.1
Somewhat important	3.9	10.9	16.9
Not important	-	0.2	5.1
Do not know	-	0.4	0.9
Total (n)	467	450	450
Reasons for being important to get clinic check-ups during pregnancy (Multiple Response)			
To examine condition of mother/child	83.1	72.7	67.4
To confirm position of fetus	69.8	58.2	53.4
To get iron tablet	64.2	50.8	51.8
For TT injection	60.4	53.0	52.2
To ensure safe pregnancy/healthy baby	38.5	31.3	23.6
To get deworming tablet	7.5	5.4	6.9
Average number of reasons known	3.2^{ab}	2.7^b	2.6
Total (n)	467	447	423

Note: Other responses including to get vitamin; to know weight and to prevent from diseases were mentioned by fewer than 1% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Those respondents who felt it to be important for receiving clinic check ups during pregnancy were further asked about the reasons. The top six reasons given by the respondents are presented in Table 6.2. The most frequently cited reasons were: to examine the condition of mother and child (67.4%-83.1%), to confirm the position of fetus (53.4%-69.8%), to get iron tablets (50.8%-64.2%) and for getting TT injection (52.2%-60.4%). The average number of reasons given by the respondents was significantly higher among RLG members (3.2) than the non-RLG members (2.7) and the respondents of control areas (2.6).

All the respondents were asked to name the places from where one should receive antenatal check ups. Majority of the respondents of all three categories suggested subhealth post (57.6%-72.7%) followed by hospital (40.4%-52.2%) and health post (32.2%-47.1%) respectively (Table 6.3). Comparatively, a higher percentage of the RLG members (20.6%) than non-RLG members

(16.9%) and respondents of control areas (6.0%) suggested private clinics or nursing home for seeking antenatal check ups. Relatively a smaller percentages of the respondents of all three categories mentioned primary health care center (8.7%-11.6%) and outreach clinics (5.3%-10.4%) from where one should receive antenatal services.

Table 6.3 Percent distribution of respondents by their opinion regarding the places from where a woman should receive antenatal check ups

Where should a woman receive antenatal check up? (Multiple Response)	RLG member	Non-RLG member	Control area
Subhealth post	57.6	58.2	72.7
Hospital	52.2	46.4	40.4
Health post	47.1	43.8	32.2
Private clinic/nursing home	20.6	16.9	6.0
Primary health care center	10.9	8.7	11.6
Outreach clinic	5.8	5.3	10.4
Other±	4.9	5.5	4.0
Total (n)	467	450	450

± Other includes: FCHV, at home, district health office; immunization center; pharmacy; FPAN; Sushma Prashichan Mahila Uthan Kendra.

On the question who should be consulted for seeking antenatal check ups, majority (57.6%-69.8%) of the respondents of all the three categories with the higher proportion of RLG members suggested for consulting nurse or ANM. Over half (54.0%) of the RLG members compared to 46% non-RLG members and only 27% of the respondents in control areas mentioned doctor for seeking pregnancy check ups. About 4 in every 10 respondents of all three categories opined that one should receive pregnancy check ups from HA or AHW and more than one third mentioned MCHW for seeking services. Considerably a higher percentage of the RLG members compared to the non-RLG members and the respondents of control areas mentioned FCHV for seeking antenatal check ups (Table 6.4).

Table 6.4 Percent distribution of respondents by their opinion regarding the person with whom a woman should receive antenatal check ups

Whom should a woman see for pregnancy check- ups during pregnancy? (Multiple Response)	RLG member	Non-RLG member	Control area
Nurse/ANM	69.8	65.3	57.6
Doctor	54.0	46.4	26.9
HA/AHW	43.3	37.3	43.1
MCHW	36.2	31.6	38.4
FCHV	16.7	10.2	8.2
VHW	9.0	5.6	14.2
TBA	2.4	0.9	1.8
Total (n)	467	450	450

b) Timing of receiving antenatal services

It is recommended that a woman should get first antenatal services during their first trimester. In order to assess the knowledge of respondents, all the respondents were asked to mention the best time to start antenatal check ups. Slightly over half (51.8%) of the RLG members followed by 49% non-RLG members and 38% respondents from control areas correctly mentioned that a woman should first receive antenatal services between 3-4 moths of pregnancy (Table 6.5). About 3 in every 10 RLG and non-RLG members and over one-third of the respondents from control areas considered after 4 months of pregnancy as the appropriate time for seeking first

antenatal check ups. Similarly, about one in every 6 respondents also opined that a woman should start antenatal check ups immediately after knowing about her pregnancy. The above information clearly indicates a sizeable percentage of the respondents of all three categories have inadequate knowledge about the correct timing for receiving first antenatal check up services.

Table 6.5 Percent distribution of respondents by their opinion regarding the best time to start and number of times a woman should receive antenatal check ups

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Best time to start antenatal check up			
Immediately after knowing of her pregnancy	17.3	15.8	14.0
Between 3-4 months of pregnancy	51.8	48.9	38.2
After 4 months of pregnancy	29.1	32.7	35.1
Anytime when a woman has problem with her pregnancy	0.6	2.7	6.0
Other (after 2 months/ after 5 months/ after 6 months)	0.9	-	0.7
Do not know	0.2	-	6.0
Number of times a woman should receive ANC			
<3	3.4	10.2	10.7
3	23.3	32.2	29.1
4+	73.1	56.5	52.2
Do not know	0.2	1.1	8.0

It is recommended that a woman have at least four antenatal visits during her pregnancy. In order to examine their knowledge about it all the respondents were asked as to how many times a woman should receive antenatal check ups during pregnancy. Data presented in Table 6.5 show that nearly three-quarters (73.1%) RLG members as against only 57% of the non-RLG members and 52% respondents of control areas correctly mentioned that a woman should receive pregnancy check ups at least four times.

c) Knowledge about iron/folic tablets and TT vaccines

Information regarding the knowledge about iron folic tablets and tetanus toxoid (TT) vaccines was collected from all three categories of the respondents included in the study. On the question whether they have heard about iron/folic tablets, almost all the RLG members (98.3%) and more than 90% of the non-RLG members and the respondents of control areas affirmed that they have heard about it. Those respondents who reported having heard about iron/folic tablets were further asked as to why a woman should take such tablets during pregnancy. Majority (73.4%-86.3%) of the respondents of all three categories with the higher percentage of RLG members reported that use of iron/folic acid tablets could help prevent women from anemia. A sizeable percentage of the respondents also mentioned that use of iron/folic tablets would give strengths to both the mother and baby (Table 6.6).

Table 6.6 Percent distribution of respondents by their knowledge about iron/folic acid tablets and knowledge about reasons for using such tablets during pregnancy

Description	RLG member	Non-RLG member	Control area
Heard of iron/folic acid tablets			
Yes	98.3	90.9	91.8
No/ do not know	1.7	9.1	8.2
Total (n)	467	450	450
Reasons for a woman who should take iron/folic acid tablets during pregnancy			
To prevent from anemia	86.3	83.1	73.4
It gives strength to the baby/for the good health of baby	12.2	7.1	17.9
It gives strength to mother/ for the good health of mother	8.9	6.1	4.6
It gives strength to both the mother and baby	8.5	10.5	7.5
Other (prevents from eye diseases/ stimulates the appetite)	0.4	-	0.5
Do not know	1.1	2.0	4.8
Total (n)	459	409	413

Almost all (99.1%) the RLG members and 97% each of the non-RLG members and the respondents of the control areas reported to have heard about immunization against tetanus. Among those who have heard were further asked to mention the importance of getting TT vaccines during pregnancy. Nearly 90% of the RLG members followed by 85% non-RLG members and 72% respondents of control areas reported that getting TT vaccines by a woman during pregnancy would protect mothers against tetanus toxoid. Likewise, 89% of the RLG members followed by 73% non-RLG members and 65% of those from control areas mentioned that it would protect baby against tetanus toxoid (Table 6.7).

Table 6.7 Percent distribution of respondents by their knowledge about TT vaccines and knowledge about reasons for importance of getting TT vaccines during pregnancy

Description	RLG member	Non-RLG member	Control area
Heard of immunization against tetanus			
Yes	99.1	97.1	97.3
No/ do not know	0.9	2.9	2.7
Total	467	450	450
Reasons for being it important to get TT during pregnancy (Multiple Response)			
To protect mother against TT	89.2	84.9	72.4
To protect baby against TT	89.2	72.8	65.1
To prevent mother from diseases	1.9	1.8	1.4
For the good health of baby/ baby will not get sick	0.9	2.3	2.3
Do not know	0.9	4.8	12.1
Total	463	437	438

In order to examine the knowledge of respondents, all women were asked about number of times a woman should receive immunization against tetanus during pregnancy. It is recommended that a pregnant woman should receive at least two doses of TT vaccination during her first pregnancy. Nearly half (49.9%) of the RLG members and 44% each of the non-RLG members and the respondents of the control areas reported that a woman should receive TT immunization two times during pregnancy. Likewise, 44% of the non-RLG members followed by 41% RLG

members and 39% of the respondents of control areas mentioned three times. About 7% of the respondents of all three categories opined that a woman should receive TT vaccines 4 times or more (Table 6.8).

Table 6.8 Percent distribution of respondents mentioning number of times a woman should receive immunization against tetanus during pregnancy

Number of times a woman should receive TT during pregnancy	RLG member	Non-RLG member	Control area
1	2.8	2.7	5.3
2	49.9	43.7	44.3
3	40.8	44.2	38.6
4+	6.3	7.3	7.0
Do not know	0.2	2.1	4.8
Total (n)	463	437	438

d) Care and support needed during pregnancy

Opinion regarding the need of receiving proper care and support during pregnancy was also sought from all three categories of the respondents. Considerably, a higher percentage of the RLG members than other two categories of the respondents were of the opinion that a woman should eat more food than usual during pregnancy. For instance, 95% of the RLG members compared to 83% non-RLG members and 75% respondents of control areas reported that a woman should eat more amount of food than usual. Relatively, a higher percentage of the respondents from control areas (13.6%) and non-RLG members (9.3%) than RLG members (1.5%) opined that a woman should be given less amount of food than usual (Table 6.9). The great majority of the RLG members (98.9%) and non-RLG members (96.2%) compared to the respondents of control areas (91.3%) also agreed that a woman should receive more than usual level of support from her family members during pregnancy.

Table 6.9 Percent distribution of respondents by opinion regarding amount of food and extent of support a woman should receive from family members during pregnancy

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Opinion on amount of food a woman should eat during pregnancy			
Less than usual	1.5	9.3	13.6
About the same	3.6	7.8	10.9
More than usual	94.9	82.9	74.9
Do not know	-	-	0.7
Opinion on amount of care/supports a woman should receive from her family members during pregnancy			
Less than usual	0.2	0.9	0.2
About the same	0.6	2.9	8.0
More than usual	98.9	96.2	91.3
Do not know	0.2	-	0.4

When asked about types of care and support a woman should be provided by family members during pregnancy, majority of the respondents of all the three categories suggested for providing more food and nutritious foods, advising woman for taking more rest and reducing heavy works. Comparatively, a higher percentage of the RLG members compared to other two categories of

respondents suggested providing such types of care and support to the pregnant woman during pregnancy. The large majority (89.1%-95.5%) of the respondents of all three categories were of the opinion that family members should provide more nutritious food to the women during pregnancy (Table 6.10). Average number of care/supports mentioned by the respondents was significantly higher among RLG members (3.5) as compared to the non-RLG members (3.0) and the respondents of control areas (2.7).

Table 6.10 Percent distribution of respondents by opinion regarding types of care and support to be provided to a woman during pregnancy

Opinion on types of care/support to be provided to a woman during pregnancy from her family members (Multiple Response)	RLG member	Non-RLG member	Control area
More nutritious food to eat	95.5	89.1	90.2
Advise for more rest	80.9	70.4	63.6
Reduce heavy load	72.4	63.8	52.7
More food to eat	71.7	63.3	54.4
Advise/accompany for physical check up	29.3	13.8	6.0
Average number of care/supports mentioned	3.5^{ab}	3.0^b	2.7
Total (n)	467	450	450

Note: Other responses including provide green vegetables, assist in her work, providing love and care were mentioned by fewer than 1% of the respondents and were excluded from the table but included in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

e) Knowledge of danger signs during pregnancy

The respondents were also asked if they had heard any of the danger signs or symptoms that may appear during pregnancy. Table 6.11 presents data on the level of knowledge of respondents of different categories about such danger signs. The higher percentages of the respondents of all the three categories were found to be aware of three dangers signs such as vaginal bleeding (56.2%-84.8%), severe lower abdominal pain (79.3%-81.6%) and severe headache (48.0%-60.0%). The average number of danger signs or symptoms mentioned by the RLG members was significantly higher (3.0) than their respective counterparts non-RLG members (2.5) and the respondents of control areas (2.2). Some of the most frequently occurring danger signs or symptoms such as convulsion and blurred vision and swelling of hands and face were mentioned by relatively a smaller percentage of the respondents of all the three categories indicating the need for imparting knowledge about these danger signs to the community people.

Table 6.11 Percent distribution of respondents by their knowledge about danger signs or symptoms that can occur during pregnancy

Knowledge about danger signs/symptoms that can occur during pregnancy (Multiple Response)	RLG member	Non-RLG member	Control area
Vaginal bleeding (any amount)	84.8	68.2	56.2
Severe lower abdominal pain	79.9	81.6	79.3
Severe headache	60.0	52.9	48.0
Blurred vision and swelling of hands and face	47.5	30.0	27.3
Convulsion	27.4	13.1	12.2
Average number of danger signs/symptoms mentioned	3.0^{ab}	2.5^b	2.2
Do not know	0.6	2.9	7.1
Total (n)	467	450	450

Note: Other responses including fever; swelling in legs or hands; vomiting; vaginal discharge or foul white discharge; dizziness; back or waist pain; no movement of fetus; fetus death; weakness; stillbirth; spontaneous abortion; less appetite; jaundice; body swelling; cough and pneumonia; diarrhea; urinary problem; high blood pressure; tuberculosis were mentioned by fewer than 12% of the respondents and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

The large majority (80.4%-89.3%) of the respondents of all the three categories reported that they would visit either the primary health care center or health post or subhealth post if they experienced any of the above mentioned (refer to Table 6.11) danger signs or symptoms. More than two-thirds of the RLG members followed by 62% of the non-RLG members and 52% respondents from control areas said that they would visit hospital. The percentage of respondents mentioning either the private clinics or nursing homes was much higher among RLG members and non-RLG members than the respondents of control areas. Quite a small percentage (4.4%-9.9%) of respondents of all the three categories reported that they would consult FCHVs for seeking services (Table 6.12).

Table 6.12 Percent distribution of respondents by preferred place for seeking services in case of danger signs or symptoms occurred during pregnancy

Preferred place for seeking services (Multiple Response)	RLG member	Non-RLG member	Control area
PHCC /HP/ SHP	89.3	80.4	84.9
Hospital	68.3	62.0	52.4
Private clinic/nursing home	21.4	22.7	10.0
Consult FCHV	9.9	7.6	4.4
Consult other health worker	6.6	4.0	1.6
Pharmacy	2.8	2.7	4.0
Consult a TBA	2.4	3.3	4.2
Consult MCHW	1.1	0.2	-
Other±	1.6	1.3	2.2
Do not know	-	1.3	1.1
Total (n)	467	450	450

± Other includes: Consult Dhami Jhakri; consult relatives, neighbors or friends; NGO clinic; District Health Office; Immunization Center.

6.3 Knowledge and attitudes towards delivery services

In this section, opinion of the respondents regarding the need for receiving delivery services from the skilled health workers, knowledge about types of preparations to be made for delivery,

places to be visited or persons to be consulted to seek assistance during delivery, things that need to be kept clean during delivery and knowledge about danger signs during delivery are discussed.

a) Need of receiving delivery services

All the RLG members and almost all (98.4%) of the non-RLG members were of the opinion that it is important (very important or somewhat important) to attend delivery by the skilled health workers such as MCHW, staff nurse, ANM, doctor, etc. The percentage of the respondents of the control areas who considered it to be important constituted 91% (Table 6.13). Among those who reported it to be important for attending the delivery by the skilled health workers were asked to give reasons. About three quarters (75.2%) of the RLG members followed by 71% of the respondents of the control areas and 63% non-RLG members expressed that it is important to have a skilled health worker in case of complications during delivery. Considerably a higher percentage of the RLG members compared to the non-RLG members and the respondents of control areas thought that presence of a skilled health worker is important in keeping the baby safe and for ensuring normal delivery.

Table 6.13 Percent distribution of respondents by their opinion regarding the importance of skilled providers' attendance during delivery

Description	RLG member	Non-RLG member	Control area
Opinion on importance of an appropriate skilled health worker (staff nurse, ANM, doctor, etc) attending the delivery			
Very important	95.3	89.1	76.7
Somewhat important	4.7	9.3	14.2
Not important	-	1.3	7.1
Do not know	-	0.2	2.0
Total (n)	467	450	450
Reasons for being important that a skilled health worker should attend (Multiple Response)			
In case of serious problem with delivery	75.2	63.0	71.1
To keep baby safe	61.0	50.6	38.6
For normal delivery	58.5	51.5	43.0
Other±	0.2	1.1	0.2
Do not know	0.6	0.9	1.5
Total (n)	467	443	409

± Other includes: to protect mother and child from infection/ for the safety of mother.

b) Knowledge about specific plans and preparation needed for the delivery

All three categories of the respondents were also asked to mention the specific plans and preparation that need to be made to ensure the safe delivery. Almost all (98.7%) of the RLG members followed by 96% non-RLG members and 88% respondents of the control areas were able to mention at least one specific plans or preparations to be made in advance for the delivery (Table 6.14). Majority (72.7%-92.3%) of the respondents with a higher percentage of the RLG members reported making arrangements of money for the delivery. Nearly half (49.5%) of the RLG members and 30% each of the non-RLG members and the respondents of control areas reported arranging clean delivery kits or clean blade and thread. More than one-third of the non-RLG members (35.6%) and respondents of control areas (34.9%) and about 30% of the RLG

members suggested making preparation of foods in advance. Other types of plans and preparations considered to be necessary to ensure the safe delivery mentioned by a sizeable percentage of the respondents were: pre-identification of nearest health facility (14.4%-31.0%), arrangement for a skilled providers to attend the delivery (8.9%-28.7%), planning for emergency or complications (12.2%-27.0%), and arrangement of transport (13.8%-22.3%). Only about 2% of all the three categories thought it to be necessary for arranging blood. The average number of specific plans and preparations that were promoted by the program mentioned by the respondents was significantly higher among RLG members (2.0) than their respective counterparts non-RLG members (1.6) and the respondents of control areas (1.2).

Table 6.14 Percent distribution of respondents by their knowledge about specific plans and preparations to be made to ensure the safe delivery

Knowledge about specific plans and preparations to be made to ensure the safe delivery (Multiple Response)	RLG member	Non-RLG member	Control area
<u>Promoted by the program</u>			
Provision/arrangement of money	92.3	86.2	72.7
Know or identify the nearest health facility	31.0	20.4	14.4
Arrangement for a skilled provider to attend the delivery	28.7	15.3	8.9
Planning for emergency/ complications	27.0	18.2	12.2
Provision/arrangement of transportation	22.3	16.0	13.8
Provision/arrangement for blood	2.4	1.1	2.4
<u>Other mentioned</u>			
Arrangement of clean delivery kits clean blade and thread	49.5	30.2	30.9
Preparation of foods; spices; sweets, ghee, etc	29.8	35.6	34.9
Clothes for newborn and mother/clothes	9.2	6.7	8.2
Do not know	1.3	4.2	12.2
Average number of specific plans and preparations mentioned, among those promoted by the program	2.0^{ab}	1.6^b	1.2
Total (n)	467	450	450

Note: Other responses including arrangement of medicines; arrangement of clean room and arrangement of soap were mentioned by fewer than 1% of the respondents and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Among those who were aware of at least one type of plans and preparations to be made for the delivery were further asked about the sources from which they learned about it. The results are presented in Table 6.15. The Radio listeners group (83.3%) followed by radio (52.5%) and relatives, friends or neighbors (42.1%) were reported to be the major sources of information by the RLG members. Relatives, friends or neighbors (60.8%-61.5%) followed by family members (26.6%-31.8%) and radio (17.5%-21.8%) was reported to be the major sources of information for the non-RLG members and the respondents of control areas. Over 30% of the RLG members and one-fifth each of the non-RLG members and respondents of the control areas also said that they learned about planning from FCHVs.

Table 6.15 Percent distribution of respondents by their sources of information about the specific plans and preparation to be made to ensure the safe delivery

Source of information about specific plans and preparations to be made for delivery (Multiple Response)	RLG member	Non-RLG member	Control area
RLG/RLG members	83.3	12.3	-
Radio	52.5	21.8	17.5
Relatives/friends/neighbors	42.1	61.5	60.8
FCHV	30.2	18.8	19.5
Self learning	14.1	26.0	32.4
Other family members	9.5	31.8	26.6
Other health worker	7.4	5.8	9.4
TV	7.2	5.1	4.8
Print materials	5.4	3.0	4.1
Husband	2.4	8.4	10.1
MCHW	1.5	2.3	3.0
TBA	1.5	2.6	1.0
Other±	2.6	1.4	2.5
Total (n)	461	431	395

± Other includes: FCHV training; street performance; book; mothers group; teacher; mother-in-law; adult literacy class; Naulo Bihan book.

c) Assistance during delivery

The respondents were further asked about the places where and with whom a woman should receive assistance during delivery. About 6 in every 10 RLG members followed by more than half of the non-RLG members and over 40% of the respondents of control areas considered doctor and nurse or ANM as important persons for receiving assistance during delivery. About 4 in every 10 respondents with the higher percentage of those from control areas considered TBA as the suitable person for receiving assistance during delivery. More than one-third of the RLG members compared to 14% each of the non-RLG members and the respondents of control areas also considered FCHVs as appropriate person for seeking assistance during delivery. Relatively a smaller percentage of the respondents from all the three categories perceived HA/AHW and MCHW as important persons for receiving assistance during delivery (Table 6.16).

Table 6.16 Percent distribution of respondents by opinion regarding the appropriate persons for receiving assistance during delivery

Opinion on persons with whom a woman should receive assistance during delivery (Multiple Response)	RLG member	Non-RLG member	Control area
Nurse/ANM	69.0	56.7	45.8
Doctor	59.7	50.7	40.2
TBA	36.6	38.9	44.4
FCHV	35.8	14.0	14.2
Family member	27.4	26.0	37.6
HA/AHW	25.7	21.6	22.2
Relative/friend/neighbor	24.6	25.6	38.2
MCHW	19.1	12.0	11.3
VHW	0.4	0.2	0.2
Other (Untrained Sudeni)	-	0.4	-
No one	-	0.2	0.2
Total (n)	467	450	450

The higher percentage of the respondents of all the three categories considered district hospital as the best place for giving birth to a child. Considerably a higher percentage (61.9%) of the RLG

members compared to those of non-RLG members (52.4%) and the respondents of control areas (44.2%) mentioned hospital as the appropriate place for it (Table 6.17). Nearly half (47.3%) of the respondents in control areas as against 37% non-RLG members and 21% RLG members mentioned that a woman should give birth at homes. Those mentioning grassroots level health facilities such as primary health care centers, health posts and subhealth posts for giving birth constituted less than 10% only.

Table 6.17 Percent distribution of respondents by opinion regarding the appropriate places where a woman should give birth to a child

Opinion regarding the appropriate place to give birth to a child	RLG member	Non-RLG member	Control area
Hospital	61.9	52.4	44.2
At home	21.2	36.7	47.3
Subhealth post	6.9	5.8	4.0
Health post	6.4	3.1	1.6
Primary health care center	3.0	1.8	2.7
Private clinic/nursing home	0.6	0.2	0.2
Total (n)	467	450	450

d) Knowledge about things that need to be kept clean

In order to protect mother and child from any kind of infection the Government of Nepal has been promoting 6 cleans of safe delivery, which are nails, hands, blades, surface, thread and perineum. In order to assess the knowledge of respondents, all three categories of the respondents were asked about the things that need to be kept clean during childbirth. The results are presented in Table 6.18. The higher percentage of the respondents of all the three categories were aware about the need for keeping blade (69.8%-79.4%) and surface (62.7%-73.9%) clean during child birth. However, knowledge of respondents about the need for keeping other four things clean was relatively low. Respondent wise data show that significantly a higher percentage of the RLG members compared to the non-RLG members and the respondents of control areas were found to be aware about these six things that need to be maintained clean.

Table 6.18 Percent distribution of respondents by their knowledge about the things that need to be kept clean during childbirth

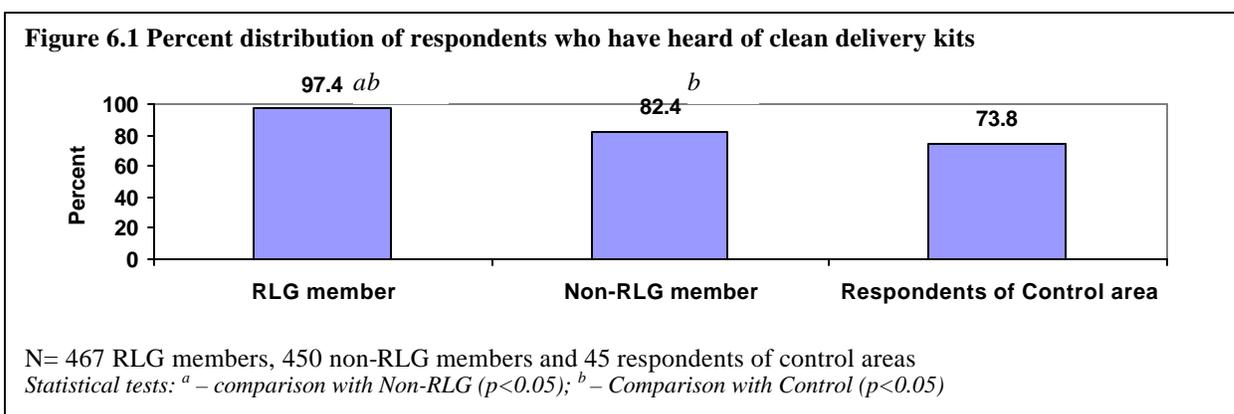
Opinion regarding things that need to be kept clean during childbirth (Multiple Response)	RLG member	Non-RLG member	Control area
Blade	79.4	75.8	69.8
Surface	73.9	64.7	62.7
Hands	63.6	46.9	35.3
Thread	57.0	45.6	46.7
Nails	45.6	26.2	11.6
Perineum	25.3	16.0	10.9
Average number of danger signs mentioned	3.5^{ab}	2.8^b	2.4
Do not know	1.1	0.7	4.4
Total (n)	467	450	450

Note: Other responses including materials needed during pregnancy; plastic coin; plastic; bed sheet; delivery room was mentioned by fewer than 5% of the respondents and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Knowledge of clean delivery kits was significantly higher among the RLG members than the respondents of other two categories ($p < .05$). Almost all (97.4%) the RLG members followed by

82% non-RLG members and 74% respondents of control areas were found to be aware of the clean delivery kits (Figure 6.1).



e) Knowledge of danger signs during delivery

Knowledge of respondents regarding the danger signs or symptoms that could occur during labor or delivery was also assessed during the survey. When asked about different danger signs that may appear during delivery or labor, the top four danger signs reported by relatively a higher percentages of the respondents were: appearance of baby’s leg first (56.2%-79.4%), labor longer than 12 hours (74.2%-79.3%), excessive bleeding before or after delivery (48.7%-75.8%) and appearance of baby’s hand first (50.7%-74.1%). Data presented in Table 6.19 indicate that considerably a higher percentage of the RLG members than the respondents of other two categories were able to mention these four types of danger signs. Knowledge of respondents of all three categories on danger signs such as appearance of baby’s umbilical cord first and convulsion was found to be quite low. The average number of danger signs/symptoms known by the respondents was significantly higher among RLG members (3.5) than their respective counterparts non-RLG members (2.7) and the respondents of control areas (2.6).

Table 6.19 Percent distribution of respondents by their knowledge about danger signs or symptoms that may appear during labor or delivery

Knowledge about the danger signs/symptoms that can occur during labor/delivery (Multiple Response)	RLG member	Non-RLG member	Control area
Appearance of baby’s leg first	79.4	61.6	56.2
Labor longer than 12 hours	75.8	74.2	79.3
Excessive bleeding before or after delivery	75.8	59.6	48.7
Appearance of baby’s hand first	74.1	52.4	50.7
Appearance of baby’s umbilical cord first	32.3	18.0	15.6
Convulsion	16.7	8.9	4.9
Average number of things mentioned	3.5^{ab}	2.7^b	2.6
Do not know	-	2.2	2.4
Total (n)	467	450	450

Note: Other responses including vaginal discharge; white fluid discharge; fever; headache; weakness; abnormal position of baby; back pain; jaundice; swelling in legs and hands; retained placenta; fetus death; no movement of fetus was mentioned by fewer than 3% of the respondents and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p<0.05$); ^b – Comparison with Control ($p<0.05$)

Majority of the respondents of all three categories reported that a woman should go to PHCC/HP/SHP (64.7%-75.2%) followed by the hospital (61.8%-74.4%) for consultation if she experienced any of the danger signs or symptoms during delivery. The percentage of women giving these responses was slightly higher among RLG members than other two categories of the respondents. Over one-fifth of the RLG members and non-members and 9% of the respondents of control areas also mentioned private clinics or nursing homes. The percentage of respondents mentioning community level providers such as FCHVs and TBAs constituted less than 15% (Table 6.20).

Table 6.20 Percent distribution of respondents mentioning the places where a woman should consult in case of danger signs or symptoms during delivery or labor

In your opinion, if a woman has experienced the above danger signs/symptoms during delivery or labor what should she do or whom should she consult? (Multiple Response)	RLG member	Non-RLG member	Control area
PHCC/HP/SHP	75.2	64.7	72.0
Hospital	74.3	74.4	61.8
Private clinic/nursing home	20.8	24.4	9.1
Consult a TBA	9.9	8.7	15.6
Consult FCHV	7.3	4.4	4.2
Consult other health worker	6.4	4.4	2.0
Pharmacy	1.7	0.7	2.7
Relatives/neighbor/friend	1.7	1.6	5.3
Consult MCHW	0.9	0.4	0.4
Other ±	0.2	0.2	0.4
Nothing/do not know	-	1.8	2.2
Total (n)	467	450	450

± Other includes: Consult Dhami Jhakri; NGO; Susma Prashichhan Mahila Utthan Kendra.

6.4 Knowledge and attitudes towards postpartum services

a) Opinion about need of getting health check up after giving birth

Table 6.21 shows opinion of respondents about the need for getting health check up from the health facility by women after giving childbirth. Analysis of responses indicates that almost all the RLG members (98.5%) followed by 96% of the non-RLG members and 86% of those from control areas perceived it to be either very important or somewhat important in receiving postpartum check ups from the clinics or health facility. About 13% of the respondents in control areas followed by 2% non-RLG members and 1% RLG members did not perceive it to be important. The main reason (73.4%-88.0%) cited by the respondents for being it to be important was for the good health of mother and child. Nearly three-fifths (55.6%-59.1%) of the respondents also mentioned that it is important to have postpartum check ups for child immunization. Other reasons mentioned by a sizeable percentage of the respondents were to measure child's weight (30.5%-38.3%) and to protect child from any kind of illness or infection (20.2%-36.5%). The overall results indicate that a higher percentage of the RLG members than the respondents of other two categories have properly understood the importance of receiving check ups from health facility after the childbirth.

Table 6.21 Percent distribution of respondents by opinion regarding the importance of receiving check ups from the clinic or health facility after the birth

Description	RLG member	Non-RLG member	Control area
Opinion regarding importance of having check-up at the clinic/health facility after the birth	<i>ab</i>	<i>b</i>	
Very important	91.4	82.4	69.3
Somewhat important	7.1	14.2	16.7
Not important	1.1	2.0	12.7
Do not know	0.4	1.3	1.3
Total (n)	467	450	450
Reasons for being it important to have check-up at the clinic/health facility after the birth of the baby (Multiple Response)			
For good health of mother and child	88.0	77.2	73.4
For child immunization	59.1	55.6	57.4
To measure child's weight	38.3	32.4	30.5
To protect child from any kind of illness or infection	36.5	20.2	20.4
To get iron tablets	2.4	0.7	0.5
Other (to get TT vaccines by mother/ to get vitamin)	0.9	0.5	0.8
Do not know	-	0.7	0.5
Total (n)	460	435	387

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

b) Knowledge about timing of receiving postnatal care

Data regarding the knowledge of respondents about the timing of receiving first check-up services after the delivery from the health workers was collected during the study. It is recommended that a woman should receive check up services twice within 42 days after the delivery – first check-up within 3 days and the second one within 6 weeks or 42 days. Knowledge of respondents of all three categories regarding the timing of receiving first check up services after the delivery was found to be low as only 30% of the RLG members, 20% non-RLG members and 12% of the respondents of control areas said that a woman should receive first check up services within 3 days after the delivery. About 16% of the RLG members followed by 11% non-RLG members and 6% respondents of the control areas mentioned 4-7 days for receiving checkup services. Quite a high percentage (48.4%-68.9%) of the respondents of all three categories mentioned that a woman should receive first check up within 8-42 days after the delivery. More than 5% of the respondents of all three categories mentioned 43 days or more for receiving check ups services after the delivery (Table 6.22).

Table 6.22 Percent distribution of respondents mentioning the timing of receiving and persons with whom a woman should receive the first check up services after the birth

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Number of days after the delivery a woman should receive the first check-up services from a health worker			
Within 3 days	30.4	20.2	12.4
4-7 days	15.8	11.3	5.6
8-42 days	48.4	61.1	68.9
43 +	5.4	7.1	6.9
Do not know	-	0.2	6.2
Persons with whom a woman should receive check up services at that time			
Doctor	40.7	35.1	27.6
Nurse/ANM	31.3	31.1	28.9
MCHW	12.0	16.9	19.6
HA/AHW	11.6	11.6	15.8
FCHV	2.4	1.6	2.2
TBA	1.7	3.3	2.0
VHW	0.4	0.2	4.0
Other	-	0.2	-

When further asked about the persons with whom a woman should receive check up services for the first time after the childbirth, the higher percentages of the respondents of all three categories mentioned that a woman should receive such services from doctors (27.6%-40.7%) and nurse or ANM (28.9%-31.3%). A sizeable proportion of the respondents with a higher percentage of those from control areas suggested MCHW (12.0%-19.6%) and HA or AHW (11.6%-15.8%) for receiving postnatal check up services.

c) Care and supports needed during postpartum period

Opinion of the respondents regarding the need for providing care and supports to the women after the delivery was also collected during the study. Almost all women of three categories perceived the need for providing more care and support by the family members after the delivery indicating that women in the study areas are well aware about the need for providing care and support to the postpartum mothers (Table 6.23).

Table 6.23 Percent distribution of respondents by their opinion regarding amount of care and support to be given to the women by family members after the delivery

Opinion regarding amount of care and supports a woman should receive from family members after delivery	RLG member	Non-RLG member	Control area
Less than usual	0.6	0.9	-
About the same	0.6	1.1	1.8
More than usual	98.7	97.8	98.2
Do not know	-	0.2	-
Total (n)	467	450	450

When asked about types of support to be provided, about 9 in every 10 respondents with slightly a higher percentage of RLG members felt that a woman should be given more nutritious foods.

Likewise, over 85% of the RLG members followed by 75% non-RLG members and 69% of those from the control areas mentioned *giving advise for more rest*. Other types of care and supports considered to be important by relatively a higher percentage of the respondents were giving more food to eat (63.3%-74.1%) and reducing heavy work load (46.0%-62.7%). About 17% of the RLG members as against only 9% of non-RLG members and 3% of the respondents of control areas considered it to be necessary to give advice or accompanying the women for check ups. Over 80% of the respondents (80.2%-89.1%) of all three categories opined that husbands and mothers-in-law should provide care and supports to the postpartum women. Likewise, nearly two-thirds of the RLG members followed by over half of the non-RLG members and the respondents of the control areas mentioned sisters-in-law who should provide care and supports to the women after delivery (Table 6.24).

Table 6.24 Percent distribution of respondents mentioning the types of care and supports to be provided by the family members to the women after the delivery and persons in the family who should provide such supports

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Opinion on types of care/support a woman should receive from family members (Multiple Response)			
Give more nutritious food to eat	94.4	90.4	89.6
Advise for more rest	85.7	75.3	68.7
Give more food to eat	74.1	65.8	63.3
Reduce heavy load	62.7	53.6	46.0
Advise/accompany for check up	17.1	9.1	3.1
Other (giving oil massage/ love)	0.9	0.2	1.8
Persons with whom a woman should receive above-mentioned care/support (Multiple Response)			
Husband	89.1	87.8	80.2
Mother-in-law	87.4	85.1	86.4
Sister-in-law	66.0	55.8	51.3
Father-in-law	24.8	20.4	18.9
Daughter/son	8.1	4.0	5.1
Other±	1.7	1.6	2.0

± Other includes: friends; daughter-in-law; neighbor; father; brother-in-law.

d) Knowledge of danger signs during postpartum period

The respondents were asked to mention the danger signs or symptoms that may occur during first four weeks after the delivery. Almost all (98.3%) of the RLG members followed by 95% non-RLG members and 88% of the respondents of control areas were able to mention at least one danger sign that may appear within first four weeks after the delivery. The most frequently cited danger signs were heavy bleeding, foul discharge and lower abdominal pain and high fever. The RLG members giving these responses ranged from 72%-86% while it was 62%-72% among non-RLG members and 54%-65% among the respondents of control areas. More than two-fifths of the RLG members compared to about one-third of non-RLG members and a quarter of the respondents of control areas also mentioned severe headache. Those mentioning convulsion and mastitis as danger signs were relatively low (8.9%-22.5%) among all three categories of the respondents (Table 6.25). Knowledge about various types of danger signs or symptoms that could occur during the first four weeks after the delivery was significantly higher among RLG members compared to the non-RLG members and the respondents of control areas.

Table 6.25 Percent distribution of respondents by their knowledge about dangers signs or symptoms that may appear during first four weeks after the delivery

Knowledge about the danger signs/symptoms that may occur to a woman during first four weeks after delivery (Multiple Response)	RLG member	Non-RLG member	Control area
Heavy bleeding	85.7	72.2	64.9
Foul discharge and lower abdominal pain	73.4	61.6	54.2
High fever	71.9	64.9	61.3
Severe headache	42.8	32.0	24.2
Convulsion	22.5	12.7	8.9
Mastitis	15.6	12.2	11.1
Average number of danger signs or symptoms known	3.1^{ab}	2.6^b	2.2
Do not know	1.7	5.3	11.6
Total (n)	467	450	450

Note: Other responses including swelling in body; swelling in legs and hands; dizziness, back pain; waist pain; retained placenta; vomiting; uterus prolapsed; diarrhea; weakness; cough; tetanus; jaundice; less appetite; chest pain; tuberculosis; pneumonia; urinary problem was mentioned by fewer than 5% of the respondents and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

On the question where they would go for consultation in case of danger signs during first four weeks after the delivery about 36% of the RLG members followed by 34% non-RLG members and 28% respondents of control areas reported that they would go to a hospital. Similarly, about 44% of the respondents of control areas and over 30% each of the RLG and non-RLG members mentioned subhealth post. About one-fifth of the respondents with slightly a higher percentage of the non-RLG members reported that they would go to health post for services. Less than 10% of the respondents of all three categories also reported visiting primary health care center and private clinic or nursing home. Quite a small percentage (<3%) of the respondents of all three categories mentioned that they would visit the community level service providers (Table 6.26).

Table 6.26 Percent distribution of respondents mentioning the places where they would go for consultation in case of danger signs during first four weeks after the delivery

Where would you go for check-up if you experience any of the symptoms that you have just mentioned?	RLG member	Non-RLG member	Control area
Hospital	36.4	33.6	28.1
Subhealth post	33.1	30.3	43.5
Health post	21.8	23.9	17.1
Primary health care center	6.3	4.9	8.3
Private clinic/nursing home	2.2	5.9	0.3
Other [±]	0.2	1.3	2.8
Total (n)	459	426	398

[±] Other includes: mobile clinic; MCHW; FCHV; TBA; AHW; pharmacy.

6.5 Interpersonal communication on safe motherhood

When asked if they had ever talked to other people about safe motherhood issues like antenatal care or delivery, the large majority (87.6%) of the RLG members compared to those of non-RLG members (66.2%) and respondents of control areas (58.2%) responded affirmatively i.e. they had talked to others (Table 6.27). Majority (70.2%-85.6%) of the respondents of all three categories with a higher percentage of the RLG members reported discussing safe motherhood issues with

their friends and neighbors. Over three-fifths (62.1%-68.9%) of the respondents of all three categories also reported that they had discussed about it with their sisters-in-law and about two-fifths (36.6%-43.8%) with their sisters. About a quarters of the RLG members (25.4%) and non-RLG members (23.2%) as well as one-fifth (20.2%) of the respondents of control areas also reported ever discussing with their husbands. The practice of discussing safe motherhood issues with mothers-in-law was relatively low in the study areas as about 20% of the respondents of all three categories reported that they discussed with mothers-in-law.

Table 6.27 Percent distribution of respondents who have ever discussed safe motherhood with others

Description	RLG member	Non-RLG member	Control area
Ever talked to other people about safe motherhood issues, like antenatal care or delivery	<i>ab</i>	<i>b</i>	
Yes	87.6	66.2	58.2
No	12.4	33.6	41.8
Do not know	-	0.2	-
Total (n)	467	450	450
With whom did you discuss? (Multiple Response)			
Friend/neighbor	85.6	77.5	70.2
Sister-in-law	68.9	62.1	64.1
Sister	43.8	36.6	39.7
Husband	25.4	23.2	20.2
Mother-in-law	20.0	19.8	20.2
Other family members[±]	17.7	17.4	12.6
Other (FCHV/ facilitator)	0.5	0.3	0.8
Total (n)	409	298	262

[±] Other family members includes: mother; daughter or son; father-in-law; daughter-in-law; brother; father.
 Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

6.6 Multivariate analysis for selected safe motherhood indicators

Multivariate regression models were used to examine the relationship between RLG membership status and the level of knowledge of safe motherhood, birth preparedness package and awareness of skilled birth attendants. Knowledge of safe motherhood was measured as an aggregate index of correct responses to the knowledge items presented above and ranged from 0 to 11 for safe motherhood and 0-6 for birth preparedness. Knowledge of the birth preparedness package was measured as the number of items in the package named. Since these analyses control for respondents' background characteristics, they remove the possibility that differences in these background characteristics across the groups may explain the association between RLG membership and safe motherhood related knowledge among respondents.

Data presented in Table 6.28 indicate that both the RLG members and non-RLG members have greater knowledge on safe motherhood and birth preparedness package compared to the respondents of control areas. The mean adjusted safe motherhood scores among RLG members were 1.50 units higher than among women in the control communities and mean safe motherhood knowledge among non-RLG members was 0.50 units higher than the respondents of the control areas. Similarly, the level of knowledge about birth preparedness was higher by 0.66 units among RLG members and 0.30 units among non-RLG members compared to the respondents of control areas. The survey results also further show that RLG members have

significantly greater knowledge about safe motherhood and birth preparedness compared to the non-RLG members of the study areas.

Table 6.28 Unadjusted and adjusted coefficients from linear regression models predicting knowledge about safe motherhood (SM) and birth preparedness (BPP), and odds ratios from logistic regression models predicting awareness of skilled birth attendants (SBA)

Respondent Type	Level of knowledge about SM		Level of knowledge about BPP		Proportion aware of SBA	
	Coefficients		Coefficients		Odds Ratio	
	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹
RLG Member	1.91 ^{***^}	1.50 ^{***^}	0.79 ^{***^}	0.66 ^{***^}	7.01 ^{***^}	5.53 ^{***^}
Non-RLG member	0.60 ^{***}	0.50 ^{***}	0.33 ^{***}	0.30 ^{***}	2.78 ^{***}	2.77 ^{**}
N	1367		1367		1367	

¹Adjusting for age, literacy, ethnic group, number of living children, socioeconomic status, husband education, fluency in Nepali, distance to nearest health facility, frequent television use, frequent radio use, participation in other community groups, recent interaction with the FCHV

Comparisons with Control group: *p<0.10; **p<0.05; ***p<0.01

[^]RLG members differ from non- RLG members: p<0.05

The adjusted odds ratios show that RLG members were 5.5 times and non-RLG members were 2.8 times more likely to be aware of skilled birth attendants than the respondents of the control areas indicating the effect of the program intervention to impart knowledge to the people of the community. Similarly, RLG members were also more likely to be informed about the skilled birth attendants than the non-RLG members living in their community (Table 6.28).

Chapter 7

Child Health

This study collected information related to respondents' knowledge about newborn care, diarrhea and its care, knowledge of ARI and its treatment, knowledge about signs and symptoms of malnutrition and use of vitamin A by children aged 6-59 months. This chapter presents general findings on these aspects.

7.1 Knowledge about newborn care

a) Newborn danger signs

Data on the level of knowledge of respondents regarding the danger signs or symptoms that may appear among newborn is presented in Table 7.1. The level of knowledge about different types of danger signs or symptoms related with newborn was found to be much higher among the RLG members than the respondents of other two categories. On average, RLG members were able to mention 2.2 types of danger signs or symptoms while this figure was 1.9 among non-RLG members and 1.8 among the respondents of control areas. More than 80% of the RLG members compared to 72% non-RLG members and 68% of those from control areas considered fast or difficult breathing as the danger sign or symptom. Nearly two-thirds of the RLG members and over half of the respondents of other two categories knew *poor sucking or feeding* as danger signs and another 40% of the RLG members and about 34% of the respondents of other two categories mentioned *hypothermia* as danger sign and symptom that could appear among newborn.

Table 7.1 Percent distribution of respondents by their knowledge about the danger signs or symptoms that may appear among newborn

Knowledge about the danger signs/symptoms that may appear among newborn (Multiple Response)	RLG member	Non-RLG member	Control area
<u>Promoted by the program</u>			
Fast or difficult breathing	80.5	71.8	67.8
Poor sucking or feeding	66.6	57.3	52.7
Hypothermia (feels cold or too hot)	41.5	34.0	34.9
Severe umbilical infection redness of skin around the cord/ foul smelling discharge or bleeding from the cord	30.2	23.3	13.3
Pustules on skin 1 large or more than 10 small ones	19.3	15.6	12.9
Difficult to wake/lethargic/unconscious	16.7	10.9	13.3
<u>Other mentioned</u>			
Cough/fever/typhoid/pneumonia/running or blocking nose	24.8	20.9	24.4
Jaundice	14.8	12.4	14.7
Do not know	1.1	2.9	6.9
Average number of danger signs or symptoms known (among those promoted by the program)	2.2^{ab}	1.9	1.8
Total (n)	467	450	450

Note: Other responses including diarrhea and vomiting; tetanus; frequently crying; malnutrition; chest indrawing; measles; weakness; tuberculosis; weight loss; swelling in legs and hands; epilepsy were mentioned by fewer than 5% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Relatively a smaller percentage of the respondents of all three categories were found to be aware of other danger signs such as *severe umbilical infections redness of skin around the cord/foul smelling*

discharge or bleeding from the cord (13.3%-30.2%), pustules on skin one large or more than 10 small ones (12.9%-19.3%) and difficult to wake or lethargic or unconscious (10.9%-16.7%) indicating the need for imparting knowledge to women of the study areas about such danger signs and symptoms.

b) Cord cutting and applying substances

Almost all the RLG members (99.6%) as well as non-RLG members (98.9%) and about 95% of the respondents of control areas reported that one should use new or sterilized blade to cut the cord of the newborn. About 4% of the respondents of the control areas and less than one percent of other two categories mentioned used blade for cutting cord (Table 7.2). Use of unhygienic objects on the cord stump could infect on the cord of the newborn. In order to assess their knowledge, all respondents were asked whether any kinds of substances be applied on the stump after cutting the newborn's cord. In response, over 60% of the respondents of all three categories with a higher percentage of the non-RLG members opined that any kinds of substances should be used on the cord stump.

Table 7.2 Percent distribution of respondents mentioning the types of instruments to be used to cut the cord of the new born and opinion regarding the use of substances on it

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Types of instruments should be used to cut the cord of the newborn			
New blade/sterilized blade	99.6	98.9	94.9
Used blade	0.2	0.7	4.2
Other (knife; grass cutter; scissor)	0.2	0.4	0.9
Whether any substances be applied on the stump after the newborn's cord is cut			
Yes	60.8	66.0	61.1
No/do not know	39.1	34.0	38.9

c) Drying, wrapping and bathing of the newborn

In order to examine the level of their knowledge, all respondents of different categories were asked about the timing of drying, wrapping and bathing of the newborn. Findings on these aspects are discussed in this section. It is recommended that the newborn should be dried and wrapped immediately after the birth and should be given bath 24 hours after the birth. On the question when the newborn should be dried and wrapped in cloth slightly over half (52.7%) of the RLG members followed by 42% non-RLG members and 38% of the respondents of control areas correctly mentioned that the newborn should be dried and wrapped before the placenta is delivered. This finding suggests the need for imparting knowledge to the community about the appropriate timing of drying and wrapping of the newborn. The respondents were also asked about the types of clothes that should be used to wrap the newborn. The possible responses i.e. *clean dry cloth, clean wet cloth or any cloth* recorded in the questionnaire was read out loudly by the interviewers during interview. Almost all the RLG members (99.6%) followed by 98% and 95% of the non-RLG members and the respondents of control areas respectively mentioned *clean dry cloth* to be used in wrapping the newborn (Table 7.3).

Table 7.3 Percent distribution of respondents by their knowledge about the timing of drying, wrapping and bathing the newborn

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Opinion on timing of drying and wrapping the newborn			
Before the placenta is delivered	52.7	42.2	38.2
After the placenta is delivered	47.1	57.1	61.1
Do not know	0.2	0.7	0.7
Type of clothes to be used to wrap the newborn			
Clean dry cloth	99.6	97.6	94.7
Clean wet cloth	0.4	0.7	0.2
Any cloth	-	1.3	5.1
Do not know	-	0.4	-
Opinion on time when the newborn should be given first bath			
Within 1 hour	28.3	52.9	59.8
2-24 hours	22.3	21.6	22.2
After 24 hours	49.5	25.6	18.0

When asked about the timing of giving first bath to the newborn, nearly half (49.5%) of the RLG members compared to only 26% non-RLG members and 18% respondents of control areas correctly mentioned that the baby should be given bath *24 hours after the birth*. More than half of the non-RLG members and the respondents of control areas as compared with 28% of the RLG members mentioned *within one hour* after the birth (Table 7.3).

The respondents were also asked about the places where the newborn should be kept before the placenta is delivered. The higher percentage of the RLG members (44.3%) and non-RLG members (37.8%) reported that the newborn should be placed with mothers while relatively a higher percentage (42.4%) of the respondents of the control areas said that the child should be placed on the floor. About a quarter of the respondents of all three categories (21.6%-25.9%) suggested keeping the child on the cot (Table 7.4).

Table 7.4 Percent distribution of respondents by their opinion regarding the placement of newborn before the placenta is delivered

Where should a baby placed before the placenta is delivered?	RLG member	Non-RLG member	Control area
With the mother	44.3	37.8	30.0
On the cot	25.9	21.6	25.1
On the floor	22.7	37.1	42.4
With someone else	6.0	1.8	-
Other (on the plastic/on the jute mat/ on straw)	1.0	1.5	2.4
Do not know	-	0.2	-
Total (n)	467	450	450

d) Initiating breastfeeding and other liquid items

In order to assess their knowledge, all the respondents were asked about the appropriate timing of initiating breast milk and food to the newborn including the advantages of feeding colostrums. The percentage of respondents who have correct knowledge about the appropriate timing of initiating breast milk to the newborn was relatively low as only about one-third of the RLG

members and just over one-fifth each of the non-RLG members and the respondents of control areas correctly reported that the baby should be first put to the breast immediately after the birth (Table 7.5). Over one-third of the RLG members and non-members and 30% of the respondents of control areas opined that a child should be initiated breastfeeding after bathing. A higher percentage of the respondents of control areas and the non-RLG members than the RLG members considered 24 hours after the birth as the appropriate time for initiating breast milk. On the question regarding the appropriate time for initiating food other than breast milk to the baby, majority of the respondents of all three categories mentioned the age of 6 months; the percentage of respondents giving this response was higher among RLG members (74.9%) than the non-RLG members (66.9%) and the respondents of control areas (66.2%).

Table 7.5 Percent distribution of respondents by their knowledge about the appropriate timing of initiating breast milk and introducing foods to the newborn

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
How long after birth a baby should be first put to the breast?			
Immediately after the birth	33.4	21.3	22.9
After the placenta is out	24.2	20.0	17.8
After bathing the new born	34.0	37.1	30.4
24 hours after birth	7.9	20.9	28.2
Other	0.2	0.4	0.4
Do not know	0.2	0.2	0.2
How long after birth a child should be first given the food other than breast milk to the baby (after months)			
<3	2.1	6.7	4.7
3	6.0	3.6	2.4
4	1.5	2.0	2.2
5	13.5	14.9	14.9
6	74.9	66.9	66.2
7+	1.9	5.3	9.1
Do not know	-	0.7	0.4

The great majority of the respondents of all three categories opined that a child should be given colostrums (the first yellow milk). The percentage of respondents giving this response was significantly higher among RLG members (94.6%) than those of the non-RLG members (81.8%) and the respondents of control areas (78.0%). Among those who responded affirmatively were further asked about the advantages of feeding colostrums to the newborn. Some of the most frequently cited advantages were that feeding colostrums to children would protect them from diseases (61.3%-81.9%) and increase their immunity (55.6%-71.3%). Slightly more than one in every 10 respondents also reported that it would stimulate mothers' milk supply. Considerably higher percentages of the RLG members than those of non-RLG members and the respondents of control areas were found to be aware of the advantages of feeding colostrums to the newborn (Table 7.6).

Table 7.6 Percent distribution of respondents by their opinion regarding the importance of feeding colostrums to the newborn

Description	RLG member	Non-RLG member	Control area
Opinion on whether a newborn be given the colostrums	<i>ab</i>	<i>b</i>	
Yes	94.6	81.8	78.0
No	5.4	18.2	22.0
Total (n)	467	450	450
Knowledge about the advantages of feeding colostrums to the newborn (Multiple Response)			
Protect from disease	81.9	65.2	61.3
Increase immunity	71.3	55.7	55.6
Stimulates mother's milk supply	14.9	14.7	13.1
Good for child health/ it is vitamin enriched and nutritious	9.7	12.2	11.7
Do not know	0.5	2.4	4.8
Total (n)	442	368	351

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

e) Importance on newborn health check ups

Opinions regarding the importance of getting health check ups by a newborn immediately after the birth was also sought from all three categories of the respondents. The great majority (88.9%-99.6%) of the respondents of all three categories considered it to be very important or somewhat important in getting health check ups by the newborn. Those giving this response were much higher among RLG members and non-members than the respondents of control areas (Table 7.7). The respondents were also asked to give their opinion about the timing of receiving first health check up by a newborn from someone. The higher percentage of the respondents of all the three categories (50.5%-76.0%) with the higher percentage of those from control areas considered 8-42 days as the appropriate time for receiving health check ups by the newborn. Nearly one-third of the RLG members followed by about 22% of the non-RLG members and 14% of the respondents of control areas mentioned within 3 days after birth for receiving health check ups.

Table 7.7 Percent distribution of respondents by their opinion regarding the importance of getting health check ups of newborn immediately after birth

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Opinion on the importance of getting health check up by newborn immediately after birth			
Very important	88.4	76.7	62.2
Somewhat important	11.1	21.1	26.7
Not important	0.4	1.1	9.1
Do not know	-	1.1	2.0
Opinion on timing of receiving health check up by a child after the delivery			
Within 3 days	31.5	21.8	14.0
4-7 days	13.7	8.9	4.2
8-42 days	50.5	62.9	76.0
43 +	4.3	4.9	3.1
Do not know	-	1.6	2.7

7.2 Diarrhea and its treatment

This section presents findings on knowledge of respondents about home care strategies to be adopted for diarrhea, sources of services for diarrhea, and prevalence of diarrhea and its treatment.

a) Knowledge about home care strategies for diarrhea and source of services

Table 7.8 show data on the level of knowledge of respondents regarding the home care strategies that should be adopted for the treatment of children with diarrhea. The program has promoted three home care strategies namely, giving more fluids than usual, giving more foods than usual and continue breastfeeding. Nearly two-fifths (37.0%) of the RLG members compared to 23% of the non-RLG members and 19% of the respondents of control areas were able to mention at least two of the above mentioned three home care strategies. The great majority (88.9%-96.4%) of the respondents of all three categories with a higher percentage of RLG members reported that they would give *Jeevan Jal* or *Nawa Jeevan* to their children in case of diarrhea. More than two-thirds (68.1%) of the RLG members followed by 46% non-RLG members and 38% of those from control areas reported that they would give more fluids than usual. A sizeable percentage of the respondents also said that they would continue breastfeeding (15.1%-29.6%), feed usual amount of food (18.4%-24.4%), feed *Khichadi*, *Jaulo* or *Lito* (14.0%-18.4%) and give *Nun-Chini-Pani* (7.8%-13.5%).

Table 7.8 Percent distribution of respondents mentioning the home care strategies that they would adopt for a child with diarrhea

How do you treat a child with diarrhea at home? (Multiple Response)	RLG member	Non-RLG member	Control area
<u>Promoted three home cares by the program</u>			
Giving more fluids to the child than usual	68.1	45.8	37.8
If breastfeed, continue breastfeeding	29.6	22.2	15.1
Giving usual amount of foods to the child	24.4	20.2	18.4
% mentioned at least 2 of the above	37.0	22.9	18.9
<u>Other types of home cares mentioned</u>			
Giving Jeevan Jal/Nawa Jeevan to child	96.4	91.1	88.9
Giving Khichadi/ Jaulo/ Lito	18.4	16.4	14.0
Giving Nun-Chini-Pani	13.5	7.8	10.9
Other±	9.4	13.2	10.6
<u>Incorrect responses</u>			
Giving less fluids to the child than usual	3.6	2.2	0.7
Giving less amount of foods to the child	2.4	0.9	1.1
If breastfed, discontinue breastfeeding	0.6	0.2	-
Do not know	0.2	0.9	3.1
Total (n)	467	450	450

± Other includes: giving herbal medicines; giving beans soup or green vegetables; keeping child clean; feeding fruit or lemon juice; Halua – porridge; milk; cow ghee; banana; oil massage; feeding yogurt; consulting Dhama Jhakri.

On the question, in what situation a child with diarrhea should be taken to health workers or facility for consultation, about 9 in every 10 respondents of all three categories said that a child with diarrhea should be taken to a health worker for consultation if a child has frequent watery stools. Over half of the RLG members and non-RLG members as well as 46% of the respondents

of control areas considered it to be necessary to consult health workers in case of repeated vomiting. Likewise, about 4 in every 10 respondents (34.0%-46.9%) also reported that the child should be taken to health workers for consultation if a child does not get better within 3 days or in case of fever. Those giving these responses were slightly higher among RLG members than other two categories of the respondents. A sizeable proportion (8.2%-23.6%) of the respondents with a higher percentage of RLG members also opined that a child should be taken to a health worker for consultation if s/he was very thirsty, not eating or drinking properly and has blood in the stool (Table 7.9). The average number of such situations mentioned by the respondents was significantly higher among RLG members (3.0) compared to those of non-RLG members (2.6) and the respondents of control areas (2.5).

Table 7.9 Percent distribution of respondents by their opinion regarding circumstances under which a child with diarrhea be taken to a health worker for consultation and preferred place for seeking advice or treatment

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Knowledge about circumstances in which a child with diarrhea should be taken to a health worker for consultation (Multiple Response)			
Frequent watery stools	91.6	88.7	90.7
Repeated vomiting	56.3	51.8	46.0
If child does not get better within 3 days	46.9	41.6	36.2
Fever	40.5	34.0	35.6
Blood in the stool	23.6	8.7	8.2
Child very thirsty	21.8	13.3	11.8
Not eating or drinking properly	21.4	18.0	20.7
Average number of situations known	3.0^{ab}	2.6	2.5
Do not know	-	0.7	0.9
Where would you seek for advice or treatment for the diarrhea?			
Subhealth post	45.2	41.6	53.3
Health post	32.5	32.7	20.4
Hospital	13.9	13.3	8.2
Primary health care center	6.0	4.7	4.4
Private clinic/nursing home	1.3	3.3	2.0
Other (mobile clinic; pharmacy; FCHV; DHO/AHW)	1.0	4.2	11.1
Do not know	-	0.2	0.4

Note: Other responses including weakness; unconsciousness; stomach pain; sunken eyes; severe headache; jaundice; cough; weakness were mentioned by fewer than 3% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

The higher percentage (41.6%-53.3%) of the respondents of all the three categories reported that in case of diarrhea they would take their child to subhealth post for consultation; those giving this response were much higher among the respondents of control areas than others. Nearly one-third of the RLG and non-RLG members and about one-fifth of the respondents of the control areas said that they would take their child to health post. About one in every 10 respondents also reported that they would take their child to hospital (Table 7.9).

b) Prevalence of diarrhea and its treatment

Two hundred and twenty three RLG members, 243 non-RLG members and 241 respondents of control areas had a child less than 5 years of age. These respondents were asked if their child below 5 years of age had diarrhea in the last 2 months preceding the survey. Slightly a higher percentage of the respondents of control areas (23.2%) followed by 21% non-RLG members and 19% RLG members reported that their child below 5 years of age had suffered from diarrhea during that period. Among those whose child had suffered from diarrhea, over 76% of the RLG members followed by 55% non-RLG members and 38% those from the control areas reported that they consulted FCHVs during the last diarrheal episode. Those respondents who did not consult FCHVs during the last diarrheal episode were asked about the reasons for not consulting them. Some of the main reasons for not consulting FCHVs mentioned by all three categories of respondents were related to: lack of knowledge about the availability of such services from FCHVs (30.0%-51.4%), unavailability of medicines from them (13.0%-50.0%), inaccessibility (10.0%-30.4%) and incompetence in providing services (8.6%-20.0%).

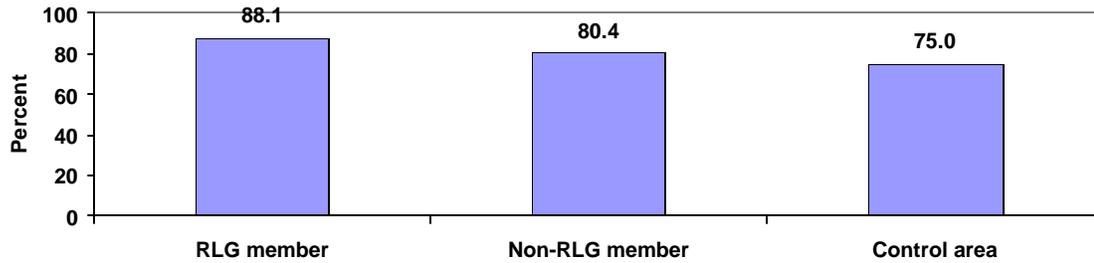
Table 7.10 Percent distribution of respondents by prevalence of diarrhea among children below 5 years of age and consultation with FCHVs during last diarrheal episode

Description	RLG member	Non-RLG member	Control area
Whether the youngest child below 5 years of age had diarrhea in the last 2 months			
Yes	18.8	21.0	23.2
No	81.2	79.0	76.8
Total (n)	223	243	241
Whether consulted FCHVs when s/he had diarrhea in the last 2 months			
Yes	76.2	54.9	37.5
No	23.8	45.1	62.5
Total (n)	42	51	56
Reasons for not consulting FCHVs for the treatment/advice for diarrhea (Multiple Response)			
FCHV has no medicine	50.0	13.0	22.9
Did not know FCHV provide diarrheal treatment	30.0	30.4	51.4
FCHV is not competent	20.0	17.4	8.6
FCHV behavior not good	10.0	8.7	5.7
FCHV too far away	10.0	30.4	17.1
Other±	10.0	13.0	11.5
Total (n)	10	23	35

± Other includes: FCHV not available; do not know FCHV, felt it unnecessary; lack of money; she asked for money; visited HP.

Among those whose youngest child was suffering from diarrhea, majority (>75%) of the respondents reported that they provided ORS (Jeevan Jal or Nava Jeevan) to their child. Considerably a higher percentage (88.1%) of the RLG members compared to those of non-RLG members (80.4%) and the respondents of control areas (75.0%) reported giving ORS to their child (Figure 7.1).

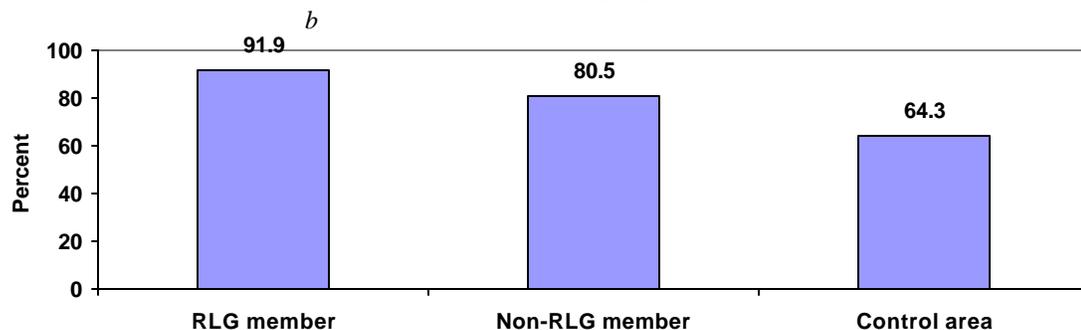
Figure 7.1 Percent distribution of respondents who provided ORS to their child during last diarrheal episode



N= 42 RLG members, 51 non-RLG members and 56 respondents of control areas

In order to assess the correct knowledge about preparing the ORS, all the respondents who had provided ORS to their child during the last diarrheal episode were asked to mention proper technique in preparing ORS. Data presented in Figure 7.2 reveal that more than 90% of the RLG members followed by 81% non-RLG members and 64% respondents of the control areas reported preparing it correctly (i.e. one packet of ORS mixed with 6 tea glasses or one liter of clean water).

Figure 7.2 Percent distribution of respondents who had prepared ORS correctly



N= 37 RLG members, 41 non-RLG members and 42 respondents of control areas

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

The respondents were also asked whether a child was given the same amount of liquid or solid food as before the diarrhea or less or more. Considerably a higher percentage of the RLG members compared to the non-RLG members and respondents of control areas reported that they provided both the liquid and solid foods more than usual quantity indicating that RLG members have more knowledge about the importance of giving more liquid and solid food items to children during diarrhea. More than 9 in every 10 RLG members compared to about two-thirds of the non-RLG members and the respondents of control areas reported that they provided more liquid items than usual. Likewise, about 62% of the RLG members compared to 53% non-RLG members and 45% respondents of the control areas reported that they fed more food than usual. Nearly a quarter (21.6%-23.2%) of the non-RLG members and respondents of control areas and about 17% RLG members reported to have fed less food than usual (Table 7.11).

Table 7.11 Percent distribution of respondents by amount of liquid and solid foods given to the children during diarrhea

Description	RLG member (n=42)	Non-RLG member (n=51)	Control area (n=56)
Amount of liquid offered to drink during diarrhea			
Less than usual	2.4	9.8	7.1
About the same	7.1	13.7	14.3
More than usual	90.5	68.6	69.6
Nothing to drink	-	7.8	8.9
Amount of food offered to eat during diarrhea			
Less than usual	16.7	21.6	23.2
About the same	19.0	19.6	28.6
More than usual	61.9	52.9	44.6
Stopped food	-	3.9	3.6
Never gave food	2.4	2.0	-

7.3 ARI and its treatment

Information regarding knowledge of respondents regarding the symptoms of serious respiratory illness, source of services for ARI, prevalence of ARI among under five children and types of treatment sought during ARI were collected. This section presents findings on these aspects.

a) Knowledge about ARI including its sources of services

The respondents of all three categories were asked to mention symptoms of serious respiratory illness that may appear in children. Almost all the RLG members and 98% of the non-RLG members and 96% of the respondents of control areas were found to be aware about at least one symptoms associated with serious respiratory illness. The respondents have given a number of symptoms associated with such illness. Considerably, a higher percentage of the RLG members compared to the respondents of other two categories were found to be aware of various symptoms associated with such illness. Majority of the respondents (82.0%-92.1%) with a higher percentage of the RLG members considered fast or difficult breathing as symptom of such illness followed by fever or low body temperature (60.7%-71.9%), inability to eat or breastfeed (47.1%-62.3%) and chest indrawing (43.6%-62.3%) respectively. Nearly, a quarter of the RLG members and about one-fifth of the respondents of other two categories also considered abnormally sleepy or difficult to wake as symptom of respiratory illness. The mean number of such symptoms mentioned by the RLG members was 3.1, which is significantly higher than that of non-RLG members (2.7) and the respondents of control areas (2.5).

Table 7.12 Percent distribution of respondents by their knowledge about symptoms of serious respiratory illness and causes of cold and cough or pneumonia

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Knowledge about symptoms of serious respiratory illness to the child (Multiple Response)			
Fast/difficult breathing	92.1	86.9	82.0
Fever/low body temperature	71.9	65.1	60.7
Inability to eat/breastfeed	62.3	50.9	47.1
Chest indrawing	62.3	45.6	43.6
Abnormally sleepy/difficult to wake	24.4	17.1	21.1
Severely malnourished	0.6	0.4	0.4
Average number of symptoms known	3.1^{ab}	2.7	2.1
Do not know	0.2	2.0	3.8
Knowledge about the causes of cough and cold/pneumonia to children (Multiple Response)			
Cold/wind	97.6	97.8	97.1
Pollution/smoke	33.6	20.0	21.6
Infection	13.1	8.4	4.0
Other§	3.2	2.4	2.4
Do not know	0.4	1.1	2.4

Note: Other responses including cough, running or blocking of nose; frequently crying; jaundice; watery stool; mouth-lips feel dry; vomiting; severe headache; stomach pain; red eyes were mentioned by fewer than 10% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

§ Other includes: eating unhygienic food; eating stale food; evil eye, curse or sin; lack of proper care; fever; eating sour and spicy foods; bad weather.

The great majority (>97%) of the respondents of all three categories reported that cold or wind could cause cough, cold or pneumonia. Pollution or smoke as the cause of cough, cold or pneumonia was mentioned by about one-third of the RLG members and one-fifth each of the non-RLG members and the respondents of control areas. Few of the respondents also considered infection as a cause of such illness (Table 7.12).

When asked about how they would treat to their child during cough, cold or pneumonia at home, highest percentage (73.3%-78.8%) of the respondents of all three categories reported that they would keep their child warm. Those giving this response was slightly higher among RLG members than other categories of respondents. Other types of home care treatment mentioned by a sizeable percentage of the respondents were looking for chest indrawing (18.7%-36.4%), looking for fast or difficult breathing (21.6%-34.7%) and giving more fluid than usual (15.3%-31.3%). Comparatively, a higher percentage of the RLG members mentioned the above three home care strategies than the respondents of other two categories. A sizeable percentage (20.9%-31.5%) of the respondents of all three categories also mentioned that they would provide herbal medicines to their child. Only a small percentage of the respondents of all three categories were found to be aware about the need for breast milk and other food items frequently and cleaning the nose during such illness (Table 7.13). Mean number of home care strategies – that are promoted by the program -- mentioned was significantly higher among RLG members (2.2) compared to the non-RLG members (1.8) and the respondents of the control areas (1.5).

Table 7.13 Percent distribution of respondents by their knowledge about appropriate home care strategies to be provided to the child during cough, cold or pneumonia

How do you treat for a child with suffering from cough/cold, pneumonia at home? (Multiple Response)	RLG member	Non-RLG member	Control area
Promoted by the program			
Keep the child warm	78.8	76.0	73.3
Look for chest indrawing	36.4	30.7	18.7
Look for fast breathing/difficult breathing	34.7	29.3	21.6
Give more fluid	31.3	21.8	15.3
Clean the nose	18.2	12.2	10.2
Breastfeed the baby frequently	13.5	8.7	7.1
Give more food frequently	8.1	5.3	3.8
Other mentioned			
Feeding herbal medicines±	31.5	24.4	20.9
Massaging with vicks/ ghee/ oil/	10.5	11.6	13.6
Feeding ghee/ cow ghee	14.1	9.8	7.3
Do not know	2.8	4.2	6.9
Average number of home care strategies promoted by the program known	2.2^{ab}	1.8^b	1.5
Total (n)	467	450	450

± Herbal medicines include: warm water with honey and ginger; warm water with Jwano, black pepper and ginger; warm water with salt, turmeric powder and ginger; Jiphal; Bhojo; Alaichi; Tulsi pani; lemon water.

Note: Other responses including give more food frequently; protect from cold, smoke and dust; consulting Dhami Jhakri; feeding milk, medicines, or warm soup; keeping on mother's lap; not feeding oily food were mentioned by fewer than 10% of the respondents and were excluded from the table but included in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

The respondents were also asked to mention the situation under which a child with cough, cold or pneumonia should be taken to a health facility or health worker for consultation or treatment. In response, majority (73.6%-82.2%) of the respondents of all the three categories thought that a child with cough or difficult breathing should be taken to a health facility or health workers for consultation or treatment. Other situations mentioned by more than 60% of the respondents of all the three categories were in case of fast breathing (62.9%-77.1%) and fever (62.7%-72.4%). About 66% of the RLG members followed by 54% non-RLG members and 46% of those from the control areas also thought that a child should be taken for consultation or treatment in case of chest indrawing. Relatively a smaller percentage of the respondents of all three categories knew the situation like inability to breastfeed or drink and soreness of throat in which he or she should be taken to health workers and health facility for consultation. The overall results indicate that RLG members are significantly more likely to know various situations under which a child should be taken to the health facility or health workers compared to other two categories of the respondents (Table 7.14).

On the question regarding the places where they would take their child or persons they would visit for seeking advice or treatment for cough, cold or pneumonia the higher percentage (36.0%-47.8%) of the respondents of all three categories mentioned subhealth post, it is followed by health post (18.0%-29.1%) and hospital (15.6%-18.4%) respectively. Quite a small percentage (<3%) of the respondents reported that they would consult FCHVs for such illness (Table 7.14).

Table 7.14 Percent distribution of respondents by their opinion regarding circumstances under which a child with cough, cold or pneumonia be taken to a health facility or health worker for consultation and preferred place for seeking advice or treatment

Description	RLG member (n=467)	Non-RLG member (n=450)	Control area (n=450)
Opinion on circumstances in which a child with cough/cold, pneumonia should be taken to a health facility or a health worker (Multiple Response)			
Cough/difficult breathing	82.2	74.9	73.6
Fast breathing	77.1	68.9	62.9
Fever	72.4	62.7	65.6
Chest indrawing	66.4	54.4	46.2
Inability to breastfeed or drink	35.1	20.9	20.9
Soreness of throat	13.7	9.3	7.6
Average number mentioned	3.5^{ab}	2.9^b	2.8
Do not know	0.2	1.1	2.0
Where would you seek advice or treatment for cough/cold, pneumonia?			
Subhealth post	40.5	36.0	47.8
Health post	29.1	29.1	18.0
Hospital	18.4	17.1	15.6
Primary health care center	5.4	3.6	4.9
Pharmacy	2.8	4.0	7.3
Private clinic/nursing home	1.7	6.4	1.6
Other±	2.1	3.0	4.4
Do not know	-	0.7	0.4

Note: Other responses including frequently crying; vomiting; abnormal sleeping; running nose; mouth-lips feel dry; headache; stomach pain; frequently unconsciousness; chest pain were mentioned by fewer than 3% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

± Other includes: FCHV; mobile clinic; VHW; MCH; DHO; Dhami Jhakri.

b) Prevalence of ARI and its treatment

All the respondents who have a living child below 5 years of age were asked if their youngest child had cough, cold or pneumonia in the last 2 months preceding the survey. Thirty two percent of the respondents of control areas followed by 31% non-RLG members and 29% RLG members reported that their child had suffered from cough, cold or pneumonia during that period (Table 7.15). Among those whose child had suffered from such illness, majority (82.9%-90.6%) of the respondents said that their child's breathing was faster than usual during illness. Over 60% of the RLG members compared to only 27% non-RLG members and 17% those of control areas reported that they consulted FCHVs during such illness. About 60% of the respondents of all three categories (59.4%-63.2%) said that they provided traditional treatment at homes. Considerably a higher percentage (65.8%) of the respondents of control areas compared to the non-RLG members (58.7%) and the RLG members (50.0%) reported that they bought medicines from the pharmacy. Nearly half of the RLG members and one-third each of the non-RLG members and the respondents of control areas reported taking their child to the subhealth post, health post or pharmacy for treatment (Table 7.15).

Table 7.15 Percent distribution of respondents by prevalence of cough, cold or pneumonia among children below 5 years of age and types of treatment sought during such illness

Description	RLG member	Non-RLG member	Control area
Whether the youngest child below 5 years of age suffered from cough/cold, pneumonia during the past 2 months			
Yes	28.7	30.9	31.5
No	71.3	69.1	68.5
Total (n)	223	243	241
When s/he had cough/cold, did he/she breathe faster than usual with short, fast breaths?			
Yes	90.6	86.7	82.9
No	9.4	13.3	17.1
Total (n)	64	75	76
Types of consultation or treatment sought during cough/cold or pneumonia			
Consulted an FCHV	60.9	26.7	17.1
Traditional treatment at home	59.4	60.0	63.2
Bought medicine from a pharmacy	50.0	58.7	65.8
Took child to SHP/HP/PHC	48.4	32.0	30.3
Took child to hospital	29.7	14.7	7.9
Consulted other health workers	21.9	9.3	5.3
Took child to a private clinic/nursing home	15.6	17.3	11.8
Consulted a Dhami/Jhankri	14.1	14.7	25.0
Gave medicine that was at home	12.5	12.0	6.6
Total (n)	64	75	76

Those respondents who reported not consulting FCHVs during cough, cold or pneumonia of their child were again asked about the reasons for not consulting FCHVs. About 40% each of the RLG members and the respondents of control areas and 29% non-RLG members reported that they were not aware about the availability of such services from FCHVs (Table 7.16). Other reasons given by a sizeable percentage of the respondents were: unavailability of medicines from FCHVs (18.2%-36.0%), incompetent in providing services (16.0%-21.8%) and living far away (12.0%-25.4%).

Table 7.16 Percent distribution of respondents by reasons for not seeking advice or treatment services from FCHVs during cough, cold or pneumonia of their youngest child

Reasons for not consulting FCHV for the treatment/advice of cough/pneumonia? (Multiple Response)	RLG member	Non-RLG member	Control area
Did not know FCHV provide pneumonia treatment	40.0	29.1	39.7
FCHV has no medicine	36.0	18.2	31.7
FCHV is not competent	16.0	21.8	17.5
FCHV too far away	12.0	21.8	25.4
FCHV was not available	8.0	5.5	-
FCHV behavior not good	4.0	5.5	1.6
Other±	4.0	9.1	7.9
Did not feel it necessary	8.0	5.5	4.8
Total (n)	25	55	63

± Other includes: do not know FCHV; provided treatment at home; does not give or have medicine.

7.4 Malnutrition and Vitamin A

In order to assess their level of knowledge, all the respondents were also asked to enumerate the symptoms of malnutrition among children. Data presented in Table 7.17 show that about 96% of the RLG members followed by 91% respondents of the control areas and 87% non-RLG members were found to have knowledge about symptoms of malnutrition among children. Some of the most frequently cited symptoms were failure to gain weight or weight loss (48.2%-66.0%), thin face, shoulders or buttocks (44.2%-55.0%) and constant crying and irritability (38.0%-52.5%). A sizeable percentage of the respondents also mentioned frequent infection (31.1%-39.0%), short for age (24.9%-34.7%), and thin and light colored hair (18.2%-32.3%) as the symptoms of malnutrition. About a quarter (21.6%-29.3%) of the respondents also mentioned “big belly with small head or small arms and leg” as the symptom of malnutrition. The level of knowledge about different types of symptoms associated with malnutrition was found to be significantly higher among RLG members than the respondents of other two categories.

Table 7.17 Percent distribution of respondents by knowledge about symptoms of malnutrition among children

Knowledge about the symptoms of malnutrition among children (Multiple Response)	RLG member	Non-RLG member	Control area
<u>Promoted by the program</u>			
Failure to gain weight or weight loss	66.0	54.7	48.2
Thin face, shoulders and buttocks	55.0	44.2	48.0
Constant crying and irritability	52.5	44.7	38.0
Frequent infection such as pneumonia or diarrhea	39.0	31.1	31.1
Short for his/her age	34.7	26.9	24.9
Thin, light-colored hair	32.3	21.6	18.2
Skin that is cold to touch	3.6	2.9	3.1
<u>Other mentioned</u>			
Big belly with small head/ small arms and legs	29.3	21.6	24.4
Do not know	3.6	12.9	9.3
Average number symptoms promoted by the program known			
	2.8^{ab}	2.3	2.1
Total	467	450	450

Note: Other responses including weakness; less appetite or indigestion; yellowish face; poor vision; anemic; difficult to move; disability were mentioned by fewer than 3% of the respondents; and were excluded from the table and also in the calculation for average number of responses mentioned.

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Those respondents who have children between 6-59 months at the time of survey were also asked if their child was given vitamin A capsule during the distribution in 2062 Kartik BS (October/November 2005). The great majority (95.9%-98.4%) of the respondents with slightly a higher percentage of the RLG members reported that their children were given Vitamin A capsule during that time. Data presented in Table 7.18 show that all the RLG members and non-RLG members and almost all the respondents of control areas with child aged 24-59 months old reported that their child was given vitamin A capsules.

Table 7.18 Percent distribution of children aged 6-59 months receiving Vitamin A during the distribution in Kartik 2062 BS by broad age categories (% yes only)

Age of child (in months)	RLG member		Non-RLG member		Control area	
	%	No.	%	No.	%	No.
	*		*		ns	
6-11	87.5	16	88.9	36	88.9	27
12-23	97.7	44	94.9	59	94.3	53
24-35	100.0	57	100.0	45	98.1	54
36-59	100.0	76	100.0	70	98.3	59
Total	98.4	193	96.7	210	95.9	193

*Significant at <.05 level

ns= Not significant

7.5 Multivariate analysis for selected newborn and child health indicators

Multivariate regression models were used to examine the relationship between RLG membership status and the level of knowledge of respondents about newborn care and child health. Similarly, relationship between RLG membership status and discussion with FCHV on child health issues was also examined. Knowledge of newborn care and child health was measured as an aggregate index of correct responses to the knowledge items presented above and ranged from 0 to 10 for newborn care and 0-6 for child health. Since these analyses control for respondents' background characteristics, they remove the possibility that differences in these background characteristics across the groups may explain the association between RLG membership and child health related knowledge among respondents.

Data presented in Table 7.19 indicate that both the RLG members and non-RLG members have greater knowledge on newborn care and child health compared to the respondents of control areas. The mean adjusted newborn care scores among RLG members were 0.97 units higher than among women in the control communities and mean newborn care among non-RLG members was 0.29 units higher than the respondents of the control areas. Similarly, the level of knowledge about child health was higher by 1.11 units among RLG members and 0.28 units among non-RLG members compared to the respondents of control areas. The survey results also further show that RLG members have significantly greater knowledge about newborn care and child health compared to the non-RLG members of the study areas.

Table 7.19 Unadjusted and adjusted coefficients from linear regression models predicting knowledge about newborn care and child health

Respondent Type	Newborn care		Child health		Spoken with FCHV	
	Coefficients		Coefficients		Odds Ratio	
	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹	Unadj.	Adjusted ¹
RLG Member	1.33 ^{***^}	0.97 ^{***^}	1.25 ^{***^}	1.11 ^{***^}	2.58 ^{***^}	2.50 ^{***^}
Non-RLG member	0.34 ^{***}	0.29 ^{**}	0.29 ^{**}	0.28 ^{**}	1.13	1.14
N	1367		1367		1367	

¹Adjusting for age, literacy, ethnic group, number of living children, socioeconomic status, husband education, fluency in Nepali, distance to nearest health facility, frequent television use, frequent radio use, participation in other community groups, recent interaction with the FCHV

Comparisons with Control group: *p<0.10; **p<0.05; ***p<0.01

[^]RLG members differ from non- RLG members: p<0.05

The adjusted odds ratios reveal that RLG members were nearly 2.5 times more likely to have spoken with FCHVs regarding newborn and child health than the respondents of the control areas. Similarly, RLG members were also more likely to have discussed with FCHVs than the non-RLG members living in their community. However, non-RLG members were not more likely to have discussed with FCHVs than respondents in the control areas (Table 7.19).

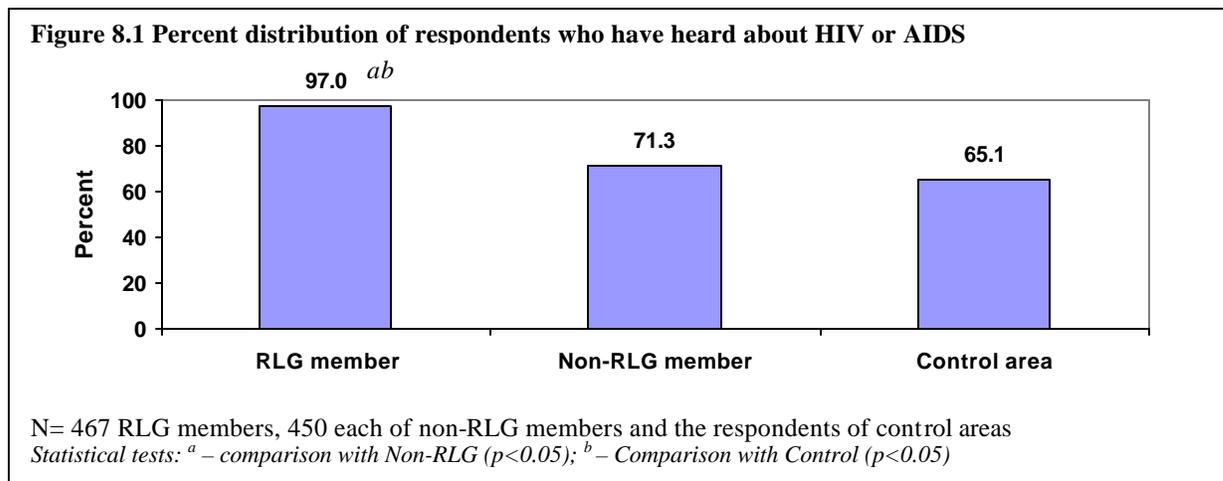
Chapter 8

Knowledge about HIV/AIDS

Information regarding respondents' level of knowledge about HIV/AIDS was collected in the study. This chapter presents the findings on knowledge about HIV/AIDS and the sources of information among the respondents of different categories.

8.1 Heard of HIV/AIDS

All the RLG members, non-RLG members and the respondents of control areas were asked whether they have heard of HIV or AIDS. Data presented in Figure 8.1 show that almost all (97.0%) the RLG members compared to 71% of the non-RLG members and 65% of the respondents of control areas were found to have heard about HIV or AIDS. The observed difference was significantly higher among RLG members than other two categories of the respondents.



Among those who reported having heard about HIV or AIDS were asked about the ways through which a person can get infected. Table 8.1 shows respondents' knowledge (spontaneous as well as after probing) about different modes of transmission of HIV or AIDS. The higher percentage of the respondents of all three categories spontaneously mentioned that HIV could be transmitted through multiple sexual relationships (67.6%-86.5%), sexual intercourse with infected persons (61.4%-77.0%), sharing needles used by HIV infected person (26.6%-51.4%) and infected blood transfusion (22.5%-37.1%). The percentage of respondents mentioning the above four modes of transmission of HIV was considerably higher among RLG members compared to the respondents of other two categories. The percentage of respondents of all three categories mentioning different modes of HIV transmission stood very high after probing each of the possible modes. For instance, the great majority (89.4%-100.0%) of the respondents of all three categories reported that HIV could be transmitted through multiple sexual relationships, sex with infected persons, sharing needles used by HIV infected person, infected blood transmission and unborn child of infected mother. The average number of correct modes of transmission spontaneously mentioned by the respondents was significantly higher among RLG members (2.6) than the non-RLG members (1.5) and the respondents of control areas (1.2).

Table 8.1 Percent distribution of respondents by knowledge about modes of transmission of HIV

Knowledge about ways in which a person can get infected with HIV	RLG member (n=453)			Non-RLG member (n=321)			Control area (n=293)		
	Spont	Prob	Total	Spont	Prob	Total	Spont	Prob	Total
<u>Correct modes</u>									
Person who have multiple sexual relationships	86.5	13.5	100.0	78.8	20.2	99.0	67.6	32.4	100.0
Through sexual intercourse with infected partner	77.0	22.5	99.5	63.6	35.8	99.4	61.4	37.5	98.9
From an infected blood transfusion	37.1	62.3	99.4	21.8	71.0	92.8	22.5	73.7	96.2
Getting injections with a needle that has been already used by someone else who is infected with HIV virus	51.4	47.7	99.1	30.5	65.4	95.9	26.6	70.3	96.9
From a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child	8.2	88.1	96.3	5.9	83.5	89.4	1.7	90.4	92.1
From a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding	5.3	79.5	84.8	4.0	77.3	81.3	1.4	80.9	82.3
Average number of modes known (spontaneous only)		2.6^{ab}			1.5^b			1.2	
<u>Incorrect modes</u>									
From a mosquito bite	5.5	68.7	74.2	1.9	67.6	69.5	0.7	68.6	69.3
If s/he uses the dishes to eat of a HIV/AIDS infected person	0.9	28.9	29.8	0.6	40.8	41.4	0.7	35.5	36.2
Sharing a meal with someone who is infected with HIV	2.0	26.9	28.9	1.2	40.5	41.7	0.7	41.3	42.0
If s/he works together with some one infected with HIV/AIDS	2.4	25.2	27.6	2.8	37.1	39.9	1.7	35.5	37.2
Other±	12.2	-	12.2	6.5	-	6.5	3.7	-	3.7

± Other includes: sharing equipment such as blade, scissor, nail cutter; not using condoms during sex; sexual intercourse with sex workers; sharing clothes used by infected person; shaking hands with infected person

Statistical tests: ^a – comparison with Non-RLG ($p < 0.05$); ^b – Comparison with Control ($p < 0.05$)

Data presented in Table 8.1 also show that quite a high percentage of the respondents have misconception regarding the modes of transmission of HIV or AIDS. For instance, about 7 in every 10 respondents with slightly a higher percentage of RLG members mentioned that a person could get HIV infection from mosquito bites. Similarly, more than 40% of the non-RLG members and the respondent of control areas and about 30% of the RLG members reported that a person could get HIV infection by sharing a meal with someone who is infected with HIV. About two-fifths of the non-RLG members and the respondents of control areas and more than a quarter of the RLG members also opined that HIV is transmitted by working together and sharing dishes with HIV infected persons. The above findings clearly indicate that still quite a significant percentage of the respondents have misconceptions about the mode of transmission of HIV or AIDS. Thus, there is a great need for giving more information about HIV/AIDS through radio program.

8.2 Sources of information about HIV/AIDS

The respondents of all three categories who reported to have heard about HIV/AIDS were asked the sources of their knowledge about HIV/AIDS. The great majority (86.8%) of the RLG

members reported that they knew about HIV/AIDS from radio listeners group followed by 59% from radio and 39% from friends or neighbors (Table 8.2). Over three-quarters (77.3%-78.8%) of the non-RLG members and the respondents of control areas reported that they knew about HIV/AIDS from their friends or neighbors. Nearly half (49.1%) the respondents of control areas and about 40% non-RLG members also reported that they got information about it from radio. About 28% of the RLG members followed by 24% non-RLG members and 22% respondents of control areas also reported knowing from FCHVs. Likewise, slightly over one in every 10 respondents also reported that they got information about it from television. The percentage of respondents mentioning printed BCC materials and grassroots level health workers as their source of information about HIV/AIDS was found to be quite low.

Table 8.2 Percent distribution of respondents by their sources of information on HIV/AIDS

Sources of information about AIDS (Multiple Response)	RLG member	Non-RLG member	Control area
RLG/RLG members	86.8	15.3	-
Radio	59.2	40.2	49.1
Neighbors/friends	39.3	77.3	78.8
FCHV	28.0	24.3	21.5
TV	11.9	12.1	12.6
Health worker	7.3	5.3	7.8
Husband	4.4	11.2	15.0
Street performance	3.3	2.5	1.7
Newspapers/magazine	2.4	4.7	3.1
Pamphlets/posters	2.6	5.0	2.0
Your children	2.0	2.8	1.4
School/teacher	1.8	2.5	1.7
VHW	0.7	0.3	0.3
Other±	5.1	3.7	5.8
Total (n)	453	321	293

± Other includes: book; adult literacy class; training; NGO; mothers group; other family members.

8.3 Multivariate analysis for selected HIV/AIDS indicators

Multivariate regression models were used to examine the relationship between RLG membership status and the level of awareness of respondents about modes of transmission of HIV/AIDS. These models included several characteristics that differed across the RLG membership categories and, therefore, may confound the association between awareness of modes of HIV/AIDS transmission and RLG membership status. By including these characteristics, these models remove the possibility that the differences in these characteristics across the groups may explain the association between RLG membership and knowledge of respondents on modes of HIV/AIDS transmission.

The adjusted odds ratios reveal that RLG members were 3.9 times more likely to have knowledge about three or more modes of transmission of HIV/AIDS compared to the respondents of control areas. The odds ratios obtained from logistics regression further show that RLG members were also more likely to be aware of three or more modes of transmission compared to the non-RLG members of the study areas. Non-RLG members, however, were not more likely to know about at least three modes of transmission of HIV/AIDS than the respondents of control areas (Table 8.3).

Table 8.3 Unadjusted and adjusted odds ratios from logistic regression model predicting awareness of modes of transmission of HIV/AIDS

Respondent Type	Odds Ratios	
	Proportion aware of at least three or more modes of transmission of HIV/AIDS	
	Unadjusted	Adjusted ¹
RLG Member	5.27 ^{***^}	3.86 ^{***^}
Non-RLG member	1.37	1.35
N	1367	

¹Adjusting for age, literacy, ethnic group, number of living children, socioeconomic status, husband education, fluency in Nepali, distance to nearest health facility, frequent television use, frequent radio use, participation in other community groups, recent interaction with the FCHV

Comparisons with Control group: *p<0.10; **p<0.05; ***p<0.01

[^]RLG members differ from non-RLG members: p<0.05

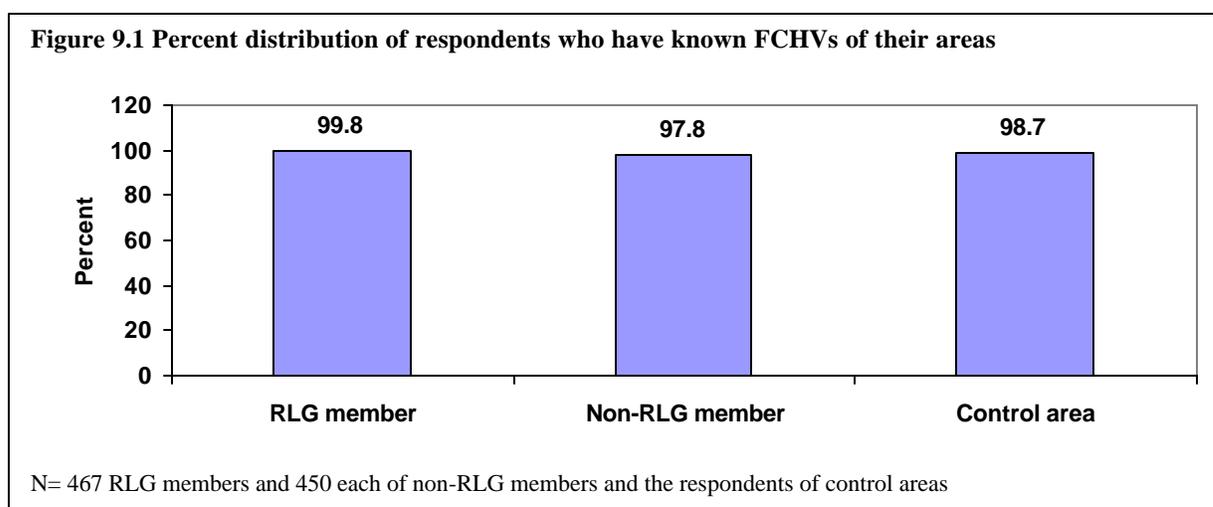
Chapter 9

Female Community Health Volunteers

Information regarding respondents' acquaintance with female community health volunteers (FCHVs), extent of interaction with FCHVs and attitude of respondents towards the FCHVs' services was collected. The first section discusses on familiarity of respondents with FCHVs and their services followed by their interaction with FCHVs in the second section and attitudes of respondents towards FCHVs' services in the last section.

9.1 Familiarity with FCHVs and their services

The respondents of all three categories namely RLG members, non-RLG members and those of control areas were asked whether they knew FCHVs of their area. Almost all (97.8%-99.8%) the respondents of all three categories reported that they knew FCHVs of their areas (Figure 9.1)



One of the responsibilities of the FCHVs is to provide FP related information and services. Among the respondents who had heard of family planning were asked if FCHVs of their areas provided information and services related to family planning. More than 93% of the RLG members compared to 77% non-RLG members and 73% respondents of control areas affirmed that FCHVs in their areas provided information and services related to family planning (Table 9.1). Among those who responded affirmatively were further asked to mention types of family planning related information and services FCHVs of their areas usually provide. Over 8 in every 10 RLG members and more than three-quarters of the non-RLG members and the respondents of the control areas reported that FCHVs of their areas provide family planning counseling. Similarly, over half of the RLG members knew that FCHVs in their areas distribute condoms and pills, and also provide referral services for family planning. The percentage of non-RLG members and the respondents of control areas mentioning the above types of services constituted 37% to 50% indicating that these categories of the respondents are less aware than the RLG members about the types of FP services the FCHVs of their areas provide in the community.

Table 9.1 Percent distribution of respondents by knowledge about FP related information and services provided by FCHVs in their areas

Description	RLG member	Non-RLG member	Control area
Whether the FCHVs provide FP information and services			
Yes	93.4	77.2	72.8
No/do not know	6.6	22.4	27.2
Total (n)	467	447	441
Type of information and services related to FP FCHV provides (Multiple Response)			
Provides FP counseling	82.6	76.8	76.0
Distributes pills	59.9	49.9	43.0
Distributes condoms	56.0	40.9	36.8
Refers for FP services	53.2	46.1	48.9
Helps in sterilization camp	29.1	21.4	34.9
Other (iron tablets/shows FP posters)	0.5	-	-
Total (n)	436	345	321

The respondents were also asked whether FCHVs of their area provided pregnancy and childbirth related information and services. In response, nearly 94% of the RLG members followed by 83% non-RLG members and 78% respondents of control areas reported that the FCHVs of their areas provide information and services related to pregnancy and childbirth (Table 9.2). Regarding the types of pregnancy and childbirth related information and services provided by FCHV, more than 70% of the RLG members and about 60% of the non-RLG members and the respondents of control areas confirmed that they provide information on TT vaccines. Likewise, nearly three-fifths of the RLG members compared to slightly over two-fifths of the non-RLG members and the respondents of control areas reported that FCHVs provide iron tablets. Over half of the respondents of all three categories also aware of FCHVs advise to give vitamin A to children and give information about child immunization. About half of the respondents of all three categories also mentioned that they give advice to women to visit health facility for seeking antenatal services. The higher percentages of the respondents of all three categories also reported that FCHVs provide counseling during pregnancy, delivery and postpartum (27.8%-43.6%), provide information on safe motherhood (24.6%-40.0%) and give advice to visit health facility for postnatal services (15.5%-22.9%). Only a few respondents mentioned that FCHVs provide assistance during pregnancy (Table 9.2).

Table 9.2 Percent distribution of respondents by knowledge about pregnancy and childbirth related information and services provided by FCHVs in their areas

Description	RLG member	Non-RLG member	Control area
Whether the FCHVs provide pregnancy and childbirth related information and services			
Yes	93.8	82.9	77.6
No/do not know	6.2	17.1	22.4
Total (n)	467	450	450
Type of pregnancy and childbirth related information and services FCHVs provide (Multiple Response)			
Provide information on TT vaccine	70.3	60.1	58.2
Provide iron tablets	58.7	46.4	43.8
Advise to give Vitamin A to children	55.0	54.2	55.3
About child immunization	53.7	55.0	54.2
Advise to visit health facility for antenatal services	52.7	49.1	49.9
Provide counseling during pregnancy, delivery and postpartum	43.6	29.8	27.8
Provide information on safe motherhood	40.0	27.3	24.6
Advise to visit health facility for postnatal services	21.2	15.5	22.9
Assist during delivery	10.5	5.9	13.8
Advise to take deworming tablets during pregnancy	5.7	1.9	0.6
Other±	2.7	1.1	2.3
Total (n)	438	373	349

± Other includes: provide information about nutritious foods; advise to eat nutritious food and bean soup; distribute condoms; provide information on birth spacing.

On the question whether the FCHVs of their areas provide information and services related to child health, the great majority (94.9%-98.5%) with slightly a higher percentage of RLG members reported that FCHVs of their areas provide such information and services (Table 9.3). Majority of the respondents with a higher percentage of RLG members were aware that FCHVs of their areas provide information on immunization (70.5%-87.8%) and on vitamin A (77.5%-82.4%). More than three-quarters of the respondents of control areas and nearly three quarters of the RLG members and non-RLG members also reported that FCHVs distribute vitamin A capsules. More than two-fifths of the RLG members (43.5%-46.3%) and about a quarter (24.8%-29.9%) of the non-RLG members and the respondents of control areas were also aware that FCHVs of their area provide information and treatment services of diarrhea. Knowledge of respondents of all three categories regarding the availability of information and services related to ARI, malnutrition, and newborn from FCHVs was found to be quite low.

Table 9.3 Percent distribution of respondents by knowledge about child health related information and services provided by FCHVs in their areas

Description	RLG member	Non-RLG member	Control area
Whether FCHVs provide child health information and services			
Yes	98.5	96.7	94.9
No/do not know	1.5	3.3	5.1
Total (n)	467	450	450
Type of information and services related to child health FCHVs provide (Multiple Response)			
Provide information on immunization	87.8	79.3	70.5
Provide information on Vitamin A	82.4	80.0	77.5
Provide Vitamin A capsules	73.9	71.0	78.7
Provide information on diarrhea	46.3	28.3	24.8
Provide diarrhea treatment services (ORS)	43.5	29.9	26.7
Provide ARI/pneumonia treatment services	22.0	10.1	15.0
Provide information on malnutrition	12.6	6.0	5.4
Provide polio	12.6	16.1	21.5
Provide information on ARI	10.7	5.7	5.2
Provide referral services	8.9	3.2	1.6
Provide newborn care services	4.1	1.8	1.4
Other±	2.4	2.3	1.4
Do not know	-	-	0.2
Total (n)	460	435	427

± Other includes: distribute deworming tablet; weighing child; advise to keep child clean; give information about nutritious food; distribute cetamol; provide medicines during fever.

On the question whether the FCHVs of their areas provide information and services related to HIV/AIDS about three quarters (74.0%) of the RLG members followed by 40% non-RLG members and 35% respondents of control areas responded affirmatively (Table 9.4). These respondents were also asked to mention about types of information and services provided by FCHVs in their community. The great majority (93.0%-97.0%) of the respondents with a higher percentage of those of control areas were aware that FCHVs provide information on ways of avoiding HIV/AIDS. Nearly three-fifths (59.1%) of the RLG members followed by 54% non-RLG members and 26% respondents of control areas were aware that their FCHVs provide information on using condom. Quite a small percentage (2.0%-6.0%) of the respondents were aware about the availability of referral services from FCHVs.

Table 9.4 Percent distribution of respondents by knowledge about HIV/AIDS related information and services provided by FCHVs in their areas

Description	RLG member	Non-RLG member	Control area
Whether FCHVs provide HIV/AIDS related information and services			
Yes	74.0	39.9	34.5
No/do not know	26.1	60.1	65.6
Total (n)	453	321	293
Type of HIV/AIDS related information and services FCHVs provide (Multiple Response)			
Provide information on ways of avoiding HIV/AIDS	95.8	93.0	97.0
Provide information on using condom	59.1	53.9	25.7
Provide referral services	6.0	3.1	2.0
Total (n)	335	128	101

9.2 Interaction with FCHVs

All the respondents were enquired about the last time they met with the FCHVs of their areas. Over 90% of the RLG members followed by 88% respondents of control areas and 85% non-RLG members reported that they had met FCHVs to seek health related information and services. Data presented in Table 9.5 indicate the occurrence of frequent interaction of respondents of all three categories with FCHVs as about half of the respondents (45.1%-54.4%) of all three categories with a higher proportion of RLG members reported to have met the FCHVs within 7 days prior to the survey. Slightly a higher percentage of the respondents (27.8%) of control areas compared to the non-RLG members (26.0%) and RLG members (25.3%) reported that they had met FCHVs 1-4 weeks prior to the survey date. Only about one in every 10 respondents of all three categories had met their FCHVs more than 5 weeks prior to the survey.

Table 9.5 Percent distribution of respondents by last time they met with the FCHVs working in their areas

Last time met with the FCHVs	RLG member	Non-RLG member	Control area
Less than a week	54.4	45.1	49.8
1-2 weeks	14.8	15.3	18.2
3-4 weeks	10.5	10.7	9.6
5 weeks or more	11.1	14.2	10.4
Never met	9.2	14.7	12.0
Total (n)	467	450	450

On the question regarding the places where their last interaction took place with FCHVs, about 27% of the RLG members reported that they visited the FCHV's place followed by 25% met them casually while doing something else and 22% were visited by FCHVs. About 18% of the RLG members also reported that they met FCHVs during RLG meeting or in the class. The highest percentage of the non-RLG members (41.9%) and the respondents of control areas (50.0%) reported that they met the FCHV casually while doing something else followed by about a quarter (24.5%-26.0%) were visited by FCHVs and over one-fifth (20.2%-24.2%) had visited themselves to the FCHVs (Table 9.6).

Table 9.6 Percent distribution of respondents by places they met and issues discussed with FCHVs during their last meeting

Description	RLG member	Non-RLG member	Control area
Places where most recent discussion with the FCHV took place			
I visited FCHV	27.4	24.2	20.2
Met casually while doing something else	24.8	41.9	50.0
FCHV visited me	22.4	24.5	26.0
Met at the RLG meeting/class	18.2	2.1	0.3
Met at other meeting	4.2	2.6	1.3
At the immunization center/ health post/ haat bazaar/ school/ met when going to the farm	3.1	4.7	2.3
Total (n)	424	384	396
Type of issues discussed with the FCHV during last meeting (Multiple Response)			
Child health	54.7	44.5	39.6
Discussed on household matter only/ about farming/ other issues	20.5	30.2	44.9
Family planning	20.5	9.9	5.1
Safe motherhood	17.0	7.3	6.3
HIV/AIDS/STI	2.1	1.6	0.3
Other±	5.2	2.9	2.3
Do not know	2.6	7.8	6.3
Total (n)	424	384	396

± Other includes: about preparing Jeevan Jal; about various types of diseases; got medicines for infection and wound; about saving scheme; about mothers group meeting; about head ache; about child health; about Gyan Nai Shakti Ho radio program; about RLG.

Over half (54.7%) of the RLG members followed by 45% non-RLG members and 40% of the respondents of control areas reported that they discussed about child health with FCHVs during their last visit. Likewise, 45% of the respondents of control areas followed by 30% non-RLG members and 21% RLG members had discussion on their household matters during that time. About a quarter of the RLG members (17.0%-20.5%) compared to less than 10% of the non-RLG members and the respondents of control areas had discussion on issues related to family planning and safe motherhood. Quite a small percentage (<3%) of the respondents of all three categories reported to have discussions with FCHVs on STIs and HIV/AIDS during their recent meetings (Table 9.6).

Among those who were aware about the availability of information and services related to family planning, pregnancy and childbirth, and child health from the FCHVs of their areas were also asked whether they discussed with FCHVs on these aspects in the last 6 months prior to the survey. Data presented in Table 9.7 show that considerably a higher percentage of the RLG members than the non-RLG members and the respondents of control areas reported to have discussed on these aspects during 6 months prior to the survey. For instance, about three-fifths of the RLG members as against less than two-fifths of the non-RLG members and respondents of control areas had discussed with FCHVs on issues related to family planning, and pregnancy and childbirth. Likewise, about two-thirds (66.3%) of the RLG members compared to 48% of non-RLG members and 45% respondents of control areas reported that they discussed child health issues with FCHVs.

Table 9.7 Percent distribution of respondents who had spoken with FCHVs in the last 6 months on issues related to FP, pregnancy/childbirth and child health

Description	RLG member	Non-RLG member	Control area
Whether spoken with FCHV with regard to the FP in the last 6 months			
Yes	58.0	36.2	39.6
No/do not know	40.6	63.5	59.5
Self or family member FCHV	1.4	0.3	0.9
Total (n)	436	345	321
Whether spoken with FCHV with regard to the pregnancy and childbirth in the last 6 months			
Yes	59.1	37.5	37.8
No/do not know	39.5	62.2	61.3
Self or family member FCHV	1.4	0.3	0.9
Total (n)	438	373	349
Whether spoken with FCHV with regard to the child health in the last 6 months			
Yes	66.3	48.0	45.2
No/DK	32.4	51.7	54.1
Self or family member FCHV	1.3	0.2	0.7
Total (n)	460	435	427

9.3 Attitude towards FCHV services

Among the respondents who were aware about the availability of information and services related to family planning, pregnancy and childbirth, and child health from the FCHVs of their areas and who or whose family members are not the FCHVs were also asked whether they have ever recommended anyone to speak to the FCHVs about family planning, pregnancy and childbirth, and child health issues. A higher percentage of the RLG members (64.7%-71.4%) compared to non-RLG members (40.1%-46.3%) and the respondents of control areas (42.2%-44.3%) reported that they had recommended others to discuss on these issues with the FCHVs of their areas (Table 9.8). The above findings indicate the positive attitude of respondents towards the information and services provided by the FCHVs in their community.

Table 9.8 Percent distribution of respondents who recommended others to discuss with FCHVs on issues related to family planning, pregnancy and childbirth, and child health

Description	RLG member	Non-RLG member	Control area
Ever recommended anyone to speak to the FCHV about FP issues			
Yes	64.7	40.1	44.3
No/do not know	35.3	59.9	55.7
Total (n)	430	344	318
Ever recommended anyone to speak to the FCHV about pregnancy and childbirth			
Yes	67.6	40.6	42.2
No/do not know	32.4	59.4	57.8
Total (n)	432	372	346
Ever recommended anyone to speak to the FCHV about child health issues			
Yes	71.4	46.3	42.9
No/do not know	28.6	53.7	57.1
Total (n)	454	434	424

Annex

Annex 1

Selection and recoding of variables for multivariate analysis

For the logistical and linear regression analysis a number of control and dependent variables were identified based on the bi-variant analysis results. These variables were further recoded in three different categories -- dichotomous variables (no or yes – 0,1), categorical variables (0, 1, 2, 3, 4) and continuous variables. Tables 1-3 below show the list of control and dependent variables used in the analysis:

Table 1 List of control variables identified for regression analysis		
Variable name	Categories	Variable type
Respondent type	RLG member Non-RLG member Control areas	Categorical
Age	15-49	Continuous
Ethnicity	Brahmin/Chhetri Tibeto-Burman Dalit Other terai caste	Categorical
SES index	0-19	Continuous
Husband's education	Never attended school Ever attended school	Dichotomous
Total number of living children	0-9	Continuous
Literacy status	Illiterate Literate	Dichotomous
Speaks Nepali	Yes No	Dichotomous
Proximity to health facility	2-120	Continuous
TV use	At least once per week Else	Dichotomous
Radio use	At least once per week Else	Dichotomous
Member of another community group	Yes No	Dichotomous
Met FCHV within a week	Yes No	Dichotomous

Table 2 List of dependent (family planning and safe motherhood) variables identified for regression analysis

Variable name	Categories	Variable type
FP variables		
Spousal communication about FP	Discussed with husband about the number of children or FP/ contraceptive use in the past 6 months Not discussed	Dichotomous
Intention to use FP, among non-users	Yes No	Dichotomous
Current use of a modern FP method	Yes No	Dichotomous
Safe motherhood variables		
Knowledge of safe motherhood	0-11	Continuous
Knowledge about the best time to start ANC (<i>within 3-4 months</i>)	Yes No	
Knowledge about number of times a woman should receive ANC (<i>at least 4 ANC visits</i>)	Yes No	
Heard of iron/folic acid	Yes No	
Heard of TT	Yes No	
Knowledge about number of times a women should receive TT (<i>2 or more TT</i>)	Yes No	
Knowledge about a woman should eat same or more than usual food during pregnancy	Yes No	
Knowledge about number of danger sings or symptoms that can occur during pregnancy	Greater than median (3) Less than or equal to median	
Knowledge about things that need to be kept clean during delivery	Greater than median (3) Less than or equal to median	
Knowledge about danger signs during delivery	Greater than median (3) Less than or equal to median	
Should receive first check up within 3 days	Yes No	
Knowledge about danger signs after delivery	Greater than median (3) Less than or equal to median	
Knowledge about BPP	0-6	Continuous
Knowledge about skilled birth attendants	Greater than median (1) Less than or equal to median	Dichotomous

Table 3 List of dependent (newborn, child health and HIV/AIDS) variables identified for regression analysis

Variable name	Categories	Variable type
Knowledge about newborn care	0-10	Continuous
Knowledge about newborn danger sings	Greater than median (2) Less than or equal to median	
Knowledge about need of using clean/sterilized instruments to cut cord	Yes No	
Knowledge about substances that should not be applied on the cord stump	Yes No	
Knowledge about bathing newborn (<i>after 24 hours</i>)	Yes No	
Knowledge about drying and wrapping newborn (<i>before placenta delivered</i>)	Yes No	
Knowledge about types of clothes to be used to wrap newborn (<i>clean dry cloth</i>)	Yes No	
Knowledge about where a baby should be placed before the placenta is delivered (<i>with mother</i>)	Yes No	
Knowledge about initiation of brastfeeding (<i>immediately after birth</i>)	Yes No	
Opinion on colostrums feeding (<i>yes</i>)	Yes No	
Knowledge about timing of health check up of newborn (<i>within 3 days</i>)	Yes No	
Knowledge about child health	0-6	Continuous
Knowledge about at least two home care strategies that should be adopted during diarrhea	Yes No	
Knowledge about circumstances under which a child with diarrhea be taken for health check up	Greater than median (3) Less than or equal to median	
Knowledge about symptoms of serious respiratory illness to child	Greater than median (3) Less than or equal to median	
Knowledge about circumstances under which a child with cough, cold or pneumonia be taken to health facility or HW	Greater than median (3) Less than or equal to median	
Knowledge about home care strategies to be provided to the child during cough, cold or pneumonia	Greater than median (2) Less than or equal to median	
Knowledge about symptoms of malnutrition among children	Greater than median (2) Less than or equal to median	
Spoken with FCHVs with regard to child health in the last 6 months	Yes No	Dichotomous
Knowledge (spontaneous) about correct modes of transmission of HIV	Greater than median (2) Less than or equal to median	Dichotomous

Annex 2
Survey Questionnaire

**A STUDY ON RADIO LISTENERS' GROUOP, 2005
QUESTIONNAIRE FOR CURRENTLY MARRIED WOMEN**

Respondent No.				
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District:.....	
Name of VDC.....	
Ward No.....	
Village name.....	
Cluster No.	
Household No.	
Name of the household head	
Name of the respondent.....	
Respondent type:	
Frequent RLG member (75% or more).....	1
Infrequent RLG member (20%-74%).....	2
Non-RLG member.....	3
Respondent from control areas.....	4

	INTERVIEWER		VISITS
	1	2	3
DATE			
INTERVIEWER'S NAME:			
RESULT*			
NEXT VISIT : DATE			
TIME			

*RESULT CODES:

1 = Completed 2 = Absent 3 = Time and date set for later	4 = Incomplete interview 5 = Refused 6 = Other (specify): _____
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INTRODUCTION AND CONSENT

Namaste! My name is _____, and I am from Valley Research Group (VaRG) Kathmandu. VaRG is conducting this study for Ministry of Health/HMG. MOH has been implementing Radio Listeners Group Program in this district with the objectives of improving mother and child health status. The program has disseminated information on health matters through the radio drama serials from these Radio Listeners Group. We are here to know about your opinion on the radio drama serials and to find about the health of mothers and children to help you and your community to keep mothers and children healthy. We are asking many women in many communities the same questions in order to understand their knowledge, attitudes and behavior regarding the mother and child health. We would very much appreciate your participation in this survey. This information will help MOH to improve its program in the districts. The survey usually takes around one hour. But I assure you that your name will not be shared with anyone else and your answers to my questions will be combined with answers from many other people so that no one will know that the answers you give me today belong to you. Your privacy is protected and I assure that your answers are kept confidential.

Your participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

May I proceed with the questions?

RESPONDENT AGREES TO BE INTERVIEWED..... 1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED..... 2 ? END INTERVIEW & THANK THE RESPONDENT

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January 3, 2006

Section 1: Respondent's Background

First I would like to ask some questions about you.

Q. #	Question	Codes	GO TO Q.
101	How old are you?	AGE IN COMPLETED YEARS... DON'T KNOW98	
102	How old were you when you (first) got married?	AGE IN COMPLETED YEARS... <input type="text"/> DON'T REMEMBER.....98	
103	Have you ever-attended school?	YES.....1 NO.....2	→106
104	What is the highest class you completed?	GRADE..... <input type="text"/>	
105	CHECK Q. 104:	GRADE 5 OR BELOW.....1 GRADE 6 AND ABOVE.....2	→107
106	Now, I would like you to read out loud as much of this sentence as you can. (CHUROT KHANU RAMRO BANI HOINA) (Show card to the respondents)	Can not read at all.....1 Able to read only parts of sentence.....2 Able to read whole sentence3	
107	Did your husband ever attend school?	YES.....1 NO.....2	→109
108	What was the highest class he completed?	GRADE <input type="text"/> DON'T KNOW98	
109	What is your caste or ethnicity? (WRITE CASTE IN SPACE RPROVIDED. DO NOT FILL BOX)	<input type="text"/> <hr style="width: 100%;"/> CASTE/ETHNICITY	
110	What language do you speak at home? (MULTIPLE RESPONSE)	Nepali.....1 Maithili.....2 Hindi.....3 Other (specify).....4	
111	Do you understand the following language? (Read All)	Yes, easily Yes, with some difficulty No	
	1 Nepali	1 2 3	
	2 Maithili	1 2 3	
112	Does your household have the following items?	Yes No	
	1 Electricity	1 2	
	2 Bicycle	1 2	

113	What is the main source of drinking water for members of your household?	Piped water • Piped into house/yard/plot 1 • Public / neighbor's tap 2 Dug well • Well in house/yard/plot 3 • Public/neighbor's well 4 Tube well/borehole • Tube well in yard/plot 5 • Public/neighbor's tube well 6 Surface water • Spring/kuwa 7 • River/stream/pond/lake 8 • Stone tap/dhara 9 Other (specify) _____ 10	
114	What type of toilet facilities does your house have?	Flush toilet 1 Traditional pit toilet 2 Ventilated improved pit latrine 3 No facility / bush / field 4 Other (specify) 5	
115	Main material of the roof Record observation	Thatch 1 Metal 2 Tiles/Khapada 3 Cement 4 No roof 5 Other (specify) _____ 6	
116	Main material of the walls Record observation	Bamboo with mud 1 Bamboo with cement..... 2 Adobe 3 Unfinished wood 4 Cement 5 Bricks 6 Cement blocks 7 Wood planks 8 No walls 9 Other (specify) _____ 10	
117	What is the walking distance from your house to the nearest health facility/clinic/nursing home?	IN MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
118	Have you visited the health facility for any type of health services in the past 6 months?	YES 1 NO 2	→120
119	For what purposes did you visit the health facility? (CIRCLE ALL RESPONSES GIVEN)	Family planning..... 1 Safe motherhood..... 2 Child health 3 Other (specify)..... 4	
120	Is there a mothers' group in your area?	YES 1 NO 2 DO NOT KNOW 8	→123 →123
121	Have you participated in the past 6 months in the mothers' group meeting	YES 1 NO 2	→123
122	Was there a discussion on the following issues during group meeting?		
		Yes	No
	1 Family planning	1	2
	2 Safe motherhood (antenatal, delivery and PP care)	1	2

	3	Child health (ARI, Diarrhea, Malnutrition, immunization, measles vaccine etc.)	1	2
	4	HIV/AIDS	1	2
123		Do you belong to any of the following groups in your locality ?	YES	NO
	1.	Mothers' group?	1	2
	2.	Literacy Class Group?	1	2
	3.	Saving/Credit Group?	1	2
	4	Other (Specify)	1	2

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Section 2: Fertility

Now I would like to ask about pregnancy and childbearing.

Q. #	Question	Codes	GO TO Q.
201	Have you ever been pregnant?	YES.....1 NO.....2	→212
202	Have you ever given birth?	YES.....1 NO.....2	→207
203	How many sons and daughters have been ever born to you (including those who might currently be away from home)? IF NONE ENTER "00".	TOTAL SONS..... <input style="width: 30px;" type="text"/> TOTAL DAUGHTERS..... <input style="width: 30px;" type="text"/>	
204	Of all the children born to you, how many sons and daughters are alive now? IF NONE ENTER "00".	SONS LIVING <input style="width: 30px;" type="text"/> DAUGHTERS LIVING..... <input style="width: 30px;" type="text"/> NONE.....97	
205	In what year and month was your youngest child born?	YEAR <input style="width: 30px;" type="text"/> MONTH..... <input style="width: 30px;" type="text"/> DON'T KNOW98	
206	How old is he/she now? Year:..... Month:.....	MONTHS <input style="width: 30px;" type="text"/> NO LIVING CHILD (YOUNGEST)...997	
207	CHECK QUESTIONS 202, 205 AND 206:	YOUNGEST LIVING CHILD LESS THAN 5 YEARS.....1 YOUNGEST LIVING CHILD MORE THAN 5 YEARS2 NEVER GIVEN BIRTH.....3 NO LIVING CHILD.....7	
208	How many living children below 5 years do you have?	Number of children:..... None.....7	→ 210
209	Is your youngest child son or daughter?	SON.....1 DAUGHTER.....2	
210	Are you pregnant now?	YES.....1 NO.....2 NOT SURE.....8	→ 212 → 212
211	How many months pregnant are you? RECORD NO. OF COMPLETED MONTHS.	MONTHS..... <input style="width: 30px;" type="text"/> DON'T KNOW.....98	

Q. #	Question	Codes	GO TO Q.
212	<p>Now I have some questions about childbearing in the future. (Check Q210 and tick appropriate box)</p> <p>Currently pregnant..... “ Would you like to have children after the child you are expecting?</p> <p>Currently not pregnant/unsure.....“ Would you like to have a child / another child or would you prefer not to have any / any more children?</p>	<p>HAVE ANOTHER CHILD.....1 NO MORE.....2 CANNOT GET PREGNANT.....3 DON'T KNOW.....8</p>	<p>} →301</p>
213	<p>When would you like to have the child?</p>	<p>IMMEDIATELY.....1 WITHIN A YEAR.....2 1 - 2 YEARS.....3 2 - 3 YEARS.....4 3 - 4 YEARS.....5 4 YEARS AND MORE.....6 DON'T KNOW.....8</p>	

Section 3: Family Planning

Q. #	Question	Codes	GO TO Q.																																																		
301	Have you ever heard of family planning?	YES..... 1 NO..... 2	→401																																																		
302	Which methods of family planning have you heard about? (INTERVIEWER: CIRCLE CODE 01 FOR EACH METHOD MENTIONED SPONTANEOUSLY UNDER "YES/SPONT" COLUMN. THEN PROCEED DOWN THE COLUMN, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE "2" IF METHOD IS RECOGNIZED, AND CODE "3" IF NOT RECOGNIZED). READ DESCRIPTION OF EACH METHOD	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">YES/ SPONT</th> <th style="width: 10%; text-align: center;">YES/ PROBED</th> <th style="width: 15%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>PILL: woman can take a pill every day. Have you ever heard of pill?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">2</td> <td>IUD: Women can have a loop or coil placed inside them by a doctor or a nurse. Have you ever heard of IUD?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">3</td> <td>INJECTION: Women can have an injection by a doctor or a nurse, which stops them from becoming pregnant for several months. Have you ever heard of Injection?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">4</td> <td>CONDOM: Men can use a rubber sheath during sexual intercourse. Have you ever heard of Condom?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">5</td> <td>NORPLANT: Capsule to be inserted into women's arm. It prevents pregnancy for seven years. Have you ever heard of Norplant?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">6</td> <td>FEMALE STERILIZATION: Women can have an operation to avoid having any more children. Have you ever heard of FEMALE sterilization?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">7</td> <td>MALE STERILIZATION: Men can have an operation to avoid having any more children. Have you ever heard of MALE Sterilization?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">8</td> <td>PERIODIC ABSTINENCE: Couples can avoid having sexual intercourse on certain days of the month when the woman is more likely to become pregnant. Have you ever heard of Periodic abstinence?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">9</td> <td>WITHDRAWAL: MEN can be careful and pull out before climax. Have you ever heard of withdrawal?</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </tbody> </table>				YES/ SPONT	YES/ PROBED	NO	1	PILL: woman can take a pill every day. Have you ever heard of pill?	1	2	3	2	IUD: Women can have a loop or coil placed inside them by a doctor or a nurse. Have you ever heard of IUD?	1	2	3	3	INJECTION: Women can have an injection by a doctor or a nurse, which stops them from becoming pregnant for several months. Have you ever heard of Injection?	1	2	3	4	CONDOM: Men can use a rubber sheath during sexual intercourse. Have you ever heard of Condom?	1	2	3	5	NORPLANT: Capsule to be inserted into women's arm. It prevents pregnancy for seven years. Have you ever heard of Norplant?	1	2	3	6	FEMALE STERILIZATION: Women can have an operation to avoid having any more children. Have you ever heard of FEMALE sterilization?	1	2	3	7	MALE STERILIZATION: Men can have an operation to avoid having any more children. Have you ever heard of MALE Sterilization?	1	2	3	8	PERIODIC ABSTINENCE: Couples can avoid having sexual intercourse on certain days of the month when the woman is more likely to become pregnant. Have you ever heard of Periodic abstinence?	1	2	3	9	WITHDRAWAL: MEN can be careful and pull out before climax. Have you ever heard of withdrawal?	1	2	3
		YES/ SPONT		YES/ PROBED	NO																																																
1	PILL: woman can take a pill every day. Have you ever heard of pill?	1		2	3																																																
2	IUD: Women can have a loop or coil placed inside them by a doctor or a nurse. Have you ever heard of IUD?	1		2	3																																																
3	INJECTION: Women can have an injection by a doctor or a nurse, which stops them from becoming pregnant for several months. Have you ever heard of Injection?	1		2	3																																																
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9	WITHDRAWAL: MEN can be careful and pull out before climax. Have you ever heard of withdrawal?	1	2	3																																																	

Now I would like to talk with you about any method of family planning you may have used or are currently using.	
303	Have you or your husband ever used any family planning method? If yes, which method or methods have you or your husband ever used?
304	Are you or your husband currently using any family planning method? If yes, what is that method? (Code in grid under <i>ever used</i> column for methods ever used and code in grid under <i>currently using</i> column for methods being currently used)

	303	304
FP method	Ever used	Currently using
Pill	1	1
IUD	2	2
Depo-Provera	3	3

	303	304
FP method	Ever used	Currently using
Condom	4	4
Norplant	5	5
Female Sterilization	6	6
Male Sterilization	7	7
Periodic abstinence	8	8
Withdrawal	9	9
None	87	87

Q. #	Question	Codes	GO TO Q.
305	Check Q 304 and circle appropriate code:		
	CURRENTLY USING A METHOD.....	1	→308
	CURRENTLY NOT USING A METHOD.....	2	
306	Can you tell me what is (are) the reasons for not currently using a family planning method? Probe: Any other? (CIRCLE ALL RESPONSES GIVEN)	NOT AVAILABLE 1 NOT AVAILABLE NEARBY..... 2 NO ONE AT HEALTH FACILITY 3 SPOUSE DID NOT LIKE..... 4 FAMILY MEMBERS DID NOT LIKE.. 5 PROVDER BEHAVIOR NOT GOOD... 6 WANT MORE CHILDREN..... 7 DIFFICULT TO GET PREGNANT..... 8 MENOPAUSAL/HYSTERECTOMY ... 9 RELIGION 10 CONFUSED ABOUT METHOD..... 11 WAS NOT SATISFIED USING IT 12 HEALTH/FERTILITY CONCERNS.. 13 INCONVENIENT TO USE 14 INFREQUENT SEX..... 15 HUSBAND AWAY FROM HOME ... 16 SIDE EFFECTS _____ 17 (SPECIFY) OTHER _____ 26 (SPECIFY)	
307	Do you think you will use a method to delay or avoid pregnancy at any time in future?	YES..... 1 NO 2 DON'T KNOW 8	

Q. #	Question	Codes	GO TO Q.
308	<p>(Check Q305 and tick appropriate box)</p> <p>Currently using..... “</p> <p>Where did you obtain (current method) the last time?</p> <p>Currently not using..... “</p> <p>Where do you go if you want to get FP methods or services?</p>	GOVERNMENT HOSPITAL 1 PHC 2 HEALTH POST 3 SHP..... 4 MOBILE CLINIC 5 PRIVATE DOCTOR 6 PRIVATE HOSPITAL / CLINIC..... 7 NGO CLINIC..... 8 PHARMACY/CHEMIST..... 9 SHOP 10 FRIENDS / RELATIVES..... 11 FCHV 12 VHW 13 MCHW..... 14 OTHER 15 (SPECIFY) DON'T KNOW 98	
309	Have you and your spouse discussed the number of children you would like to have in the past 6 months?	YES..... 1 NO 2 DON'T KNOW 8	
310	Have you discussed FP/contraceptive use with your spouse in the past 6 months?	YES..... 1 NO 2 DON'T KNOW 8	
311	In the past 6 months, have you discussed FP with any of your friends, neighbors or relatives? (Other than FCHV)	YES..... 1 NO 2 DON'T KNOW 8	→313 →313
312	<p>With whom did you discuss?</p> <p>Any one else?</p> <p>(CIRCLE ALL RESPONSES GIVEN)</p>	MOTHER 1 MOTHER-IN-LAW 2 SISTER 3 SISTER-IN-LAW 4 DAUGHTER 5 FRIEND/NEIGHBOR..... 6 OTHER 7 (SPECIFY)	
313	Does the FCHV of your area provide FP information and services?	YES..... 1 NO 2 DON'T KNOW 8	→401 →401
314	<p>What type of information and services related to FP does she provide?</p> <p>(CIRCLE ALL RESPONSES GIVEN)</p>	PROVIDES FP COUNSELLING..... 1 DISTRIBUTES CONDMS 2 DISTRIBUTES PILLS..... 3 REFERS FOR FP SERVICES 4 HELPS IN STERILIZATION CAMP ... 5 OTHER 6 (SPECIFY)	
315	Have you spoken with FCHV with regard to the FP in the last 6 months?	YES..... 1 NO 2 DON'T KNOW 8	
316	Have you ever recommended anyone to speak to the FCHV about FP issues?	YES..... 1 NO 2 DON'T KNOW 8	

Section 4: Safe Motherhood

Now, I would like to ask about safe motherhood.

Q. #	Question	Codes	GO TO Q.
401	In your opinion, what is the ideal age of marriage for a girl?	Age:.....	
402	In your opinion, what is the ideal age for a woman to first become pregnant?	Age:.....	
403	In your opinion, what is the ideal age of marriage for a boy?	Age:.....	
404	In your opinion, what is the ideal birth spacing/gap between two children?	Years:	
405	How important do you feel that a pregnant woman should get clinic check-ups during her pregnancy?	VERY IMPORTANT..... 1 SOMEWHAT IMPORTANT 2 NOT IMPORTANT 3 DON'T KNOW..... 8	→407 →407
406	Why do you think it is important for a pregnant woman to get clinical check-ups during her pregnancy? (CIRCLE ALL RESPONSES GIVEN)	TO EXAMINE CONDITION OF MOTHER/CHILD..... 1 TO CONFIRM POSITION OF FETUS. 2 FOR TT INJECTION..... 3 TO GET IRON TABLET..... 4 TO GET DEWORMING TABLET 5 TO ENSURE SAFE PREGNANCY/ HEALTHY BABY..... 6 OTHER..... 7 (SPECIFY) DON'T KNOW..... 98	
407	Where should a woman receive antenatal check up? (CIRCLE ALL RESPONSES GIVEN)	HOSPITAL..... 1 PRIMARY HEALTH CARE CENTER. 2 HEALTH POST..... 3 SUBHEALTH POST..... 4 PVT. CLINIC/ NURSING HOME 5 AT HOME..... 6 OTHER..... 7 (SPECIFY)	
408	Whom should a woman see for pregnancy check- ups during pregnancy? Anyone else? (CIRCLE ALL RESPONSES GIVEN)	DOCTOR..... 1 NURSE/ANM..... 2 HA/AHW..... 3 MCHW..... 4 VHW..... 5 FCHV..... 6 TBA 7 OTHER..... 8 (SPECIFY)	

Q. #	Question	Codes	GO TO Q.
409	In your opinion, when is the best time to start antenatal check up?	Immediately after knowing of her pregnancy1 Between 3-4 months of pregnancy.....2 After 4 months of pregnancy.....3 Anytime when a woman has problem with her pregnancy.....4 Other (specify).....5 Do not know.....98	
410	In your opinion, how many times should a woman receive antenatal check up during pregnancy?	No. of times:..... Do not know.....98	
411	Have you heard of iron/folic acid tablets?	YES.....1 NO2 DON'T KNOW.....8	→413 →413
412	Why should a woman take iron/folic acid tablets during pregnancy?	To prevent from anemia.....1 Other (specify).....2	
413	Have you heard of immunization against tetanus?	YES.....1 NO2 DON'T KNOW.....8	→416 →416
414	In your opinion, why it is important to get TT during pregnancy? (CIRCLE ALL RESPONSES GIVEN)	To protect mother against TT.....1 To protect baby against TT.....2 Other (specify).....3 Do not know.....8	
415	How many times should a woman receive immunization against tetanus (TT) during pregnancy?	NUMBER OF SHOTS..... <input type="text"/> <input type="text"/> DON'T KNOW.....98	
416	In your opinion, should a woman eat less than usual, about the same amount or more than usual during pregnancy?	LESS THAN USUAL.....1 ABOUT THE SAME.....2 MORE THAN USUAL.....3 DON'T KNOW.....8	
417	In your opinion, should a woman receive less care/support than usual, about the same or more than usual care from her family members during pregnancy?	LESS THAN USUAL.....1 ABOUT THE SAME.....2 MORE THAN USUAL.....3 DON'T KNOW.....8	
418	What types of care/support should be provided to a woman during pregnancy from her family members? Probe: Any other? (CIRCLE ALL RESPONSES GIVEN)	MORE FOOD TO EAT1 MORE NUTRIOUS FOOD TO EAT.....2 ADVISE FOR MORE REST.....3 REDUCE HEAVY LOAD4 ADVISE/ACCOMPANY FOR PHYSICAL CHECK-UP5 OTHER _____ 6 (SPECIFY)	

Q. #	Question	Codes	GO TO Q.
419	What are the danger signs/symptoms that can occur during pregnancy? Any others? (CIRCLE ALL RESPONSES GIVEN)	VAGINAL BLEEDING (ANY AMOUNT) 1 SEVERE LOWER ABDOMINAL PAIN.....2 SEVERE HEADACHE.....3 CONVULSION.....4 BLURRED VISION AND SWELLING OF HANDS AND FACE.....5 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 98	
420	If you have any of the above symptoms what would you do or whom would you consult? (CIRCLE ALL RESPONSES GIVEN)	HOSPITAL..... 1 PHCC /HP/ SHP.....2 PVT. CLINIC/N. HOME.....3 PHARMACY.....4 CONSULT FCHV5 CONSULT MCHW.....6 CONSULT A TBA.....7 CONSULT OTHER HW.....8 CONSULT DHAMI/JHANKRI.....9 CONSULT RELATIVE/NEIGHBOR/FRIEND 10 OTHER _____ 11 (SPECIFY)	
421	In your opinion, having an appropriate skilled health worker (staff nurse, ANM, doctor, etc) attending the delivery is very important, somewhat important or not important?	VERY IMPORTANT..... 1 SOMEWHAT IMPORTANT 2 NOT IMPORTANT 3 DON'T KNOW..... 8	→423 →423
422	Why do you think it is important that a skilled health worker should attend? (CIRCLE ALL RESPONSES GIVEN)	IN CASE OF SERIOUS PROBLEM WITH THE DELIVERY 1 TO KEEP BABY SAFE.....2 FOR NORMAL DELIVERY3 OTHER _____ 4 (SPECIFY) DON'T KNOW..... 8	
423	What specific plans and preparations should be made to ensure that the delivery is safe for the mother and the baby? (CIRCLE ALL RESPONSES GIVEN)	Know or identify the nearest health facility.....1 Arrangement for a skilled provider to attend the delivery..... 2 Planning for emergency/ complications....3 Provision/arrangement of transportation.4 Provision/arrangement of money.....5 Provision/arrangement for blood.....6 Other (specify).....7 Do not know.....98	→425

Q. #	Question	Codes	GO TO Q.
429	What are the danger signs/symptoms that can occur during labor/delivery? Any others? (CIRCLE ALL RESPONSES GIVEN)	LABOR LONGER THAN 12 HOURS.. 1 APPEARANCE OF BABY'S HAND FIRST 2 APPEARANCE OF BABY'S LEG FIRST 3 APPEARANCE OF BBY'S UMBILICAL CORD FIRST 4 EXCESSIVE BLEEING BEFORE OR AFTER DELIVERY..... 5 CONVULSION..... 6 OTHER_____ 7 (SPECIFY) DON'T KNOW..... 98	
430	In your opinion, if a woman has experienced the above danger signs/symptoms what should she do or whom should she consult? (CIRCLE ALL RESPONSES GIVEN)	HOSPITAL..... 1 PHCC/HP/SHP.....2 PVT. CLINIC/N. HOME3 PHARMACY.....4 CONSULT FCHV5 CONSULT MCHW.....6 CONSULT A TBA.....7 CONSULT OTHER HW.....8 CONSULT DHAMI/JHANKRL.....9 RELATIVES/NEIGHBOR/FRIEND ... 10 OTHER _____ 11 (SPECIFY) Nothing 12	
431	In your opinion, having check-up at the clinic/health facility after the birth is very important, somewhat important or not important?	VERY IMPORTANT..... 1 SOMEWHAT IMPORTANT 2 NOT IMPORTANT 3 DON'T KNOW..... 8	→433 →433
432	Why do you think it is important to have check-up at the clinic/health facility after the birth of the baby? (CIRCLE ALL RESPONSES GIVEN)	FOR GOOD HEALTH OF MOTHER AND CHILD 1 TO MEASURE CHILD'S WEIGHT 2 FOR CHILD IMMUNIZATION 3 TO PROTECT CHILD FROM ANY KIND OF ILLNESS OR INFECTION.. 4 OTHER_____ 5 (SPECIFY) DON'T KNOW..... 8	
433	How many days after the delivery should a woman receive the first check-up services from a health worker? IF SAME DAY RECORD '00'	DAYS.....	

Q. #	Question	Codes	GO TO Q.
434	With whom should a woman receive check up services at that time? PROBE FOR MOST QUALIFIED PERSON.	DOCTOR..... 1 NURSE/ANM..... 2 HA/AHW..... 3 MCHW..... 4 VHW..... 5 FCHV..... 6 TBA..... 7 OTHER..... 8 (SPECIFY)	
435	In your opinion, should a woman receive less care/support than usual, about the same or more than usual care from family members after delivery?	LESS THAN USUAL..... 1 ABOUT THE SAME..... 2 MORE THAN USUAL..... 3 DON'T KNOW..... 8	
436	What types of care/support should a woman receive from family members? (CIRCLE ALL RESPONSES GIVEN)	GIVE MORE FOOD TO EAT..... 1 GIVE MORE NUTRIOUS FOOD TO EAT..... 2 ADVISE FOR MORE REST..... 3 REDUCE HEAVY LOAD..... 4 ADVISE/ACCOMPANY FOR CHECK-UP..... 5 OTHER..... 6 (SPECIFY)	
437	From whom should a woman receive above-mentioned care/support? (CIRCLE ALL RESPONSES GIVEN)	HUSBAND..... 1 MOTHE-IN-LAW..... 2 FATHER-IN-LAWS..... 3 SISTER-IN-LAWS..... 4 DAUGHTER/SON..... 5 OTHER..... 6 (SPECIFY)	
438	What are the danger signs/symptoms that may occur to a woman during first four weeks after delivery? Any others? (CIRCLE ALL RESPONSES GIVEN)	FOUL DISCHARGE AND LOWER ABDOMINAL PAIN..... 1 HIGH FEVER..... 2 HEAVY BLEEDING..... 3 MASTITIS..... 4 SEVERE HEADACHE..... 5 CONVULSION..... 6 OTHER..... 7 (SPECIFY) DON'T KNOW..... 98	→440

Q. #	Question	Codes	GO TO Q.
439	Where would you go for check-up if you experience any of the symptoms that you have just mentioned?	HOSPITAL..... 1 PRIMARY HEALTH CARE CENTER . 2 HEALTH POST 3 SUBHEALTH POST..... 4 MOBILE CLINIC 5 PVT. CLINIC/NURSING HOME..... 6 MCHW 7 FCHV 8 TBA 9 VHW..... 10 OTHER _____ 11 (SPECIFY)	
440	Have you ever talked to other people about safe motherhood issues, like antenatal care or delivery?	YES..... 1 NO 2 DON'T KNOW 8	→442 →442
441	With whom did you discuss? Any one else? (CIRCLE ALL RESPONSES GIVEN)	HUSBAND..... 1 MOTHER..... 2 FATHER 3 MOTHER-IN-LAW 4 FATHER-IN-LAW..... 5 SISTER 6 SISTER-IN-LAW..... 7 BROTHER..... 8 DAUGHTER/SON 9 FRIEND/NEIGHBOR 10 OTHER (SPECIFY) 11	
442	Does the FCHV of your area provide pregnancy and child birth related information and services?	YES..... 1 NO 2 DON'T KNOW 8	→501 →501
443	What type of pregnancy and childbirth related information and services does she provide? Probe: Any others? (CIRCLE ALL RESPONSES GIVEN)	PROVIDE INFORMATION ON SAFE MOTHERHOOD..... 1 PROVIDE COUNSELING DURING PREGNANCY, DELIVERY AND POSTPARTUM..... 2 ASSIST DURING DELIVERY..... 3 ADVISE TO VISIT HF FOR ANTENATAL SERVICES..... 4 ADVISE TO VISIT HF FOR POSTNATAL SERVICES..... 5 ADVISE TO GIVE VITAMIN A TO CHILDREN 6 ABOUT CHILD IMMUNIZATION 7 PROVIDE INFORMATION ON TT VACCINE 8 PROVIDE IRON TABLETS..... 9 TAKING DEWORMING TABLETS DURING PREGNANCY 10 OTHER _____ 11 (SPECIFY)	

Q. #	Question	Codes	GO TO Q.
444	Have you spoken with FCHV with regard to the pregnancy and childbirth in the last 6 months?	YES..... 1 NO 2 DON'T KNOW..... 8	
445	Have you ever recommended anyone to speak to the FCHV about pregnancy and childbirth?	YES..... 1 NO 2 DON'T KNOW..... 8	

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Section 5: Child Survival

Now, I would like to ask about your children.

Q. #	Question	Codes	GO TO Q.
501	What are the danger signs/symptoms that may appear among newborn? (Prompt: “Any other symptoms?”) (Circle all responses)	Poor sucking or feeding..... 1 Fast or difficult breathing 2 Hypothermia (feels cold or too hot).... 3 Difficult to wake/lethargic/unconscious.4 Pustules on skin 1 large or more than 10 small ones.....5 Severe umbilical infection redness of skin around the cord/ foul smelling discharge OR bleeding from the cord.....6 Other (specify) _____ 7 Don’t know.....98	
502	What types of instruments should be used to cut the cord of the newborn?	NEW BLADE/STERILIZED BLADE ...1 USED BLADE.....2 KNIFE.....3 GRASS CUTTER (HASIYA).....4 WEAPON (KHUKURI).....5 SCISSOR.....6 OTHER.....7 (SPECIFY) DON’T KNOW.....98	
503	In your opinion, should any substances be applied on the stump after the newborn’s cord is cut?	YES.....1 NO.....2 DON’T KNOW.....8	
504	In your opinion, how long after the birth a baby should be given bath?	WITHIN 1 HOUR.....1 2-24 HOURS.....2 AFTER 24 HOURS.....3	
505	In your opinion, when should a newborn dried and wrapped in cloth – before the placenta is delivered or after the placenta is delivered?	Before the placenta is delivered1 After the placenta is delivered2 Do not know8	
506	What type of clothes should be used to wrap the newborn? (Read all)	Clean dry cloth1 Clean wet cloth2 Any cloth3 Do not know8	
507	Where should a baby placed before the placenta is delivered?	On the floor1 On the cot.....2 With the mother3 Other (specify)4 Do not know8	
508	How long after birth a baby should be first put to the breast?	Immediately after the birth.....1 After the placenta is out.....2 After bathing the new born.....3 After 24 hours after birth.....4 Other (specify) _____ 5 Don’t know.....8	
509	In your opinion, should a newborn be given the first yellow milk (Bigauti) that came from your breasts?	YES.....1 NO.....2	→511

Q. #	Question	Codes	GO TO Q.
510	What are the advantages of feeding colostrums to the newborn? (MULTIPLE RESPONSE)	INCREASE IMMUNITY.....1 PROTECT FROM DISEASE.....2 STIMULATES MOTHER'S MILK SUPPLY.....3 OTHER.....4 (SPECIFY) DON'T KNOW.....8	
511	How long after birth (in completed months) a child should be first given the food other than breast milk to the baby?	After months: _____ Don't know 98	
512	In your opinion, how important it is a newborn should get health check up immediately after birth?	VERY IMPORTANT.....1 SOMEWHAT IMPORTANT2 NOT IMPORTANT3 DON'T KNOW.....8	
513	Within how many days after the delivery a child should get health check from someone? IF SAME DAY, RECORD '00'	NO OF DAYS..... DON'T KNOW.....98	
514	How do you treat a child with diarrhea at home? Probe: Any other? (CIRCLE ALL RESPONSES GIVEN)	GIVING MORE FLUIDS TO THE CHILD THAN USUAL.....1 GIVING USUAL AMOUNT OF FOODS TO THE CHILD.....2 IF BREASTFED, CONTINUE BREASTFEEDING.....3 GIVING JEEVAN JAL/NAWA JEEVAN TO CHILD.....4 GIVING LESS FLUIDS TO THE CHILD THAN USUAL.....5 GIVING LESS AMOUNT OF FOODS TO THE CHILD.....6 IF BREASTFED, DISCONTINUE BREASTFEEDING.....7 OTHER.....8 (SPECIFY) DON'T KNOW.....98	
515	Under what circumstances a child with diarrhea should be taken to a health worker for consultation? Probe: Any other? (CIRCLE ALL RESPONSES GIVEN)	IF CHILD DOES NOT GET BETTER WITHIN 3 DAYS.....1 FREQUENT WATERY STOOLS2 REPEATED VOMITING.....3 CHILD VERY THIRSTY4 EATING OR DRINKING POORLY.....5 FEVER.....6 BLOOD IN THE STOOL.....7 OTHER.....8 (SPECIFY) DON'T KNOW.....98	

Q. #	Question	Codes	GO TO Q.
516	Where would you seek for advice or treatment for the diarrhea?	HOSPITAL.....1 PRIMARY HEALTH CARE CENTER..2 HEALTH POST.....3 SUBHEALTH POST.....4 MOBILE CLINIC.....5 PVT. CLINIC/NURSING HOME.....6 PHAMACY.....7 FCHV.....8 TBA.....9 VHW/MCHW.....10 DHAMI/JHANKRI.....11 OTHER.....12 (SPECIFY) DON'T KNOW.....98	
517	CHECK Q 208 AND CIRCLE BELOW: Has living child less than 5 year.....1 Has living child more than 5 years/No Child.....2		→525
518	Has your child had diarrhea in the last 2 months?	YES.....1 NO.....2 DON'T KNOW.....8	→525 →525
519	When s/he had diarrhea in the last 2 months did you consult FCHV?	YES.....1 NO.....2 DON'T KNOW.....8	→521 →521
520	Why did not you consult a FCHV for the treatment/advice for diarrhea? (CIRCLE ALL RESPONSES GIVEN)	DO NOT KNOW WHO FCHV IS.....1 FCHV WAS NOT AVAILABLE.....2 DID NOT KNOW FCHV PROVIDE DIARRHEAL TREATMENT.....3 FCHV IS NOT COMPETENT.....4 FCHV HAS NO MEDICINE.....5 FCHV BEHAVIOR NOT GOOD.....6 FCHV TOO FAR AWAY.....7 OTHER.....8 (SPECIFY) DON'T KNOW.....98	
521	Was s/he given fluid made from a special packet such as Jeevan Jal or Nava Jeevan to drink?	YES.....1 NO.....2 DON'T KNOW.....8	→523 →523
522	Would you please tell me how did you prepare ORS? (Correct answer is 1 packet of ORS mixed with 6 tea glasses or 1 liter of clean water)	CORRECT.....1 INCORRECT.....2	
523	When s/he had diarrhea was he/she offered less than usual to drink, about the same amount, more than usual, or nothing to drink?	LESS THAN USUAL.....1 ABOUT THE SAME.....2 MORE THAN USUAL.....3 NOTHING TO DRINK.....4 DON'T KNOW.....8	

Q. #	Question	Codes	GO TO Q.
524	When s/he had diarrhea was he/she offered less than usual to eat, about the same amount, more than usual, or nothing to eat?	LESS THAN USUAL.....1 ABOUT THE SAME.....2 MORE THAN USUAL.....3 STOPPED FOOD4 NEVER GAVE FOOD.....5 DON'T KNOW8	
Now, I would like to talk you some questions about respiratory illness of your child.			
525	What symptoms would tell you that your child was developing a serious respiratory illness? Probe: Any other? (CIRCLE ALL RESPONSES GIVEN)	FAST/DIFFICULT BREATHING.....1 INABILITY TO EAT/BREASTFEED...2 ABNORMALLY SLEEPY/DIFFICULT TO WAKE.....3 FEVER/LOW BODY TEMPERATURE4 CHEST INDRAWING.....5 SEVERELY MALNOURISHED.....6 OTHER_____7 (SPECIFY) DON'T KNOW98	
526	What are the causes of cough and cold/pneumonia? (CIRCLE ALL RESPONSES GIVEN)	INFECTION.....1 COLD/WIND.....2 POLLUTION/SMOKE3 EVILEYE/CURSE/SIN4 OTHER_____5 (SPECIFY) DON'T KNOW98	
527	Under what circumstances a child with cough/cold, pneumonia should be taken to a health facility or a health worker for consultation/treatment? (CIRCLE ALL RESPONSES GIVEN)	COUGH/DIFFICULT BREATHING....1 FAST BREATHING.....2 CHEST INDRAWING.....3 FEVER4 INABILITY TO BREASTFEED OR DRINK5 SORENESS OF THROAT.....6 OTHER_____7 (SPECIFY) DON'T KNOW98	
528	How do you treat for a child with suffering from cough/cold, pneumonia at home? (CIRCLE ALL RESPONSES GIVEN)	LOOK FOR FAST BREATHING / DIFFICULT BREATHING.....1 LOOK FOR CHEST INDRAWING.....2 GIVE MORE FLUID.....3 KEEP THE CHILD WARM.....4 BREASTFEED THE BABY FREQUENTLY5 CLEAN THE NOSE.....6 GIVE MORE FOOD FREQUENTLY...7 OTHER_____8 (SPECIFY) DON'T KNOW98	

Q. #	Question	Codes	GO TO Q.
529	Where would you seek advice or treatment for cough/cold, pneumonia?	HOSPITAL.....1 PRIMARY HEALTH CARE CENTER..2 HEALTH POST.....3 SUBHEALTH POST.....4 MOBILE CLINIC.....5 PVT. CLINIC/NURSING HOME.....6 PHAMACY.....7 FCHV.....8 TBA.....9 VHW/MCHW10 DHAMI/JHANKRI.....11 OTHER.....12 (SPECIFY) DON'T KNOW.....98	
530	CHECK Q 208 AND CIRCLE BELOW: Has living child less than 5 year1 Has living child more than 5 years/No Child.....2		→536
531	Did your child suffer from cough/cold, pneumonia during the past 2 months?	YES.....1 NO.....2 DON'T KNOW.....8	→536 →536
532	When s/he had cough/cold, did he/she breathe faster than usual with short, fast breaths?	YES.....1 NO.....2 DON'T KNOW.....8	
533	When s/he had cough/cold or pneumonia did you do the following consultations/treatments? (Read All)	Yes	No
	1 Traditional treatment at home?	1	2
	2 Gave medicine that was at home?	1	2
	3 Consulted a Dhami/Jhankri?	1	2
	4 Consulted an FCHV?	1	2
	5 Took child to SHP/HP/PHC?	1	2
	6 Took child to hospital?	1	2
	7 Took child to a private clinic/nursing home?	1	2
	8 Consulted other health workers?	1	2
	9 Bought medicine from a pharmacy?	1	2
534	CHECK QUESTIONS: 533 and circle in appropriate code	CONSULTED FCHV1 NOT CONSULTED FCHV.....2	→536
535	Why did not you consult a FCHV of your area for the treatment/advice of cough/pneumonia? (CIRCLE ALL RESPONSES GIVEN)	DO NOT KNOW WHO FCHV IS1 FCHV WAS NOT AVAILABLE.....2 DID NOT KNOW FCHV PROVIDE PNEUMONIA TREATMENT.....3 FCHV IS NOT COMPETENT.....4 FCHV HAS NO MEDICINE.....5 FCHV BEHAVIOR NOT GOOD.....6 FCHV TOO FAR AWAY.....7 OTHER.....8 (SPECIFY) DON'T KNOW.....98	

Q. #	Question	Codes	GO TO Q.
536	What are the symptoms of malnutrition among children? (CIRCLE ALL RESPONSES GIVEN)	Failure to gain weight or weight loss1 Thin face, shoulders and buttocks2 Thin, light-colored hair3 Skin that is cold to touch4 Short for her/her age5 Frequent infection such as pneumonia or diarrhea.....6 Constant crying and irritability7 OTHER8 (SPECIFY) DON'T KNOW98	
537	Did your child receive Vitamin A capsule in the Kartik distribution?	YES1 NO.....2 NO CHILD BELOW 5 YRS OF AGE...7 DON'T KNOW8	
538	Does the FCHV of your area provide child health information and services?	YES1 NO.....2 DON'T KNOW8	→601 →601
539	What type of information and services related to child health does she provide? (CIRCLE ALL RESPONSES GIVEN)	PROVIDE INFORMATION ON IMMUNIZATION..... 1 PROVIDE INFORMATION ON DIARRHEA..... 2 PROVIDE DIARRHEA TREATMENT SERVICES (ORS) 3 PROVIDE INFORMATION ON ARI.. 4 PROVIDE ARI/PNEUMONIA TREATMENT SERVICES 5 PROVIDE INFORMATION ON MALNUTRITION..... 6 PROVIDE INFORMATION ON VITAMIN A 7 PROVIDE VITAMIN A CAPSULES .. 8 PROVIDE NEWBORN CARE SERVICES..... 9 PROVIDE REFERRAL SERVICES.. 10 OTHER 11 (SPECIFY) DON'T KNOW98	
540	Have you spoken with FCHV with regard to the child health in the last 6 months?	YES1 NO.....2 DON'T KNOW8	
541	Have you ever recommended anyone to speak to the FCHV about child health issues?	YES1 NO.....2 DON'T KNOW8	

Section 6: HIV/AIDS

Now, I would like to ask you a few questions about HIV/AIDS.

Q. #	Question	Codes				GO TO Q.
601	Have you ever heard of HIV or AIDS?	YES.....	1			
		NO.....	2			→701
		DON'T KNOW.....	8			→701
602	Mention all the ways in which you believe a person can get infected with HIV? For spontaneous responses include 2 probes-Anything else? Anything else? After 2 probes for all responses not circled spontaneously ask from list and circle response in probed category.					
	Questions		Spont. yes	Read out		
				Yes	No	DK
1	Can a person get HIV/AIDS by sharing a meal with someone who is infected with HIV?	1	2	3	8	
2	Can a person get HIV/AIDS from a mosquito bite?	1	2	3	8	
3	Can a person get HIV/AIDS by getting injections with a needle that has been already used by someone else who is infected with HIV virus?	1	2	3	8	
4	Can people get HIV/AIDS from an infected blood transfusion?	1	2	3	8	
5	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1	2	3	8	
6	Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	1	2	3	8	
7	Can people get HIV/AIDS if they have multiple sexual relationships?	1	2	3	8	
8	Can people get HIV/AIDS through sexual intercourse with infected partner?	1	2	3	8	
9	Can a person get HIV/AIDS if s/he work together with some one infected with HIV/AIDS?	1	2	3	8	
10	Can a person get HIV/AIDS if s/he uses the dishes to eat of a HIV/AIDS infected person?	1	2	3	8	
11	Other (specify)	1	2	3	8	

Section 6: HIV/AIDS

Now, I would like to ask you a few questions about HIV/AIDS.

Q. #	Question	Codes				GO TO Q.
601	Have you ever heard of HIV or AIDS?	YES.....	1			
		NO.....	2			→701
		DON'T KNOW.....	8			→701
602	Mention all the ways in which you believe a person can get infected with HIV? For spontaneous responses include 2 probes-Anything else? Anything else? After 2 probes for all responses not circled spontaneously ask from list and circle response in probed category.					
	Questions	Spont. yes	Read out			
			Yes	No	DK	
1	Can a person get HIV/AIDS by sharing a meal with someone who is infected with HIV?	1	2	3	8	
2	Can a person get HIV/AIDS from a mosquito bite?	1	2	3	8	
3	Can a person get HIV/AIDS by getting injections with a needle that has been already used by someone else who is infected with HIV virus?	1	2	3	8	
4	Can people get HIV/AIDS from an infected blood transfusion?	1	2	3	8	
5	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1	2	3	8	
6	Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	1	2	3	8	
7	Can people get HIV/AIDS if they have multiple sexual relationships?	1	2	3	8	
8	Can people get HIV/AIDS through sexual intercourse with infected partner?	1	2	3	8	
9	Can a person get HIV/AIDS if s/he work together with some one infected with HIV/AIDS?	1	2	3	8	
10	Can a person get HIV/AIDS if s/he uses the dishes to eat of a HIV/AIDS infected person?	1	2	3	8	
11	Other (specify)	1	2	3	8	

Section 7: ACCESS AND EXPOSURE TO MASS MEDIA HEALTH MESSAGES

Q. #	Question	Codes	GO TO Q.
701	Is there a TV set in your house?	YES.....1 NO.....2	→703
702	How often do you get to choose what is watched on the television in your house. Do you get to choose always, often, sometimes, rarely, or never?	ALWAYS.....1 OFTEN.....2 SOMETIMES.....3 RARELY.....4 NEVER.....5	
703	Do you watch television almost every day, at least once a week, less than once a week, or not at all?	ALMOST EVERY DAY.....1 AT LEAST ONCE A WEEK.....2 LESS THAN ONCE A WEEK.....3 NOT AT ALL.....4	→707
704	Have you seen anything on the TV about health or family planning in the past year?	YES.....1 NO.....2 DON'T KNOW.....8	→706 →706
705	What were the main messages that you saw?	
706	Did you ever watch a telefilm on television called "Good husband"?	YES.....1 NO.....2 DON'T KNOW.....8	
707	Is there a radio in your house?	YES.....1 NO.....2	→709
708	How often do you get to choose what is listened to on the radio in your house. Do you get to choose always, often, sometimes, rarely, or never?	ALWAYS.....1 OFTEN.....2 SOMETIMES.....3 RARELY.....4 NEVER.....5	
709	Do you listen to the radio almost every day, at least once a week, less than once a week, or not at all?	ALMOST EVERY DAY.....1 AT LEAST ONCE A WEEK.....2 LESS THAN ONCE A WEEK.....3 NOT AT ALL.....4	→711
710	How well are you able to hear programs on Radio Nepal?	Very good and clear.....1 Fair.....2 Poor.....3	
711	What health or family planning programs have you heard on the radio in the past year? PROBE TWICE: Anything else? ASK: Have you heard _____? PROGRAM NOT MENTIONED SPONTANEOUSLY PROBE EACH ONE AND RECORD UNDER PROMPTED COLUMN.	SPONT YES	PROMPTED YES NO DK
	1 GYAN NEI SHAKTI HO	1	2 3 8
	2 SEWA NEI DHARMA HO	1	2 3 8
	3 GYANAI SHAKTI HAI	1	2 3 8
	4 JAN SWASTHA KARYAKRAM	1	2 3 8
	5 OTHER (SPECIFY) _____	1	2 3 8

Q. #	Question	Codes			GO TO Q.
712	Other than these programs, what else have you heard on the radio or seen on the television about health or family planning? PROBE TWICE: Anything else? RECORD ALL MENTIONED			
713	In the past year, have you seen or heard any health messages: (Read All)	YES	NO	DK	
	1 In the newspaper?	1	2	8	
	2 In a magazine?	1	2	8	
	3 While at the cinema?	1	2	8	
	4 During a community group meeting?	1	2	8	
	5 During a festival or other community event?	1	2	8	
714	CHECK Q711 AND CIRCLE BELOW: HEARD GYAN NEI SHAKTI HO OR GYANAI SHAKTI HAL.....1 DID NOT HEAR GYAN NEI SHAKTI HO AND GYANAI SHAKTI HAL.....2				→736
715	How often do you listen to Gyan Nai Shakti Ho?	EVERY WEEK.....1 A COUPLE OF TIMES A MONTH.....2 ONCE A MONTH.....3 LESS THAN ONCE A MONTH.....4 ONLY LISTENED ONCE OR TWICE..5			→717 →717
716	Why did not you listen more often? (CIRCLE ALL RESPONSES GIVEN)	LACK OF A RADIO.....1 DO NOT KNOW BROADCAST TIME.2 PROGRAM NOT INTERESTING.....3 BORADCAST TIME INCONVENEINT4 LANGUAGE DIFFICULTY5 LACK OF LEISURE6 OTHER.....7 (SPECIFY)			
717	How long have you been listening to the "Gyan Nai Shakti Ho." radio drama serial? (Year:..... Month:.....)	Months:..... Do not know.....98			
718	How many episodes of "Gyan Nai Shakti Ho" radio drama serial have you listened in the last 3 months?	No. of episodes:..... Do not know.....98			
719	Usually, in what language do you listen the "Gyan Nai Shakti Ho" radio drama serial?	Nepali.....1 Maithili.....2			
720	How easy it is to understand the dialogue spoken by the characters in the drama?	Easy to understand.....1 With some difficulty2 Do not understand at all.....3			
721	What is your opinion regarding the broadcast duration of "Gyan Nai Shakti Ho" radio drama serial?	Short.....1 Just right.....2 Long.....3 Do not know.....8			

Q. #	Question	Codes	GO TO Q.
722	What is your main impression about "Gyan Nai Shakti Ho" radio drama serial?	It is more entertaining.....1 It is more educational2 It is entertaining and educational as well.....3 DK8	
723	In the past 6 months, have you discussed the "Gyan Nai Shakti Ho" radio drama serial with any of your friends, neighbors or relatives?	Yes.....1 No2	→725
724	With whom did you discuss? (CIRCLE ALL RESPONSES GIVEN)	Spouse.....1 Mother.....2 Father.....3 Mother-in-law.....4 Father-in-law.....5 Sister.....6 Sister-in-law.....7 Brother.....8 Daughter/son.....9 Friend/neighbor.....10 Other (specify).....11	
725	Please tell me the names of the characters "Gyan Nai Shakti Ho." radio drama serial that you remember? (CIRCLE ALL RESPONSES GIVEN)	Madho Bbabu.....1 Janaki.....2 Kamalesh.....3 Abdul.....4 Champa.....5 Tara.....6 Jeevan.....7 It Kumati.....8 Til Bam.....9 Other (specify).....10 None of the above.....97	→727
726	Of the characters you mentioned, which is your most favorite character? (CIRCLE ONLY ONE ANSWER)	Madho Bbabu.....1 Janaki.....2 Kamalesh.....3 Abdul.....4 Champa.....5 Tara.....6 Jeevan.....7 It Kumati.....8 Til Bam.....9 Other (specify).....10	
	Now I would like to ask you some specific questions about the story.		
727	Could you tell the game that Kamlesh played in the Drama Serial ?	Cricket1 Football2 Do not know.....8	

Q. #	Question	Codes	GO TO Q.
728	In the drama serial, with whom Tara falls into love?	Kamalesh.....1 Jeevan.....2 Other (specify).....3 Do not know.....8	
729	Can you recall who suggested Champa to start tailor business ?	Janaki.....1 Dhaniram.....2 Abdul.....3 Do not know.....8	
730	Who helped Madhobabu while he was admitted in hospital for treatment?	Kamalesh.....1 Tara.....2 Do not know.....8	
731	What business Joginder holds?	Tea shop.....1 Grocery shop.....2 Do not know.....8	
732	What type of job does Dhaniram have?	A Teacher.....1 A Businessman.....2 Do not know.....8	
733	There was often quarrel between Champa and Jeevan. Could you recall what was the main reason for dispute between them? (Multiple response)	Jeevan has no earning.....1 Jeevan takes un necessary interest.....2 On Tara and Kamlesh's affair3 Others (specify)4	
734	What happened to Abdul bicycle and icebox when he went to toilet while selling Icecream in the school?	Bicycle and icebox was stolen.....1 Someone was jokingly hide his bicycle and icebox2 Other (specify)3	
735	At the end of Drama Serial, how did Kamlesh and Tara's love affair ends?	Marrying each other1 Other (specify)2	
736	CHECK Q711 AND CIRCLE BELOW: HEARD SEWA NAI DHARMA HO.....1 DID NOT HEAR SEWA NEI DHARMA HO.....2		→739
737	How often do you listen to Sewa Nai Dharma Ho?	EVERY WEEK.....1 A COUPLE OF TIMES A MONTH.....2 ONCE A MONTH.....3 LESS THAN ONCE A MONTH.....4 ONLY LISTENED ONCE OR TWICE..5	
738	How many episodes of "Sewa Nai Dharma Ho." radio distance education have you listened in the last 3 months?	No. of episodes:..... Do not know.....98	
739	CHECK Q711 AND CIRCLE BELOW: HEARD GYAN NEI SHAKTI HO OR SEWA NAI DHARMA HO OR GYANAI SHAKTI HAI1 DID NOT HEAR BOTH GYAN NAI SHAKTI HO AND SEWA NEI DHARMA HO AND GYANAI SHAKTI HAI.....2		→741

Q. #	Question	Codes			GO TO Q.	
740	<p>What health topics did you hear while listening to Gyan Nai Shakti Ho or Sewa Nai Dharma Ho?</p> <p>PROBE TWICE: Anything else?</p> <p>THEN ASK, Did you hear _____ while listening to Gyan Nai Shakti Ho or Sewa Nai Dharma Ho?</p>					
		SPONT YES	PROMPTED			
			YES	NO	DK	
	1 Puberty: physical and emotional changes among boys and girls	1	2	3	8	
	2 Age at marriage	1	2	3	8	
	3 How child sex is determined	1	2	3	8	
	4 Contraceptive methods	1	2	3	8	
	5 Well planned family	1	2	3	8	
	6 Spousal communication	1	2	3	8	
	7 Care during delivery and birth preparedness	1	2	3	8	
	8 Danger signs during pregnancy	1	2	3	8	
	9 Danger signs during delivery	1	2	3	8	
	10 New born danger signs	1	2	3	8	
	11 Neonatal care	1	2	3	8	
	12 Immunization	1	2	3	8	
	13 Vitamin A	1	2	3	8	
	14 Nutrition	1	2	3	8	
	15 Breast feeding and supplemental food	1	2	3	8	
	16 Diarrhea and three home rules	1	2	3	8	
	17 Cough/cold and home based treatment	1	2	3	8	
	18 FCHV's roles	1	2	3	8	
	19 Recognizing signs and symptoms of pneumonia and home based care	1	2	3	8	
	20 Other (specify)_____	1	2	3	8	
741	Have you seen any posters about family planning in the past year?	YES				
		NO				→801
		DON'T KNOW				→801
742	What posters have you seen?	SPONT YES	PROMPTED (show pictures of posters if not mentioned spontaneously)			
			YES	NO	DK	
	1 Danger sign poster	1	2	3	8	
	2 Sumata poster	1	2	3	8	
	3 Poster showing 5 types of methods	1	2	3	8	
	4 FP Poster	1	2	3	8	
	5 Abhibadan Poster	1	2	3	8	
	6 Other (specify)	1	2	3	8	

Section 8: USE OF FCHV's SERVICES

Q. #	Question	Codes	GO TO Q.
801	Do you know the FCHV working in this area?	YES1 NO.....2 DON'T KNOW8	→805 →805
802	When was the last time you met with the FCHV working in this area? IF LESS THAN A WEEK WRITE '00'	WEEKS AGO..... <input type="text"/> <input type="text"/> NEVER MET97	→805
803	What health issue or issues did you discuss with the FCHV the last time you met her? PROMPT ONCE: Anything else? RECORD ALL RESPONSES	FAMILY PLANNING1 SAFE MOTHERHOOD.....2 CHILD HEALTH3 HIV/AIDS/STL.....4 OTHER5 (SPECIFY) DON'T REMEMBER.....8	
804	Where did your most recent discussion with the FCHV take place?	I VISITED FCHV1 FCHV VISITED ME.....2 MET AT THE RLG MEETING/CLASS 3 MET CASUALLY WHILE DOING SOMETHING ELSE.....4 MET AT OTHER MEETING.....5 OTHER6 (SPECIFY)	
805	CHECK BOX	RLG members.....1 None RLG.....2	→901
806	Do you know about the Radio Listeners Group in your area?	Yes..... 1 No..... 2	
807	Do you know any one who belongs to RLG member?	Yes..... 1 No..... 2	
808	Did any one talk to you about family planning, safe motherhood, child health or STI/HIV/AIDS matters in the past one year?	Yes..... 1 No..... 2	→Stop
809	What issues did s/he discuss with you? PROBE TWICE: Anything else?	SPONT YES	PROMPTED
			YES NO DK
	1 Puberty: physical and emotional changes among boys and girls	1	2 3 8
	2 Age at marriage	1	2 3 8
	3 How child sex is determined	1	2 3 8
	4 Contraceptive methods	1	2 3 8
	5 Well planned family	1	2 3 8
	6 Spousal communication	1	2 3 8
	7 Care during delivery and birth preparedness	1	2 3 8
	8 Danger signs during pregnancy	1	2 3 8
	9 Danger signs during delivery	1	2 3 8

Q. #	Question	Codes				GO TO Q.
10	New born danger signs	1	2	3	8	
11	Neonatal care	1	2	3	8	
12	Immunization	1	2	3	8	
13	Vitamin A	1	2	3	8	
14	Nutrition	1	2	3	8	
15	Breast feeding and supplemental food	1	2	3	8	
16	Diarrhea and three home rules	1	2	3	8	
17	Cough/cold and home based treatment	1	2	3	8	
18	FCHV's roles	1	2	3	8	
19	Recognizing signs and symptoms of pneumonia and home based care	1	2	3	8	
20	Other (specify) _____	1	2	3	8	

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Section 9 Participation in RLG

Section 9 Participation in RLG						
	CHECK BOX	RLG members.....1 None RLG.....2				→Stop
	Name of RLG Center:	Name:.....				
901	Now I would like to ask about the listening group. What is the name of your listening group facilitator?	Name:.....				
902	How long have you been affiliated with this RLG as a member?	Number of months:				
903	What are your main reasons for joining the listening group? (CIRCLE ALL RESPONSES GIVEN)	Can learn health related matters.....1 Can learn new things.....2 FCHV advised.....3 Friends advised.....4 It is entertaining.....5 NGO advised.....6 Other (specify).....7				
904	Who encouraged you to join the RLG group? (CIRCLE ALL RESPONSES GIVEN)	FCHV.....1 NGO Staff.....2 Husband.....3 Mother-in-law.....4 Father-in-law.....5 Other family member.....6 Friend/neighbor/relative.....7 Other (specify).....8 No one/self.....97				
905	Have you encouraged others to join the listening group?	Yes.....1 No.....2				
906	Who facilitates the listening group that you belong to?	FCHV.....1 NGO Staff.....2 Social worker.....3 Other (specify).....4				
907	How well do you think the person facilitating the group.....?	Very well	Well	Not well	DK	
	1 Ensures that every member participates in the discussion	1	2	3	8	
	2 Summarizes the messages in the drama serial	1	2	3	8	
	3 Summarizes the main points made during the discussion	1	2	3	8	
908	How often does the listening group meet?	Once a week1 Twice a week.....2 Once every fifteen days.....3 Other (specify).....4				

909	On an average, how long does a typical listening session take place?	<30 minutes.....1 30-45 minutes.....2 45-60 minutes.....3 60-90 minutes.....4 90 minutes or more.....5 Do not know.....8	
910	Normally how many persons participate in your RLG?	Number of persons: Do not know.....98	
911	Do any of your family member belong to this group? If yes, who are they? (CIRCLE ALL RESPONSES GIVEN)	Sister-in law.....1 Daughter-in law.....2 Husband.....3 Mother-in-law.....4 Brother-in-law.....5 Other (specify).....6 NONE.....97	
912	How much influence do you have on listening group discussions?	A lot.....1 Some.....2 Very little.....3 None.....4 Do not know.....8	
913	To what extent has participation in the listening group made changes in your life?	A lot.....1 Some.....2 Very little.....3 None.....4 Do not know.....8	
914	To what extent is the listening group able to make changes in the community?	A lot.....1 Some.....2 Very little.....3 None.....4 Do not know.....8	
915	Does your listening group have discussion sessions after you listen the Drama Serial?	Yes.....1 No.....2	
916	How frequently do you discuss the content of the Gyan Nai Shakti Ho episodes with group members outside the group meetings?	Five to six times a week.....1 Three to five times a week2 Once or twice a week.....3 Once a month.....4 Rarely.....5 Never.....6	
917	How frequently do you discuss the content of the Gyan Nai Shakti Ho episodes with non-members?	More than five times a week.....1 Between three to four times a week2 About two times a week.....3 Less than once in a month.....4 Rarely.....5 Never.....6	
918	In your opinion, what are the reasons for not joining by other people of this community in this listening group i?	1..... 2..... 3.....	

THANK YOU FOR YOUR VALUABLE TIME FOR THE INTERVIEW.

C:\Questionnaire English\NFHP\RLG\January 3 2006\Section 9 RLG January 3 2006.doc
January 3, 2006

NEPAL FAMILY HEALTH PROGRAM RADIO LISTENER GROUP STUDY

Focus Group Discussion Guide

Guidelines for Interviewers
A. <u>Introduce yourself and the organization you are representing.</u>
Good (morning/afternoon). My name is _____ and I am here on behalf of Valley Research Group.
B. <u>Introduce objectives of the study</u>
We are talking to women around your age to learn about their use of radio and the radio programs they listen to. We want you to know that your ideas will help us to develop programs that we hope will better meet the health needs of women throughout Nepal.
C. <u>Format of the interview</u>
I want you to feel free to say exactly what you think; there are no right or wrong answers to the questions that we ask. Your opinions and experiences are important to us. We will try to write down what you say, but we will also be using this tape recorder to record the session. This will enable us to accurately capture everything that we discuss today.
D. <u>Consent to participate</u>
Your participation in this study is voluntary. After this meeting is over, we ask that you not tell people outside of this meeting what other participants said during this meeting. Do you have any questions?
If you want to talk to anyone about this study or you have any questions, you can call the VaRG at [INSERT PHONE NUMBER 5-523477]. Persons in this office will answer your questions or address your concerns.
<u>Notes for Interviewers</u>
1. Remember that this is meant to be a discussion and not a structured interview.
2. Let the informants do most of the talking
3. Make sure that your body language shows that you are interested in the subject matter and the informants. Maintain eye contact and use gestures to convey to the participants that you are listening to what they say.
4. Use follow up questions (e.g. Please tell me more about that, how did that make you feel, etc) to get more information or to clarify statements made by the informants.
5. Silence can be important. Allow the informants enough time to compose their answers.
6. Try to maintain a natural flow to the discussion. There is no need to ask a question that an informant answered while discussing a prior topic – Be alert to informant's answers.
7. Probe when differences of opinion come up during the discussion.

SECTION 1: RADIO

1	First, I would like to discuss the use of radio in this community. How often do people in this area listen to the radio?
1a	PROMPT IF UNMENTIONED: Which people in this community listen to the radio more often and which people listen less often?
1b	PROMPT IF UNMENTIONED: What times of the year do people in this area listen to the radio more often and which times of the year do people listen to the radio less often?
2	Do you think people listen to the radio more nowadays than they did a few years ago, do they listen to the radio less than they did a few years ago, or do they listen as often as they did a few years ago? IF DIFFERENT, ASK WHY?
3	What times of the day do people in this area usually listen to the radio?
3a	PROMPT IF UNMENTIONED: Why do people in this area listen to the radio at these times of the day?
4	When people in this area listen to the radio, what radio stations do they listen to most often? Why do people in this area listen to these stations more than others?
4a	PROBE ON RADIO NEPAL.

SECTION 2: PERCEPTIONS OF GYAN NAI SHAKTI HO

1	What specific radio programs are popular among people living in this area? Why do you think these programs are popular?
2	For those of you who did not mention it, have you ever listened to the radio program called Gyan Nai Shakti Ho?
3	For those of you who have never listened to Gyan Nai Shakti Ho, what are some reasons why you have not listened to it before?
4	Now, I would like to ask some questions to those of you who have ever listened to Gyan Nai Shakti Ho.
4a	For how long have you been listening the program?
4b	How frequently do you listen to Gyan Nai Shakti Ho?
4c	What are some reasons why you may not listen to Gyan Nai Shakti Ho every week?
4d	What are some things that you like about Gyan Nai Shakti Ho? What are some things that you don't like about it?
4e	What do you think was the most memorable episode of Gyan Nai Shakti Ho? PROBE: What made this episode so memorable?
4f	Overall, how much do you enjoy listening to Gyan Nai Shakti Ho? Why or why not?
4g	Who are your favorite characters in Gyan Nai Shakti Ho? Why?
4h	Who are your least favorite characters? Why?
4i	How well do the characters in Gyan Nai Shakti Ho resemble people in your own community? Why or why not?

4j	The stories in Gyan Nai Shakti Ho often include issues concerning health. What health messages can you recall hearing in an episode of Gyan Nai Shakti Ho?
4k	How well do the health topics discussed in Gyan Nai Shakti Ho reflect the problems that people in your community worry about?
	PROMPT IF UNMENTIONED: What health problems do people in this community have that should be mentioned more in Gyan Nai Shakti Ho?

SECTION 3: PERCEPTIONS OF RLG

Questions for RLG participants

1	Now, I would like to ask you about your participation in the radio listeners group that meets each week to listen to Gyan Nai Shakti Ho. How did you become a member of the radio listeners group?
2	How often do you attend the group's meetings?
3	What are some reasons why you might not attend some of the group meetings?
4	How often would you listen to Gyan Nai Shakti Ho if you were not a member of a group? IF LESS, ASK WHY?
5	How different is it to listen to Gyan Nai Shakti Ho in the group compared to listening to the program at home? IF DIFFERENT, ASK WHY?
6	How useful is it to discuss the program after you listen to it? Why?
7	How many members of the group participate in the discussions about the program? What are some reasons why people don't talk much during the group meetings?
8	How often do you talk about Gyan Nai Shakti Ho with people who are not members of the group?
9	How has participation in the radio listeners group affected your life?

Questions for non-participants

1	In some communities, groups of women get together each week to listen to the Gyan Nai Shakti Ho radio drama. Is there a group like this in your community?
2	IF THERE IS A GROUP IN COMMUNITY: What are some reasons why you do not participate in this group?
3	IF THERE IS NOT A GROUP: How interested would you be in participating in this type of group?
	THANK THE GROUP FOR PARTICIPATING AND ASK THEM IF THEY HAVE ANY QUESTIONS.