

# Female Community Health Volunteer National Survey Report 2014



Ministry of Health and Population  
Department of Health Services  
Family Health Division, Teku, Kathmandu





Ref :

Government of Nepal  
**Ministry Of Health & Population**

Ramsharpath, Kathmandu, Nepal

Phone : 4-262534, Fax : 4-262565



**Mon'ble Khaga Raj Adhikari**  
Minister for Health and Population

Date : 4.10.2015

**Message**

It is my pleasure to congratulate you for sharing the Female Community Health Volunteers (FCHV) National Survey Report 2014 regarding the contribution of FCHV promoting community health care at household level across the country.

Recognizing their importance of women's participation Government of Nepal initiated FCHV program from 2045/46 (2088/89) and expanded throughout the country. They are contributing to promote health and healthy behavior of mothers and community people promoting safe motherhood, child health, family planning and other community health activities. I am very proud of their continuous support to reduce the maternal and child mortality as desired. I am sure it was not possible if they were not in place with their tireless effort without any monetary support.

I believe this report should have revealed their significant contribution and identified to strengthen and expand their role for quality community health service. The findings of this report will contribute for program implementation, program manager to re design the program in future. It will be equally important to policy maker to design the policy for universal health coverage. I hope this report has identified their changing role in the context of changing political and social environment.

Finally I would like to extend my appreciation and thanks to entire survey team and individual involved directly and indirectly to make this survey most successful. I appreciate Family Health Division (FHD) of MoHP taking lead role for providing technical support in the survey. I also extend my thanks to USAID, UNICEF and Save the Children for their financial and technical support to produce this meaningful document.

Khaga Raj Adhikari  
Minister



Government of Nepal  
Ministry of Health and Population  
Department of Health Services

☎977-1-4261436  
4261712  
Fax: 977-1-4262238  
Pachali, Teku  
Kathmandu  
Nepal

Ref No:

## Foreword

The Family Health Division of Nepal's Department of Health Services has pioneered the National Female Community Health Volunteers (FCHV) Program since 1988. Thousands of local women choose to volunteer in all 75 districts of Nepal to improve maternal, newborn, and child health in their community. During their community mobilization process, FCHVs have been empowered and have in turn empowered other women. These FCHVs have been an essential component of our health system and appreciated by various sectors nationally and internationally.

The FCHV survey was first conducted in 2006, and since then there have been many changes in the country's economic, political, and development climates. With the emerging changes, there has been need to understand the FCHVs service motivation, benefits they are receiving and their perception toward volunteer work, their workload, etc. This survey report attempts to answer the current changing needs and context in Nepal. It will be a very useful document for related divisions, including non-governmental organizations, who work with FCHVs as they revise their strategies and programming.

I would like to congratulate the Family Health Division for taking the lead in conducting this relevant study with support from USAID, UNICEF, and Save the Children/Saving Newborn Lives, and assistance from JSI/APC, FHI360, and HERID. I hope this report will be utilized for the future strategic and programmatic decision-making related to FCHVs and the FCHV program.

Dr. Senendra Raj Upreti  
Director General



Government of Nepal  
Ministry of Health & Population  
**DEPARTMENT OF HEALTH SERVICES**

Tel. : 4261436  
: 4261712  
Fax : 4262238

Pachali, Teku  
Kathmandu, Nepal

Ref. No.

Date : .....

## Acknowledgments


The *Female Community Health Volunteer (FCHV) National Survey Report 2014* is the result of earnest effort put forth by a number of organizations and individuals. It is my great pleasure to release this report to the public. FCHVs have been a bridge between the formal health system and the community for more than 25 years, and their contribution to the success of public health programs in Nepal is recognized nationally and internationally. As our health care delivery system improves, so must the FCHV program, and I am confident that this report will help Ministry of Health and Population (MoHP) refine the program going forward.

First and foremost, I would like to thank Dr. Senendra Raj Uprety, Director General, Department of Health Services (DoHS), for their guidance in the completion of this study. I would also like to thank my colleagues at Family Health Division (FHD), particularly the efforts and dedication of Mr. Ghanshyam Pokhrel, Family Planning Section Chief, and Mr. Paban Ghimire, Planning and Demography Section Chief. I would also like to acknowledge the hard work done by Dr. Kiran Regmi, Mr. Bhogendra Raj Dotel, and Ms. Mangala Manadhar in moving this study forward during their time with FHD.

I would like to extend my appreciation to the USAID Mission team in Nepal. My sincere thanks goes to Ms. Shanda Steimer, Director; Mr. Daniel Sinclair, Deputy Director; Mr. Daniel Verschneider, Health Development Officer; Mr. Netra Bhatta, FP/RH Specialist; and Ms. Sabita Tuladhar, MNCH Specialist, from the Office of Health and Education, for funding this survey and providing technical input and management throughout the study period. My sincere thanks also go to Dr. Asha Pun, Maternal and Neonatal Health Specialist; Ms. Chahana Singh, Health Officer, UNICEF; and Dr. Stephen Hodgins, Technical Advisor; Mr. Bharat Ban, National Program Manager; and Mr. Sujan Karki, MEAR Specialist, from Save the Children/Saving Newborn Lives, for their technical support and cooperation.

The efforts of APC's team are highly commendable. My deep sense of gratitude goes to the team members, including Ms. Savitha Subramanian, Monitoring and Technical Advisor; Ms. Leela Khanal, Project Director, and her team; Ms. Binjwala Shrestha, Consultant, FHI 360; and Dr. Sushil Baral, Executive Director, HERD, and his team for ensuring the quality and successful completion of the survey and providing rich information to MoHP.

I am also very thankful to all the well-wishers of FCHVs who contributed their time, constructive feedback, and expertise to nurture the study findings in the report. I am also very grateful to all the researchers who collected quality data for this survey despite monsoons and other challenges. Last but not least, I would like to express my sincere gratitude to all the FCHVs and other participants in this study, who provided their valuable time and information. This study would not have been completed without their cooperation and willingness to participate.

  
Dr. Pishpa Chaudhary  
Director, Family Health Division  
Department of Health Services



# EXECUTIVE SUMMARY

## BACKGROUND

Since its introduction in 1988, the Female Community Health Volunteer (FCHV) program in Nepal has promoted prevention and treatment of key diseases; helped increase the use of modern health services; and contributed to the reduction in infant, child, and maternal mortality. The 2014 FCHV survey described in this document provides a comprehensive assessment of the FCHV program. The document reports the findings of a national-level quantitative survey of FCHVs and from complementary qualitative interviews with key national, district level, and community stakeholders. The results are intended to increase understanding of the current status of the FCHV program and reflect on stakeholder perceptions of program experience and performance. The last comprehensive national FCHV survey was conducted in 2006 (Government of Nepal, New ERA, and USAID 2007).

## GOAL AND OBJECTIVES

The goal of this study was to produce a cross-sectional (point in time) assessment of the FCHV program in Nepal to inform future policy and investment decisions. The specific objectives were to:

- Carry out a comprehensive national survey of FCHVs across 13 domains in Nepal, focusing on the sociodemographic and work profile of FCHVs, the services they provide, their perceptions and motivations, and the support they receive from different levels of the health system
- Understand how FCHVs perceive their work and what motivational factors sustain FCHVs' contributions
- Understand how FCHV program stakeholders and communities perceive the role of FCHVs and
- Identify possible strategies to sustain the FCHV program.

The study was not designed to evaluate the overall performance of the FCHV program but rather to provide a snapshot of FCHV characteristics, services provided, support received, and FCHV and stakeholder perceptions of the program across geographic and technical areas.

## METHODOLOGY

The methodology and tools for the 2014 survey were developed in collaboration with key stakeholders including the Family Health Division of Nepal's Ministry of Health and Population, Department of Health Services, the U.S. Agency for International Development, the United Nations Children's Fund, Saving Newborn Lives/Save the Children, and FHI 360. The approach included a two-part, mixed-methods strategy consisting of a quantitative survey of FCHVs and qualitative research including interviews with FCHVs, program stakeholders, and community. The quantitative survey was administered to 4,302 FCHVs across 13 domains according to the geography and development region distribution across the country, including 257 urban wards and 4,045 rural wards. The 13 domains are based on the Demographic and Health Survey and are representative of the entire country. Qualitative data were collected from a wide range of respondents using key informant interviews, semi-structured interviews, and focus group discussions in 12 rural and urban districts within 8 domains.

## **FINDINGS**

Overall, the survey results and thematic analysis of interviews with stakeholders and community members provided consistent, strong affirmation of the important role that FCHVs play in linking communities to health facilities and in directly providing services in a number of important areas in maternal and child health. For the purpose of comparison, in some cases, findings from this survey are presented alongside results from the national FCHV survey conducted in 2006.

### **FCHV CHARACTERISTICS**

Ninety-four percent of the 4,302 FCHVs surveyed were based in rural areas and six percent were based in urban areas.<sup>1</sup> The average age of FCHVs across all domains was 41.3 years. Only 4 percent were aged less than 25 years, which is slightly older than the average age of FCHVs surveyed in 2006. Sixty-seven percent of FCHVs reported attending school; of these, nearly half (45 percent) had attend sixth through tenth grades. FCHV literacy was estimated at 83 percent in 2014 versus 62 percent in 2006, using a comparable definition of literacy. At the time of the 2006 survey, 53 percent of FCHVs had served for over 10 years. In the 2014 survey, this percentage increased slightly to 59 percent. In both surveys, 20 percent of FCHVs had served for less than five years, corresponding to an annual turnover of 4 percent.

### **FCHV WORK PROFILE**

The average amount of time that FCHVs report spending on FCHV-related activities per day (1.7 hours in 2006 versus 3.1 hours in 2014) or per week (3 days in 2006 versus 2.2 days in 2014) has only increased slightly from 2006 to 2014, despite the large number of new programs in which FCHVs are expected to play a role, and in contrast to qualitative respondents' perceptions that the FCHVs' work program is "overloaded." Almost all (95 percent) of FCHVs surveyed reported living in the ward where they performed FCHV functions and reaching their respective health facilities on foot. On average, FCHVs reported that they had made two to three visits to the health facility (HF) in the past month.

### **AVAILABILITY OF COMMODITIES**

Availability of health commodities varied. Over half (59 percent) of FCHVs had condoms available on the day of the survey, but the proportion varied across domains. Availability of oral contraceptives averaged 58 percent (range: 44 to 79 percent by location). Among FCHVs who lived further away from a health facility (>60 minutes), 64 percent were observed to have pills, compared to 52 percent of FCHVs who lived closer (<30 minutes). Over half of FCHVs were observed having oral rehydration solution, vitamin A, and iron (75 percent, 65 percent, and 65 percent respectively) and approximately half had zinc and cotrimoxazole. In general, these commodities were more likely to be present among FCHVs living in wards that were more than one hour's travel from the health facility.

---

<sup>1</sup> For the purposes of this report, "urban area" refers to municipalities that were classified as urban at the time the survey was conducted. Some wards have since been reclassified from rural to urban.



## SUPPORT RECEIVED BY FCHVS

Virtually all FCHVs (96 percent) have had basic training. Seventy-eight percent reported participating in an FCHV meeting at their local HF within the past month and 65 percent took part in a two-day review meeting within the past six months. Ninety-six percent of FCHVs reported having contact with health workers from their local HF in the last month. Reports from stakeholders about supervision approaches varied. They emphasized the high frequency of supervisors' visits to FCHVs in the villages, which contrasts with the FCHVs' report that 77 percent of meetings with supervisors were held during visits to HFs. Reported challenges include the absence of monitoring or supervision of FCHVs from remote Village Development Committees (VDCs) and a desire among FCHVs for more regular feedback or support. Ninety-six percent of FCHVs received an incentive in the form of a NPRs 4,000 "dress allowance" in the last year. Ninety-seven percent of FCHVs had an FCHV fund in their VDC and about 60 percent of FCHVs had used the fund.

## SERVICES PROVIDED BY FCHVS

- *Treatment of diarrhea and acute respiratory infections:* In the last three months, 52 percent of all FCHVs reported providing oral rehydration solution (ORS) for children suffering from diarrhea, with significant variation across domains. Relatively low use of ORS may reflect the timing of the survey, which took place after the monsoon season. Only 44 percent of all FCHVs reported providing zinc tablets to children suffering from diarrhea, with variation by domain. About 44 percent of all FCHVs reported examining children for cough and cold; only 24 percent of all FCHVs provided cotrimoxazole for possible pneumonia cases.
- *Immunization:* Sixty-four percent of FCHVs reported that an immunization clinic had taken place in their ward. In the last three months in all domains, immunization clinics were held twice and generally, almost all clinics were supported by FCHVs. FCHV referral to immunization clinics varied by domain; only 37 percent of FCHVs reported providing referrals in Central Mountain, compared to 95 percent in Eastern Terai and 90 percent in Central Hill domains.
- *Family planning counseling:* Ninety-seven percent of FCHVs provided family planning (FP) services in the three months prior to the survey, mostly during contacts with pregnant or postpartum women (83 percent and 79 percent, respectively). Among FCHVs distributing family planning commodities, 68 percent distributed condoms and 67 percent distributed oral contraceptives. Distribution varied considerably across domains, with a high proportion of FCHVs reporting this activity in Far Western Terai (condoms 97 percent; pills 83 percent), and a low proportion in Central Mountain (condoms 29 percent; pills 43 percent).
- *Nutrition activities:* Of the 4,302 FCHVs surveyed, about 90 percent reported providing counseling on nutrition, breastfeeding, and complementary feeding for infants and young children. However, only 9 percent of FCHVs reported providing counseling to or referring malnourished children for care.
- *Counseling for pregnant women:* A high proportion of FCHVs (93 percent) reported counseling pregnant women in the preceding three months, seeing on average four pregnant women. The most common advice (unprompted) focused on antenatal care (95 percent), tetanus injections (74 percent), taking iron tablets (87 percent), and eating nutritious food during pregnancy (89 percent). Approximately half of all FCHVs (46 percent) reported that they advised women to deliver in a health facility. Fifty-one percent of FCHVs advised women to take deworming pills.
- *Knowledge of pregnancy complications:* The proportion of FCHVs who could list pregnancy danger signs varied: respondents mentioned vaginal bleeding (91 percent), severe headache (77 percent), seizures (62 percent), severe abdominal pain (60 percent), and swelling of hands and face (59 percent).

- *Pregnancy and newborn services:* Forty-seven percent of FCHVs had distributed iron tablets to mothers in the preceding three months. FCHVs from Far-western Terai (83 percent) and Far-western Hill (74 percent) were most likely to report iron distribution, while those in Eastern and Central Mountain domains were least likely (18 percent). In areas with chlorhexidine (CHX) programs, 29 percent of FCHVs reported distributing CHX in the past three months, with a range from 53 percent of FCHVs in Western Terai to 15 and 10 percent, respectively, in Eastern and Western Mountain. Across districts implementing misoprostol programs, 10 percent of FCHVs reported having distributed the commodity over the previous three months. Among districts where pregnancy tests and abortion counseling have been introduced, 41 percent of FCHVs reported testing a woman for pregnancy in the previous three months.
- *Recognizing and referring for newborn complications:* The proportion of FCHVs recalling (unprompted) danger signs in newborns was as follows: poor feeding, fever, and fast or difficult breathing were most often mentioned (83 percent, 72, and 67 percent, respectively), followed by chest in-drawing, cord infection, hypothermia, and lethargy (58 percent, 55 percent, 52 percent, and 42 percent, respectively). Only one in five FCHVs (19 percent) mentioned very small size at birth.

## PERCEPTIONS OF THE FCHV PROGRAM

Interviews with stakeholders and community members provided consistent and strong affirmation of the important role that FCHVs play in linking communities to health facilities and in promoting maternal and child health services and practices. Respondents noted that FCHVs accompany mothers to health services, provide counseling, conduct household visits, support the work of NGOs, and facilitate the introduction of new programs and ideas in the community, often by establishing trust with women, families, and communities.

## FCHV MOTIVATION

In 2006, 76 percent of FCHVs responded that they would like to spend more time serving as an FCHV. In 2014, 75 percent reported the same desire. In the 2014 survey, FCHVs gave highly favorable responses to specific statements focusing on happiness in their role, intent to be in the same role in the next five years, community appreciation, increased recognition and respect from the community, familial support for their work, and supervisory support. Scores were less favorable on questions about the adequacy of FCHV benefits, fair treatment of FCHVs by the government, and the burden of completing forms and registries.

## DISCUSSION

The success of the FCHV Program in Nepal is characterized by very low attrition, very high motivation, and very high levels of involvement across a range of health services. Other key characteristics include:

- *Effective and culture-appropriate health education:* Communities feel comfortable talking with FCHVs, including about certain sensitive health topics. FCHVs focus on health promotion activities including use of available commodities. Community acceptance and even preference for health education from FCHVs is an important program success, and is derived from a variety of programmatic factors, including appropriate selection, training and support.
- *Essential community linkages:* FCHVs perform many functions, including household-level support, encouraging new hygiene and health practices, introducing improved nutrition practices, and non-health development work. Thus they serve as gateways to knowledge, practices, and services for communities in all domains.

- *Regular contact between FCHVs and supervisors:* FCHVs travel to health facilities where they interact with their supervisors. However, the content and quality of the interaction is unknown.
- *Contribution to improving access to and outcomes of maternal and child health:* FCHVs have contributed in myriad ways to reducing maternal, infant, and child morbidity and mortality, primarily through behavior change and increased use of services.

## **FCHV MOTIVATION**

A prominent concern in recent years is the perception that FCHVs are discontented and potentially unwilling to provide service unless they receive more generous financial incentives. However, the findings in the 2006 and 2014 surveys were essentially identical, reporting high levels of satisfaction and intent to continue working, and low attrition rates (4 percent). New questions, introduced in the 2014 survey to clarify FCHVs' motivation, reveal that FCHVs report they are happy in their work; that communities appreciate their activities; that their families and supervisors are supportive; and that they are treated fairly and respectfully by health workers at their HF. Responses on key motivational factors were extremely favorable, suggesting that emotional, social, professional, and financial drivers maintain FCHVs' commitment to continued service.

## **GAPS AND AREAS FOR CONSIDERATION**

- *Uneven supply of commodities:* Inconsistent availability of commodities (condoms, oral contraceptives, zinc, and cotrimoxazole) suggests the need for attention to the supply chain, as does the low stocks of chlorhexidine (CHX) and misoprostol within program implementation districts. Clearly, FCHVs who lack commodities are not able to provide the quality of service that they were trained to provide.
- *Supervision:* FCHV supervision is designed to occur at the FCHVs' workplace. However, FCHVs reported that they mainly received supervision at the HF (77 percent), not in their village (8 percent). Also, the survey revealed some loss of knowledge of critical pregnancy danger signs. These findings suggest that supervision may not be taking place as designed.
- *Understanding of FCHV roles:* There is evidence that FCHVs and stakeholders have inconsistent knowledge of FCHV status and program benefits. The survey shows a need for clearer information on standard benefits, and for improved community awareness that FCHVs are volunteers, and not government employees.
- *Involvement in new programs:* FCHV involvement in new maternal and child health programs is lower than expected compared to more established programs. The survey did not explore why certain programs may have had lower rates of involvement by FCHVs; but given this cadre's gateway role in the community, each program may wish to examine this question independently.
- *Urban FCHVs:* Although the proportion of urban FCHVs surveyed was limited, interviews with national stakeholders raised the question of the need for additional urban FCHVs and for defining a unique role for them. The experience of urban FCHVs is clearly different from that of their rural counterparts. Overall, they tend to provide fewer services and have less access to commodities. While urban populations in general have better access to services and care from various sources, not all urban residents are well served. It may be useful to explore whether investment in urban FCHVs can help increase access to health care for underserved urban populations.

## **GEOGRAPHY, ACCESS, AND SUPPLIES**

Overall, there are significant differences across the 13 domains in terms of access to health facilities, delivery of health services, and availability of commodities. Distance to facilities is a critical factor, given that FCHVs traveled one hour on average to reach the HF, but travel time ranged from 30 to over 120 minutes. These findings raise several important considerations for the FCHV program, particularly the potential need to tailor FCHV roles and activities by geographic setting to make better use of available resources.

## **POLICY IMPLICATIONS**

The 2014 FCHV Survey provides evidence on the current status of the national FCHV program and highlights potential areas for future investment, challenges to be addressed, and areas in need of further exploration before advancing policies and practices. The survey was not designed to evaluate the performance of the program overall, or to assess in-depth important areas such as the quality of supervision, FCHV record-keeping, and generation of demand for services. These questions should be explored separately through existing data sources or topic-specific research.

The potential policy implications drawn from this survey include:

1. The Nepal FCHV program is successful, with high involvement of the volunteers in key community health interventions, high FCHV and stakeholder satisfaction, and low drop-out rates. The program should be maintained but adapted to meet changing needs.
2. The existing FCHV policy should be reviewed to determine the potential benefit of adapting elements of the program to reflect the specific needs of each domain.

There are adequate data available to suggest that tailoring resources geographically to support specific high-impact FCHV activities would better address health and community profiles across different domains. Targeting could be based on analysis of community needs, access to and use of other services, under-served populations, and growing non-communicable disease needs based on the Nepal Demographic Health Survey (NDHS) and other survey data, as well as FCHV survey results. The program would also benefit from additional analyses to clarify programmatic needs and priority investments by domain. These analyses include cost-benefit analysis, impact measurement (including urban FCHVs), service mapping, and comparative analysis of findings from the FCHV survey and NDHS 2011.

3. Along with the potential benefits of geographic profiling and targeting, lowering commodity stock-out rates across Nepal would lead to improved service quality and improved health outcomes. Limited commodity availability severely restricts FCHVs' ability to provide services consistently and effectively. Supply chain security requires more attention than it currently receives.
4. FCHV supervision and support structures at various levels, including the national, district, and Village Development Committee levels, warrant an in-depth study including, but not limited to, FCHV incentives, retirement benefits, and supervisory approaches.

Additional investment in site supervision or FCHV incentives and benefits should be based on more comprehensive knowledge of the current systems and their field application, particularly the relationship between the quality and quantity of FCHV work; the quality of services available at local health facilities, and the degree and quality of support and supervision to the FCHV.

5. Additional time and investment should be inbuilt into the national program to build the capacity of FCHVs to improve their service deliveries for e.g. regularize monthly meeting, supportive supervision, exchange visit, one to one coaching by supervisor and or explore use of mobile technology and distance education program from radio/TV for capacity building



## **Advancing Partners & Communities**

Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

### **Recommended Citation**

Female Community Health Volunteer National Survey, 2014. Family Health Division, Department of Health Services, Ministry of Health and Population, Kathmandu, Nepal.

### **JSI Research & Training Institute, Inc.**

1616 Fort Myer Drive, 16th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

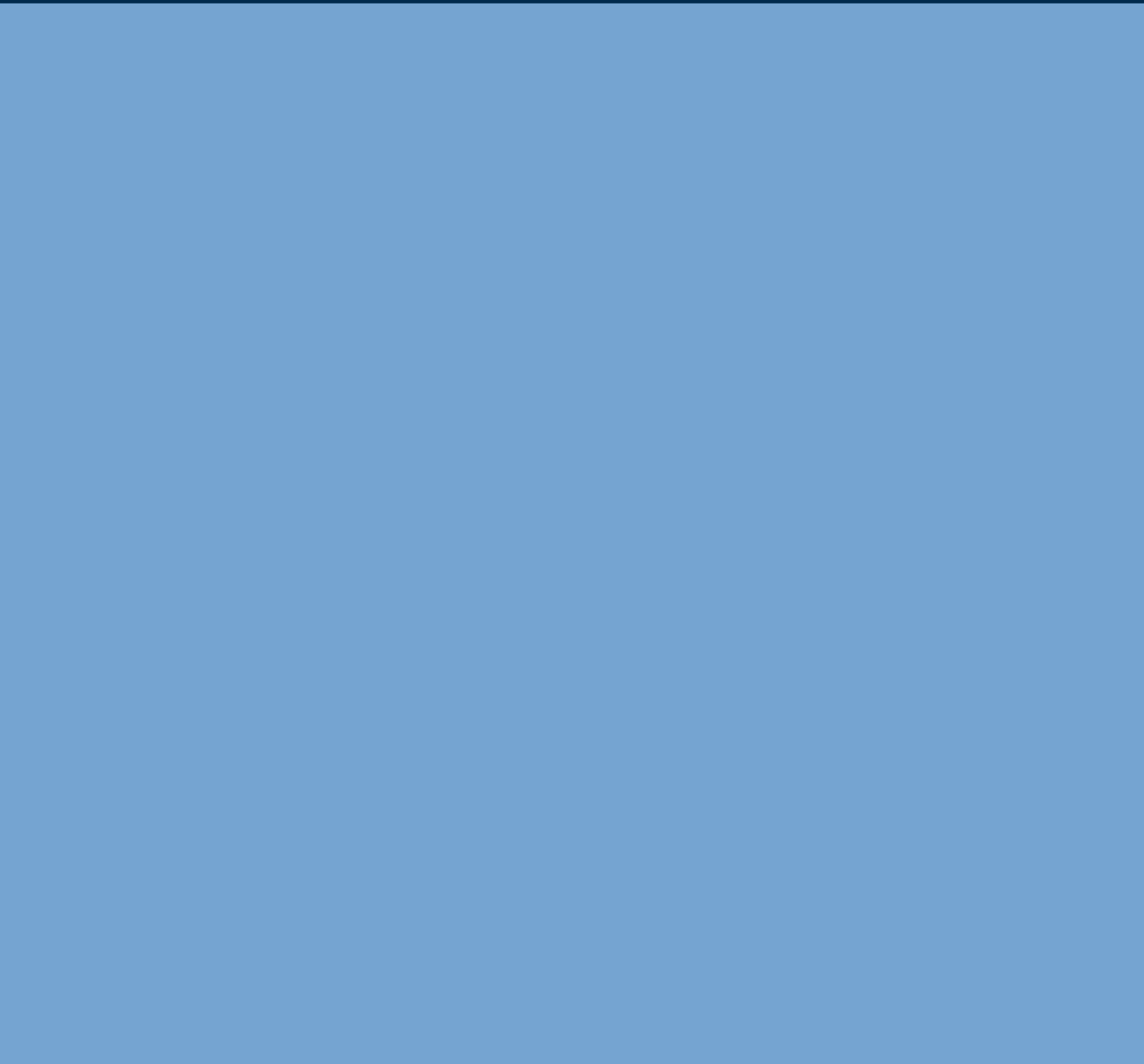
Fax: 703-528-7480

Email: [info@advancingpartners.org](mailto:info@advancingpartners.org)

Web: [advancingpartners.org](http://advancingpartners.org)







Supported by:



Implemented by:

