



# Female Community Health Volunteers in Nepal: What We Know and Steps Going Forward

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What we know.

## The FCHV program in Nepal has evolved over the past 30 years

The female community health volunteer (FCHV) program was launched in 1988 by the Ministry of Health and Population to enhance Nepal's primary health care network, improve community participation, and expand the outreach of health services.

FCHVs are local women who function as a bridge between the government and the community. They receive basic training, identity cards, dress allowance,<sup>1</sup> and an FCHV sign board to post outside their homes, provided by the Ministry of Health and Population.

With more than 52,000 FCHVs currently active, the program is widely acclaimed for its contribution to reducing child mortality and improving maternal health in the country as well as in extending coverage of important primary health care programs.

*The FCHV program has developed over the years, changing and growing to reflect new community health opportunities and population-based needs in Nepal.*

The primary focus of FCHVs work is health promotion activities for mothers and children by raising awareness and promoting use of family planning and maternal, neonatal, and child health services.

*A variety of other programs, including programs that have not yet been implemented nationwide, have used FCHVs at the district level.*

These programs include use of chlorhexidine (CHX) for newborn umbilical stump care and misoprostol to manage maternal hemorrhage.

<sup>1</sup>Blue saris designed with the FCHV logo accompanied by an official name badge

# The goal and objectives of the FCHV study

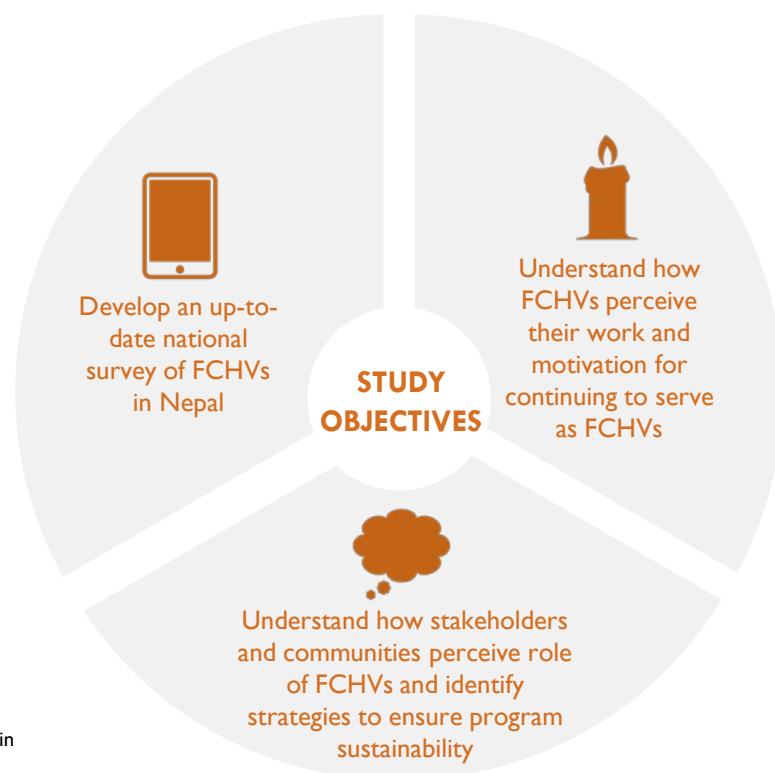
The goal of this study was to produce a cross-sectional (point in time) assessment of the FCHV program in Nepal to inform future policy and investment decisions.

The last comprehensive FCHV survey was conducted in 2006<sup>2</sup>. It was the first survey conducted on a national scale. Since then, significant developmental and health-related changes have emerged in Nepal, such as improved roads, a greater proportion of births taking place in health facilities, modest increases in human resources, and considerable growth in the number of private pharmacies and clinics. In addition, several initiatives involving FCHVs have been taken to national scale.

The 2014 FCHV survey was supported by USAID, Save the Children, and the United Nations Children's Fund (UNICEF). It was implemented by JSI Research & Training Institute, Inc. and FHI360 as part of Advancing Partners & Communities<sup>3</sup> in partnership with Health Research and Social Development Forum in Nepal.

<sup>2</sup>Government of Nepal, New ERA, and USAID 2007.

<sup>3</sup>A five-year project funded and managed by USAID and implemented by JSI Research & Training Institute, Inc. in partnership with FHI360.



Our approach.

## A two-part, mixed method strategy

The methodology and tools for the 2014 survey were developed in collaboration with key stakeholders. The approach included a two-part, mixed-method strategy consisting of a quantitative survey and qualitative research.

### QUANTITATIVE

Systematic random sampling with the ward/FCHV as the primary sampling unit in each of the 13 domains.

Sample selection stratified by urban and rural wards to ensure adequate representation.

Use of SurveyCTO and Enketo in PC tablets for data collection and storage.

Total of 4,302 FCHVs interviewed.

### QUALITATIVE

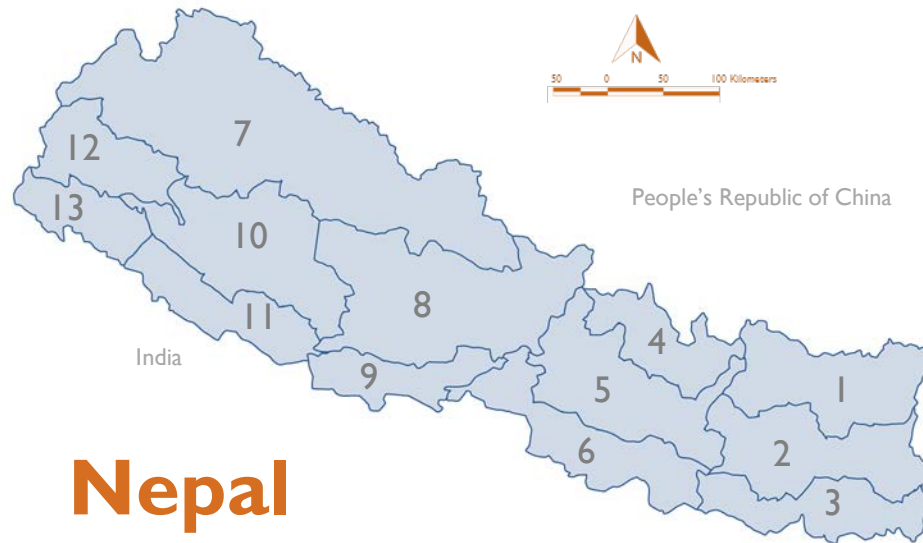
Purposive sampling to include various levels of respondents from 12 (rural and urban) districts within 8 of the 13 domains.

48 key informant interviews and 34 focus group discussions with 106 participants.

Respondents included representatives from national bilateral agencies, NGOs, and international agencies; district and community beneficiaries; and FCHVs from rural, urban, and marginalized communities.

# A comprehensive national survey across 13 domains

Univariate and bivariate analysis were conducted for the quantitative data, and results were weighted based on the relative size of the districts in the 13 domains. For qualitative data, thematic coding was applied.



**Nepal**

| Label | Domain            | No. of respondents |
|-------|-------------------|--------------------|
| 1     | Eastern Mountain  | 291                |
| 2     | Eastern Hill      | 358                |
| 3     | Eastern Terai     | 357                |
| 4     | Central Mountain  | 308                |
| 5     | Central Hill      | 365                |
| 6     | Central Terai     | 369                |
| 7     | Western Mountain  | 336                |
| 8     | Western Hill      | 371                |
| 9     | Western Terai     | 334                |
| 10    | Midwestern Hill   | 348                |
| 11    | Midwestern Terai  | 294                |
| 12    | Far Western Hill  | 330                |
| 13    | Far Western Terai | 241                |



## Challenges and limitations of our approach



Urban estimates are **representative nationally** but not by domain.



**Timing of survey** may have affected responses on child health services due to seasonality of services.



**Limited comparability** between the 2006 national FCHV survey and the 2014 survey due to differing sampling methodology and question wording.



Triangulation of quantitative and qualitative data not possible for all topics because of **differences in focus** of data collection tools.

What we found.

# Age, literacy, and mobile usage of FCHVs

FCHVs are women of reproductive age who are married and have at least one child.



FCHVs in 2014 survey had an **average age of 41.3 years**, whereas in the 2006 survey FCHVs had an average age of 40 years. Only 2% of FCHVs in the 2014 survey were over 60 years of age.



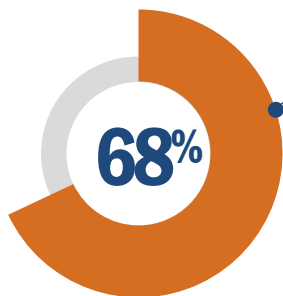
In 2014, **83% of FCHVs were literate** compared to 62% of FCHVs in 2006. 67% of FCHVs in 2014 attended school.



**83%** of FCHVs in 2014 **used mobile phones**. On average, they spent 207 NRs on mobile phone expenses for FCHV activities per month.

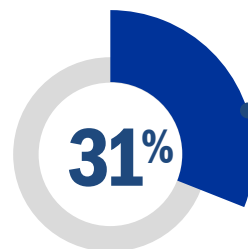
## FCHVs provide family planning services<sup>4</sup>

### Distributed condoms



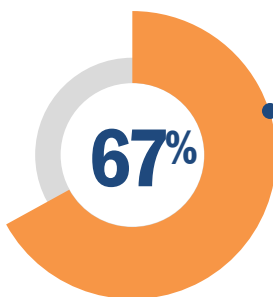
FCHVs were asked about condom distribution in the *three months prior to the survey*, and proportions varied considerably across domains (for example, 97% in Far Western Terai; 29% in Central Mountain). FCHVs who had limited literacy distributed more condoms than FCHVs who were fully literate.

### Referred women for sterilization



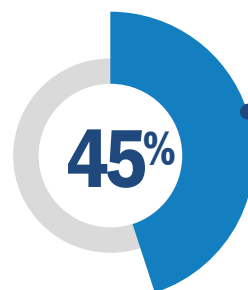
FCHVs were asked about referrals for sterilization in the *year prior to the survey*. Proportions varied across domains, with the lowest proportion of referrals in Central Terai and the highest in Central Mountain.

### Distributed pills



Proportions also varied considerably across domains (83% in Far Western Terai; 43% in Central Mountain). Fully literate FCHVs provided more pills than FCHVs who had limited literacy.

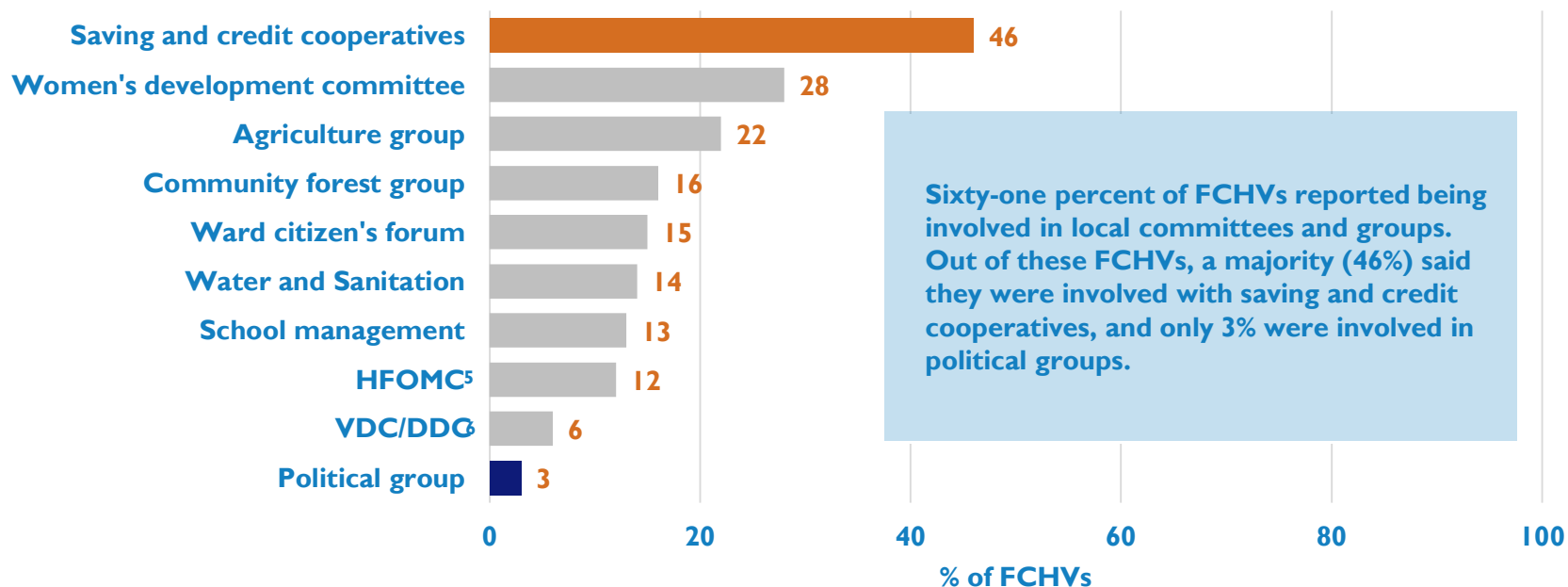
### Referred men for sterilization



Proportions were high in Eastern, Central, and Western Terai, with 64 to 70% of FCHVs reporting referrals for male sterilization. In addition, only 27% of the youngest group of FCHVs (under 25 years) provided referrals for male sterilization compared to 50% of oldest FCHVs (55 years or older).

<sup>4</sup>Data presented as percent of FCHVs. FCHVs were asked about condom and pill distribution in the 3 months prior to survey and about referrals for sterilization in the year prior to the survey.

## FCHVs are involved in different committees and groups



<sup>5</sup>Health Facility Operation and Management Committee

<sup>6</sup>VDC is the village development committee; DDC is the district development committee

# FCHVs are highly motivated

## *Extremely favorable factors*

- ✓ Happiness in role
- ✓ Family support for work
- ✓ Respect and appreciation in community
- ✓ Intent to stay in role in next 5 years
- ✓ Good treatment at facilities
- ✓ Supervisory support

FCHVs were highly satisfied and intended to continue working, and attrition rates at 4% were low.

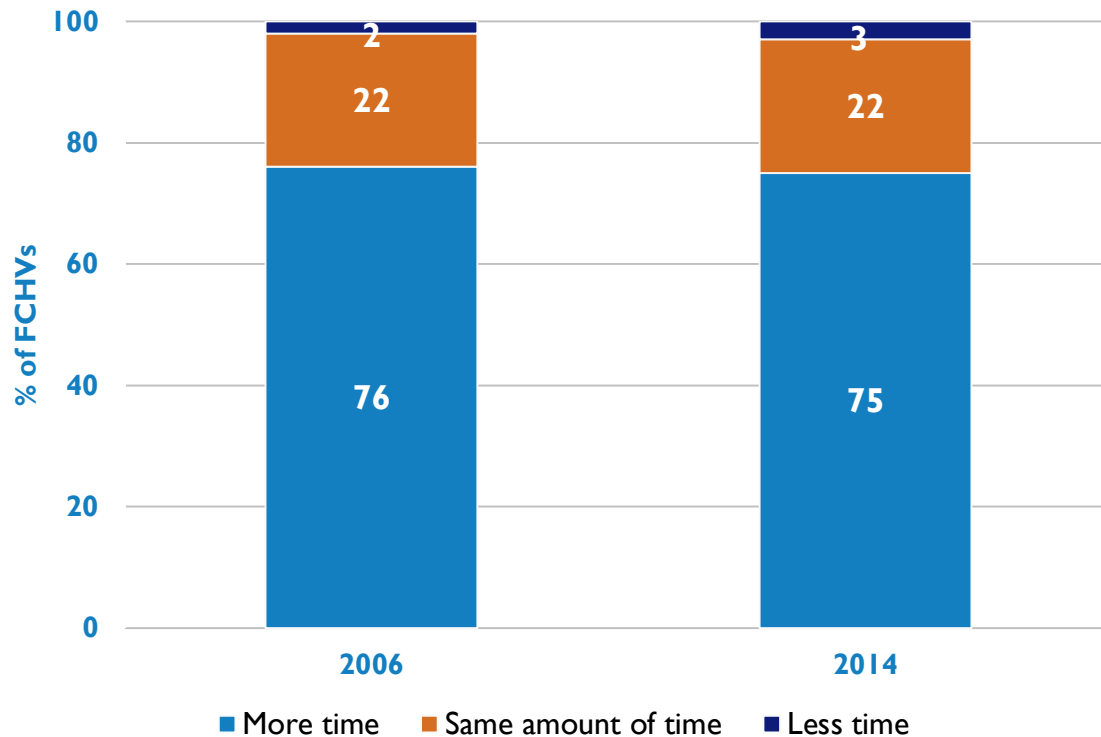
FCHV responses on key motivational factors were *extremely favorable*, suggesting that emotional, social, professional, and financial drivers maintain FCHVs' commitment to continued services.

On the other hand, responses to questions such as treatment by the government and work environment were *less favorable*.

## *Less favorable factors*

- ⊖ Adequate benefits
- ⊖ Fair treatment by government
- ⊖ Budget for completing forms and registries

## They are willing to devote their time in the future



A majority of FCHVs reported to be willing to devote more of their time towards FCHV activities in the future. On average, the total working hours per week for FCHVs was 6.82 in 2014, which has increased compared to the 5.27 hours per week from 2006.

# The Government of Nepal provides benefits and supplies for FCHVs

## The following benefits were provided by the government:

- An FCHV fund established at the VDC and DDC levels, where the government deposits funding for FCHVs to borrow money for income-generating activities
- Dress allowance
- FCHV Day celebration on the same day as international volunteer's day (5<sup>th</sup> December)
- Prize distribution on FCHV Day
- Free health care services
- Acknowledgement for their hard work by sending them to different learning visits nationally and internationally
- Incentives such as umbrellas, cupboard, torch light, snacks, transportation costs, etc. at the local level (e.g. VDC)

## FCHVs also received the following supplies:



Bag



Certificate



Flip chart



Identity card



Manual



Medicine kit box



Signboard



## But FCHVs would like better incentives



**96% received a dress allowance** in the past year in the value of NRS 4,000. To date, it has been increased to NRS 7,000<sup>7</sup>.



**97% have an FCHV fund** in their village development committee. About half of FCHVs reported having between NRS 50,000 – 100,000.



**79% received money**, which was more common among rural FCHVs compared to urban FCHVs (79% vs 58%).



**60% have drawn on the FCHV fund** (normally as a loan) over the past year.

### Interviews with key respondents found that:

- Current incentive arrangements are inadequate.<sup>8</sup>
- FCHVs should receive an incentive every month when they submit their report to the health post.
- FCHVs should receive incentives for conducting ward visits and increased travel allowances.
- Allowances for special festivals such as Dasain, recharging phones, and bicycles for transportation should be considered.

<sup>7</sup>4,000 NRS is equivalent to \$37.05, whereas 7,000 NRS is \$65.15

<sup>8</sup>During the time the study was being conducted, the Government made the decision to double the FCHVs' daily allowance, from NRS 200 to 400 (\$1.85 to \$3.70), although this had not yet been put into effect at the time data were being gathered.

## Overall FCHVs are commended for their role

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.

*“We visit community for supervision during vaccination program and PHC/ORC. We have observed that FCHV are working actively to promote vaccination program and PHC/ORC despite of busy schedule of household work as volunteer. We have to admire their contribution.”*

*- Health Assistant*

*“FCHV are playing important role to breaking cultural barrier, because in remote community women are illiterate and feel shame to visit health facility, especially family planning, ANC, and delivery care.”*

*- Auxiliary nurse midwife*

*“In this mountain district most of the communities are dependent upon the FCHVs. Because hospital and health facilities are not accessible near to their village. In some wards the people need to walk more than 2 days to reach health facilities.”*

*- Family planning supervisor*

““ *FCHVs are the eyes and ears of the health programs, because they are working as the main media of the community problem. They bring all the health problems to health facility. With her information we are organizing the community health program.* ””

*Auxiliary health worker*



Going forward.

## What this means for FCHV strategy



The Nepal FCHV program is successful, with high involvement of the volunteers in key community health interventions, high FCHV and stakeholder satisfaction, and low dropout rates.

The program should be maintained but adapted to meet changing needs:

- Provide specific, contextualized FCHV services vs. blanket approach.
- Target resources to specific high-impact activities by FCHVs (maternal and child health, FP, and nutrition).
- Ensure regular availability of commodities to improve FCHV performance.
- Increase investments in FCHV incentives and benefits based on improved knowledge of the current systems and their field applications.
- Ensure that additional time and investment are built into the national program to increase FCHV capacity to improve service delivery.

## Data use: past and present



Results from the study were presented at:

- The International Conference on Family Planning in Indonesia, January 25–28, 2016
- The External Development Partner forum in Nepal, Sept 9, 2015
- The USAID mission in Nepal, Sept 14, 2015
- The Implementing Partner forum in Nepal, September 11, 2015
- The International FCHV Day in Nepal, Dec 5, 2015



Plans are underway to further analyze data.



Save the Children is preparing technical briefs for advocacy, specifically on workload of FCHVs, how they spend their time, and whether their contributions have declined since program inception.

