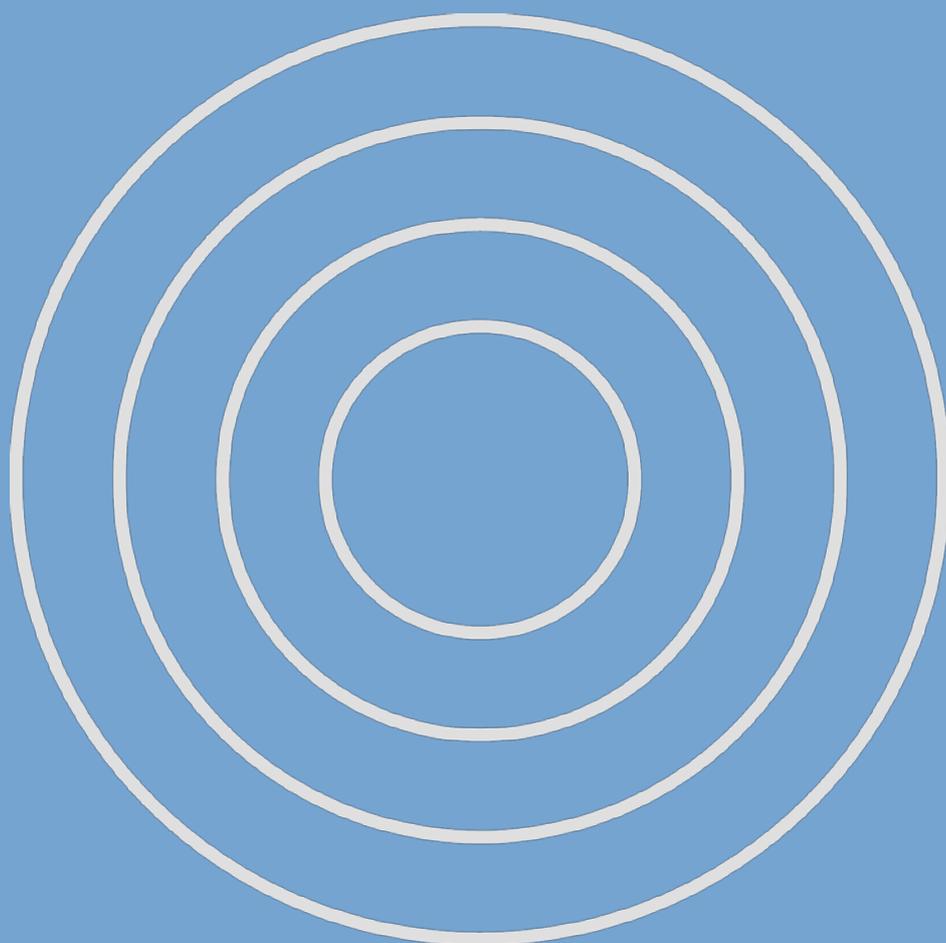


Female Community Health Volunteer National Survey Report 2014



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



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Hon'ble Khaga Raj Adhikari
Minister for Health and Population

Date : 21.02.2015

Message

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

Recognizing the importance of women's participation Government of Nepal initiated CHV program from 2045/46 (2008-09) and extended 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 contributions 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 and selfless voluntary 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 redesign the program or more. 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 process this meaningful document.

Khaga Raj Adhikari
Minister



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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 HERD. 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



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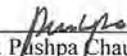
The *Female Community Health Volunteer (FCHV) National Survey Report 2014* is the result of earnest effort put forth by a number of organizations and individuals. It is my great pleasure to release this report to the public. FCHVs have been a bridge between the formal health system and the community 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
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ACRONYMS

AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BPP	Birth Preparedness Package
CBNCP	Community-based Newborn Care Program
CHX	Chlorhexidine
Co-PI	Co-principal Investigator
DDC	District Development Committee
DPHO	District Public Health Office
EPI	Expanded Program on Immunization
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FHI 360	Family Health International 360
FP	Family Planning
HA	Health Assistant
HERD	Health Research and Social Development Forum
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HMG	Health Mothers Group
HP	Health Post
HW	Health Worker
INGO	International Non-governmental Organization
IRB	Internal Review Board
JSI	JSI Research & Training Institute, Inc.
KII	Key Informant Interview
LGCDP	Local Governance and Community Development Program
MCHW	Maternal and Child Health Worker
MOFALD	Ministry of Federal Affairs and Local Development
MOHP	Ministry of Health and Population

NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organization
NHRC	Nepal Health Research Council
NPR	Nepali Rupee
ORS	Oral Rehydration Solution
PHC/ORC	Primary Health Care Outreach Clinic
PHCC	Primary Health Care Center
PI	Principal Investigator
SLC	School Leaving Certificate
SSI	Semi-structured Interviews
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WDO	Women Development Office
WHO	World Health Organization

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.¹ 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.

¹ 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 building.

CHAPTER I: BACKGROUND

The Female Community Health Volunteer (FCHV) program in Nepal, introduced in 1988 by Nepal's Ministry of Health and Population (MOHP), was designed to enhance Nepal's primary health care network, improve community participation, and expand the outreach of health services. The goal of the FCHV program, as outlined in the most recent FCHV Strategy (updated in 2010; the strategy was previously revised in 1990 and 1992), is to support achievement of national health goals through community involvement in public health activities. FCHVs—local women volunteering at the community level—function as a bridge between the government and the community.

Health promotion and health education are the primary focus areas of FCHV work. However, treatment and administration of preventive commodities have been added to FCHVs' work program over the years. In the mid-1990s, additional FCHVs were recruited in 28 districts according to a population-based ratio, and some FCHVs were recruited in urban areas, leading to a current total of more than 52,000 FCHVs. Many of the FCHVs' current activities date from the start of the program; but vitamin A and deworming activities were added between 1993 and 2002, and treatment of childhood pneumonia, zinc therapy for diarrhea, and distribution of iron/folate to pregnant women were added later on. A variety of other programs have used FCHVs at the district level, including programs that have not yet been implemented nation-wide, such as chlorhexidine (CHX) for newborn umbilical stump care, misoprostol to manage maternal hemorrhage, and Balvita multi-micronutrient supplement.

Since its introduction, the program has contributed to increasing the rural population's use of modern health services; reducing infant, child, and maternal mortality; and ensuring the prevention and treatment of key diseases. Currently, in addition to providing community-based family planning services, FCHVs contribute to key public health programs for maternal care, sick child care, health and nutrition counseling, vitamin A supplementation/de-worming, and immunization. FCHVs also provide basic health information to women, including information needed during pregnancy. As such, they are critical resources that extend the reach of the public health care system far beyond physical health care facilities, deep into the community.

At the central level, the Family Health Division (FHD) oversees FCHV activities, with significant involvement from the Child Health Division and other divisions and centers of the Department of Health Services. In addition, an FCHV sub-committee provides input on policies and strategies relevant to the FCHV program.

To ensure that the FCHV program in Nepal remains responsive to the evolving health landscape and adapts to the needs of the FCHVs themselves, it is necessary to monitor the program on an ongoing basis. In 2006, under the auspices of the FHD and with financial support from the U.S. Agency for International Development (USAID) and technical support from ORC Macro, the Nepalese non-governmental organization (NGO) New ERA conducted a national survey of FCHVs. Similar surveys had been conducted at subnational scale; this was the first survey conducted on a national scale. It provided essential information about the women who serve as FCHVs, their roles, and how their roles vary across Nepal's regions and geographic terrains.

Since the 2006 survey, there have been significant developmental and health-related changes in Nepal, including improved roads in almost every district in the country; increased use of mobile phones; a greater proportion of births taking place in health facilities; modest increases in human resources, notably with upgraded staffing in the most remote health facilities; and considerable growth in the number of private pharmacies and clinics. In addition, several initiatives involving

FCHVs were taken to national scale during this period, notably community-based integrated management of childhood illness, the Birth Preparedness Package (BPP), and iron intensification. A follow-on FCHV survey was conducted in 2008 at a subnational scale.

As Nepal finalizes a new national strategic plan for health services, it is important to review the current status of the FCHVs and their work on behalf of Nepali communities. Thus, the 2014 FCHV survey supported by USAID, Save the Children, and United Nations Children's Fund (UNICEF) takes a comprehensive look at the FCHV program. The 2014 survey reflects on issues that were addressed in the 2006 survey to understand FCHVs' evolution, and investigates important issues that were not addressed in the earlier survey. This cross-sectional study includes a national-level quantitative survey of FCHVs and qualitative interviews with key national-, district-, and community-level stakeholders. The results are intended to increase understanding among the governmental and other stakeholders of the current status of the FCHV program, covering the profile of FCHVs; the types of training and support FCHVs receive; and the basic health services that FCHVs provide, including essential functions such as health information, referral services, and distribution of commodities. The study also reports FCHVs' and stakeholders' perceptions of the program.

1.1 Goal and Objectives of Study

The scope of work states that the goal of this survey is to provide a cross-sectional (point in time) assessment of the FCHV program in Nepal for the purpose of informing future policy and investment decisions.

The main objectives of the study are 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' involvement
- Understand how FCHV program stakeholders and communities perceive the role of FCHVs and identify possible strategies to sustain the FCHV program.

The survey is not meant to evaluate the overall performance of the FCHV program, but to provide a snapshot of FCHV characteristics, services provided, support received, and FCHV and stakeholder perceptions of the program across geographic and technical areas. It is expected that the results will illuminate the strengths and challenges of the current FCHV program and help contribute to policies affecting FCHVs, ultimately enhancing the potential of this cadre and mitigating programmatic limitations.

CHAPTER 2: METHODOLOGY

2.1 Data Collection Methods and Tools

The methodology and tools for the 2014 survey were developed in collaboration with key stakeholders including the FHD, USAID, UNICEF, Save the Children's Saving Newborn Lives program, and FHI 360. The approach included a two-part, mixed-method strategy consisting of a quantitative survey of FHCVs in 13 domains across the country, and qualitative research including interviews with FCHVs, program stakeholders, and community members in eight of the same study domains.

The quantitative survey included questions adapted from the 2008 FCHV survey (the most recent of past FCHV surveys), and incorporated new questions based on the current design and context of the FCHV program. FCHVs were the key respondents. Data were collected on FCHVs' sociodemographic characteristics, work profile, and perceptions of their work; and also on the degree of support they received from higher levels; their role in delivering basic health services; and their performance during mobilization for social and development activities.

The qualitative data collection tools included guides for semi-structured interviews (SSIs), focus group discussions (FGDs), and key informant interviews (KIIs). Stakeholders reviewed these tools and recommended adjustments to ensure that questions reflected the Nepali context.

Representatives of stakeholder groups were interviewed as part of the qualitative portions of the survey. At the national level this included the Ministry of Health and Population, Planning Division, Family Planning and FCHV Program (FHD), Nutrition Program Office (Child Health Division), Ministry of Local Development, and Ministry of Women and Child Development. In addition, representatives from bilateral agencies, NGOs, and international agencies including USAID, Save the Children, UNICEF, and the World Health Organization were interviewed. At the district level, family planning (FP) supervisors were interviewed, along with auxiliary nurse midwives (ANMs), persons in charge at health posts, representatives from the Women's Development Office (WDO), and representatives from health facility operations and management committees (HFOMCs). In addition, FGDs were conducted with community beneficiaries and FCHVs from rural, urban, and marginalized communities.

2.2 Sample for Quantitative and Qualitative Data Collection

To attain appropriate precision of results from each of the 13 domains, separate sample sizes per domain were calculated using the total number of urban (municipal) and rural wards per domain. The following formula was applied to calculate each of the domain-specific sample sizes using a 95 percent confidence interval:

$$n = N \times ((N-1)E^2 + x)$$

Where:

n=domain-specific sample size

N=population size (total number of urban/rural wards per domain)

E=margin of error (5 percent)

X=response distribution (50 percent)

The final domain-specific sample sizes were then added to obtain a total sample size of 4,313, including 260 urban wards and 4,053 rural wards, which included a 3 percent drop-out rate based on the 2006 FCHV survey (see Table I). The quantitative survey was administered to FCHVs across 13 domains according to geography and the distribution of development regions across the country. The 13 domains are based on the Demographic and Health Survey, and are representative of the entire country. A total sample of 4,313 FCHVs was included in the quantitative survey.

The sampling and urban rural disaggregation in the report is based on old 58 municipalities. There were about 17 percent people residing in urban areas in Nepal. During the survey, the Government of Nepal announced new municipalities in 2 phases (72 and 61 municipalities). Furthermore, the area of 23 municipalities was increased by merging near villages. This has resulted in a total of 191 municipalities covering 38 percent population of Nepal. Therefore to address this new urban proportion, additional analysis was conducted by Save the Children after the completion of the survey for the newly established urban areas, old urban areas and rest of the rural areas and this can be found in Annex 37.

Table I. Quantitative Sample for FCHV Survey

Domain	Number of urban wards	Number of rural wards	Total number of wards	Sampled urban wards	Sampled rural wards	Drop out rate (%)	Total sample size needed with 3% dropout
Eastern Mountain	13	1,053	1,066	4	287	3	291
Eastern Hill	35	3,555	3,590	11	347	3	358
Eastern Terai	136	3,429	3,565	44	313	3	357
Central Mountain	13	1,332	1,345	4	304	3	308
Central Hill	183	4,176	4,359	59	306	3	365
Central Terai	112	5,292	5,404	36	334	3	370
Western Mountain	0	2,502	2,502	0	344	3	344
Western Hill	105	5,553	5,658	34	337	3	371
Western Terai	55	1,971	2,026	18	316	3	334
Mid-western Hill	21	2,925	2,946	7	343	3	350
Mid-western Terai	53	1,044	1,097	17	277	3	294
Far-western Hill	38	1,863	1,901	12	318	3	330
Far-western Terai	42	549	591	14	227	3	241
Total	806	35,244	36,050	260	4,053		4,313

The total sample after the completion of data collection was 4,302 FCHVs. The difference in the initial calculated sample size and the final sample size falls within the 3 percent dropout range. Therefore, the resulting sample size enables both national- and domain-level estimates.

For the KIIs, SSIs, and FGDs, 12 districts from 8 domains were included. Table 2 shows the distribution of the qualitative sample across urban and rural districts. Results are based on a total of 82 interviews and FGDs that included 106 respondents with the following breakdown:

- 12 FGDs with community beneficiaries (mothers and women of reproductive age group in study village development committees, or VDCs)

- 16 FGDs with FCHV of selected VDCs (12 rural and 4 urban sites)
- 6 FGDs with members of HFOMCs
- 18 SSIs with health workers working in health posts (HPs), sub-health posts, and primary health care centers (PHCCs)
- 18 SSIs with district stakeholders
- 12 KIIs with national stakeholders.

Table 2. Sample Districts for Qualitative Data Collection in Urban and Rural Settings

Ecology	Region	District	Urban/rural	Study*
Mountain	Eastern	Taplejung	rural	All study
	Far-western	Bajhang	rural	All study
Hill	Eastern	Ilam	rural	All study
	Central	Kavre	rural	FGD with FCHV and community beneficiaries
		Kathmandu	urban	FGD with FCHV
	Western	Syangja	rural	All study
		Pokhara (Kaski)	urban	FGD with FCHV
Terai	Eastern	Sunsari	rural	All study
		Baratnagar (Morang)	urban	FGD with FCHV
		Siraha	rural	FGD with FCHV and community beneficiaries
	Western	Banke	rural	FGD with FCHV and community beneficiaries
	Far-western	Kanchanpur	urban and rural	All study

*"All study" indicates that FGDs, KIIs, and DSSIs were conducted in the district.

2.3 Sampling Procedure

For the quantitative survey, a systematic random sampling technique was applied with the ward/FCHV as the primary sampling unit. In each domain, a sampling frame of wards was developed; and a sampling interval was applied to randomly select every "kth" ward until the appropriate sample for that domain was reached. Ward-based districts were understood to have one FCHV per ward, while population-based districts were understood to have more than one FCHV per ward, depending on the size of the ward. Within each ward, if two or more FCHVs were present, a single FCHV would be randomly selected, so only one FCHV would be sampled for each ward. Sample selection was stratified by urban and rural wards to ensure adequate representation. Both ward-based and population-based districts were included in the sampling frame. The detailed sampling protocol can be found in Annex 1.

For the qualitative survey, purposive sampling was applied to include various categories of community beneficiaries, stakeholders (central-level, district-level, health workers, and health facility management committee members), and FCHVs from rural, urban, remote, and marginalized communities. Descriptions of respondents for qualitative data can be found in Annex 3.

Every FGD with community beneficiaries included at least three women of 1,000 days (the 1,000-day window between pregnancy and a child under the age of two years) along with other women of reproductive age (15 to 49 years) within each ward selected. For marginalized communities, respondents from the Dalit communities in the Hill and Mountainous Districts were selected; if no Dalit community members were available, members of the Janajati (indigenous population groups),

or from the next-most marginalized group within the local context, were selected. The District Health Office helped identify remote wards, based on the location of health facility within the selected VDC.

2.4 Ethics Approval

The research proposal for this FCHV survey was submitted to the Nepal Health Research Council (NHRC) in Kathmandu on June 18, 2014. The principal investigator (PI) was the director of FHD at the time of the survey. Co-PIs were from the FHD and JSI Nepal. The research protocol included the study design, draft data collection tools, informed consent forms, sampling plan, and timeline for the study. Following approval from the NHRC, received on July 1, 2014, preparations for training of data collectors began. The tools were further revised based on feedback received during training and after piloting, and were submitted to NHRC for approval before the start of data collection. In addition, IRB approval from JSI was attained on July 29, 2014.

Informed consent for both quantitative and qualitative data collection was secured from every respondent. Data collectors were asked to read the informed consent forms to all respondents. When the respondent agreed to participate in the interview, s/he was asked to sign the informed consent form to affirm that s/he had understood the informed consent process. The forms were returned to supervisors for checking and filing.

2.5 Mobile Data Collection Platform

A mobile platform called Enketo was used to streamline quantitative data collection and analysis. This was linked to another mobile platform called Survey CTO, which housed the data forms and the data. The paper-based survey was programmed into Microsoft Excel 2010 and uploaded into SurveyCTO's online platform. The electronic form was then downloaded to Enketo from the SurveyCTO platform on to Windows-based tablets, ready for use by data collectors. After data were collected and saved, they were sent to the SurveyCTO server; data were then saved there until all data collection was complete. The account was password-protected and only accessible to key staff working with the data.

2.6 Training and Pre-Testing

A total of 50 field researchers were recruited for quantitative data collection; six were recruited for qualitative data collection. Field researchers were trained in Kathmandu from August 4–11, 2014. Representatives from Health Research and Social Development Forum (HERD), JSI, and key stakeholders (FHI 360, Save the Children, and UNICEF), including members of FHD, helped facilitate the training, which included a description of the FCHV program and activities, survey goal and objectives, study design, sampling protocol, and a detailed discussion of the data collection instruments. In addition, the training included sessions on interviewing, probing (specifically for qualitative field researchers), and role-playing. Quantitative field researchers were trained on SurveyCTO and Enketo; they learned to navigate the form on their tablets, start a questionnaire, save a completed questionnaire, and conduct quality checks on the mobile data collection platform.

Qualitative data collectors were trained on note-taking and transcribing methods. Teams of data collectors, supervisors, and observers from JSI and USAID went to different geographic areas to pre-test the tools. These areas, the districts of Kavre and Sindhupalchowk, were not part of the sampling frame for the study. Feedback from the training was sought from all data collection teams after pre-testing, and tools and field guidelines were revised accordingly in preparation for data collection.

2.7 Quality Assurance

A team of supervisors received training on data quality assurance methods, the re-sampling protocol, and managing data collection teams in the field. During the training sessions, to provide context for their interviews, field staff received orientation on the commodities that FCHVs were distributing in the community, and on any registers or training materials provided to the FCHVs. Data collection was conducted in three phases between August 2014 and February 2015.

Two supervisors from Kathmandu were responsible for monitoring field work through regular telephone communication with the field researchers. At the field level, supervisors from Kathmandu visited field researchers during the initial training sessions and periodically thereafter; observed quantitative and qualitative interviews and FGDs; and provided feedback. Qualitative data were transcribed and submitted to FHI 360, which led the qualitative analysis in country. Ten percent of the transcripts were translated into English; analysis of the translated transcripts took place in JSI's Washington, DC office. Quantitative data were directly uploaded on the SurveyCTO platform and then cleaned by the local partner, HERD, before being submitted to JSI for analysis. A “no skip” option was programmed into the online survey, which meant that data collectors could only upload data once all questions in the survey were completed. This prevented incomplete surveys from being uploaded to the server.

2.8 Analysis

At JSI's Washington, DC office, quantitative data from SurveyCTO were directly transferred into Microsoft Excel, cleaned, and uploaded to STATA 13 for data analysis. Univariate and bivariate analyses were conducted for key variables outlined in the analysis plan. The team used STATA 13 data analysis and statistical software to analyze data from the quantitative survey. Results were weighted based on the relative size of the districts in the 13 domains. Weights were calculated using ward as the primary sampling unit and residence (urban versus rural) as the strata. The weights used for each domain can be found in Annex 4. The weighted outcomes are presented as percentages, and the total Ns are presented as absolute numbers where only respondents who were eligible for analysis were included (taking skip patterns into account). Both national-level estimates and domain-level comparisons are presented. Data were also stratified by residence (urban versus rural), literacy, FCHV age, and time it takes FCHV to reach the HF. The chi-square was used to test significance between groups.

Qualitative interviews were transcribed and typed in Microsoft Word. The team developed a general analysis protocol for each qualitative data collection activity, which consisted of a codebook with broad themes that responded to the questions asked. This analysis protocol was modified based on review of the data once analysis commenced. Data analysis consisted of: 1) organizing the data; 2) generating new categories/themes in addition to broad themes that had been already identified; 3) coding data by theme; and 4) interpreting the findings. The analysis team used NVivo 10 Software to analyze transcripts and notes from the interviews and focus group discussions. English summaries of analyzed Nepali-language transcripts were reviewed by the research team in JSI Washington and analyzed along with the subset of translated transcripts noted above.

Quantitative and qualitative results were triangulated where possible, and are presented throughout the report under the relevant results sections.

2.9 Limitations

While the sample size allowed development of both national- and domain-level estimates, urban and rural estimates were representative nationally, and not by domain. The latter was difficult given that

in some domains there were no urban FCHVs. The sample size of 4,302 FCHVs was representative, but the original sample size of 4,313 FCHVs could not be attained because of difficulties reaching some wards.

The sample of urban FCHVs was drawn in such a way that the major urban areas (Kathmandu Valley, Biratnagar, etc.) were not represented in proportion to population, but to the total number of FCHVs. The total urban sample for the survey was quite small, which limits the generalizability of findings from this survey to all urban FCHVs.

Since the survey methodology used similar sampling procedures for FCHVs from ward-based and population-based districts, there is a potential bias of overrepresentation of FCHVs who served population-based wards with low numbers of FCHVs. This limits the ability to compare results between FCHVs from population-based wards with fewer FCHVs to findings on FCHVs from districts with more FCHVs, and to generalize findings between ward-based and population-based districts.

Data collection teams experienced some challenges with long distances, and had difficulties reaching remote households because of washed-out bridges, poor roads, and illness. This did not significantly delay data collection, but the fatigue resulting from these challenges may have led to some human error during data collection, which is to be expected.

Because of poor Internet connection, data from the field could only be uploaded once teams arrived in Kathmandu, which resulted in a delay in data cleaning and the start of analysis. In addition, inconsistencies between the Nepali and English translations were discovered in the field, and although supervisors tried their best to communicate these to their teams, some questions may have been misunderstood across the sampled FCHVs.

Due to the timing of the survey, responses on child health services may not be representative of seasons when prevalence of diarrhea and pneumonia is higher.

There are some differences in design and sampling methodology between the 2006 national survey and the 2014 survey. In addition, some survey questions were worded differently, which limits exact comparisons between the two surveys. However, since both are national-level surveys, some comparisons between results have been made for selected variables highlighted throughout the report.

Triangulation of quantitative and qualitative data could not be conducted for all topics, because the data collection tools were designed to ask different but complementary questions. Therefore, comparisons between the quantitative and qualitative results have only been made for selected topics; and in some cases, data from only one type of data collection activity are presented, to maintain the integrity of the study design.

Finally, the design of this survey does not lend itself to a comprehensive evaluation of the FCHV program. Instead, both the quantitative and qualitative data provide evidence on the current status of the program, and highlight potential challenges and positive lessons learned that should be further evaluated to inform policy recommendations.

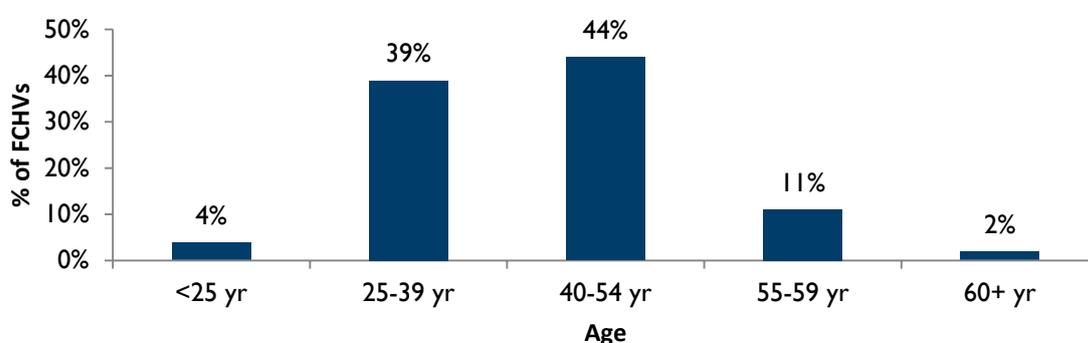
CHAPTER 3: FCHV CHARACTERISTICS

The sample for the FCHV survey comprised 58 percent and 42 percent, respectively, of ward-based and population-based FCHVs. Ninety-four percent of FCHVs were rural and 6 percent were urban.

3.1 Age, Caste, and Language spoken

The average age of FCHVs across all 13 domains was 41.3, with only 4 percent aged below 25 years (see Figure 1). In comparison with findings of the 2006 survey, FCHVs in 2014 are somewhat older. In 2006, 43 percent of FCHVs were 40 years of age or older. By 2014, this had increased to 57 percent. Only 2 percent of FCHVs were 60 years of age or older.

Figure 1. Percent Distribution of FCHVs by Age Nationally in 2014



The two most common caste and ethnic groups among FCHVs were high caste (40 percent) and Janajatis (38 percent). Dalits and Muslims made up less than 10 percent of all sampled FCHVs. The majority of FCHVs in the Far-western Hill, Western Mountain, and Mid-western Hill domains were high caste (>60 percent). A majority of FCHVs from Eastern Mountain, Eastern Hill, Far-western Terai, and Central Hill domains were Janajatis (>50 percent). Over half of the FCHVs in this survey spoke Nepali as their first language (52 percent). However, other languages were predominant in other domains. This included Maithili, spoken in Eastern Terai and Central Terai domains; Bhojpuri, spoken in Central Terai domain; Awadhi in Western Terai and Mid-Western Terai domains; and Tamang, spoken in Central Mountain and Central Hill domains. More details can be found in Annex 5.

3.2 Education, Literacy, and Writing Levels

As Table 3 shows, 67 percent of the 4,302 FCHVs surveyed reported attending school; of these, nearly half (45 percent) had attend sixth through tenth grades. The reading and writing tests, which consisted of reading or writing a simple sentence on a card carried by the field researchers, was only administered to those FCHVs who had less than a sixth-grade education level. Nearly half of these women (46 percent) could read the sentence fully, and 22 percent were able to partially read the sentence. When asked to write the sentence “My country is Nepal,” 40 percent were able to fully write the sentence and 38 percent could write part of it (see Annex 6).

Table 3. Percent Distribution of FCHVs by Education, Literacy, and Writing Levels^a

Characteristic		N	% of FCHVs
Attended school		4,302	67
Denominator (N)	2,876*		
Highest grade attended in school	0-5	952	35
	6-10	1,283	45
	SLC pass	442	14
	Intermediate/+2	122	4
	BS/MS	77	3
Denominator (N)	2,377**		
Reading level	Cannot read	708	33
	Able to read partially	559	22
	Able to read fully	1,110	46
Denominator (N)	2,379***		
Writing level	Unable to write	500	22
	Able to write partially	916	38
	Able to write fully	963	40
Denominator (N)	4,302		
Literacy	Literate	3,592	83
	Not literate	711	17

^aSignificant difference between domains for all comparisons, $p < 0.05$. See Annex 6 for details. *Only administered to FCHVs who had ever attended school. See Annex 6 for details. ** Only administered to FCHV who had < 6th grade education with 2 missing data values, since reading card was not available in the local language. *** Only administered to FCHVs who had < 6th grade education.

Literacy was calculated as per the Demographic and Health Survey definition; FCHVs were labeled as literate if they had an education level of sixth grade and above, or if those with less than that level of schooling could fully or partially read a sentence from a card. When literacy was calculated, 83 percent of 4,302 FCHVs were found to be literate. In the 2006 survey, literacy was calculated somewhat differently; FCHVs were labeled as literate if they had completed primary education (fifth grade and above) or they could fully read or partially read in the reading test. Based on this calculation, 62 percent of FCHVs were found to be literate, demonstrating an increase in FCHV literacy between 2006 and 2014.

3.3 Family Structure and Marital Status

Results from this survey show that 90 percent of FCHVs reported being married and nearly half (43 percent) said that they lived within a nuclear family (Table 4). See Annex 7 for details on family structure and marital status.

Table 4. Percent Distribution of FCHVs by Marital Status and Family Structure

		DENOMINATOR (N)	NATIONAL
Marital status	Married	4,302	90
	Unmarried		1
	Divorced/Separated		1
	Widow		8
Where husband stays	Stays together at home	3,878*	80
	Stays elsewhere (in country)		6
	Stays elsewhere (abroad)		14
	Missing		0
Type of family*	Nuclear	4,302	43
	Joint		51
	Extended		7

*Only administered to married FCHVs.

CHAPTER 4: FCHV WORK PROFILE

4.1 Years of Work Experience

At the time of the 2006 survey, 53 percent of FCHVs had served for over 10 years (see Table 5). By the time of the 2014 survey, this percentage had increased slightly to 59 percent. Only a small percentage of FCHVs, ranging between 1 percent and 6 percent across 13 domains, reported having less than one year of experience in 2014. The mean number of years of experience ranges from 10.5 to 16.9 years, depending on the domain. Among literate FCHVs, there is some variation in the mean number of years of experience, which ranges from 10.5 years to 16.9 years. The average number of years of work experience was 13 years among literate FCHVs, compared to 17 years among those who had limited or no literacy skills. In both surveys, 20 percent of FCHVs had served in this role for less than five years, corresponding to an annual turnover of 4 percent. See Annex 8 for more details.

Table 5. Percent Distribution of FCHVs by Years of Work Experience

Characteristics	Years of work experience*					Mean	Median
	<1	1-5	6-10	11-15	16+		
Denominator (N)	4,302						
Domain							
Eastern Mountain	6	20	16	17	40	12.3	13
Eastern Hill	5	13	21	16	45	13.6	14
Eastern Terai	2	11	14	12	61	16.9	19
Central Mountain	5	21	23	12	39	12.5	11
Central Hill	4	17	20	15	44	13.8	13
Central Terai	1	19	14	9	56	15.9	19
Western Mountain	3	18	32	13	33	11.3	10
Western Hill	4	15	20	10	50	13.7	15
Western Terai	2	12	10	14	62	16.2	19
Mid-western Hill	2	25	35	13	26	10.5	8
Mid-western Terai	1	15	25	14	44	13.8	14
Far-western Hill	3	20	27	15	35	11.5	10
Far-western Terai	3	16	15	28	39	13.3	14
Literacy							
Not literate	1	10	13	13	63	17.1	19
Literate	4	18	22	13	43	13.1	13
NATIONAL	3%	17%	20%	13%	46%	13.9	14

*Significant difference among domains for all comparisons $p < 0.05$.

4.2 Time Spent on Job

Table 6 gives details from the 2014 survey on the time that FCHVs spent doing their work. These data reveal some differences between FCHVs' activities in 2006 and 2014. In the 2006 survey, 6 percent of FCHVs reported that they had not spent any time over the previous week on FCHV-related duties; this increased to 12 percent in the 2014 survey. In 2006, FCHVs overall reported spending 3 days on average on FCHV-related work in the previous week, compared to an average of 2.2 days reported in the 2014 survey. On average, survey participants reported 1.7 hours spent daily on FCHV work in 2006, compared to 3.1 hours in 2014. In terms of average working hours per week, FCHVs reported 5.1 hours in 2006 and 7.2 hours in 2014. When comparing ward-based with population-based FCHVs, there was little difference in the numbers of days worked in the last week (2.2 versus 2.3 days). However, population-based FCHVs reported working slightly more hours per week (7.7 hours) compared to ward-based FCHVs (6.9 hours).

Table 6. Percent Distribution of FCHVs by Time Spent on Job

Characteristics	No. of days worked last week ^{abcd}				Average working hour per day ^{abcde}					Average working hours per week ^{abcd}				
	4,302				4,302					4,302				
DENOMINATOR (N)	0 days	1-3 days	4+ days	Mean days	<1 hr	1 hr	2 hr	3+ (3-8 hr)	Mean hours /day	=<2 hr	2.1-4 hr	4.1-6 hr	6.1 +	Mean hour s/week
Eastern Mountain	8	73	18	2.3	2	12	32	53	3.1	17	23	15	45	7.2
Eastern Hill	18	75	7	1.6	0	5	25	69	3.3	26	25	16	33	5.7
Eastern Terai	13	67	19	2.3	3	14	30	54	2.9	26	20	12	41	7
Central Mountain	9	67	24	2.5	4	22	25	49	2.9	20	18	18	44	7.3
Central Hill	16	63	21	2.3	1	12	24	62	3.2	22	13	16	49	7.5
Central Terai	10	73	17	2.2	2	29	32	37	2.3	27	24	19	30	5.4
Western Mountain	14	59	27	2.6	1	11	29	58	3.2	17	13	14	55	8.3
Western Hill	13	65	22	2.2	1	5	23	70	3.6	18	19	16	47	7.9
Western Terai	9	55	37	3	0	5	18	76	3.7	12	6	14	67	11.1
Mid-western Hill	15	67	18	2	1	9	22	68	3.4	21	21	18	39	7.2
Mid-western Terai	3	86	11	2	1	5	19	76	3.2	8	32	18	41	6.3
Far-western Hill	8	73	19	2.4	2	19	35	44	2.7	18	27	17	38	6.5
Far-western Terai	5	70	25	2.5	1	16	26	57	3	15	16	16	52	8
Time to facility HF														
<30 min	13	68	19	2.2	2	17	26	56	3	23	19	18	40	6.9
30-60 min	12	68	20	2.2	2	12	28	58	3	22	21	16	42	6.8
>60 min	12	67	20	2.3	1	8	25	66	3.4	18	20	15	47	7.9
NATIONAL	12	68	20	2.2	1	13	26	59	3.1	21	20	16	43	7.2

^aSignificant difference between domains $p < 0.05$; ^bsignificant difference between literacy levels $p < 0.05$; ^c significant difference between age $p < 0.05$; ^d significant difference between residence $p < 0.05$; ^e significant difference between time to closest HF $p < 0.05$.

Overall, the total number of hours reported for FCHV-related activities was slightly higher in 2014 than in 2006, with almost half of survey participants (43 percent) reporting more than six hours in the previous week. A gradient, for example, is observed by how far away the FCHV lives from the HF, with 47 percent of those living more than an hour away (versus 40 percent of those living less than 30 minutes away) reporting more than six hours (Annex 9). While the question was generally posed in terms of time spent on FCHV activities, it is assumed that some FCHVs included their travel time to health facilities in this estimate, particularly those who lived far away. In the Western Terai, two-thirds (67 percent) of FCHVs reported putting in more than six hours. By contrast, only

33 percent of survey participants in the Eastern Hills and thirty percent of survey participants in Central Terai spent six hours on FCHV work per week.

Based on the results presented above, in terms of the typical number of hours engaged in FCHV-related activities, there has only been a slight increase in the amount of time FCHVs are spending. It is true, however, that as the number of programs expecting FCHVs to play a role increases, some activities receive higher priority than others. However, during qualitative interviews, the theme of FCHVs being “overloaded” emerged frequently from respondents at various levels. Representatives from the district level reported that the duties of FCHVs had gradually increased during the past 10 years, saying that village committees (such as social security committees and ward civil forums) now mobilize FCHVs across different development sectors. However, a representative from FHD stated that the added range of duties of FCHVs was not due to government activities, but to local and international NGOs that were mobilizing FCHVs for their own programs. Representatives from key donor agencies mentioned that because of the absence of a clear FCHV policy on the boundaries of FCHV work, activities from other development sectors and national and international organizations are now added to FCHV functions. One representative from this group felt that FCHVs’ participation in work within other development sectors has diluted their main role as health promoters.

This discordance between the quantitative and qualitative data perhaps highlights differences between perceptions of FCHVs’ workload at district and higher levels, compared to the realities of the program on the ground, suggesting the need for further exploration to clarify these differences.

4.3 Place of Residence, Provision of Services, and Mode of Transportation to Facility

Almost all (95 percent) of FCHVs surveyed reported living in the ward where they performed FCHV functions and walking to their respective health facilities. On average, FCHVs reported that they had made two to three visits to the health facility in the last month. Even FCHVs who were further away from the health facility (>60 minutes) reported making between one and two visits (Table 7).

On average, FCHVs reported spending almost one hour to reach the closest health facility, but many FCHVs spent longer. FCHVs in Eastern Mountain, Central Mountain, and Mid-western Hill reported spending about one and a half hours to reach the nearest health facility. Also, FCHVs who were >60 minutes from the health facility reported spending more than two hours to reach the nearest facility. The survey revealed some variations in primary location for providing services. A little over half of FCHVs (57 percent) named the client’s residence as their primary location, while 29 percent reported providing most of their FCHV functions from their own homes. Fourteen percent reported another site as the primary location for giving services. The proportion of FCHVs who reported providing services primarily in beneficiaries’ homes was particularly high in the Central and Western Terai (82 percent and 79 percent, respectively); and quite low in the Western Hills (27 percent) and Central Mountain (36 percent), where other locations in the community were often cited as principal service locations. See Annex 10 for details.

Table 7. Percent Distribution of FCHVs by Place of Residence, Provision of Services, and Mode of Transportation to Facility

Characteristics	Living in ward where FCHV works		Average number of times visited health facility in the last month	Mode of transportation to reach health facility ^a					Average amount of time to reach facility (minutes)	Provide services to clients generally ^{ab}		
	In ward	Outside ward		Walk	Cycle	Motor cycle	Bus/ jeep/ van	Other		Own residence	Client residence	Other place
Total N (denominator)	4,302		4,302	4,302					4,302	4,302		
Domain												
Eastern Mountain	96	4	2.3	100	0	0	0	0	98.9	38	51	11
Eastern Hill	96	4	2	98	0	0	2	0	70.6	19	70	11
Eastern Terai	96	4	2.6	83	11	1	4	1	34.6	25	69	6
Central Mountain	94	6	2.4	98	0	0	2	0	86.2	31	36	33
Central Hill	95	5	2.3	98	0	0	2	0	61.1	35	53	12
Central Terai	96	4	2.9	96	2	1	1	0	28.7	17	82	1
Western Mountain	92	8	2.5	100	0	0	0	0	72.2	25	67	7
Western Hill	95	5	2.2	100	0	0	0	0	67.3	43	27	30
Western Terai	95	5	3	82	11	1	5	0	42.1	20	79	1
Mid-western Hill	96	4	2.2	99	0	0	1	0	84.7	35	41	24
Mid-western Terai	97	3	3.2	81	12	0	7	0	38.8	33	51	16
Far-western Hill	97	3	2.6	99	0	0	1	0	61.6	28	48	24
Far-western Terai	97	3	2.6	64	30	0	6	0	59.8	49	51	0
Time to closest health facility												
<30 min	95	5	3.3	92	4	1	3	0	12.2	27	61	12
30-60 min	96	4	2.2	94	4	0	2	0	44.4	28	58	14
>60 min	96	4	1.8	99	0	0	0	0	136.1	33	50	17
NATIONAL	95	5	2.5	95	3	0	2	0	58.6	29	57	14

^aSignificant difference between time to HF p<0.05;^bsignificant difference between domains p<0.05. See Annex 10 for details.

4.4 Recording and Reporting by FCHVs

Overall, as shown in Table 8, 72 percent of FCHVs were capable of recording data on the various forms without assistance. As expected, 88 percent of FCHVs who had limited or no literacy skills needed assistance completing the recording forms, compared to 14 percent who were literate. However, 12 percent of limited-literacy FCHVs reported that they complete forms themselves. Demographic factors influenced the need for assistance. Older FCHVs (>55 years of age) were much more likely to need help than those under age 25 (61 percent versus 6 percent, respectively); and rural FCHVs were less likely than their urban counterparts to record all data on their own (72 versus 93 percent). On average, FCHVs spent two hours per month completing forms and registers for services provided. See Annex 11 for details.

Table 8. Percent Distribution of FCHVs by Recording and Reporting Practices

Characteristic	Capable of recording*		Average time spent on recording in a month(hours)
	On own	Need assistance of others	
DENOMINATOR (N)	4,302		4,296**
Literacy			
Not literate	12	88	1.6
Literate	86	14	2.0
Age			
<25 yr	94	6	1.6
25-39 yr	87	13	2.0
40-54 yr	67	33	1.9
55+ yr	39	61	1.8
Geographic area			
Urban	93	7	1.8
Rural	72	28	1.9
NATIONAL	72	28	1.9

*Significant difference between domains, literacy, age, and geographic area $p < 0.05$; **six observations missing.

In the qualitative assessment, FCHVs were asked about their perceptions of and experiences with reporting. It should be noted that prior to the time of data collection, FCHVs in all 75 districts received training on the revised FCHV register and updated health management information system. Some said that there were many columns to fill and that they needed special training to complete all reports, while others found the forms easier to complete now that they are increasingly integrated. FCHVs from several districts said that if they had problems completing forms, they sought assistance mainly from family members. FCHVs reported that they submitted these reports every month to the health post and received feedback on incorrect reporting during review meetings, or received support from health workers. Key respondents from the District Health Office said that FCHVs brought their reports in monthly as per the schedule. However, the FP supervisor from one district said that only about half of FCHVs reported on a regular basis.

When asked what could be done to improve recording and reporting, FCHVs from two districts said that they should receive training. One person in charge of a health facility recommended prioritizing refresher training for recording and reporting, since many FCHVs may have forgotten what they learned during basic training. One FP supervisor recommended close supervision to monitor what services are being recorded and reported by FCHVs. This supervisor stated that while some FCHVs had limited or no literacy skills, they were still required to complete a large amount of reporting and recording and relied on family members to help them complete various forms; a national-level respondent expressed similar view, saying that the quality of reporting by FCHVs continues to be an issue.

CHAPTER 5: AVAILABILITY OF COMMODITIES, REGISTERS, EQUIPMENT, AND JOB AIDS

5.1 Availability of Recording and Reporting Registers and Equipment

The availability of registers and equipment was assessed through observations. On average, 80 percent of FCHVs had the new FCHV ward register and 77 percent had their identity cards (Annex 12). However, fewer than half of FCHVs had registers on treatment for acute respiratory infection or ARI (39 percent) and iron distribution (34 percent), with variation across the domains.² In terms of equipment, an average of 65 percent of FCHVs had a timer for detecting ARI. FCHVs in rural areas were more likely to have ARI timers than those in urban areas (65 percent versus 36 percent, respectively), which could reflect a higher level of testing and detection of ARI among FCHVs in rural areas compared to urban areas. Only a very small percentage of FCHVs had other equipment, such as iodine test kits and blue plastic cups.

5.2 Availability of Commodities

Although they have other duties, FCHVs' primary functions have been health education and distribution of key program commodities (see Table 9). Clearly, for functions involving use of commodities, FCHVs' effectiveness and reliability as service providers depends on a secure supply chain. Therefore, data collectors noted the health commodities that FCHVs had in their possession during the day of visit.

Availability of basic commodities was mixed. Over half (59 percent) of FCHVs had condoms available on the day of the visit, but the proportion varied across domains. For example, 89 percent of FCHVs in Far-western Terai reporting availability of condoms, compared to 37 percent in Eastern Hill. Availability of oral contraceptives also varied, averaging 58 percent among FCHVs overall, while ranging between 44 and 79 percent according to the location. Also, 64 percent of FCHVs who lived further away from a health facility (>60 minutes) were observed to have pills, compared to 52 percent of FCHVs who lived closer (<30 minutes). However, there were no differences in availability of condoms between FCHVs who lived closer or further away from a health facility.

Overall, the majority of FCHVs (75 percent, 46 percent, and 65 percent, respectively) were observed having oral rehydration solution, vitamin A, and iron, while a plurality (53 percent and 49 percent, respectively) had zinc and cotrimoxazole. Only four domains reported having >70 percent availability of zinc (Mid-western Hill, Mid-western Terai, Far-western Hill, and Far-western Terai) whereas eleven domains reported having >70 percent availability of oral rehydration solution (ORS). 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 HF. This is encouraging, since those living in more

² It should be noted that when data collection for this survey was taking place, a revised health management information system was introduced in which FCHVs received an integrated ward register that replaced the previous ARI and iron registers.

remote wards have less access to other sources of services. Notably, FCHVs from these more remote wards were likely to have cotrimoxazole (59 percent), whereas those living less than 30 minutes from the HF were not (40 percent) (Annex 13). In addition, FCHVs in rural areas had more stock than urban areas across all commodities. This might be because clients in urban areas were more likely to visit health facilities or hospitals than FCHVs for medicines.

Table 9. Percent Distribution of FCHVs by Availability of Commodities

Characteristic	Condom*	Pills*	ORS packet*	Zinc tablets*	Cotrimoxazole*	Iron*	Vitamin A*
Total N (denominator)	4,302						
Domain							
Eastern Mountain	47	45	78	44	60	48	33
Eastern Hill	37	48	72	43	47	44	32
Eastern Terai	58	65	67	51	47	64	59
Central Mountain	41	44	82	38	34	41	30
Central Hill	49	63	80	55	41	61	52
Central Terai	70	48	60	44	36	67	51
Western Mountain	54	59	76	60	63	71	30
Western Hill	65	64	81	57	51	70	50
Western Terai	61	59	75	37	22	63	50
Mid-western Hill	70	79	81	71	70	79	45
Mid-western Terai	86	70	87	73	65	88	43
Far-western Hill	65	39	84	71	68	74	41
Far-western Terai	89	74	93	72	44	85	41
Time to closest HF							
<30 min	58	52	71	49	40	59	45
30-60 min	62	59	76	54	49	68	47
>60 min	58	64	80	59	59	67	45
NATIONAL	59	58	75	53	49	65	46

*Significant difference between domains $p < 0.05$. For more details see Annex 13.

Availability of commodities for certain programs was only calculated for FCHVs in districts where these activities had been introduced. Four such commodities were assessed, as shown in Annex 13. CHX was present with just over half of FCHVs (52 percent), and coverage was particularly low in program districts in Western and Eastern Mountain domains (34 percent and 40 percent, respectively). The Balvita multi-micronutrient supplement was available among 33 percent of FCHVs in program districts. This was quite variable, with especially low availability in Central Terai and Central Hill (6 percent and 7 percent, respectively). Similarly, low availability was documented for pregnancy test kits: an average of 26 percent of FCHVs had such kits with them. Of the commodity-dependent programs considered, the poorest-performing was *matri suraksha chaki* (misoprostol); only 15 percent of FCHVs in program districts had misoprostol on the day of the visit. Positive outliers included FCHVs in program districts in Western Terai (35 percent), Mid-western Terai (26 percent), and Western Mountain (25 percent). The list of districts for specific programs can be found in Annex 14.

5.3 Availability of Job Aids

As Table 10 illustrates, observers documented mixed availability of job aids. While 59 percent of FCHVs overall were observed having the basic flip chart, this varied among domains, ranging from 41

percent in Central Hill to 72 percent in Far-Western Terai; and from 40 percent in urban areas to 59 percent among rural FCHVs. Forty-eight percent of FCHVs were observed having an ARI classification card, and between 50 and 60 percent FCHVs reported having job aids on cotrimoxazole, zinc, and a home therapy card (58 percent). Sixty-eight percent of FCHVs on average reported having the FCHV manual, with minimal differences across domains. Availability of job aids was higher among rural than urban FCHVs. Importantly, one-third of FCHVs did not have a BPP flip chart (Annex 15).

Table 10. Percent Distribution of FCHVs by Availability of Job Aids

	ARI classification card ^{ab}	Cotrim card ^{abc}	Zinc card ^{ab}	Home therapy card ^{ab}	CHX/ Kawach card ^{ab}	Chlorhexidine doll ^{ab}	Basic flip chart ^{ab}	FCHV sign board ^{ab}	FCHV Manual ^a	BPP flip chart ^{ab}	BPP action card ^{ab}
DENOMINATOR (N)	4,302				2,626[†]		4,302				
Geographic area											
Urban	23	23	25	28	21	30	40	28	63	41	26
Rural	49	55	57	58	50	69	59	50	68	67	43
NATIONAL	48	55	57	58	50	69	59	50	68	67	43

^aSignificant difference between domains $p < 0.05$; ^bsignificant difference between residence $p < 0.05$; ^csignificant difference between time to closest HF $p < 0.05$; [†]program districts only.

CHAPTER 6: SUPPORT RECEIVED BY FCHVS

6.1 Training and Meetings

Virtually all FCHVs (96 percent) have had basic training (although in Eastern Mountain, the proportion was lower at 89 percent) (Annex 16). The majority (78 percent) reported having participated in an FCHV meeting at their local HF within the past month, and 65 percent said that they had taken part in a two-day review meeting within the past six months. Only 2 percent and 6 percent, respectively, had not taken part in an FCHV meeting at their local HF or a two-day review meeting during the past year.

6.2 FCHVs' Sources of Information

The two most common sources of information for FCHVs were health workers (91 percent) and meetings/trainings (71 percent). Twenty-four percent reported getting health information through television and 46 percent through the radio (Annex 17).

6.3 Contact with Health Workers and Supervisors

Almost all FCHVs (96 percent) reported having had some contact with health workers from their local health facility, whom they considered to be their supervisors, over the preceding month (Table 11). Generally, this contact took place at the HF (77 percent) and can be presumed to correspond to visits made for FCHV meetings or to submit reports. For about half of FCHVs (48 percent), the designated contacts are cadres who have traditionally been responsible for this function - former maternal and child health workers (MCHWs) and former village health workers (VHWs). Almost as many (42 percent) reported that their main contact was a health assistant (HA) or senior auxiliary health worker (AHW) (in most cases, the facility in-charge). Forty-eight percent of FCHVs reported contact with their supervisors within the last seven days. The proportion reporting contact in the past week was lower (39 percent) among FCHVs living further away from the health facility (>60 minutes) than among those living within 30 minutes from a facility (56 percent), as would be expected. See Annex 18 for details.

Table 11. Percent Distribution of FCHVs by Contact with Supervisors

	Supervisor for FCHV work ^{ad}					Last time FCHV had contact with supervisor ^{be}					Where FCHV had contact with supervisor ^{ade}				
	H.A./Sr. AHW/AHW	Staff nurse/Sr. ANM/ANM	AHW (Upgraded VHW)	ANM (Upgraded MCHW)	Other	Within last 7 days	1 wk 1 month	1 12 months	More than a year	Don't know/Never	Home of FCHV	Immunization clinic	PHC/ORC	Health Facility	Others
DENOMINATOR (N)	4,302					4,302					4,302				
Domain															
Eastern Mountain	62	11	15	12	0	45	46	7	0	2	6	4	2	84	5
Eastern Hill	62	12	9	16	0	48	49	2	0	1	4	6	2	84	4
Eastern Terai	40	7	21	31	0	60	37	2	0	2	7	8	4	77	3
Central Mountain	21	6	26	46	0	43	51	6	0	0	8	7	5	75	5
Central Hill	39	8	20	33	0	45	49	5	0	1	9	5	3	78	5
Central Terai	50	8	14	27	0	59	39	1	0	1	8	6	2	79	6
Western Mountain	43	8	24	24	1	34	57	9	0	1	9	5	2	76	8
Western Hill	41	9	17	32	1	41	54	5	0	0	13	9	4	67	6
Western Terai	24	6	25	44	1	56	41	3	0	0	4	11	5	78	2
Mid-western Hill	44	11	19	26	0	35	60	3	0	2	5	10	3	78	4
Mid-western Terai	19	12	29	39	0	64	35	1	0	0	5	14	8	71	3
Far-western Hill	26	13	16	45	0	48	50	2	0	1	4	7	5	79	5
Far-western Terai	50	3	18	29	0	49	48	1	0	1	4	6	3	86	2
NATIONAL	42	9	18	30	0	48	48	3	0	1	8	7	3	77	2

^aSignificant difference between domains $p < 0.05$; ^bsignificant difference between literacy levels $p < 0.05$; ^csignificant difference between age $p < 0.05$; ^dsignificant difference between residence $p < 0.05$; ^esignificant difference between time to closest HF $p < 0.05$.

“We visit community for supervision during vaccination program and PHC ORC (outreach clinic in specific place once in a month). We observed the participation of FCHV in these programs. I 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.” –KII, HA FCHVs, 2014.

“Every month we conduct meeting with all FCHV and staff of health facility. During this meeting, discuss about the coverage, challenges, and progress of the regular and new health program conducted by FCHV. We also plan for supervision visit during this meeting so that we could meet them in field and rectify the issue at field level.” –KII, HP IN CHARGE OF FCHVs, 2014.

Stakeholders gave mixed reports about how supervision of FCHVs was taking place. District-level FP supervisors reported that they regularly visited villages and FCHVs for training, providing feedback, and hearing how FCHVs are performing from the community. The person in charge of one health post said that the upgraded ANMs and AHWs visited the ward every month to monitor FCHVs and mothers group meetings and review records and reports. FCHVs from marginalized areas said that ANMs visited the wards, attended health mothers group (HMG) meetings, and helped explain key health messages. An AHW added that she sometimes called on district supervisors to clear confusion over program details. In addition, health workers from remote VDCs said that they met with FCHVs every month to discuss challenges and progress, and planned jointly for supervision in the field. These findings are interesting, given that the quantitative results show that 77 percent of such contacts took place at the health facilities and not within the wards.

In addition, FCHVs reported some challenges. FCHVs from a remote VDC said that they had not received any monitoring or supervision from health facilities or district-level staff. The same FCHVs said that when they went to drop their reports at the health post every month, the health post in-charge was sometimes not available. These FCHVs stated that they wanted more regular feedback from health staff or supervisors so they could perform better. FCHVs from another VDC said that often they were unable to meet with supervisors in the ward, because the supervisors usually came to the ward without letting the FCHVs know ahead of time. This survey did not explore in detail the type of activities conducted during supervision; nor were any supervision visits observed. Further research is warranted to better understand how supervision of FCHVs is actually taking place.

6.4 Incentives

Table 12 illustrates FCHVs' report of incentives received. The most important incentive in monetary terms is the "dress allowance." Virtually all FCHVs (96 percent) reported having received it in the past year (Annex 19), and virtually all reported that they received NPRs 4,000. Of those reporting receiving other incentives, the one most commonly reported was money (79 percent). However, only 58 percent of urban FCHVs reported receiving financial incentives (not specific to whether this was a travel allowance), compared to 79 percent of rural FCHVs. In addition, FCHVs from three domains—Western Terai (48 percent), Far-western Terai (35 percent), and Far-western Hill (58 percent)—were the least likely to report receipt of financial incentives.

One of the most common themes that came out in interviews with respondents at all levels was that the incentive arrangements currently in place for FCHVs are not adequate. A FP supervisor and community beneficiaries from different areas said that incentives have remained the same even though the number of activities that FCHVs conduct has increased. Note, however, that during the time the study was being conducted, the Government made the decision to double the FCHVs' daily allowance, from NPRs 200 to 400, although this had not yet been put into effect at the time data were being gathered.

Table 12. Percent Distribution of FCHVs Who Received Work Incentives

Characteristics	Received dress allowance in the past year	Average Dress allowance amount received (NPR)	Received incentives or anything other than dress allowance in past year*	Incentives received								
				Money*	Sari/shawl*	Bag*	Box	Umbrella*	Torch light	Cycle	Recognition/appreciation*	Others*
N	4,302	4,068**	4,302	1,567***								
Domain												
Eastern Mountain	90	3,970	38	83	10	15	4	0	0	0	18	14
Eastern Hill	95	3,981	36	88	8	6	7	3	6	0	6	2
Eastern Terai	97	3,983	29	75	2	17	5	7	3	0	2	5
Central Mountain	96	4,071	34	83	6	2	3	1	0	0	13	10
Central Hill	95	3,971	44	95	4	1	0	2	0	0	7	2
Central Terai	97	3,987	27	70	2	21	4	26	6	0	2	9
Western Mountain	94	3,895	43	82	3	8	3	1	0	0	4	16
Western Hill	95	3,988	34	89	2	4	3	3	1	0	13	4
Western Terai	96	3,977	43	48	13	7	3	18	3	11	15	18
Mid-western Hill	97	4,004	28	92	2	5	0	3	1	0	2	2
Mid-western Terai	99	4,007	37	80	0	4	0	4	10	7	4	13
Far-western Hill	95	3,830	54	58	35	3	1	1	0	0	10	38
Far-western Terai	97	3,991	35	35	16	0	15	2	1	31	0	38
Geographic area												
Urban	97	3,964	24	58	5	16	11	15	7	0	15	19
Rural	95	3,974	36	79	7	8	3	6	2	1	7	10
National	96	3,974	36	79	7	8	3	6	2	1	7	10

*Significant difference between domains $p < 0.05$; **only includes FCHVs who reported receiving a dress allowance in the year prior to the survey; ***only includes FCHVs who reported receiving incentives in the past year. For more details see Annex 19.

This concern about inadequate allowances was expressed by others in charge of health posts, who stated that they felt helpless when FCHVs complained about incentives. They said that since there was no clear policy on the incentive amounts for FCHVs, different organizations provided different amounts for food, transportation, and attending meetings. It is acknowledged, however, that all external development partners know that there are standard rates for incentives, so these differences in perceptions on incentives may reveal misconceptions by these respondents. Health workers thought there was a need to increase the travel and snack allowance for FCHVs (as mentioned above, such a policy change actually happened during the period of data-gathering). They also thought that FCHVs should receive an incentive every month when they submitted their report to the health post. Along the same lines, a key informant from a District Health Office said that FCHVs should receive incentives for conducting ward visits, and increased travel allowances. Other suggested incentives included allowances for special festivals such as Dasain, recharging of phones, and bicycles for transportation.

6.5 FCHV Fund

The FCHV fund is established at VDC and district development committee (DDC) levels and is used as a source of motivation for FCHVs. Funding from the government is deposited in the FCHV fund for use in accordance with FCHV guidelines. The FCHV fund allows FCHVs to borrow money for income-generating activities. Other sources of income or donations can also be deposited in the FCHV fund. In this survey, some FCHVs reported that some NGOs, VDCs, and DDCs supplemented government contributions to the FCHV funds.

Virtually all FCHVs (97 percent) reported having an FCHV fund in their VDC. Around 50 percent of FCHVs reported having between NPRs 50,000-100,000 in their fund, followed by 24 percent of FCHVs who reported having > NPRs 100,000, highest in Mid-western Terai, where 50 percent of FCHVs reported this amount. Sixty percent report having drawn on the fund (normally as a loan) over the past year. There is an age gradient, with older FCHVs more likely to report having used the fund (64 percent among those 55+). In addition, 60 percent of rural FCHVs reported having used the fund compared to 32 percent of urban FCHVs (see Table 13). See Annex 20 for details.

Table 13. Percent Distribution of FCHVs Who Reported on FCHV Fund Details in their VDC

Characteristics	Have FCHV fund in VDC	Amount of money in fund at present ^a				Used money from FCHV fund in last 1 year prior to survey
		<50,000 NPRs	50,000 100,000 NPRs	>100,000	Don't know	
Total N (denominator)	4,302	4,142*				4,142**
Age						
<25 yr	87	7	50	17	26	44
25-39 yr	97	5	51	25	20	58
40-54 yr	98	6	52	25	18	62
55+ yr	96	9	47	19	26	64
Geographic area						
Urban	93	9	25	36	30	32
Rural	97	6	51	24	20	60
NATIONAL	97	6	50	24	20	60

^aSignificant difference between domains $p < 0.05$; **only includes FCHVs reported having FCHVs fund in VDC. For more details see Annex 20.

One representative from the District Health Office said that in his district, FCHV orientation on the FCHV fund was becoming an annual activity. However, a program officer from the DDC in another district said that FCHVs need training on how to manage the FCHV fund. FCHVs from urban areas stated that they were under the impression that there were no guidelines for managing the FCHV fund in urban areas. Another FP supervisor stated that FCHVs do not get specific training on how to use these funds, and that there was no auditing system, so information on how and if FCHVs use this fund was limited.

In FGD discussions, some FCHVs stated that they would use money from the FCHV fund for income generation and for educating their children.

“Some of the FCHVs are taking loan from this fund ranging from 4,000 to 6,000 rupees. The money is used for domestic work and cattle farming (goat, vegetables). We meet every 6 months to review this account.” –FGD, remote FCHVs, 2014.

These FCHVs stated that sometimes NGOs deposited incentives into the FCHV fund for specific activities or campaigns (e.g., Vitamin A), but that this did not happen immediately after the completion of the activity or campaign. During district- and national-level interviews with international NGOs (INGOs), it was suggested that additional incentives to motivate FCHVs should be added to the fund, and that the DDC and VDC should contribute more to the fund.

6.6 Involvement with Networks/Associations OR Committees/Groups

Among FCHVs surveyed, one in five FCHVs (19 percent) reported knowing of the existence of an active FCHV network or association in their district (see Table 14). A higher percentage of urban than rural FCHVs knew about such groups (36 percent versus 18 percent). Of the 19 percent who knew about the network, just over half (54 percent) reported being involved. So overall, about 10 percent reported being associated with an organization addressing FCHV benefits and working conditions (Annex 21). Sixty-one percent of FCHVs reported being involved in other local committees/groups, with the majority, 46 percent, saying they were involved with the saving and credit cooperatives. Involvement was also common in women’s development committees (28 percent) and agricultural groups (22 percent) as reported by FCHVs in this survey.

There were some regional variations in terms of participation in such groups. For example, 66 percent of FCHVs from Far Western Terai reported participating in saving and credit cooperatives compared to 39 percent of FCHVs in Mid-Western Hill. However, since this survey did not go into depth on the type of FCHV involvement in these groups, further research is warranted to obtain a better understanding on this topic.

Table 14. Percent of FCHVs by Involvement in Network/Associations or Committees/Groups

		DENOMINATOR (N)	URBAN	RURAL	NATIONAL
FCHVs with active FCHV network/association present in district ^{ab}	Yes	4,302	36	18	19
	No		48	44	44
	Don't know		17	38	37
FCHVs reporting and being associated with any organization or association dealing with FCHV benefits	Yes	870*	64	54	54
	No		35	46	46
	Don't want to disclose		1	0	0
FCHVs involved in any other local committees/ groups ^a		4,302	65	61	61
Type of committee	VDC/DDC committee ^{ab}	2,706**	2	6	6
	Community forest ^a		13	16	16
	Agricultural group ^{ab}		10	22	22
	HFOMC ^a		8	12	12
	School management committee ^{ab}		6	13	13
	Water and sanitation ^{ab}		7	14	14
	Political group ^b		10	3	3
	Ward citizen's forum ^a		13	15	15
	Saving and credit cooperatives ^a		53	46	46
	Women development committee ^{ab}		19	28	28
	Others ^{ab}		37	28	28

^aSignificant difference between domains $p < 0.05$; ^bsignificant difference between residence $p < 0.05$; *only includes FCHVs who reported active FCHV network/association present in district; **only includes FCHVs who reported being involved in any of the other local committee/groups.

CHAPTER 7: SERVICES PROVIDED BY FCHVS

FCHVs were asked what types of services they provided as part of their work; subsequently they were asked specific questions about the types of services provided in the three months preceding the survey. Results are presented in the sections below and quantified in the respective Tables and Annexes.

7.1 Child Health

VITAMIN A/DEWORMING

The twice-annual vitamin A supplement distribution has relied primarily on FCHVs for delivering vitamin A to beneficiaries (Table 15). Essentially all FCHVs (99 percent) report having participated in the most recent round of vitamin A distribution, with minimal variation across domains and demographic characteristics. See Annexes 22 and 23 for details on child health activities.

DIARRHEA, PNEUMONIA, AND ARI TREATMENT

Table 15. Percent Distribution of all FCHVs Who Engaged in Child Health Activities in the Three Months Prior to the Survey

Characteristics	FCHV gave ORS to children suffering from diarrhea*	Average number of children suffering from diarrhea who were given ORS by FCHV	FCHV gave zinc tablets to children suffering from diarrhea	Average number of children suffering from diarrhea who were given zinc tablet by FCHV	FCHV examined children for cough and cold*	Average number of children examined for cough and cold by FCHV	FCHV provided cotrimoxazole for possible pneumonia cases	Average number of children given cotrimoxazole by FCHV for possible pneumonia
Total denominator (N)	4,302	2,250**	4,302	1,924**	4,302	1,933**	4,302	1,047**
Domains								
Eastern Mountain	35	9.4	24	6.6	31	5.8	25	3.6
Eastern Hill	52	7.5	41	6.2	40	7.8	28	4.5
Eastern Terai	69	8.8	64	8.1	63	11.3	37	5.7
Central Mountain	32	8.8	20	7.4	22	6.8	7	5.0
Central Hill	54	8.1	45	6.5	30	7.9	15	5.3
Central Terai	42	8.1	43	7.8	41	8.2	23	5.1
Western Mountain	25	13.4	23	12.5	24	10.8	14	7.1
Western Hill	48	5.7	33	6.3	45	6.4	17	3.4
Western Terai	61	12.5	49	17.3	50	8.7	17	4.3
Mid-western Hill	61	7.9	58	14.1	55	8.8	42	4.2
Mid-western Terai	65	8.5	66	10	70	12.4	37	7.5
Far-western Hill	71	8.1	65	8.7	66	10.6	40	4.8
Far-western Terai	83	8.4	71	7.8	67	10.7	27	6.7
NATIONAL	52	8.3	44	8.9	44	8.8	24	4.9

*Significant differences between domains $p < 0.05$; **denominator includes only FCHVs who recorded providing medicine/treatment for >0 children suffering from specific illness. More details found in Annex 23.

When asked about services provided for children in the last three months, an average of 52 percent of all FCHVs reported providing ORS for children suffering from diarrhea, with significant variation across domains. It was expected that a higher percentage of FCHVs would have reported providing ORS, but given the timing of this survey, which took place between August 2014 and March 2015, data collection was mostly done after the monsoon season. Twenty-five percent and 35 percent of FCHVs in Western Mountain and Eastern Mountain, respectively, reported providing ORS, compared to 71 percent of FCHVs in Far-western Hill and 83 percent in Far-western Terai. Only 44 percent of all FCHVs reported providing zinc tablets to children suffering from diarrhea, but again there was variation among FCHVs from different domains. Provision of zinc also varied, ranging from a reported 20 percent in Central Mountain to 71 percent among FCHVs in Far-Western Terai. 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. In addition, 27 percent of FCHVs living > 60 minutes away from a health facility reported treating pneumonia with cotrimoxazole, compared to 20 percent of FCHVs living < 30 minutes away from a health facility. For pneumonia diagnostic equipment, 65 percent of FCHVs had a timer; with FCHVs from rural areas were more likely to have these timers than those in urban areas (65 percent versus 36 percent).

IMMUNIZATION ACTIVITIES

Of 4,302 FCHVs, 64 percent reported saying that an immunization clinic had taken place in their ward. This proportion rises to 84 percent for FCHVs living more than an hour away from their HF and drops to 42 percent among urban FCHVs. For wards where such outreach is held, almost all FCHVs reported being involved (91 percent). In the last three months, the immunization clinics were conducted about twice and on average were supported by FCHVs in all domains. Among FCHVs who reported providing support to at least one immunization clinic during the past three months, 75 percent referred clients to the immunization clinics. There were variations between domains (Annex 22). 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.

7.2 Family Planning and PHC/Outreach Clinic

FAMILY PLANNING COUNSELING

All FCHVs were asked if they provided FP counseling services in the three months prior to the survey; 97 percent reported having provided at least some (Table 16). This counseling was most often provided during contacts with pregnant or postpartum women (83 percent and 79 percent, respectively), although almost two-thirds of FCHVs (63 percent) also reported having provided such counseling to other adult women over that period. On average, only 28 percent of FCHVs reported providing FP counseling to newly married couples, and only 15 percent of FCHVs provided counseling to women who had undergone an abortion. Interestingly, only 8 percent of older FCHVs (55+ years) reported providing FP counseling to women following an abortion, compared to 18 percent of younger women (<25 years) FCHVs. In addition, 41 percent of FCHVs reported providing FP counseling to adolescents, and 34 percent provided FP counseling to returnee migrants. Some regional variation was found in the results. For example, 26 percent of FCHVs in Eastern Hill reported provided FP counseling to adolescents compared to 62 percent in Far-Western Terai (Annex 24).

Table 16. Percent Distribution of all FCHVs Who Provided Family Planning Counseling, by Background Characteristics

Characteristics	Ever provided family planning counseling in the 3 months prior to survey*	In the last 3 months, provided counseling on family planning							
		Pregnant woman	Postnatal woman	Newly married couple	Woman undergone abortion	Adolescent	Returnee migrant	Other adult male	Other adult female
N	4,302*	4,302	4,302	4,302	4,302	4,302	4,302	4,302	4,302
Domain									
Eastern Mountain	93	88	68	30	8	32	22	24	32
Eastern Hill	94	79	69	20	7	26	21	21	29
Eastern Terai	99	93	93	37	17	50	35	50	83
Central Mountain	91	64	58	30	7	40	24	46	72
Central Hill	97	74	73	25	11	35	18	29	53
Central Terai	99	92	92	19	13	37	41	37	74
Western Mountain	93	84	76	36	23	43	25	46	54
Western Hill	97	71	70	28	14	37	45	55	64
Western Terai	98	94	89	35	27	58	55	49	84
Mid-western Hill	99	87	82	36	17	44	33	60	75
Mid-western Terai	100	98	89	32	19	47	34	35	67
Far-western Hill	99	86	74	31	20	54	38	49	68
Far-western Terai	99	94	85	32	27	62	25	34	44
NATIONAL	97	83	79	28	15	41	34	42	63

*Calculated if FCHVs said yes to providing FP counseling to any clients listed in the table within the 3 months prior to the survey. For more details, see Annex 24.

Among FCHVs who had reported on contraceptive distribution in their registers, 68 percent and 67 percent, respectively, reported having distributed condoms and oral contraceptives over the past three months (Table 17). Proportions 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). In addition, 74 percent of illiterate FCHVs reported distributing condoms in the previous three months, compared to 67 percent of literate FCHVs. The opposite was found for pill distribution, with 68 percent of illiterate and 60 percent of literate FCHVs reporting that they had provided pills. See Annex 25 for details.

Table 17. Percent Distribution of all FCHVs Who Distributed Condoms or Pills in the 3 Months Prior to the Survey

Characteristics		DENOMINATOR (N)	Eastern Mountain	Eastern Hill	Eastern Terai	Central Mountain	Central Hill	Central Terai	Western Mountain	Western Hill	Western Terai	Mid western Hill	Mid western Terai	Far western Hill	Far western Terai	Illiterate	Literate	NATIONAL	
Condoms (%)	Ever distributed condoms in the 3 months prior to survey ^{ac}	2,664 [^]	47	42	79	29	48	89	77	61	78	73	91	76	97	74	67	68	
	No. of condoms ^{ae}	<50	1,859 ^{^^}	94	67	29	74	60	44	63	66	50	45	18	37	7	43	48	47
		51-100		2	22	38	11	21	30	28	14	19	29	25	30	17	29	24	25
		100+		5	11	33	14	19	27	8	20	31	26	57	33	76	28	28	28
	Mean	No. of condoms		20	50	99	59	68	80	54	63	94	79	136	105	226	81	86	85
	Missing data	Register submitted	1,638 [†]	43	13	42	29	51	55	56	25	30	36	42	62	66	41	41	41
		Incomplete record		42	43	42	52	30	35	16	50	47	49	42	27	19	35	39	38
No register		16		44	16	19	20	10	27	24	22	15	17	10	15	24	20	21	
Pills (%)	Ever distributed pills in the 3 months prior to survey ^{abe}	2,661 [*]	46	61	82	43	59	67	56	68	79	77	77	48	83	60	68	67	
	No. of cycle (packet) ^{ad}	1-5	1,774 ^{**}	65	34	28	59	39	46	52	58	46	51	25	61	16	51	43	44
		6-10		24	37	27	30	38	35	22	26	29	31	32	25	33	31	31	31
		10+		12	28	45	11	23	19	26	15	24	17	43	13	51	18	26	25
	Mean no. of cycles		5	10	13	6	9	9	9	6	8	7	12	7	18	7	9	9	
	Missing data	Register submitted	1,641 [†]	43	13	41	28	50	55	57	26	31	36	43	58	69	41	41	41
		Incomplete record		42	43	42	53	31	35	15	50	47	48	40	32	20	36	39	38
No register		16		44	16	19	19	10	28	24	23	16	17	10	11	24	20	21	

Significant difference between ^adomains p<0.05; ^bliteracy p<0.05; ^cage p<0.05; ^dresidence p<0.05; ^etime to closest HF p<0.05; [^]only includes FCHVs who have data on whether condoms were distributed or not in the 3 months prior to survey and does not include those with missing data; ^{^^}only includes FCHVs who distributed at least one condom in the 3 months prior to survey; ^{*}only includes FCHVs who have data on whether pills were distributed or not in the 3 months prior to the survey and does not include those with missing data; ^{**}only includes FCHVs who distributed at least one cycle of pills in the 3 months prior to survey; [†]FCHVs missing data on condoms or pills were not included in denominators for other columns. For more details see Annex 25.

Thirty-one percent of FCHVs reported referring women for sterilization, with the lowest proportion of referrals in Central Terai (11 percent of FCHVs) and the highest in Central Mountain (46 percent). By comparison, 45 percent of FCHVs reported providing referrals for male sterilization, with 64 to 70 percent of FCHVs reporting referrals in Eastern, Central, and Western Terai. Also, 27 percent of FCHVs under age 25 reported providing referrals for male sterilization, compared to half of those aged 55 years or older (Annex 27).

PHC/ORC ACTIVITIES

FCHVs support routine outreach activities in their wards, notably primary health care and immunization outreach services (PHC/ORC). Half (52 percent) of FCHVs reported that PHC outreach clinics were held in their wards (Annex 27). As expected, the proportion was higher in more remote wards (59 percent reported by FCHVs living 30–60 minutes from their HF; 73 percent among those living more than an hour away). In addition, 53 percent of rural FCHVs reported that a clinic had been conducted in their catchment area, compared to 20 percent of urban FCHVs. FCHVs from Central Mountain were least likely to report providing referrals to the PHC/ORC (38 percent), followed by Eastern Hill, Western Hill, and Eastern Mountain where a little more than half of the FCHVs reported doing this (51, 56, and 58 percent respectively). In all other domains, >70 percent of FCHVs reported providing referrals, with the highest percentage in Eastern Terai (92 percent). Sixty-eight percent of FCHVs living more than 60 minutes away from the closest health facility reported providing referrals, compared to 78 percent of those who were located less than 30 minutes away. Across most domains, high proportion (>80 percent) of FCHVs reported attending outreach clinics to provide assistance.

7.3 Nutrition

Of the 4,302 FCHVs surveyed, around 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, as shown in Table 18. Fifteen districts were implementing the Balvita (micronutrient supplement) program at the time of the survey (referenced in Annex 14). Questions related to the distribution of Balvita were asked only in domains where the program was active. In these districts, 39 percent of the 939 participating FCHVs reported having done at least some distribution over the preceding three months.

Table 18. Percent Distribution of FCHVs Who Provided Nutrition-related Activities in 3 Months Prior to Survey

Characteristics	Distributed Balvita to children	Counseling pregnant woman on nutrition	Providing nutritional education on breastfeeding	Counseling on infant and young child feeding complementary feeding ^{cde}	Health education on sanitation	Provided counseling to or referred malnourished children for care ^b
Total N (denominator)	939*	4,302	4,302	4,302	4,302	4,302
Literacy						
Illiterate	37	91	92	88	94	12
Literate	39	91	92	89	94	9
Age						
<25 yrs	26	87	87	75	85	10
25-39 yrs	40	92	92	89	95	9
40-54 yrs	39	91	92	90	95	10
55+ yrs	38	93	92	88	94	9
Geographic area						
Urban	34	91	90	84	92	14
Rural	39	91	92	89	94	9
Time to closest HF						
<30 min	32	91	92	89	94	9
30-60 min	42	92	93	90	95	9
>60 min	41	90	90	86	94	10
NATIONAL	39	91	92	89	94	9

*Only in districts where Balvita program was active.

7.4 Pregnancy and Newborn Care

ADVICE PROVIDED TO PREGNANT WOMEN

As Table 19a shows, a very high proportion of FCHVs (93 percent) reported having provided at least some counseling to pregnant women over the preceding three months. On average, these FCHVs had seen four pregnant women over that period. Respondents were asked (unprompted) what advice they gave pregnant women (Table 19b). The four most common responses were ANC check-up (95 percent), tetanus injections (74 percent), taking iron tablets (87 percent), and eating nutritious food during pregnancy (89 percent). Approximately half of all FCHVs reported that they advised women to deliver in a health facility and to take deworming pills (46 percent and 51 percent, respectively). Literate FCHVs were somewhat more likely to provide advice on tetanus injections, taking deworming pills, and delivering in a health facility; and rural FCHVs were more likely than their urban counterparts to promote deworming pills. Reported counseling was much less common for family planning (10 percent), night blindness (7 percent), and saving money and making emergency transportation plans (9 percent). There was no difference on these responses between Community-based Newborn Care Program (CBNCP) and non-CBNCP districts (see Annex 28).

Table 19a. Percent Distribution of FCHVs Who Had Given Information, Advice, or Service about Pregnancy to at Least One Pregnant Woman in the 3 Months Prior to Survey

Characteristics	Provided information, advice or services about pregnancy to at least one pregnant woman in the 3 months prior to survey ^a	Average number of pregnant women given information, advice or services about pregnancy in the 3 months prior to survey
DENOMINATOR (N)	4,234*	3,956**
Literacy		
Illiterate	93	5
Literate	93	4.6
Geographic area		
Urban	93	6.1
Rural	93	4.6
NATIONAL	93	4.7

^aSignificant difference between domains $p < 0.05$; *only includes FCHVs who reported at least one pregnant woman in their catchment/ward area in the last year; **only includes FCHVs who reported providing information, advice or services about pregnancy to at least one pregnant woman in the 3 months prior to survey. For more detail see Annex 28.

Table 19b. Percent Distribution of FCHVs by Advice Provided to Pregnant Women about Pregnancy Care

Characteristics	What is the advice that you provide to pregnant women about pregnancy care? (unprompted)											
	ANC checkup ^{a,r}	Injecting tetanus ^{abf}	Having iron tablets ^{abdf}	Related to night blindness ^a	Related to deworming tablets ^{abcde}	Related to dangerous signs ^{abd}	Related to giving birth at a HF ^{abd}	Making arrangements for transportation in case of emergency and saving money ^{abef}	Eating nutritious food ^a	Family Planning ^a	Others ^{acdf}	Don't know
DENOMINATOR (N)	4,302											
Literacy												
Illiterate	95	68	83	4	36	17	38	7	91	10	36	0
Literate	96	75	88	7	54	24	47	10	89	10	40	0
Geographic area												
Urban	97	70	79	7	39	29	54	11	92	12	46	0
Rural	95	74	87	7	51	23	46	9	89	10	39	0
NATIONAL	95	74	87	7	51	23	46	9	89	10	39	0

^aSignificant difference between domains $p < 0.05$; ^bsignificant difference between literacy levels $p < 0.05$; ^csignificant difference between age $p < 0.05$; ^dsignificant difference between residence $p < 0.05$; ^esignificant difference between time to closest HF $p < 0.05$; ^fsignificant difference between CB-NCP districts $p < 0.05$. For more detail see Annex 28.

KNOWLEDGE OF PREGNANCY COMPLICATIONS

The survey assessed the knowledge of FCHVs about danger signs or complications related to pregnancy that required medical attention. When asked (unprompted) to list danger signs in pregnancy, almost all (91 percent) mentioned vaginal bleeding. Most mentioned severe headache (77 percent), seizures (62 percent), severe abdominal pain (60 percent), and swelling of hands and face (59 percent) (Annex 29). Comparatively few (30 percent) mentioned blurred vision. There were some regional variations as well. Fifty three percent of FCHVs from Central Mountain compared to 84 percent of Mid-western Terai, listed fits and unconsciousness as a danger sign. Between 45 percent to 77 percent of FCHVs across domains reported swelling of hands and face as a danger sign; and interestingly, 64 percent of older FCHVs (55+years) listed this danger sign, compared to 49 percent of younger FCHVs (<25 years). Similarly, between 45 and 87 percent of FCHVs across domains listed severe lower abdominal pain as a danger sign.

PROVISION OF PREGNANCY- AND NEWBORN-RELATED SERVICES

FCHVs from all districts were asked if they had distributed iron tablets to mothers in the preceding three months, and on average 47 percent reported doing so. Fewer urban than rural FCHVs (28 percent versus 47 percent) had provided iron pills. 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).

As mentioned earlier, several programs for mothers and newborns have been introduced in a limited number of districts to date. Only 29 percent of FCHVs said that they had distributed CHX in the CHX districts in the past three months; twice the proportion of older FCHVs (55+years) compared to younger FCHVs (<25 years) had distributed CHX over the same time period (28 versus 14 percent). The proportion distributing CHX varied by domain, with 53 percent of FCHVs in Western Terai reporting such activity, but much lower participation in program districts in Eastern and Western Mountain (15 and 10 percent, respectively) (Annex 30).

Overall, across misoprostol program districts, 10 percent of FCHVs reported having distributed the commodity over the previous three months but in some domains <5 percent of FCHVs reported such activity (Central Hill, Central Terai, Western Hill and Far Western Terai). Among districts where pregnancy tests and abortion counseling have been introduced, 41 percent of FCHVs reported testing a woman for pregnancy in the three months prior to the survey. Thirty-two percent of these FCHVs provided counseling about institutional abortion.

FCHVS RECOGNIZING AND REFERRING FOR NEWBORN COMPLICATIONS

FCHVs were asked (unprompted) for their recall of newborn danger signs. Poor feeding, fever, and fast or difficult breathing were most often mentioned (83 percent, 72, and 67 percent, respectively). Chest in-drawing, cord infection, and hypothermia lethargy were less often recalled (58 percent, 55 percent, 52 percent and 42 percent, respectively). Only one in five FCHVs (19 percent) mentioned very small size at birth. For some dangers signs, regional variations were more pronounced. For example, 25 percent of FCHVs from the Eastern Mountain listed lethargy as a danger sign, compared to 69 percent of FCHVs from Far-western Hill. For cord infection as a danger sign, 33 percent of FCHVs from Central Terai listed this danger sign, compared to 80 percent of FCHVs from Mid-western Terai. Generally, recall was slightly better in districts where CBNCP training had been given (Annex 31).

7.5 Health Mothers Group Meetings

Monthly health mothers group meetings (HMG) are viewed as a routine FCHV activity. The FCHV is expected to share knowledge obtained during basic and refresher training and from reviews and seminars, and members of HMGs are expected to disseminate this and other relevant information to other community members. When FCHVs were asked what activities they perform, only 46 percent reported conducting HMGs. Furthermore, from the questions asked on the survey, it cannot be determined how often health education actually takes place in these meetings (it is known that in many cases meetings are held for the purpose of credit and savings activities, but are called mothers group meetings).

FCHVs were asked about conducting HMG meetings during FGDs. FCHVs from one district reported that they did conduct HMG meetings on a monthly basis, and that these meetings were helpful for sharing knowledge about health as well as new health care/health camps in the area. FCHVs from another district said that the HMG meeting was a forum for discussing such issues as danger signs of pregnancy and delivery, the importance of breastfeeding, and sanitation. They said there had been some challenges getting mothers to come to these meetings, but that more mothers now understand the importance of these meetings, and want updates on how much money is available in the mother's health group savings account; and so they are more willing to attend.

During an interview, a health worker in charge was asked about the roles of FCHVs in monthly meetings. He responded that even though HMGs have been formed, they do not always meet regularly, as reflected in the quantitative data. He added that people do not attend the meetings, and felt that more active FCHVs were needed to make the mother's group functional. Some FCHVs said that the lack of an allowance to buy tea and snacks for HMG meetings made it difficult, because attendees often requested them during meetings. HFOMC members from both remote and non-remote VDCs said it would be helpful if NGOs and/or the VDC would allocate funds for tea and snacks. They also thought that developing audiovisual materials for these meetings would make discussions more effective and encourage more mothers to attend.

CHAPTER 8: PERCEPTIONS OF FCHV PROGRAM

A major theme from the qualitative interviews on the role of FCHVs was that they are a key link between communities and health facilities and play an important role in promoting maternal and child health services.

FCHVs have “built the trust for health-related activities, because they are the first counselor in the community in difficult situations.” –KII, HP INCHARGE FCHV, 2014.

“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.” –KII, AHW FCHV, 2014.

“Yes, we are benefited from FCHV service in many ways. Child deaths are decreased and the mothers are also aware about the risk of home delivery and they prepared us for safe delivery.” – FGD, Community Beneficiaries FCHV, 2014.

“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.” –KII, FP supervisor FCHV, 2014.

“We can discuss with FCHVs openly, we don't feel shame to discuss family planning, pregnancy. We don't feel easy to outsider in this matter. We are satisfied with FCHV's service.” –FGD, Community Beneficiaries FCHV, 2014.

Respondents from the DHO added that FCHVs accompanied mothers and other women to facilities for various services, including primary care, immunization, permanent family planning methods, and institutional deliveries. HFOMC members from a non-remote district mentioned in addition to providing counseling and education on health and sanitation, FCHVs conducted follow-up visits to every household to observe health and sanitation practices.

FCHVs also participated in programs run by NGOs, including Suaahara, a nutrition program, and programs run by international NGOs such as CARE/Nepal. A representative of a Women Development Office (WDO) reported that FCHVs had been mobilized in the eradication of the practice of *Chhaupadi* (isolation of women outside the house during the menstrual period) in this district.

Key informants from WDOs stated that FCHVs helped launch development programs because they understand the community context and are able to break through barriers. As FCHVs establish close relationships with families, trust increases; so any programs that FCHVs facilitate are well received by the community. Similarly, a key informant from a local development office stated that FCHVs have an important role in changing traditional beliefs about health, resulting in increased utilization of health services.

“We always involved FCHVs during our group formation, basic training of the new group, refresher training of the women’s group. FCHVs also [will participate in] the women development program. It is easy to facilitate the program due to presence of FCHVs. FCHVs help understand the community issues, culture, and also barriers of women development. Because they are knowledgeable and have skills to facilitate the process with local community context, family dimensions, etc.” –KII, WDO FCHV, 2014.

Community beneficiaries from both remote and non-remote areas stated that FCHVs take on the leadership of many events at the village level: for example, encouraging women to attend key services during pregnancy and delivery, and to seek child care, including immunization services. These beneficiaries said that sometimes FCHVs helped arrange ambulances for emergencies during delivery. Some community members said that FCHVs had come to their homes and taught them how to prepare ORS to treat diarrhea, and how to take care of newborns. However, community respondents in some more remote communities reported that FCHV visits were infrequent, because FCHVs lived far from the village, so that some communities had not received consistent newborn care household visits. Upon further checking, it was found that this specific district did not receive the CBNCP package, and therefore received minimal household visits for newborn care.

8.1 FCHV Reports on Factors Potentially Influencing Motivation

The 2006 survey addressed FCHVs’ motivation using questions about whether they would like to put in more time, about the same, or less time in the future than at present. Three-quarters (76 percent) responded that they would like to spend more time, 22 percent about the same, and only 2 percent less. The findings were essentially identical in 2014 (75 percent, 22 percent and 3 percent, respectively). As mentioned above, in both the 2006 and 2014 surveys, 20 percent of FCHVs have served in this role for less than five years, corresponding to an annual attrition of 4 percent, which is very low (Annex 32).

This survey also added new questions to assess FCHVs’ motivation. Statements about work were read to FCHVs, who were given the response choices of: completely agree (+2); somewhat agree (+1); neutral/unsure (0); somewhat disagree (-1); or completely disagree (-2). Scores are presented below.

FCHVs scored between 1.5 and 1.9 (between “somewhat agree” and “completely agree”) for statements about happiness in the role, intent to be in the same role in the next five years, community appreciation, increased recognition and respect, familial support for their work, and supervisory support. Interestingly, even though data from this survey showed that commodity availability was lower than expected across all domains, on average, FCHVs said that they had a regular supply of drugs and other supplies. In terms of whether current benefits for FCHVs were adequate to provide services to the communities, the average score was -0.5, or between “unsure” and “somewhat disagree.” As to whether FCHVs were being treated fairly by the government, the average score was 0.2, which is closer to an “unsure” response. When FCHVs were asked if completing forms and registries was a burden, the average score was again -0.5. Finally, when asked whether their work burden as an FCHV had significantly increased as compared to the past, almost all FCHVs completely agreed. See Table 20 for details by region.

Table 20. Score Distributions on Perceptions and Satisfaction of FCHVs

Characteristics	Happy to be an FCHV	5 yrs from now will still be a FCHV	Communities appreciate FCHVs	Working as an FCHV contributed to greater respect in community	Family Supports work as an FCHV	Receive sufficiency support from supervisor	Regular supply of drugs & other supplies	Treated fairly and respectfully by health workers at health facilities	Current provision of benefits is adequate for me to the services I provide to the community	FCHVs are treated fairly by the gov't	Duties as an FCHV interferes with other important responsibilities	Filling in forms or registers related to my FCHV duties is burden to me	As compared to the past, my work burden as an FCHV has significantly increased
Total N (denominator)	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301	4,301
Domain													
Eastern Mountain	1.9	1.8	1.6	1.5	1.8	1.7	1.3	1.6	-0.4	0	0.7	-0.6	1.8
Eastern Hill	1.8	1.7	1.7	1.6	1.9	1.7	1.4	1.7	-0.8	0	0.7	-0.3	1.9
Eastern Terai	1.9	1.8	1.8	1.6	1.9	1.8	1.5	1.7	-0.5	0.6	-0.2	-1	1.8
Central Mountain	1.8	1.7	1.8	1.8	1.9	1.7	1.3	1.7	-0.1	0.5	0.2	-0.7	1.9
Central Hill	1.9	1.8	1.8	1.8	1.9	1.8	1.6	1.8	-0.2	0.1	0.3	-0.6	1.7
Central Terai	1.9	1.8	1.6	1.6	1.8	1.6	1.3	1.6	-1.1	-0.3	0.4	0.1	1.9
Western Mountain	1.9	1.8	1.7	1.7	1.9	1.6	1.1	1.6	0.1	0.7	0.3	-0.1	1.5
Western Hill	1.8	1.7	1.6	1.5	1.9	1.7	1.6	1.7	-0.2	0.1	0.2	-0.9	1.8
Western Terai	1.9	1.8	1.8	1.7	1.9	1.8	1.5	1.7	-0.4	0.9	0	-0.5	1.8
Mid-western Hill	1.8	1.7	1.7	1.4	1.9	1.7	1.6	1.8	-0.6	0.1	0.5	-0.6	1.9
Mid-western Terai	2	2	2	1.9	2	1.9	1.8	1.8	-1.2	-1	0	-0.8	1.9
Far-western Hill	1.9	1.9	1.7	1.7	1.9	1.8	1.7	1.8	-0.6	0.6	0.7	-0.7	1.9
Far-western Terai	1.8	1.8	1.8	1.8	1.9	1.7	1.7	1.7	-0.8	-0.3	0.7	-0.5	1.9
NATIONAL	1.9	1.8	1.7	1.6	1.9	1.7	1.5	1.7	-0.5	0.2	0.3	-0.5	1.8

For more details see Annex 32.

In terms of disaggregated responses (Annex 33 a-h), on average, when FCHVs were asked if they were happy in their roles, 90 percent completely agreed, while 8 percent somewhat agreed. An average of 85 percent of FCHVs completely agreed that they wanted to continue being an FCHV for the next five years, while 11 percent somewhat agreed. However, there were also factors of concern. Two-thirds (66 percent) reported that their FCHV duties sometimes interfered with other important responsibilities, and two in five (39 percent) found filling in forms and registers burdensome. Although somewhat more than half (54 percent) felt the government treats them fairly, 39 percent disagreed. Three out of five FCHVs (60 percent) felt that the benefits they receive for their services are not adequate. About one-third of FCHVs reported that at their health facility, there was a problem with certain health workers not being available at work when they should be (34 percent) or that some services are not being provided properly (33 percent).

This survey also posed questions to FCHVs on six factors that affected their motivation to do this work (Annex 34 a-c). The highest-ranked factor was the opportunity to obtain new knowledge and skills; with 98 percent reported this as very important to them. All FCHVs found that the opportunity to help people in their community be healthy was important to them; 94 percent rated this as very important. Almost all FCHVs valued the respect and recognition they gained in their communities from serving in this role; 90 percent rated this as very important. Similarly, almost all reported as important that their FCHV duties were stimulating and interesting; 85 percent reported this as very important to them. A smaller proportion (76 percent) reported that the opportunity this work provides to contribute to family income is important to them; half reported it as very important (49 percent).

CHAPTER 9: CHALLENGES OF THE FCHV PROGRAM

Highlighted below are a few examples of challenges mentioned by key informants. While an in-depth analysis of the challenges that FCHVs face was beyond the scope of this survey, the examples cited reflect the range of responses and warrant further research.

9.1 Expansion of Services Provided by FCHVs

Some district-level respondents commented that certain health problems within the community require a qualified health professional, rather than an FCHV. One respondent from an HFOMC said, “FCHVs are not technical persons and they can manage minor illness...They might not be a suitable person to provide care for a complicated health problem; there could be adverse effects if not managed appropriately.” However, some respondents from remote districts said that FCHVs should be trained to provide specific curative services. A FP supervisor from a remote district said that most communities depended on FCHVs, because hospital and health facilities were not accessible, and that in some wards the people had to walk more than two days to reach health facilities. Thus, the respondent said, providing additional training for FCHVs was important. Similar opinions were expressed by community members and health workers from several remote districts, as shown in interviewees’ statements below.

“Health facility is located far from this community (one hour walking in stiff geography). We need active FCHVs for this community. It would be better for the FCHV to visit us to respond our primary care according to their task designed by government FCHV program.” –FGD, remote community beneficiaries FCHV 2014.

“Regarding the change in role of FCHV in remote wards where mothers cannot reach the birthing center the FCHV should have some skill to provide primary care to manage delivery care, because all women cannot reach health facility due to distance and cannot manage transportation. In that case FCHVs can help a lot if they have knowledge and skill to handle it.” –KII, health worker remote VDC FCHV, 2014.

“We should increase the roles and responsibilities of FCHV with additional training, because in remote community they are available, health facilities are not accessible to all community.” –KII, health worker, remote VDC, FCHV 2014.

9.2 Retirement of FCHVs

A retiring FCHV will receive a letter and a designated amount of money upon retiring, and will be eligible for benefits experienced by active FCHVs, including free essential health care. Interviews with FP supervisors and members of the WDO revealed a view that the amount awarded to FCHVs at retirement should be increased to encourage older FCHVs to retire when they can no longer perform their duties. An upgraded ANM said during an interview that it is difficult to implement a voluntary retirement policy, because some FCHVs refuse to leave even though they have trouble conducting some activities. Representatives of the WDO and the HFOMC thought that the amount provided for retirement of FCHVs should be correlated with performance and duration of service. Community members felt that the retirement policy should be updated to replace older FCHVs and

FCHVs who have limited or no literacy skills. Similar sentiments were expressed during KIs with health post in-charges.

9.3 Community-Level Challenges

FCHVs reported that sometimes communities did not listen to their advice and refused to accept the information or medicines that they offered to mothers or children. Health workers also pointed out that some communities believed more in traditional healers, and thus did not heed the FCHVs. FCHVs also said that they were sometimes blamed if a mother or child reacted badly to a medicine or became sick.

“Some FCHVs were harassed by the community due to side effects of the medicine distributed to prevent filaria. When we said that we don't know about this then they started to scold us saying 'being a FCHV you should know, you are taking salary for this.' We feel so helpless when we face this kind of problems in the community. We are working so hard and there increasing expectation from the community.” –FGD, FCHV, 2014.

District-level respondents mentioned a developing challenge: increasingly, communities demand high-quality services from all health workers and facilities. When services are not available at health facilities, FCHVs are often blamed, because there is a misperception that FCHVs are salaried health workers from health facilities. FCHVs said that communities sometimes demand that FCHVs make household visits and distribute vitamins and iron tablets, and consider them more as government workers than volunteers.

An AHW who was interviewed said that difficult terrain and the remoteness of some households made it difficult for FCHVs to conduct household visits within communities. Sometimes bridges are washed out, rivers are too deep, and walking to some villages takes more than a day, with nowhere to spend the night.

9.4 Health Facility-Level Challenges

Respondents from the HFOMC stated that some health facilities lacked skilled health workers, waiting rooms for mothers, beds, and other needed items. FCHVs also complained of the lack of medicines and contraceptives at health facilities. Also, given the long distances to health facilities in more remote areas, FCHVs said that it was often difficult to get to the HF because no transportation was available, and that sometimes they had to spend their own money when accompanying mothers to the HF for delivery.

CHAPTER 10: DISCUSSION

The FCHV Program in Nepal was launched in 1988 by the Ministry of Health and Population, with the original goal of providing one FCHV per ward in rural areas. It developed into a remarkably dynamic program, changing and growing to reflect new community health opportunities and population-based needs in Nepal.

Due to this dynamism, changes in the FCHV Strategy, and variations in the survey questionnaires, this section is structured around the findings of the 2014 survey, with limited comparisons to the 2006 FCHV survey. The 2014 national FCHV survey provides significant insights into the functioning of FCHVs and identifies critical issues that should be considered during policy discussions related to FCHVs.

10.1 FCHV Program Successes

The goal of this survey was to describe FCHVs as a group and assess the services they provide, their motivation, the support they receive, and their perceptions of their work. Findings reveal significant program successes:

VERY LOW FCHV DROP-OUT RATE

FCHVs remain in their positions for many years. Only 3 percent of FCHVs have less than one year of service; 20 percent have served for less than five years. This level of attrition is unusually low for health volunteer programs,³ and has not changed since 2006. Moreover, most current FCHVs (98 percent) report that they are happy in their work. Since high drop-out rates are costly to the program, requiring identification, training, and equipping of new FCHVs, this high level of commitment among volunteers is a boon to the program.

VERY HIGH INVOLVEMENT IN MULTIPLE PROGRAMS

Traditionally, FCHVs have been expected to support outreach activities occurring in their wards, notably PHC and immunization outreach. The survey found that FCHVs routinely provide support for PHC outreach in their wards, and 91 percent routinely attend immunization clinics where these are provided.

However, FCHVs' activities cover a very broad range of services, with special contributions in the area of maternal and child health. Overall, FCHVs have contributed in myriad ways to reducing maternal and infant and child morbidity and mortality primarily through behavior change and increased use of services. This survey did not measure these successes. However, it quantified FCHVs' involvement in specific services:

³ Globally, reported attrition rates of CHWs are between 3% and 77%, and the higher rates are generally associated with volunteer CHWs. Karabi Bhattacharyya, Peter Winch, Karen LeBan, and Marie Tien. 2001. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention and Sustainability*. Arlington, VA: Basic Support for Institutionalizing Child Survival Project (BASICS II).

- *Vitamin A*: The biannual vitamin A supplement distribution has relied primarily on FCHVs. Essentially all FCHVs (99 percent) report having participated in the most recent round of vitamin A distribution.
- *Family planning*: Almost all FCHVs (97 percent) report having provided at least some family planning counseling over the previous three months, most commonly during contacts with pregnant and postpartum women (83 percent and 79 percent, respectively), but also for other women (63 percent). A smaller proportion of around 40 percent of FCHVs reported involvement in distribution of family planning commodities, including oral contraceptive pills and condoms. Contraceptive distribution varied considerably across domains. A far greater proportion of FCHVs reported distribution in Far Western Terai (76 percent reported pills and 87 percent reported condoms), compared to Central and Western Mountain (between 11 and 21 percent). (See the discussion on geography and access later in this section.) Involvement in referral for family planning services was less common, with only one in five FCHVs (22 percent) reporting three referrals in the past three months.
- *Age and literacy status* had little bearing on FCHVs' family planning-related functions. However, the unreliability of the supply chain had an impact on service provision. For example, only 59 percent of FCHVs had condoms at the time of the survey, and 58 percent had pills.
- *Maternal and child health*: A very high proportion of FCHVs (93 percent) reported having done at least some counseling of pregnant women over the preceding three months. Those who reported this counseling saw an average of 4.4 pregnant women over that period. Virtually all FCHVs who counseled pregnant women said that they had discussed early and exclusive breastfeeding (87 percent), eating nutritious food during pregnancy (94 percent), and nutrition for infants and young children (89 percent). Likewise, virtually all FCHVs said that they had advised women to attend ANC visits. Most also reported urging women to be vaccinated against tetanus (74 percent) and take iron-folate tablets (87 percent). About half of FCHVs reported counseling women to deliver at a health facility and take deworming medicine; and 10 percent or fewer advised women to save money or make emergency transportation plans. There was no difference on these responses between CBNCP and non-CBNCP districts. Notably, one-third of FCHVs did not have a BPP flip-chart (along with other commodities).
- *Iron*: About half of FCHVs (47 percent) reported having dispensed iron to at least one pregnant woman over the preceding three months, reaching an average of 5.7 women. This figure seems high, given that the expected annual number of pregnancies per FCHV catchment population would be approximately 9.2, based on DHS data. Also, only 65 percent of FCHVs had iron tablets in stock at the time of the survey. The number may reflect the way the question was posed. To some extent, the survey is capturing the number of *contacts* for iron dispensing, rather than individuals. Similar overestimations were found in the 2006 FCHV survey.
- *Supplements*: In the 15 districts where the Balvita micronutrient supplement has been introduced, two in five FCHVs (39 percent) reported having done at least some distribution over the preceding three months.

EDUCATION ON SENSITIVE TOPICS

FGDs revealed that community members feel more comfortable talking with FCHVs about certain health topics (including pregnancy and family planning) than they do with other health workers according to the focus group discussion results. FCHVs promote use of all available health commodities and resources within communities. The broad community acceptance of and even preference for health education from FCHVs is an important programmatic success. It is the result of several fundamental program strategies, including FCHV selection, training, and support.

BROAD RANGE OF FUNCTIONS

FCHVs serve their communities in many ways. At the individual level they provide household support, helping to change hygiene and health practices. As importantly, they help to link communities with appropriate health services; enhance understanding of maternal and child nutrition; and make connections with beneficial non-health development work. While extra demands on FCHVs may be burdensome for some volunteers, the numerous requests for their involvement reflect a significant degree of recognition by the community and partners.

PROGRAMMATIC SUPPORT AND STRUCTURE

Almost three-quarters of FCHVs can complete recording independently; this includes many women with limited literacy skills. The tasks include recording information in registers and reporting monthly service provision and commodity availability data to health facilities. The survey did not collect information on actual reporting rates or data quality.

Nearly all FCHVs (99 percent) reported that they have regular contact with their supervisors. The survey results indicate that the FCHVs are traveling to health facilities where they interact with their supervisors. However, since data-gatherers' contacts were primarily at the FCHVs' house or within the community and not at the health facility, expected supervision could not be observed, and therefore the content and quality of the interaction is unknown.

FCHV MOTIVATION AND INTENTION TO CONTINUE PROVIDING SERVICE

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. The 2006 survey examined FCHVs' motivation by asking whether they would like to spend more time, the same amount, or less time in their future work. Three-quarters (76 percent) responded that they would like to be putting in more time, 22 percent about the same, and only 2 percent less time. The findings were essentially identical in 2014 (75 percent, 22 percent, and 3 percent, respectively). As mentioned above, in both the 2006 and 2014 surveys, only 20 percent of FCHVs had served in this role for less than five years, corresponding to an annual attrition of 4 percent, which is considerably lower than attrition of paid staff under the Public Service Commission.

The current survey includes a new set of questions to describe FCHVs' motivation. Essentially all FCHVs report they are happy being FCHVs, with 90 percent strongly agreeing and 8 percent agreeing somewhat. Similarly, 95 percent said that they expected to be FCHVs five years from now. Essentially all FCHVs agreed that communities appreciate FCHVs, and that their families are supportive. Likewise, almost all agreed that they received adequate support from their supervisor and that they were treated fairly and respectfully by health workers at their HF (96 percent for each item). A slightly lower proportion reported that they had regular supplies of drugs and commodities (92 percent).

However, the 2014 survey also revealed concerns. Two-thirds of FCHVs said that their duties sometimes interfered with other important responsibilities; and two FCHVs in five found filling in forms and registers burdensome (further discussion of this is found below). While just over half of FCHVs felt that the government treats them fairly, more than one-third (39 percent) did not feel this way. Three out of five FCHVs felt that the benefits they receive for their services are not adequate.

The 2014 survey also suggested some problems with health workers themselves. About one-third of FCHVs reported that certain health workers at their facilities were not present at the facilities when they should be, or that some services are not being provided properly.

10.2 Gaps and Areas for Consideration

Overall, the findings of the 2014 survey do not support concerns about drop-out rates, low satisfaction or motivation, or problematic relations with staff at health facilities. Yet the results do identify a few gaps and areas needing additional attention.

LIMITED SUPPLIES OF COMMODITIES

Despite FCHV reports of regular supplies and commodities, the survey shows limited availability of supplies for specific services. Of FCHVs providing family planning services, fewer than 60 percent had condoms or oral contraceptive pills when interviewed. Only about half of FCHVs had supplies of zinc and cotrimoxazole (53 and 49 percent, respectively).

The availability of commodities also varied by domain. This variation, along with the very low levels of availability of iron and cotrimoxazole nationwide, must be addressed. Supply chain problems due to stock-outs at health facilities or districts, poor distribution between health facilities and FCHVs, poor reporting on commodities by FCHVs, and higher-level issues related to procurement of commodities may be factors in FCHVs' limited commodity supplies. The survey findings also reveal low stocks of specific program drugs, such as CHX and misoprostol, in districts where these programs are implemented, limiting the quality and consistency of service provision.

LIMITED AVAILABILITY OF REGISTERS, SUPPLIES, AND JOB AIDS

The survey showed that FCHVs commonly lacked basic equipment needed for their work. While 80 percent of FCHVs had the new ward registers, fewer than half had ARI and iron distribution registers (though 65 percent had ARI timers). The supply of a number of job aids (described in Annex 15) was consistently inadequate. Fewer than 60 percent of FCHVs overall had appropriate job aids. The exception was the set of tools for the new CHX programs; 69 percent of FCHVs in the districts implementing this program had one of two tools.

The survey did not measure the effect of access to supplies on FCHVs' ability to function effectively. However, the absence of supplies implies significant impact on service delivery capacity. The lack of registers affects not only reporting but service management and community follow-up. ARI services cannot be properly provided without a timer or substitute. The overall impact of missing job aids on FCHVs in Nepal is unknown.

LIMITED COMMUNITY-BASED SUPERVISION OF FCHVS

The survey found that 77 percent of reported supervision takes place at the health facility, and only 8 percent at the home of the FCHV. Supervision is designed to take place at the workplace of FCHVs so that supervisors can observe FCHV activities. It is likely, therefore, that supervisory activities may not be taking place as designed. This survey did not go into depth about the content of supervision visits; it is unclear whether FCHVs' skills and knowledge are assessed and support provided for any issues identified. Survey results point to some loss of knowledge of danger signs in pregnant women and newborns, which are among the routine topics for supervision.

INCONSISTENT KNOWLEDGE OF FCHV STATUS AND PROGRAM BENEFITS

The FCHV Strategy states clearly what benefits a working FCHV should receive and what retirement benefits are available to retiring FCHVs. The survey shows a need for additional information about standard benefits. In addition, the qualitative study results reveal a belief in some communities that the FCHVs are salaried employees of the government, which could lead to unrealistic expectations and community tensions.

FEW MEETINGS OF HEALTH MOTHERS GROUPS

Only 46 percent of FCHVs conducted HMGs, although HMGs are supposed to be a basic FCHV function. FCHVs stated that lack of allowance for tea and snacks during meetings was a demotivating factor, discouraging mothers from attending these meetings. Attendance also varied, with some mothers attending meetings more regularly than others. A few respondents said that regular HMG meetings required an active FCHV to coordinate and set up the meeting. Although a few supervisors and ANMs reported observing HMG meetings, it was not clear from the data whether they did so routinely.

The data do not make it clear whether the low number of HMGs is a problem or merely a reflection of FCHVs adapting to changing circumstances and community needs. There has been a large decline in HMG meetings since the 2006 FCHV survey, with 85 percent of FCHVs reporting working with a HMG an average of 12 times per year in 2006.

LOW LEVELS OF INVOLVEMENT IN NEW PROGRAMS

Several special programs for mothers and newborns have been implemented in a limited number of districts to date. Interestingly enough, these programs have lower levels of FCHV involvement than more established programs. In CHX program districts, 52 percent of FCHVs were found to have chlorhexidine in stock at the time of the survey, but only 29 percent overall said that they had distributed it to any pregnant women over the previous three months. FCHVs who did distribute CHX reported providing it for 2.9 newborns on average. Distribution varied by domain, from 53 percent in Western Terai to much lower distribution in Eastern and Western Mountain (15 percent and 10 percent, respectively).

Performance was notably worse for misoprostol. Overall, across program districts, 10 percent of FCHVs reported having distributed misoprostol to an average of 2.3 women over the previous three months, but in some districts this distribution was very low: 3 percent in Eastern and Western Hill and Central Terai, for instance. Only 15 percent of FCHVs in misoprostol districts had the drug in stock. The survey did not explore why certain programs had lower rates of involvement by FCHVs.

URBAN FCHVS IN THE 2014 FCHV SURVEY

The 2010 FCHV Strategy focuses mainly on rural FCHVs and does not set any guidelines for urban FCHVs. Urban-based FCHVs made up a very small portion of the sample for this study, and drawing conclusions from such a small sample is not possible. It is beyond the scope of this survey to make specific conclusions on domain level results, because some domains did not have any urban FCHVs. Furthermore, the survey does not distinguish between new urban FCHVs who operate under the new PHC revitalization and long-term FCHVs whose places of residence have changed status from VDC to municipality during their time of service.

Interviews with national stakeholders raised the question of whether there is a need for urban FCHVs, and if their role should be different from that of rural FCHVs. Results showed that 20 percent of urban FCHVs (compared to 53 percent of rural FCHVs) reported that a PHC/ORC clinic had ever been conducted in their catchment areas. Similarly, 42 percent of urban FCHVs (compared to 64 percent of rural FCHVs) reported that an expanded program on immunization (EPI) clinic had ever been conducted in their catchment areas. In the three months prior to the survey, 42 percent of FCHVs in rural areas reported distributing condoms and pills, while about one-third of urban FCHVs reported such distribution. ORS and zinc distribution also varied (42 and 28 percent, respectively, among urban FCHVs compared to 52 and 45 percent among rural FCHVs; and far fewer urban FCHVs (8 percent) provided cotrimoxazole for childhood pneumonia than rural FCHVs

reported (25 percent). Knowledge of pregnancy danger signs and availability of job aids and equipment were also lower among urban FCHVs as compared with their rural colleagues.

FCHVS, WORKLOAD, AND TASK SHIFTING

A key question has been whether the FCHVs' workload has increased as a result of the new activities requested of them. At the time of the 2006 survey, 6 percent of FCHVs reported that they had not spent any time over the previous week in FCHV-related duties. On average they reported doing FCHV-related work on three days in the preceding week, and averaging 1.7 hours per day, for a total of just over 5 hours a week. Note that this time would include actual services, visits to the health facility, and involvement in trainings and meetings. How, if at all, has that changed between 2006 and 2014?

In 2014, 12 percent of FCHVs reported no FCHV-related work in the previous week (i.e., double the proportion in 2006). They reported fewer days per week on average than in 2006 (2.2), but more hours per day on days when they were doing FCHV duties (3.1). Overall, the total number of reported FCHV-related activities was slightly higher than in 2006, with almost half (43 percent) reporting more than six hours in the previous week. Note that this is the average across the country. Some FCHVs put in considerably more hours and others far fewer. A gradient, for example, is observed by how far away the FCHV lives from the HF, with 47 percent of those living more than an hour away reporting more than six hours per week, compared to only 40 percent of those living less than 30 minutes away. In summary, although new program activities have been added, there has been relatively little change in reported number of hours/ per week engaged in FCHV activities between 2006 and 2014.

The survey did not explore task-shifting to FCHVs. However, the survey findings clearly show some task-shifting, with FCHVs typically visiting their local HF several times a month and taking advantage of these opportunities to submit reports—despite the fact that the FCHV Strategy asks supervisors to collect reports from FCHVs.

FCHV SUPERVISION

As noted above, 99 percent of FCHVs report having regular contact with their supervisor and that 77 percent of this contact takes place at the health facility, not at their place of work. The survey does not measure content or quality of the interaction, but focuses on FCHVs' perceptions about supervision. For example, 77 percent of FCHVs said that they receive sufficient supervision; only 1 percent felt strongly that they do not. Literate FCHVs were more likely than illiterate FCHVs to feel that they receive sufficient supervision (80 percent versus 67 percent), and fewer urban FCHVs (69 percent) than rural FCHVs (77 percent) strongly agree that they receive adequate supervision.

FCHV PARTICIPATION IN NETWORKS/ASSOCIATIONS AND OTHER GROUPS

There has been a perception among policymakers that FCHVs have become increasingly politicized, including engagement with labor organizations. Those who most vocally bring demands to the attention of politicians and policy makers tend to be based in municipalities; and until recently, urban FCHVs were not part of the FCHV program. Within the sample for this survey, one in five FCHVs reported knowing of the existence of an FCHV network or association active in their district, and about 10 percent report being associated with an organization addressing FCHV benefits and working conditions. Among urban FCHVs, knowledge of networks is higher: 36 percent said they knew of such associations, and 22 percent said that they were members. This pattern of knowledge of associations among FCHVs varies across geographic and development zone domains, with the

highest proportion comprising FCHVs from Eastern Terai and Hill domains (39 percent and 32 percent, respectively).

Detailed data on FCHVs' involvement in various groups, including FCHV groups and other types of groups, can be found in Annex 21. Sixty-one percent of FCHVs reported being involved in local committees/groups. These included savings and credit cooperatives (46 percent), women's development committees (28 percent) and agricultural groups (22 percent). As noted above, a higher percentage (22 percent) of urban FCHVs are involved in an advocacy group than among the national sample (10 percent).

GEOGRAPHY, ACCESS, AND SUPPLIES

Overall, there were significant differences across the 13 domains in terms of geography, access and supplies. For example, access to health facilities was not uniform; delivery of health promotion services by FCHVs differed by program type across domains; and availability of commodities differed significantly, with some domains showcasing a much better supply chain for commodities than others.

Distances to health facilities varied among the domains. On average, FCHVs reported that it took them one hour to reach a health facility, but in Eastern and Central Mountain and Midwestern Hill, FCHVs reported spending about 90 minutes in travel, while FCHVs living 60 minutes or more from a health facility reported spending around two hours to reach the facilities. These results highlight travel difficulties that affect not only FCHVs, but potentially also mothers and babies who must visit facilities in such areas. A factor affecting the work of FCHVs in remote areas, identified through qualitative data, was that FCHVs in these areas were often expected to provide more health services. Key respondents felt that given the difficulty of obtaining services in such areas, these FCHVs should receive increased training to enable them to provide more curative services.

There were also differences in the number of outreach and EPI clinics that FCHVs reported. Traditionally, FCHVs have been expected to support outreach activities occurring in their wards, notably PHC and immunization outreach clinics. Half of FCHVs (52 percent) report that PHC outreach clinics are held in their wards. As one would expect, the proportion is higher in wards that are farther from the health facility (59 percent reported by FCHVs living 30–60 minutes from their HF; 73 percent among those living more than an hour away).

Variations in service provision and availability of commodities affected multiple types of services. For example, eighty-three percent of FCHVs reported providing ORS for children with diarrhea in the past three months compared to 25 percent in Western Mountain. Similarly, provision of such varied commodities as zinc, contraceptive pills, and condoms varied widely across domains. Distance appeared to have an impact on provision; 27 percent of FCHVs living >60 minutes from a health facility reported treating pneumonia with cotrimoxazole, compared to 20 percent of FCHVs living < 30 minutes away; and a similar pattern was found for provision of ORS for diarrhea. (It should be noted that seasonal variations in the incidences of diarrhea and pneumonia would also affect the use of these services; data were collected between August 2014 and February 2015).

Urban FCHVs: While FCHVs classified as urban generally provided fewer commodities and less treatment, they also had lower access to commodities than rural FCHVs. The growth of the private sector has changed access to and choice of service delivery points for many populations, but urban FCHVs do not always serve populations with better access to care.

Literacy and FCHVs: Survey findings showed that literate FCHVs reported slightly more working hours than FCHVs who had limited or no literacy skills. Fully-literate FCHVs were found to have provided slightly more treatment for diarrhea and pneumonia in the last three months, and had a

slightly higher knowledge of danger signs than did those who had limited or no literacy skills. Also, 68 percent of literate FCHVs reported having a regular supply of drugs and other supplies, compared to 59 percent of limited literacy FCHVs. This may be connected to the ability of literate FCHVs ability to complete their reports more easily.

These results raise several important considerations for the FCHV program. **First**, the distance to health services varies across the country. This means that achieving full utilization of key ANC, delivery and PNC services maybe quite challenging, despite FCHVs' promotion of these services. **Second**, low availability of commodities in some districts limits FCHVs' ability to provide contraception or treatment for diseases such as diarrhea, or provide contraception. **Third**, FCHVs living further away sometimes provide more of certain services compared to FCHVs living nearer to health facilities. This suggests that additional FCHV support for services may be needed in some geographic settings but not in others.

Data from this survey raise the question of the need to tailor roles for FCHVs by geographic setting. It may be appropriate that FCHVs in more remote communities play a relatively expanded role. The role of FCHVs who are less active, such as those closer to health facilities or in urban areas, where mothers are able to access health facilities and hospitals more easily, could be scaled back.

Considering the diversity of Nepal, a stratified FCHV workforce may be required to optimize the use of available resources and provide more consistent health service delivery.

CHAPTER 11: POLICY IMPLICATIONS

The 2014 FCHV National Survey collected quantitative and qualitative data to provide an overview of the current status of the FCHV program and FCHV and stakeholder perceptions of the program. The survey does not provide evidence to evaluate program performance in terms of coverage or impact on population health. Instead, the findings highlight important program characteristics and raise potentially vital questions about the role of FCHVs in creating demand, the quality of FCHV supervision, and the frequency and quality of FCHV reporting. These findings reveal lessons learned and highlight challenges that should be further explored to inform policy recommendations.

The potential policy implications drawn from this survey include:

1. The Nepal FCHV program is successful, with high FCHV involvement 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. Areas requiring further study include cost-benefit analysis, impact measurement, service mapping including in urban areas, and comparative analysis of FCHV survey results and NDHS 2011.
3. The survey findings suggest a review of the existing FCHV policy to determine the benefits of tailoring it to reflect the specific needs of each domain, instead of applying a universal approach for the whole country.
4. There are sufficient data available to suggest that targeting resources to support specific high-impact activities by FCHVs would better reflect local health and community profiles. Targeting could be based upon analysis of community needs, access to and use of other services, under-served populations, and growing non-communicable disease needs, and could combine NDHS and other survey data as well as FCHV survey results.
5. Limited availability of commodities severely restricts FCHVs' ability to provide services, and deserves more attention than it currently receives. Reducing commodity stock-out rates across Nepal could reasonably be assumed to contribute to improved health outcomes.
6. FCHV supervision and support structures at all levels, from the national FHD level through districts and VDCs, warrant in-depth study, including but not limited to FCHV incentives, retirement benefits, and supervisory methodologies. Additional research should focus on gaps on on-site coaching and supervision and how to improve supervision to provide adequate support for FCHVs
7. Additional investment in site supervision or FCHV incentives and benefits should be based upon more comprehensive knowledge of the current systems and their field application. From this survey, we know that FCHV motivation and job satisfaction are high, and that FCHVs desire additional opportunities to learn and better incentives.
8. 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 building .

9. Specific suggestions and requests from the FCHVs include training in record-keeping and use of registers. The fact that FCHVs in all 75 districts received training on the revised FCHV register and updated health management information system in 2014 prior to the time of data collection suggests that the training content may need to be revised. In addition, results from unprompted recall on pregnancy danger signs indicate that refresher training or directed supervision on this topic is warranted.

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ANNEXES

Annex I. Sampling protocol for quantitative survey

SAMPLING SELECTION

A full list of urban and rural wards was provided to the JSI team for each domain. A systematic sampling approach was taken where a sampling interval “k” was calculated using the following formula:

$$\text{Sampling interval (k)} = \frac{\text{Total number of wards (N)}}{\text{Required sample of wards (n)}}$$

Using the determined sampling interval, every kth ward was selected, stratified by urban and rural areas, in each domain. A sampling frame was developed for each domain and a random point was selected as a first sample, after which the specific sampling interval was used to select subsequent wards.

The number of urban wards in each domain was selected as a proportion of “the total number of urban wards within a domain/total number of urban wards in Nepal required for a nationally representative sample (260).” Since the number of urban wards within each domain varied, we wanted to ensure that the number of sampled urban wards was in proportion to the total number of urban wards within a domain. The number of rural wards required in each domain was calculated by subtracting the total number of wards that needed to be sampled in each domain from the number of urban wards sampled. Table I gives details about the wards sampled.

Annex 2. Distribution of number of wards utilized in domain-specific sample size calculations

Domain	Number of municipal wards	Number of rural wards	Total number of wards	Sampled urban wards	Sampled rural wards	Minimum sample size required	Drop out rate (%)	Total sample size needed with 3% dropout	Urban sampling interval*	Rural sampling interval*
Eastern Mountain	13	1,053	1,066	4	287	283	3	291	3	3
Eastern Hill	35	3,555	3,590	11	347	348	3	358	3	10
Eastern Terai	136	3,429	3,565	44	313	347	3	357	3	10
Central Mountain	13	1,332	1,345	4	304	299	3	308	3	4
Central Hill	183	4,176	4,359	59	306	354	3	365	3	13
Central Terai	112	5,292	5,404	36	334	359	3	370	3	15
Western Mountain	0	2,502	2,502	0	344	334	3	344	0	7
Western Hill	105	5,553	5,658	34	337	360	3	371	3	16
Western Terai	55	1,971	2,026	18	316	324	3	334	3	6
Mid-western Hill	21	2,925	2,946	7	343	340	3	350	3	8
Mid-western Terai	53	1,044	1,097	17	277	285	3	294	3	3
Far-western Hill	38	1,863	1,901	12	318	320	3	330	3	5
Far-western Terai	42	549	591	14	227	234	3	241	3	2
Total	806	35,244	36,050	260	4053			4313		

*Rounding down for sample interval; using whole numbers.

Annex 3. Description of respondents for qualitative data collection

Category of participants	Tools used	Respondents	Total dataset
National stakeholders	Key informant interviews	Ministry and divisions of government (MOHP, Ministry of Local Development, and Ministry of Woman and Child Development)	7
		Government development partners (INGO, UN bodies, and donor agencies)	5
District stakeholders	Semi-structured interviews	District health office (DHO)	6
		Local development officer (LDO)	6
		Woman development officer (WDO)	6
Health workers		Family planning supervisor, health post in-charge, auxiliary nurse midwife (ANM), and upgraded auxiliary nurse midwife/auxiliary health worker (AHW)	18
Health facility operation and management committees		Health facility and district	6
Female Community Health Volunteers	Focus group discussions	Rural remote	4
		Rural non-remote	4
		Urban	4
		Terai marginalized communities	4
Community beneficiaries		Remote	4
		Non-remote	4
		Terai marginalized group	4
		Total	82

Annex 4. Sampling weights

Domain	Number of municipal wards (A)	Number of rural wards (B)	Sampled urban wards (C)	Sampled rural wards (D)	Sampled urban/number of urban wards (C/A)	Sampled rural/number of rural wards (D/B)	Weight urban (A/C)	Weight rural (B/D)	Adjusted for overall population urban (total urban wards/sampled urban wards) (E)	Adjusted for overall population rural (total rural wards/ sampled rural wards) (F)	Overall weight for urban wards (A/C)*(E)	Overall weight for rural wards (B/D)*(F)
Eastern Mountain	13	1,053	4	287	0.31	0.27	3.25	3.67	3.10	8.70	10.08	31.90
Eastern Hill	35	3,555	11	347	0.31	0.10	3.18	10.24	3.10	8.70	9.86	89.09
Eastern Terai	136	3,429	44	313	0.32	0.09	3.09	10.96	3.10	8.70	9.58	95.26
Central Mountain	13	1,332	4	304	0.31	0.23	3.25	4.38	3.10	8.70	10.08	38.10
Central Hill	183	4,176	59	306	0.32	0.07	3.10	13.65	3.10	8.70	9.62	118.67
Central Terai	112	5,292	36	334	0.32	0.06	3.11	15.84	3.10	8.70	9.64	137.78
Western Mountain	0	2,502	0	344	-	0.14	0.00	7.27	3.10	8.70	0.00	63.25
Western Hill	105	5,553	34	337	0.32	0.06	3.09	16.48	3.10	8.70	9.57	143.29
Western Terai	55	1,971	18	316	0.33	0.16	3.06	6.24	3.10	8.70	9.47	54.24
Mid-western Hill	21	2,925	7	343	0.33	0.12	3.00	8.53	3.10	8.70	9.30	74.15
Mid-western Terai	53	1,044	17	277	0.32	0.27	3.12	3.77	3.10	8.70	9.66	32.77
Far-western Hill	38	1,863	12	318	0.32	0.17	3.17	5.86	3.10	8.70	9.82	50.94
Far-western Terai	42	549	14	227	0.33	0.41	3.00	2.42	3.10	8.70	9.30	21.03

Annex 5. Percent distribution of all FCHVs by age, caste, and language spoken, nationally and by domain

	Average Age (years)	Age distribution (%) ^a				Caste (%) ^a							Language spoken (%) ^a										
		<25 yr	25-39 yr	40-54 yr	55+ yr	Hilgh caste	Tarai/Madhesei castes	Dalits	Janajatis	Muslim	Others	Terai others	Nepali	Maithili	Bhojपुरी	Awadhi	Newari	Hindi	Tamang	Magar	Tharu	Other	
Denominator (N)	4,302	4,302				4,302							4,302										
Domain																							
Eastern Mountain	41	5	39	47	9	27	0	2	71	0	0	0	52	0	0	0	1	0	3	0	0	43	
Eastern Hill	41.5	4	39	45	11	37	0	2	61	0	0	0	62	0	0	0	1	0	5	4	1	27	
Eastern Terai	43.6	2	30	52	16	14	32	10	40	2	1	1	24	59	0	0	0	0	0	1	9	6	
Central Mountain	40.5	6	39	44	11	46	0	4	50	0	0	0	63	0	0	0	6	0	22	0	0	10	
Central Hill	41.6	4	42	36	17	45	0	1	54	0	0	0	57	0	0	0	8	0	25	6	0	4	
Central Terai	44.9	2	29	44	25	5	53	10	23	7	0	1	10	39	43	0	0	0	2	1	3	2	
Western Mountain	37.4	8	52	35	5	78	1	4	16	0	0	0	59	0	0	0	0	0	2	0	0	39	
Western Hill	41.3	3	38	51	8	53	0	5	42	0	0	0	78	0	0	0	1	0	1	11	0	9	
Western Terai	45.2	2	24	53	21	18	37	14	28	3	0	0	31	0	19	30	0	2	0	7	10	1	
Mid-western Hill	35.9	10	57	30	3	61	0	9	30	0	0	0	95	0	0	0	0	0	0	5	0	0	
Mid-western Terai	42.2	3	35	49	13	29	20	7	31	10	0	3	44	0	0	31	0	0	0	0	24	0	
Far-western Hill	36.6	10	49	35	5	89	1	8	2	0	0	0	56	0	0	0	0	0	0	1	0	43	
Far-western Terai	38	5	49	43	3	33	8	3	57	0	0	0	39	0	0	0	0	0	0	4	46	10	
NATIONAL	41.3	4	39	44	13	40	14	6	38	2	0	0	52	12	7	3	1	0	5	4	3	12	

^aSignificant difference among domains p<0.05.

Annex 6. Percent distribution of FCHVs by education, literacy, reading, and writing skills, nationally and by domain

	Attended School ^a (%)	Highest grade attended in school, among those who have attended ^a (%)					Literacy ^a (%)	Reading (among those with no education or <6 grade) ^a (%)			Writing (among those with no education or <6 grade) ^a (%)		
		0-5	6-10	SLC pass	Intermediate/+2	BS/MS		Cannot read	Partial	Full	Unable to Write	Partial	Full
Denominator (N)	4,302	2,876*					4,302	2,377**			2,379***		
Domain													
Eastern Mountain	64	32	50	13	2	3	95	8	35	57	6	55	40
Eastern Hill	73	34	40	21	2	2	92	16	30	54	17	35	48
Eastern Terai	78	31	48	18	2	1	79	45	14	41	33	30	37
Central Mountain	51	43	40	8	5	3	83	24	16	60	18	31	52
Central Hill	60	38	38	13	8	3	88	20	22	59	18	31	51
Central Terai	48	40	42	12	3	4	55	63	21	15	25	66	9
Western Mountain	61	40	35	11	10	4	72	44	17	39	44	28	29
Western Hill	82	30	53	12	2	3	96	10	15	75	10	19	70
Western Terai	59	34	49	12	3	2	65	56	16	28	52	26	22
Mid-western Hill	77	33	44	15	7	2	93	14	27	59	10	35	55
Mid-western Terai	66	28	54	13	3	2	81	36	30	33	3	57	40
Far-western Hill	65	44	37	10	6	3	84	25	29	46	20	38	42
Far-western Terai	62	24	59	14	0	2	96	7	42	51	3	56	41
NATIONAL	67	35	45	14	4	3	82	33	22	46	22	38	40

^aSignificant difference among domains p<0.0; *only administered to those who had ever attended school; **two missing because there was no card for the required language; ***only administered to those who had no education or < 6th grade.

Annex 7. Percent distribution of FCHVs by family structure, nationally and by domain

	Marital status ^a				Where husband stays				Type of family ^a		
	Married	Unmarried	Divorced/ Separated	Widow	Stays together at home	Stays elsewhere (in country)	Stays elsewhere (abroad)	Missing	Nuclear*	Joint**	Extended***
DENOMINATOR (N)	4,302				3,878*				4,302		
Domain											
Eastern Mountain	91	1	1	7	88	4	7	0	51	46	3
Eastern Hill	91	2	1	6	81	4	14	1	49	49	2
Eastern Terai	89	0	1	10	88	4	8	0	33	57	10
Central Mountain	91	2	1	7	79	12	9	0	59	35	7
Central Hill	92	1	0	6	81	9	10	0	44	52	4
Central Terai	84	0	0	15	89	3	7	0	30	59	10
Western Mountain	92	1	1	6	82	9	9	0	43	49	8
Western Hill	91	1	1	7	68	7	25	1	51	45	4
Western Terai	86	0	1	13	86	3	11	0	34	56	10
Mid-western Hill	94	1	1	4	70	6	24	0	48	47	5
Mid-western Terai	88	0	1	10	84	6	10	0	28	64	8
Far-western Hill	92	1	2	5	71	5	23	0	45	43	11
Far-western Terai	94	0	1	5	84	5	10	0	43	55	2
NATIONAL	90	1	1	8	80	6	14	0	43	51	7

^a Significant difference among domains $p < 0.05$; *only administered to married FCHVs; * nuclear refers to immediate family of parents and their children; **joint refers to a family under the same roof (several generations); ***extended family refers to the family members who extend beyond the immediate or nuclear family of parents and their children.

Annex 8. Percent distribution of all FCHVs by years of experience

Characteristics	Years of FCHV experience ^a					Mean (years)	Median (years)
	<1	1-5	6-10	11-15	16+		
DENOMINATOR (N)	4,302						
Domain							
Eastern Mountain	6	20	16	17	40	12.3	13
Eastern Hill	5	13	21	16	45	13.6	14
Eastern Terai	2	11	14	12	61	16.9	19
Central Mountain	5	21	23	12	39	12.5	11
Central Hill	4	17	20	15	44	13.8	13
Central Terai	1	19	14	9	56	15.9	19
Western Mountain	3	18	32	13	33	11.3	10
Western Hill	4	15	20	10	50	13.7	15
Western Terai	2	12	10	14	62	16.2	19
Mid-western Hill	2	25	35	13	26	10.5	8
Mid-western Terai	1	15	25	14	44	13.8	14
Far-western Hill	3	20	27	15	35	11.5	10
Far-western Terai	3	16	15	28	39	13.3	14
Literacy							
Not literate	1	10	13	13	63	17.1	19
Literate	4	18	22	13	43	13.1	13
Age							
<25 yr	32	58	11	0	0	2.4	2
25-39 yr	4	30	36	16	13	8.4	7
40-54 yr	0	6	12	14	68	17.6	19
55+ yr	0	1	4	6	90	21.7	24
Geographic area							
Urban	1	13	21	22	43	13.7	14
Rural	3	17	20	13	46	13.9	14
NATIONAL	3	17	20	13	46	13.9	14

^aSignificant difference by domains, literacy, age, and geographic area $p < 0.05$

Annex 9. Percent distribution of all FCHVs according to number of days involved in FCHV activities the last one week, average hours per day, average per week, and willingness to devote amount of time in future, by background characteristics

Characteristics	No. of days worked last week ^{abcd}				Average working hour per day ^{abcde}					Average working hours per week ^{abcd}					Time willing to devote in future ^{abce}		
DENOMINATOR (N)	4,302				4,302					4,302					4,302		
Domain	0 days	1-3 days	4+ days	Mean	<1 hr	1 hr	2 hr	3+ (3-8) hr	Mean	=<2 hr	2.1-4 hr	4.1-6 hr	6.1+	Mean	Same	More	Less
Eastern Mountain	8	73	18	2.3	2	12	32	53	3.1	17	23	15	45	7.2	26	68	6
Eastern Hill	18	75	7	1.6	0	5	25	69	3.3	26	25	16	33	5.7	25	69	7
Eastern Terai	13	67	19	2.3	3	14	30	54	2.9	26	20	12	41	7	12	87	2
Central Mountain	9	67	24	2.5	4	22	25	49	2.9	20	18	18	44	7.3	21	74	5
Central Hill	16	63	21	2.3	1	12	24	62	3.2	22	13	16	49	7.5	20	77	3
Central Terai	10	73	17	2.2	2	29	32	37	2.3	27	24	19	30	5.4	23	74	3
Western Mountain	14	59	27	2.6	1	11	29	58	3.2	17	13	14	55	8.3	21	77	2
Western Hill	13	65	22	2.2	1	5	23	70	3.6	18	19	16	47	7.9	30	66	4
Western Terai	9	55	37	3	0	5	18	76	3.7	12	6	14	67	11.1	15	83	3
Mid-western Hill	15	67	18	2	1	9	22	68	3.4	21	21	18	39	7.2	30	66	4
Mid-western Terai	3	86	11	2	1	5	19	76	3.2	8	32	18	41	6.3	7	92	1
Far-western Hill	8	73	19	2.4	2	19	35	44	2.7	18	27	17	38	6.5	19	80	2
Far-western Terai	5	70	25	2.5	1	16	26	57	3	15	16	16	52	8	19	81	0
Literacy																	
Illiterate	14	72	14	2	1	20	30	48	2.8	27	22	19	31	5.7	28	68	5
Literate	12	67	21	2.3	2	11	26	62	3.2	20	19	16	45	7.5	21	76	3
Age																	
<25 yr	22	63	15	1.9	3	15	27	55	2.9	28	19	14	39	5.8	20	78	2
25-39 yr	10	69	21	2.3	2	13	25	60	3.1	19	19	17	45	7.5	20	78	2
40-54 yr	12	68	20	2.3	1	12	26	61	3.2	20	21	15	44	7.3	23	74	3
55+ yr	17	66	17	2.1	1	16	30	53	2.9	28	18	18	36	6.2	25	67	8
Geographic area																	
Urban	18	58	25	2.3	0	12	18	70	3.5	24	11	14	52	8	19	79	2
Rural	12	68	20	2.2	1	13	27	59	3.1	21	20	16	43	7.1	22	75	3
Time to closest HF																	
<30 min	13	68	19	2.2	2	17	26	56	3	23	19	18	40	6.9	20	77	3
30-60 min	12	68	20	2.2	2	12	28	58	3	22	21	16	42	6.8	21	76	3
>60 min	12	67	20	2.3	1	8	25	66	3.4	18	20	15	47	7.9	26	70	5
NATIONAL	12	68	20	2.2	1	13	26	59	3.1	21	20	16	43	7.2	22	75	3

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; ^esignificant difference by time to closest HF p<0.05

Annex 10. Percent distribution of FCHVs by residence and work-related activities and expenses

Characteristics	Living in ward where FCHV activities done		Average number of times visited HF in the last month	Mode of transportation to reach HF ^{bde}					Average amount of money spent to reach facility (NPRs)	Average amount of time to reach facility (minutes)	Use mobile phone ^{ab} _{cd}	Average expenses on mobile phone for FCHV activities per month (NRs)	Location for providing services generally ^{abce}		
	In ward	Outside ward		Walk	Cycle	Motor cycle	Bus/ jeep/ van	Others					Own residence	Client residence	Other place
DENOMINATOR (N)	4,302		4,302	4,302					141*	4,302	4,302	3,558**	4,302		
Domain															
Eastern Mountain	96	4	2.3	100	0	0	0	0	325	98.9	78	241.6	38	51	11
Eastern Hill	96	4	2	98	0	0	2	0	79.2	70.6	85	273.1	19	70	11
Eastern Terai	96	4	2.6	83	11	1	4	1	114.1	34.6	86	160.3	25	69	6
Central Mountain	94	6	2.4	98	0	0	2	0	224.3	86.2	89	213.3	31	36	33
Central Hill	95	5	2.3	98	0	0	2	0	107.1	61.1	86	167	35	53	12
Central Terai	96	4	2.9	96	2	1	1	0	94.7	28.7	68	150.9	17	82	1
Western Mountain	92	8	2.5	100	0	0	0	0	-	72.2	59	278.8	25	67	7
Western Hill	95	5	2.2	100	0	0	0	0	309.6	67.3	97	208.6	43	27	30
Western Terai	95	5	3	82	11	1	5	0	235.2	42.1	76	244.2	20	79	1
Mid-western Hill	96	4	2.2	99	0	0	1	0	37.5	84.7	92	213.7	35	41	24
Mid-western Terai	97	3	3.2	81	12	0	7	0	49.8	38.8	89	233.9	33	51	16
Far-western Hill	97	3	2.6	99	0	0	1	0	70	61.6	79	218	28	48	24
Far-western Terai	97	3	2.6	64	30	0	6	0	70.9	59.8	93	241.5	49	51	0
Literacy															
Illiterate	94	6	2.6	98	1	0	1	0	190.4	47.8	57	146.6	22	70	8
Literate	96	4	2.4	94	3	0	2	0	120.3	61.1	88	215.6	31	54	15
Age															
<25 yr	96	4	2.1	96	3	0	1	0	200	67.7	92	207	37	50	13
25-39 yr	95	5	2.5	95	3	0	1	0	78.2	62.5	90	202.4	31	54	15
40-54 yr	96	4	2.5	94	4	0	2	0	162.6	56.4	80	218.7	28	57	15
55+ yr	95	5	2.6	96	1	0	3	0	88.1	51	66	175.9	26	65	9
Geographic area															
Urban	93	7	2.5	83	2	1	9	5	130	31.5	95	219.4	30	52	18
Rural	95	5	2.5	95	3	0	2	0	124.7	58.8	83	206.7	29	57	14
Time to closest health facility															
<30 min	95	5	3.3	92	4	1	3	0	104	12.2	81	180.8	27	61	12
30-60 min	96	4	2.2	94	4	0	2	0	165.4	44.4	83	210.8	28	58	14
>60 min	96	4	1.8	99	0	0	0	0	68.8	136.1	84	232.5	33	50	17
NATIONAL	95	5	2.5	95	3	0	2	0	125	58.6	83	206.8	29	57	14

^aSignificant difference among domains $p < 0.05$; ^bsignificant difference by literacy $p < 0.05$; ^csignificant difference by age $p < 0.05$; ^dsignificant difference by residence $p < 0.05$; ^esignificant difference by time to closest HFHF $p < 0.05$; *only administered to FCHVs who reported using motorcycle, bus/jeep/van, or others to reach health facility; **only administered to FCHVs who reported using a mobile phone.

Annex II. Percent distribution of FCHVs who are capable of recording, by background characteristics

Characteristic	Capable of recording ^a		Average time spent on recording in a month (hours)
	On own	Need assistance of others	
DENOMINATOR (N)	4,302		4,296*
Domain			
Eastern Mountain	74	26	1.7
Eastern Hill	81	19	1.8
Eastern Terai	68	32	1.6
Central Mountain	70	30	2.9
Central Hill	79	21	1.9
Central Terai	41	59	1.0
Western Mountain	61	39	3.4
Western Hill	90	10	2.4
Western Terai	63	37	2.3
Mid-western Hill	86	14	2.1
Mid-western Terai	74	26	1.8
Far-western Hill	78	22	1.4
Far-western Terai	91	9	1.0
Literacy			
Not literate	12	88	1.6
Literate	86	14	2.0
Age			
<25 yr	94	6	1.6
25-39 yr	87	13	2.0
40-54 yr	67	33	1.9
55+ yr	39	61	1.8
Geographic area			
Urban	93	7	1.8
Rural	72	28	1.9
NATIONAL	72	28	1.9

^aSignificant difference by domains, literacy, age, and geographic area $p < 0.05$; *six observations missing.

Annex 12. Percent distribution of all FCHVs by availability of recording and reporting registers and equipment

	Recording and reporting						Equipment
	FCHV ward register ^{ab}		ARI treatment book ^a	Iron distribution register ^{ab}	Vitamin A register ^{ab}	FCHV Identity card ^{ab}	Timer (ARI) ^{abc}
	New	Old					
DENOMINATOR (N)	4,302						
Domain							
Eastern Mountain	85	58	57	54	60	76	78
Eastern Hill	78	23	22	43	73	84	58
Eastern Terai	84	46	28	18	76	80	51
Central Mountain	72	61	34	42	56	58	63
Central Hill	82	46	35	29	67	72	70
Central Terai	70	46	34	70	77	77	51
Western Mountain	68	36	42	32	58	68	70
Western Hill	85	44	49	44	70	83	74
Western Terai	82	39	43	47	67	74	56
Mid-western Hill	83	33	44	43	76	79	77
Mid-western Terai	87	27	56	54	68	81	67
Far-western Hill	89	52	60	66	88	79	79
Far-western Terai	92	36	25	40	71	84	62
Geographic area							
Urban	66	41	19	20	56	69	36
Rural	80	42	39	45	71	77	65
Time to closest HF							
<30 min	78	43	38	45	69	76	60
30-60 min	82	41	40	44	73	79	67
>60 min	80	41	40	44	71	76	68
NATIONAL	80	42	39	44	71	77	65

Annex 13. Percent distribution of FCHVs with commodities available, by domain and geographic area

Characteristic	% FCHV with commodity (observations)										
	Condom ^{ab}	Pills ^{abc}	ORS packet ^{abc}	Zinc tablets ^{abc}	Cotrimoxazole ^{abc}	Iron tablets ^{ab_c}	Vitamin A ^{abc}	Navi malam kawach ^{ab}	Matri surakshya chakki ^{bc}	Balvita ^a	Pregnancy test kit ^{abc}
DENOMINATOR (N)	4,302							2,626 [†]	2,063 [†]	943 [†]	1,627 [†]
Domain											
Eastern Mountain	47	45	78	44	60	48	33	40	-	40	-
Eastern Hill	37	48	72	43	47	44	32	43	10	-	20
Eastern Terai	58	65	67	51	47	64	59	44	-	50	19
Central Mountain	41	44	82	38	34	41	30	-	-	0	-
Central Hill	49	63	80	55	41	61	52	69	4	7	25
Central Terai	70	48	60	44	36	67	51	64	0	6	32
Western Mountain	54	59	76	60	63	71	30	34	25	-	17
Western Hill	65	64	81	57	51	70	50	48	16	43	29
Western Terai	61	59	75	37	22	63	50	64	35	27	33
Mid-western Hill	70	79	81	71	70	79	45	53	20	38	2
Mid-western Terai	86	70	87	73	65	88	43	49	26	39	20
Far-western Hill	65	39	84	71	68	74	41	51	10	41	-
Far-western Terai	89	74	93	72	44	85	41	43	5	-	27
Geographic area											
Urban	51	49	66	36	16	43	42	23	1	34	12
Rural	59	58	75	54	49	65	46	52	15	33	26
Time to closest HF											
<30 min	58	52	71	49	40	59	45	53	13	34	26
30-60 min	62	59	76	54	49	68	47	50	16	32	28
>60 min	58	64	80	59	59	67	45	53	15	36	23
NATIONAL	59	58	75	53	49	65	46	52	15	33	26

^aSignificant difference between domains p<0.05; ^bsignificant difference by residence; ^csignificant difference by time to closest HF p<0.05; † program districts only.

Annex 14. List of districts implementing special programs as of 2014

Program	Districts
Balvita	Aachham, Bardiya, Dadeldhura, Dang, Gorkha, Kapilbastu, Makwanpur, Morang, Palpa, Parsa, Rasuwa, Rukum, Rupandehi, Sankhuwasabha, Sunsari
Community Based Neonatal Care Program (CB-NCP)	Argakhachi, Baglung, Baitadi, Bajhang, Bajura, Banke, Bara, Bardiya, Bhojpur, Chitwan, Dadeldhura, Dailekh, Dang, Darchula, Dhankuta, Dolpa, Doti, Humla, Jumla, Kailali, Kanchanpur, Kapilbastu, Kavre, Khotang, Lamjung, Mahotari, Morang, Myagdi, Nawalparasi, Nuwakot, Palpa, Parsa, Rautahat, Rolpa, Salyan, Sankhuwasabha, Saptari, Sarlahi, Sunsari, Taplejung, Terthum, Udaypur
Pregnancy Test	Baglung, Banke, Bara, Chitwan, Dang, Dhading, Dhankutta, Dhanusha, Jhapa, Jumla, Kailali, Kalikot, Kanchanpur, Kapilbastu, Kaski, Kavre, Myagdi, Nawalparasi, Panchthar, Parsha, Rautahat, Rupandehi, Saptari, Surkhet, Tanahu
Matri Surakshya Chakki (Misoprostol MSC)	Achham, Arghakhanchi, Baglung, Baitadi, Bajhang, Bajura, Banke, Bhojpur, Dadeldhura, Dailekh, Dang, Darchula, Dhankuta, Dolpa, Doti, Humla, Jajarkot, Jumla, Kailali, Kalikot, Kapilvastu, Khotang, Mugu, Nuwakot, Okhaldunga, Panchthar, Pyuthan, Ramechhap, Rautahat, Rolpa, Rukum, Salyan, Sindhuli, Surkhet, Tanahu, Tehrathum, Udayapur
Navi Malam (Chlorhexidine (CHX))	Arghakhanchi, Baglung, Baitadi, Bajhang, Bajura, Banke, Bara, Bardiya, Bhojpur, Chitawan, Dadeldhura, Dailekh, Dang, Darchula, Dhankutta, Dolpa, Doti, Humla, Jumla, Kailali, Kanchanpur, Kapilvastu, Kavre, Khotang, Lamjung, Mahottari, Morang, Myagdi, Nawalparasi, Nuwakot, Palpa, Parsa, Rautahat, Rolpa, Salyan, Saptari, Sarlahi, Shankhuwashaba, Sunsari, Taplejung, Terhathumb, Udayapur

Annex 15. Percent distribution of FCHVs by availability of job aids

	ARI classification card ^{ab}	Cotrim card ^{abc}	Zinc card ^a _b	Home therapy card ^{ab}	Chlorhexidine/Kawach card ^{ab}	Chlorhexidine doll ^{ab}	Basic flip chart ^{ab}	FCHV sign board ^{ab}	FCHV Manual ^a	BPP flip chart ^{ab}	BPP action card ^{ab}
DENOMINATOR (N)	4,302				2,626[†]		4,302				
Domain											
Eastern Mountain	61	62	46	68	45	91	69	49	73	75	55
Eastern Hill	48	62	57	57	52	78	62	58	71	70	26
Eastern Terai	33	26	44	33	3	19	42	51	68	45	26
Central Mountain	37	46	48	41	-	-	58	46	68	71	43
Central Hill	45	50	52	58	70	91	41	50	63	69	37
Central Terai	48	59	64	61	60	71	67	37	74	68	58
Western Mountain	52	57	51	56	39	65	66	63	56	71	42
Western Hill	54	58	59	61	49	71	67	56	74	66	42
Western Terai	36	36	40	45	59	82	55	20	59	66	64
Mid-western Hill	67	76	76	75	73	90	57	56	65	70	39
Mid-western Terai	50	69	76	82	67	62	78	62	80	72	26
Far-western Hill	48	56	54	63	33	58	53	50	65	73	61
Far-western Terai	55	58	68	71	70	87	72	67	71	75	68
Geographic area											
Urban	23	23	25	28	21	30	40	28	63	41	26
Rural	49	55	57	58	50	69	59	50	68	67	43
Time to closest HF											
<30 min	46	51	54	55	50	67	59	47	70	66	43
30-60 min	50	56	59	59	49	67	60	52	69	66	44
>60 min	49	57	57	59	50	73	58	51	65	69	41
NATIONAL	48	55	57	58	50	69	59	50	68	67	43

^aSignificant difference among domains p<0.05; ^bsignificant difference by residence p<0.05; ^csignificant difference by time to closest HF p<0.05; [†] program districts only.

Annex 16. Percent distribution of all FCHVs who have received training/ participated in meeting, by background characteristics

Characteristics	Received basic training ^{abc}	Last time at the HF for FCHV meeting ^{ade}					Last time participated in 2 day review meeting ^{abc}			
		<1 week	2-4 wks	1 month to 1 yr	>1 yr	Don't know/meeting did not take place	Less than 6 months ago	6-12 months ago	1 year ago	Don't know/don't remember
DENOMINATOR	4,302	4,302					4,302			
Domain										
Eastern Mountain	89	16	51	24	3	6	82	4	1	14
Eastern Hill	93	29	52	16	2	1	70	9	9	12
Eastern Terai	98	36	50	12	1	1	69	9	9	13
Central Mountain	92	25	55	18	1	1	78	2	4	16
Central Hill	97	20	53	21	5	2	76	9	2	13
Central Terai	99	26	61	10	1	2	43	26	10	21
Western Mountain	93	14	59	21	4	2	76	8	1	15
Western Hill	99	17	50	27	4	2	72	9	2	17
Western Terai	97	28	48	22	1	1	66	12	5	17
Mid-western Hill	95	22	57	17	3	0	44	30	13	13
Mid-western Terai	98	32	58	9	0	1	65	26	4	5
Far-western Hill	91	31	60	8	0	1	58	14	7	21
Far-western Terai	99	34	44	20	0	1	71	11	9	10
Literacy										
Illiterate	98	25	62	10	0	4	53	16	7	23
Literate	96	24	54	18	2	1	67	13	6	14
Age										
<25 yr	76	21	49	22	5	3	58	9	5	28
25-39 yr	95	25	54	17	3	1	63	15	7	15
40-54 yr	99	25	53	19	2	1	66	13	6	14
55+ yr	99	19	64	14	3	1	67	13	5	15
Geographic area										
Urban	98	19	42	22	4	13	64	12	7	17
Rural	96	24	54	18	2	1	65	14	6	15
Time to closest HF										
<30 min	97	25	56	15	2	1	62	14	7	17
30-60 min	97	26	54	16	2	2	66	14	6	14
>60 min	95	21	50	24	3	1	66	13	6	15
NATIONAL	96	24	54	18	2	1	65	14	6	15

Annex 17. Percent distribution of all FCHVs by sources of information on health issues

Characteristics	Health workers ^{ad}	FCHV meeting/training ^{ad}	Radio ^{abce}	TV ^{abcd}	Other FCHVs ^a	Poster & Flip charts ^{abc}	Others ^{abcd}	News paper ^{abcd}	Mobile phone ^c
DENOMINATOR (N)	4,302								
Domain									
Eastern Mountain	91	69	63	21	20	12	24	3	9
Eastern Hill	97	71	59	22	23	22	14	3	0
Eastern Terai	87	70	48	28	10	14	6	5	0
Central Mountain	87	69	45	28	15	15	30	4	4
Central Hill	87	87	45	38	20	10	24	12	1
Central Terai	94	62	19	11	24	14	4	4	0
Western Mountain	94	61	47	6	13	12	29	2	6
Western Hill	90	59	51	39	11	22	17	8	0
Western Terai	94	93	52	29	23	10	13	7	0
Mid-western Hill	93	70	56	13	16	16	6	6	0
Mid-western Terai	97	97	49	32	60	34	3	9	0
Far-western Hill	87	75	54	11	16	11	20	4	0
Far-western Terai	96	82	42	27	20	9	5	5	0
Literacy									
Illiterate	92	69	25	7	19	6	10	0	1
Literate	91	71	51	28	19	18	15	7	1
Age									
<25 yr	94	67	55	20	17	26	18	9	2
25-39 yr	90	71	49	25	18	17	17	7	2
40-54 yr	91	71	47	26	19	14	13	6	0
55+ yr	92	72	29	16	21	11	8	3	0
Geographic area									
Urban	81	79	53	57	16	14	20	24	1
Rural	91	71	46	24	19	16	14	6	1
Time to closest HF									
<30 min	90	72	41	26	19	14	14	7	1
30-60 min	91	71	47	23	19	17	14	6	1
>60 min	93	70	51	23	17	17	17	5	1
NATIONAL	91	71	46	24	19	16	14	6	1

^aSignificant difference among domains $p < 0.05$; ^bsignificant difference by literacy $p < 0.05$; ^csignificant difference by age $p < 0.05$; ^dsignificant difference by time to closest HF $p < 0.05$.

Annex 18. Percent distribution of all FCHVs by contact with supervisor

	Supervisor for FCHV work ^{ad}					Last time FCHV had contact with supervisor ^{be}					Where FCHV had contact with supervisor ^{ade}				
	H.A./ Sr. AHW / AHW	staff nurse/ Sr. ANM/ ANM	AHW (Upgraded VHW)	ANM (Upgraded MCHW)	Other	Within last 7 days	1 wk 1 month	1 12 months	More than a year	Don't know/ Never	Home of FCHV	Immunization clinic	PHC/ ORC	Health Facility	Others
DENOMINATOR (N)	4,302					4,302					4,302				
Domain															
Eastern Mountain	62	11	15	12	0	45	46	7	0	2	6	4	2	84	5
Eastern Hill	62	12	9	16	0	48	49	2	0	1	4	6	2	84	4
Eastern Terai	40	7	21	31	0	60	37	2	0	2	7	8	4	77	3
Central Mountain	21	6	26	46	0	43	51	6	0	0	8	7	5	75	5
Central Hill	39	8	20	33	0	45	49	5	0	1	9	5	3	78	5
Central Terai	50	8	14	27	0	59	39	1	0	1	8	6	2	79	6
Western Mountain	43	8	24	24	1	34	57	9	0	1	9	5	2	76	8
Western Hill	41	9	17	32	1	41	54	5	0	0	13	9	4	67	6
Western Terai	24	6	25	44	1	56	41	3	0	0	4	11	5	78	2
Mid-western Hill	44	11	19	26	0	35	60	3	0	2	5	10	3	78	4
Mid-western Terai	19	12	29	39	0	64	35	1	0	0	5	14	8	71	3
Far-western Hill	26	13	16	45	0	48	50	2	0	1	4	7	5	79	5
Far-western Terai	50	3	18	29	0	49	48	1	0	1	4	6	3	86	2
Literacy															
Illiterate	47	9	16	28	0	53	42	3	0	1	7	7	4	78	4
Literate	41	9	19	31	0	47	49	3	0	1	8	8	3	76	5
Age															
<25 yr	43	11	15	30	1	36	57	5	0	3	5	8	1	80	6
25-39 yr	42	9	20	29	1	46	49	4	0	1	8	7	3	77	5
40-54 yr	41	9	18	32	0	50	46	3	0	1	8	8	3	76	5
55+ yr	45	9	16	29	0	51	46	2	0	1	7	6	4	79	4
Residence															
Urban	55	16	11	13	5	39	54	5	0	2	4	6	1	66	19
Rural	42	9	18	30	0	48	48	3	0	1	8	7	3	77	2
Time to closest HF															
<30 min	42	8	20	30	0	56	39	2	0	2	10	5	1	80	4
30-60 min	41	9	18	31	0	47	50	2	0	1	7	8	4	76	6
>60 min	43	10	17	30	1	39	54	6	0	1	6	11	5	73	5
NATIONAL	42	9	18	30	0	48	48	3	0	1	8	7	3	77	2

^aSignificant difference between domains p<0.05; ^bsignificant difference by literacy p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; ^esignificant difference by time to closest HF p<0.05.

Annex 19. Percent distribution of FCHVs who reported receiving incentives

Characteristics	Received dress allowance in the past year ^{ac}	Average Dress allowance amount received (NR)	Received incentives or anything other than dress allowance in past year ^{abcd}	Incentives received, among those receiving incentives other than dress allowance								
				Money ^{abc} _d	Sari/Shawl ^{ac}	Bag ^{abd}	Box ^d	Umbrella ^{abcd}	Torch light ^{bd}	Cycle	Recognition /Appreciation ^{ab}	Others ^{ac} _d
DENOMINATOR (N)	4,302	4,068*	4,302	1,567**								
Domain												
Eastern Mountain	90	3,970	38	83	10	15	4	0	0	0	18	14
Eastern Hill	95	3,981	36	88	8	6	7	3	6	0	6	2
Eastern Terai	97	3,983	29	75	2	17	5	7	3	0	2	5
Central Mountain	96	4,071	34	83	6	2	3	1	0	0	13	10
Central Hill	95	3,971	44	95	4	1	0	2	0	0	7	2
Central Terai	97	3,987	27	70	2	21	4	26	6	0	2	9
Western Mountain	94	3,895	43	82	3	8	3	1	0	0	4	16
Western Hill	95	3,988	34	89	2	4	3	3	1	0	13	4
Western Terai	96	3,977	43	48	13	7	3	18	3	11	15	18
Mid-western Hill	97	4,004	28	92	2	5	0	3	1	0	2	2
Mid-western Terai	99	4,007	37	80	0	4	0	4	10	7	4	13
Far-western Hill	95	3,830	54	58	35	3	1	1	0	0	10	38
Far-western Terai	97	3,991	35	35	16	0	15	2	1	31	0	38
Literacy												
Illiterate	97	3,973	33	68	8	13	5	14	5	1	4	11
Literate	95	3,975	37	81	7	7	3	4	2	2	8	10
Age												
<25 yr	69	3,877	28	67	16	10	4	5	0	3	3	23
25-39 yr	94	3,980	37	83	7	6	2	4	2	1	6	10
40-54 yr	98	3,976	37	78	7	8	3	6	3	2	9	10
55+ yr	98	3,978	32	77	4	12	4	14	3	1	7	5
Geographic area												
Urban	97	3,964	24	58	5	16	11	15	7	0	15	19
Rural	95	3,974	36	79	7	8	3	6	2	1	7	10
NATIONAL	96	3,974	36	79	7	8	3	6	2	1	7	10

^aSignificant difference between domains p<0.05; ^bsignificant difference by literacy p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05. *only includes FCHVs who reported receiving a dress allowance in the year prior to the survey; **only includes FCHVs who reported receiving incentives in the past year.

Annex 20. Percent distribution of FCHVs who reported on FCHV fund details in their VDCs

Characteristics	Have FCHV Fund in VDC ^{bcd}	Amount of money in Fund at present ^{abcd}				Used money from FCHV Fund in last 1 year prior to survey ^{abcd}
		<50,000 NRs	50,000 100,000 NRs	>100,000	Don't know	
DENOMINATOR (N)	4,302	4,142*				4,142*
Domain						
Eastern Mountain	94	2	64	22	12	65
Eastern Hill	97	5	60	25	9	71
Eastern Terai	96	6	40	34	20	65
Central Mountain	91	6	53	16	24	48
Central Hill	97	3	44	31	22	62
Central Terai	98	18	49	10	23	61
Western Mountain	95	5	68	12	16	37
Western Hill	96	2	58	22	18	54
Western Terai	96	7	43	16	34	56
Mid-western Hill	98	4	49	35	13	69
Mid-western Terai	100	2	26	50	22	68
Far-western Hill	99	2	51	18	29	60
Far-western Terai	97	5	28	45	22	50
Literacy						
Illiterate	95	10	44	12	34	55
Literate	97	5	52	26	17	61
Age						
<25 yr	87	7	50	17	26	44
25-39 yr	97	5	51	25	20	58
40-54 yr	98	6	52	25	18	62
55+ yr	96	9	47	19	26	64
Geographic area						
Urban	93	9	25	36	30	32
Rural	97	6	51	24	20	60
NATIONAL	97	6	50	24	20	60

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; *only includes FCHVs reported having FCHVs fund in VDC

Annex 21. Percent distribution of FCHVs who reported on involvement with network/associations or other local committees/groups

	FCHVs with active FCHV network/association present in district ^{ab}			Among those who reported active FCHV network/association present in district, FCHVs associated with any organization or association dealing with FCHV benefits			FCHVs involved in any other local committees/ groups ^a	Among those FCHVs who reported being involved in any of the other local committee /groups, which committee/group involved in:										
	Yes	No	Don't know	Yes	No	Don't want to disclose		VDC/DDC committee ^{ab}	Community forest ^a	Agricultural group ^{ab}	HFOMC ^a	School management committee ^{ab}	Water and sanitation ^{ab}	Political group ^b	Ward citizens forum ^a	Saving and credit cooperatives ^a	Women development committee ^{ab}	Others ^{ab}
DENOMINATOR (N)	4,302			870*			4,302	2,706**										
Domain																		
Eastern Mountain	22	42	35	61	37	2	71	4	24	21	9	10	9	2	9	42	32	36
Eastern Hill	32	37	31	41	59	0	61	5	20	26	11	19	10	0	12	42	32	23
Eastern Terai	39	42	19	59	41	0	56	11	4	10	17	7	11	4	12	41	17	25
Central Mountain	17	55	28	51	49	0	66	8	23	18	11	16	9	2	3	53	37	37
Central Hill	12	36	52	46	51	3	69	3	12	21	15	14	14	6	7	56	34	22
Central Terai	7	51	42	83	17	0	40	7	6	13	10	6	13	5	14	45	22	32
Western Mountain	10	52	38	38	63	0	53	4	12	25	13	19	20	2	13	32	30	39
Western Hill	22	35	44	46	54	0	74	6	23	21	7	16	10	3	20	44	31	32
Western Terai	28	38	33	77	23	0	64	10	12	28	14	10	19	2	23	54	28	28
Mid-western Hill	5	53	42	48	52	0	62	1	24	32	12	15	18	2	13	39	30	15
Mid-western Terai	30	32	37	66	34	0	67	5	11	26	7	5	3	3	23	46	13	31
Far-western Hill	9	65	26	64	36	0	74	14	22	29	24	16	31	4	23	46	27	29
Far-western Terai	23	49	29	21	75	4	63	2	16	34	7	6	4	1	14	66	24	18
Geographic area																		
Urban	36	48	17	64	35	1	65	2	13	10	8	6	7	10	13	53	19	37
Rural	18	44	38	54	46	0	61	6	16	22	12	13	14	3	15	46	28	28
NATIONAL	19	44	37	54	46	0	61	6	16	22	12	13	14	3	15	46	28	28

^aSignificant difference among domains p<0.05; ^bsignificant difference by residence p<0.05; *three observations missing; *only includes FCHVs who reported active FCHV network/association present in district; **only includes FCHVs who reported being involved in any of the other local committee/groups.

Annex 22. Percent distribution of FCHVs who reported being involved in supporting immunization activities

Characteristics	EPI clinic ever been conducted in their ward/catchment area ^{cde}				Average # of immunization clinics conducted in catchment area 3 months prior to survey, with immunization clinics	Average # of immunization clinics supported by FCHV of those conducted in 3 months prior to survey	Role as FCHV in immunization clinic		
	Yes	No	HF delivers service	Don't know			Refer clients to clinic ^{abe}	Attend the clinic to help ^{ab}	Others ^{be}
DENOMINATOR (N)	4,302				2,728*	2,713**	2,549***		
Domain									
Eastern Mountain	61	14	25	0	2.7	2.1	61	92	6
Eastern Hill	63	2	35	0	2.8	2.3	55	89	0
Eastern Terai	66	1	33	0	2.9	2.7	95	95	1
Central Mountain	54	13	32	1	2.8	2.2	37	93	6
Central Hill	50	8	42	0	3	2.4	90	99	1
Central Terai	69	2	29	0	2.9	2.6	77	84	0
Western Mountain	58	8	33	1	2.8	2.5	86	72	6
Western Hill	65	4	31	0	3	2.4	60	94	2
Western Terai	73	2	25	0	2.9	2.8	85	97	0
Mid-western Hill	66	1	33	0	2.8	2.3	72	97	0
Mid-western Terai	78	0	21	0	3	2.9	84	98	0
Far-western Hill	63	5	32	0	2.9	2.6	86	92	1
Far-western Terai	79	4	17	0	3	2.8	76	98	0
Literacy									
Not literate	63	4	33	0	2.9	2.6	81	86	0
Literate	64	4	32	0	2.9	2.5	74	93	2
Age									
<25 yrs	66	6	25	2	2.8	2.4	75	93	2
25-39 yrs	62	4	34	0	2.9	2.5	74	93	2
40-54 yrs	66	4	31	0	2.9	2.5	74	90	1
55+ yrs	63	5	32	0	2.9	2.6	81	91	1
Geographic area									
Urban	42	16	42	0	3.3	2.4	70	93	1
Rural	64	4	32	0	2.9	2.5	75	91	1
Time to closest HF									
<30 min	40	2	58	0	3	2.6	78	90	3
30-60 min	70	4	25	0	2.9	2.5	77	91	1
>60 min	84	6	9	0	2.8	2.4	71	93	1
NATIONAL	64	4	32	0	2.9	2.5	75	91	1

^aSignificant difference among domains $p < 0.05$; ^bsignificant difference by literacy $p < 0.05$; ^csignificant difference by age $p < 0.05$; ^dsignificant difference by residence $p < 0.05$; ^esignificant difference by time to closest HF $p < 0.05$; *only includes FCHVs who reported having an EPI clinic conducted in their ward/catchment area; **only includes FCHVs who reported that immunization clinics were conducted in their catchment area in the 3 months prior to the survey; ***only includes FCHVs who reported providing support to at least one immunization clinic conducted in the 3 months prior to the survey.

Annex 23. Percent distribution of FCHVs who reported involvement in child health activities over the 3 months prior to the survey

Characteristics*	In the 3 months prior to survey:							
	Gave ORS to children suffering from diarrhea ^{abd}	Average number of children suffering from diarrhea who were given ORS in the 3 months prior to survey	Gave zinc tablet to children suffering from diarrhea ^{bd}	Average number of children suffering from diarrhea who were given zinc tablet in the 3 months prior to survey	Examined children for cough and cold ^{abd}	Average number of children examined for cough and cold in the 3 months prior to survey	Provided cotrimoxazole for possible pneumonia case ^{bd}	Average number of children given cotrimoxazole for possible pneumonia cases in the 3 months prior to survey
DENOMINATOR (N)	4,302	2,250*	4,302	1,924*	4,302	1,933*	4,302	1,047*
Domains								
Eastern Mountain	35	9.4	24	6.6	31	5.8	25	3.6
Eastern Hill	52	7.5	41	6.2	40	7.8	28	4.5
Eastern Terai	69	8.8	64	8.1	63	11.3	37	5.7
Central Mountain	32	8.8	20	7.4	22	6.8	7	5.0
Central Hill	54	8.1	45	6.5	30	7.9	15	5.3
Central Terai	42	8.1	43	7.8	41	8.2	23	5.1
Western Mountain	25	13.4	23	12.5	24	10.8	14	7.1
Western Hill	48	5.7	33	6.3	45	6.4	17	3.4
Western Terai	61	12.5	49	17.3	50	8.7	17	4.3
Mid-western Hill	61	7.9	58	14.1	55	8.8	42	4.2
Mid-western Terai	65	8.5	66	10.0	70	12.4	37	7.5
Far-western Hill	71	8.1	65	8.7	66	10.6	40	4.8
Far-western Terai	83	8.4	71	7.8	67	10.7	27	6.7
Literacy								
Illiterate	41	7.8	39	8.0	37	7.7	19	4.6
Literate	54	8.4	46	9.1	46	9.1	26	5.0
Age								
<25 yr	48	9.1	42	8.1	38	8.5	25	4.1
25-39 yr	52	8.2	45	9.0	45	8.8	25	5.0
40-54 yr	51	8.3	43	9.5	45	9.0	24	4.9
55+ yr	53	8.3	48	7.5	45	8.5	25	5.1
Geographic area								
Urban	42	10.0	28	12.2	29	10.6	8	5.6
Rural	52	8.3	45	8.9	45	8.8	25	4.9
Time to closest HF								
<30 min	49	8.6	42	9.4	42	9.7	20	5.1
30-60 min	54	8.0	46	8.9	48	8.4	27	4.8
>60 min	52	8.3	45	8.5	42	8.5	27	4.9
NATIONAL	52	8.3	44	8.9	44	8.8	24	4.9

^aSignificant difference among domains $p < 0.05$; ^bsignificant difference by literacy $p < 0.05$; ^csignificant difference by age $p < 0.05$; ^dsignificant difference by residence $p < 0.05$; *denominator includes only FCHVs who recorded providing medicine/treatment for > 0 children suffering from specific illness.

Annex 24. Percent distribution of all FCHVs who provided family planning counseling

Characteristics	Provided any family planning counseling in the 3 months prior to survey ^{bc*}	In the last 3 months, provided counseling on family planning for:							
		Pregnant woman ^d	Postnatal woman ^{cde}	Newly married couple ^{bcd}	Woman undergone abortion ^{bc}	Adolescent ^{bc}	Returnee migrant ^{bc}	Other adult male ^{bcde}	Other adult female ^{ce}
DENOMINATOR (N)	4,302	4,302							
Domain									
Eastern Mountain	93	88	68	30	8	32	22	24	32
Eastern Hill	94	79	69	20	7	26	21	21	29
Eastern Terai	99	93	93	37	17	50	35	50	83
Central Mountain	91	64	58	30	7	40	24	46	72
Central Hill	97	74	73	25	11	35	18	29	53
Central Terai	99	92	92	19	13	37	41	37	74
Western Mountain	93	84	76	36	23	43	25	46	54
Western Hill	97	71	70	28	14	37	45	55	64
Western Terai	98	94	89	35	27	58	55	49	84
Mid-western Hill	99	87	82	36	17	44	33	60	75
Mid-western Terai	100	98	89	32	19	47	34	35	67
Far-western Hill	99	86	74	31	20	54	38	49	68
Far-western Terai	99	94	85	32	27	62	25	34	44
Literacy									
Illiterate	95	84	81	24	12	35	29	35	66
Literate	98	83	78	29	16	42	35	44	63
Age									
<25 yr	91	80	67	28	18	38	27	36	56
25-39 yr	98	83	79	30	17	42	33	42	64
40-54 yr	97	83	79	29	15	41	35	44	64
55+ yr	97	84	81	21	8	35	31	37	60
Geographic area									
Urban	96	88	85	33	27	41	32	36	66
Rural	97	83	79	28	15	41	34	42	63
Time to closest HF									
<30 min	97	84	80	26	14	39	33	39	65
30-60 min	98	84	80	30	16	43	35	43	64
>60 min	97	80	75	30	14	39	32	45	59
NATIONAL	97	83	79	28	15	41	34	42	63

Annex 25. Percent distribution of FCHVs who distributed condoms or pills according to the number of condoms and pills distributed in the 3 months prior to survey

Characteristics	Condoms(%)								Pills(%)							
	Ever distributed condoms in the 3 months prior to survey ^{ac}	No. of condoms ^{ae}			Mean No. of condoms	Missing data			Ever distributed pills in the 3 months prior to survey ^{abe}	No. of cycle (packet) ^{ad}			Mean No. of cycles	Missing data		
		<50	51-100	100+		Register submitted	Incomplete record	No register		1-5	6-10	10+		Register submitted	Incomplete record	No register
DENOMINATOR (N)	2,664^A	1,859^{AA}				1,638[†]			2,661[*]	1,774^{**}				1,641[†]		
Domains																
Eastern Mountain	47	94	2	5	20	43	42	16	46	65	24	12	5	43	42	16
Eastern Hill	42	67	22	11	50	13	43	44	61	34	37	28	10	13	43	44
Eastern Terai	79	29	38	33	99	42	42	16	82	28	27	45	13	41	42	16
Central Mountain	29	74	11	14	59	29	52	19	43	59	30	11	6	28	53	19
Central Hill	48	60	21	19	68	51	30	20	59	39	38	23	9	50	31	19
Central Terai	89	44	30	27	80	55	35	10	67	46	35	19	9	55	35	10
Western Mountain	77	63	28	8	54	56	16	27	56	52	22	26	9	57	15	28
Western Hill	61	66	14	20	63	25	50	24	68	58	26	15	6	26	50	24
Western Terai	78	50	19	31	94	30	47	22	79	46	29	24	8	31	47	23
Mid-western Hill	73	45	29	26	79	36	49	15	77	51	31	17	7	36	48	16
Mid-western Terai	91	18	25	57	136	42	42	17	77	25	32	43	12	43	40	17
Far-western Hill	76	37	30	33	105	62	27	10	48	61	25	13	7	58	32	10
Far-western Terai	97	7	17	76	226	66	19	15	83	16	33	51	18	69	20	11
Literacy																
Illiterate	74	43	29	28	81	41	35	24	60	51	31	18	7	41	36	24
Literate	67	48	24	28	86	41	39	20	68	43	31	26	9	41	39	20
Age																
<25 yr	65	45	25	29	99	36	39	26	64	56	25	19	7	36	39	25
25-39 yr	71	48	24	27	87	44	35	21	68	44	29	26	9	44	36	21
40-54 yr	67	45	27	28	84	38	40	22	68	42	33	24	9	38	39	22
55+ yr	61	52	19	30	81	41	42	17	63	45	28	27	10	41	42	17
Geographic area																
Urban	64	42	27	31	97	19	32	49	63	31	32	37	11	19	34	48
Rural	68	47	25	28	85	41	38	21	67	44	31	25	9	41	38	21
Time to closest HF																
<30 min	69	44	28	29	88	43	36	20	62	41	32	26	10	43	36	20
30-60 min	68	47	24	29	87	40	40	19	69	47	28	24	8	40	40	19
>60 min	65	53	24	23	80	38	38	25	70	42	33	25	9	38	38	25
NATIONAL	68	47	25	28	85	41	38	21	67	44	31	25	9	41	38	21

Significant difference by ^adomains p<0.05; ^bliteracy p<0.05; ^cage p<0.05; ^dresidence p<0.05; time to closest HF p<0.05 ^Aonly includes FCHVs who have data on whether condoms were distributed or not in the 3 months prior to survey and does not include those with missing data; ^{AA}only includes FCHVs who distributed at least one condom in the 3 months prior to survey; ^{*}only includes FCHVs who have data on whether pills were distributed or not in the 3 months prior to the survey and does not include those with missing data; ^{**}only includes FCHVs who distributed at least one cycle of pills in the 3 months prior to survey; [†]FCHVs missing data on condoms or pills were not included in denominators for other columns.

Annex 26. Percent distribution of FCHVs who provided referrals for FP services in the 3 months prior to survey

Characteristics	Couples referred for family planning services in the 3 months prior to survey					Women referred for sterilization in the year prior to survey				Men referred for sterilization in the year prior to survey									
	Ever referred couples ^{ae}	No. of couples referred ^{ad}			Mean	Missing data			Ever referred women ^a _{bce}	No. of women referred ^{abcd}			Mean	Ever referred men ^{abce}	No. of men referred ^{abd}			Mean	
		1	5	10		10+	Register submitted	Incomplete record		No register	1	3			4	5	5+		1
DENOMINATOR (N)	2,662[^]	1,020^{^^}				1,639[†]				4,302	1,383[*]				4,302	1,937^{**}			
Domains																			
Eastern Mountain	45	85	13	2	3	43	41	16	26	58	28	15	4	26	59	23	18	4	
Eastern Hill	32	71	19	10	5	14	42	44	34	50	26	24	5	39	50	20	30	6	
Eastern Terai	49	54	29	17	7	39	44	17	16	55	22	24	6	64	37	32	31	6	
Central Mountain	34	79	10	11	6	27	52	21	46	50	25	24	5	48	47	23	30	5	
Central Hill	27	59	23	17	7	50	32	19	42	55	21	24	4	37	50	26	24	4	
Central Terai	41	67	25	8	5	54	36	10	11	62	24	14	3	66	48	31	20	5	
Western Mountain	27	92	4	4	7	55	15	30	46	47	28	25	6	29	51	19	30	6	
Western Hill	23	80	16	4	4	25	50	24	32	66	15	19	4	34	59	22	19	4	
Western Terai	50	71	19	10	5	30	48	23	34	54	19	27	5	70	50	22	29	5	
Mid-western Hill	28	74	14	12	7	37	47	16	40	69	22	9	3	27	59	27	14	4	
Mid-western Terai	45	70	14	16	6	40	45	16	27	77	14	8	3	43	54	30	16	4	
Far-western Hill	33	72	12	16	8	61	29	10	31	66	16	18	4	37	71	11	18	4	
Far-western Terai	59	65	19	16	7	69	20	11	37	68	16	16	3	71	58	24	17	5	
Literacy																			
Illiterate	32	66	24	11	5	40	36	24	23	55	29	16	4	54	46	30	24	5	
Literate	36	69	19	12	6	40	39	21	32	59	20	21	4	43	52	24	24	5	
Age																			
<25 yr	26	84	13	3	4	36	38	26	27	54	9	37	6	27	61	17	23	5	
25-39 yr	37	70	18	13	6	43	36	21	34	59	21	20	4	42	49	25	26	5	
40-54 yr	36	68	21	11	6	38	39	22	30	58	24	18	4	48	54	25	21	4	
55+ yr	31	62	28	10	6	40	43	17	24	58	17	25	4	50	44	31	25	5	
Geographic area																			
Urban	42	46	37	16	7	19	33	49	29	50	18	32	6	48	49	19	33	6	
Rural	35	69	20	12	6	40	38	21	31	58	21	20	4	45	51	26	23	5	
Time to closest HF																			
<30 min	36	66	20	14%	6	43	37	21	27	59	21	20	4	50	52	26	22	5	
30-60 min	38	69	21	11	5	40	40	19	29	57	24	19	4	45	53	24	24	4	
>60 min	29	72	17	10%	7	37	38	25	37	59	19	22	4	39	46	28	26	5	
NATIONAL	35	69	20	12%	6	40	38	21	31	58	21	20	4	45	51	26	24	5	

Significant difference by ^adomains p<0.05; ^bliteracy level p<0.05; ^cage p<0.05; ^dresidence p<0.05; ^etime to closest HF p<0.05; [^]only includes FCHVs who have data for number of couples referred for family planning and does not include those with missing data; ^{^^}only includes FCHVs who referred at least one couple for family planning; [†]FCHVs missing data for couples referred for family planning were not included in denominator; ^{*}only includes FCHVs who reported at least one women referred for sterilization in the year prior to survey; ^{**}only includes FCHVs who reported at least one man referred for sterilization in the year prior to survey

Annex 27. Percent distribution of FCHVs who reported supporting PHC/ORC activities

Characteristics	A PHC outreach clinic ever been conducted that covers ward/catchment area ^a				Average # of PHC/ORCs in ward/catchment area conducted over the 3 months prior to the survey	Average # of PHC/ORC supported by FCHV out of those conducted in the 3 months prior to the survey	Role as FCHV in PHC/ORC		
	Yes	No	HF delivers service	Don't know			Refer clients to clinic ^a	Attend the clinic to help ^a	Others
DENOMINATOR (N)	4,302				2,215*	2,187**	2,042***		
Domain									
Eastern Mountain	43	23	31	3	2.4	2.1	58	95	2
Eastern Hill	49	13	37	1	2.6	2.1	51	96	0
Eastern Terai	61	4	35	0	2.9	2.7	92	96	1
Central Mountain	51	16	30	4	2.7	2.1	38	94	8
Central Hill	39	11	49	1	2.8	2.4	90	93	1
Central Terai	49	8	42	1	2.8	2.5	76	83	0
Western Mountain	37	19	41	3	2.8	2.6	81	79	8
Western Hill	59	8	33	0	2.9	2.3	56	97	5
Western Terai	60	8	32	0	2.9	2.7	87	97	2
Mid-western Hill	57	8	35	1	2.7	2.3	71	95	0
Mid-western Terai	67	2	30	1	3	2.8	80	99	0
Far-western Hill	58	11	31	1	2.8	2.5	84	89	1
Far-western Terai	66	12	22	0	3	2.6	72	99	0
Literacy									
Illiterate	47	9	42	2	2.8	2.6	79	90	1
Literate	54	10	36	1	2.8	2.4	72	94	2
Age									
<25 yrs	48	12	36	3	2.8	2.5	78	88	1
25-39 yrs	51	9	38	1	2.8	2.4	73	93	2
40-54 yrs	53	10	36	1	2.8	2.4	71	94	2
55+ yrs	54	10	36	1	2.9	2.6	78	89	1
Geographic area									
Urban	20	25	54	0	3	2.3	71	100	0
Rural	53	10	37	1	2.8	2.4	73	93	2
Time to closest HF									
<30 min	28	5	66	1	2.9	2.5	78	91	2
30-60 min	59	10	30	0	2.8	2.5	75	93	2
>60 min	73	16	10	2	2.8	2.4	68	94	2
NATIONAL	52	10	37	1	2.8	2.4	73	93	2

^aSignificant difference by domains, literacy levels, residence, and time to closest HF $p < 0.05$; *only includes FCHVs who reported that a PHC outreach had ever been conducted in their ward/catchment area; **only includes FCHVs who reported that at least one PHC/ORC was conducted in their ward/catchment area in the 3 months prior to the survey; ***only includes FCHVs who reported supporting at least one PHC/ORC in their ward/catchment area in the 3 months prior to the survey.

Annex 28. Percent distribution of FCHVs who reported giving advice to pregnant women about pregnancy care

Characteristics	Provided information, advice or services about pregnancy to at least one pregnant woman in the 3 months prior to survey ^a	Average number of pregnant women given information, advice or services about pregnancy in the 3 months prior to survey	What is the advice that you provide to pregnant women about pregnancy care? (unprompted)											
			ANC checkup ^f	Injecting tetanus ^{abc f}	Having iron tablets ^{abaf}	Related to night blindness ^a	Related to deworming tablets ^{abcd e}	Related to dangerous signs ^{abd}	Related to giving birth at a HF ^{ab d}	Making arrangements for transportation in case of emergency and saving money ^{abc f}	Eating nutritious food ^a	Family Planning ^a	Others ^{acdf}	Don't know
DENOMINATOR (N)	4,234*	3,956**	4,302											
Domains														
Eastern Mountain	91	3.3	93	63	83	5	46	17	43	2	90	10	23	0
Eastern Hill	89	3.1	97	77	87	9	63	12	37	4	90	7	21	0
Eastern Terai	98	7.8	97	78	90	8	38	25	48	10	89	9	39	0
Central Mountain	86	3.5	90	61	77	2	46	29	43	5	86	4	55	1
Central Hill	90	3.7	98	82	89	7	62	24	53	9	93	10	36	0
Central Terai	95	5.7	98	73	88	6	33	19	36	8	92	14	34	0
Western Mountain	93	4.8	88	66	86	4	48	20	47	12	87	11	46	0
Western Hill	87	3.2	92	70	83	7	55	23	33	6	87	4	48	0
Western Terai	97	6	97	74	90	8	47	38	53	16	86	12	33	0
Mid-western Hill	96	4.1	93	72	91	4	56	23	56	11	87	14	45	0
Mid-western Terai	98	5.2	100	93	94	17	71	39	85	27	96	25	33	0
Far-western Hill	98	4.7	98	75	91	5	51	22	57	6	89	5	54	0
Far-western Terai	98	4.5	99	77	91	9	65	28	50	20	87	5	42	0
Literacy														
Illiterate	93	5	95	68	83	4	36	17	38	7	91	10	36	0
Literate	93	4.6	96	75	88	7	54	24	47	10	89	10	40	0
Age														
<25 yr	90	4.2	94	63	86	6	49	20	43	9	89	8	44	1
25-39 yr	94	4.6	95	76	89	7	56	24	46	10	89	9	41	0
40-54 yr	92	4.7	96	74	88	7	49	23	47	9	90	10	38	0
55+ yr	94	4.7	96	70	84	6	42	22	41	7	91	11	34	0
Geographic area														
Urban	93	6.1	97	70	79	7	39	29	54	11	92	12	46	0
Rural	93	4.6	95	74	87	7	51	23	46	9	89	10	39	0
Time to closest HF														
<30 min	93	5.1	95	74	88	6	46	25	44	10	90	9	39	0
30-60 min	93	4.6	97	75	88	7	52	23	47	10	90	10	40	0
>60 min	92	4.2	94	73	87	8	54	19	46	7	88	10	39	0
Districts implementing CB-NCP program														
No	92	4.4	94	72	85	6	51	24	44	7	90	8	43	0
Yes	94	4.9	96	75	89	7	51	22	47	10	89	11	36	0
NATIONAL	93	4.7	95	74	87	7	51	23	46	9	89	10	39	0

^aSignificant difference between domains p<0.05; ^bsignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; ^esignificant difference by time to closest HF p<0.05; ^fsignificant difference between CB-NCP districts p<0.05; *only includes FCHVs who reported at least one pregnant woman in their catchment/ward area in the last year; **only includes FCHVs who reported providing information, advice or services about pregnancy.

Annex 29. Percent distribution of all FCHVs recalling danger signs of pregnancy complications that require medical attention (unprompted)

Characteristics	Any vaginal bleeding ^{ab}	Severe headache ^{abd}	Fits and unconsciousness ^{abce}	Severe lower abdominal pain ^a	Swelling of hands and face ^{ac}	Blurred vision ^a	Others ^{acd}	Don't know ^{bc}
DENOMINATOR (N)	4,302							
Domains								
Eastern Mountain	90	74	63	45	45	21	13	1
Eastern Hill	92	81	60	58	54	33	5	0
Eastern Terai	90	61	48	48	47	23	36	1
Central Mountain	90	65	53	51	55	24	35	2
Central Hill	95	84	73	69	70	32	24	1
Central Terai	89	83	58	69	58	31	20	0
Western Mountain	86	71	59	63	54	28	32	2
Western Hill	92	69	57	45	58	33	25	1
Western Terai	91	78	64	54	72	16	23	1
Mid-western Hill	94	84	67	68	62	35	23	0
Mid-western Terai	99	95	84	87	77	44	13	0
Far-western Hill	93	85	76	74	64	31	29	1
Far-western Terai	91	88	68	72	72	24	27	1
Literacy								
Illiterate	87	73	52	59	58	29	21	1
Literate	92	78	64	60	60	30	24	1
Age								
<25 yr	90	75	59	65	49	26	15	3
25-39 yr	92	78	66	61	59	30	25	0
40-54 yr	91	77	60	59	59	31	24	0
55+ yr	91	75	54	57	64	30	17	1

Geographic area								
Urban	91	63	61	56	54	26	34	1
Rural	91	77	62	60	59	30	23	1
Time to closest HF								
<30 min	91	78	61	60	62	31	24	1
30-60 min	91	77	60	60	59	29	24	1
>60 min	92	76	65	59	57	31	22	1
NATIONAL	91	77	62	60	59	30	23	1

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; ^eSignificant difference by time to closest HF p<0.05

Annex 30. Percent distribution of FCHVs reporting treating ≥one woman for the following pregnancy and newborn related services, over the 3 months preceding the survey

Characteristics	Tested woman for pregnancy ^d	Average number of women tested for pregnancy	Informed woman about institution for safe abortion ^{ac}	Average number of women informed about institution for safe abortion	Gave iron tablets to pregnant woman ^{abde}	Average number of pregnant women given iron tablets	Give Matri Surakshya Chakki to pregnant woman ^{ab}	Average number of pregnant women given Matri Surakshya Chakki	Provide chlorhexidine to woman/family member and/or applied chlorhexidine to babies born at home ^{abcd}	Average number of women/family members provided chlorhexidine	Average number of babies born at home applied chlorhexidine
DENOMINATOR	1,627†	687	1,728†	572	4,302	2,023	2,063†	218	2,626†	647*	385**
Domains											
Eastern Mountain	-	-	-	-	18	2.8	-	-	15	1.5	1.4
Eastern Hill	47	3.1	51	4.7	34	3.6	7	1.7	27	2.4	1.6
Eastern Terai	51	3.6	36	5.4	67	10.2	-	-	30	4.6	2.7
Central Mountain	-	-	-	-	18	10.5	-	-	-	-	-
Central Hill	28	2	15	1.8	38	2.9	4	1.5	31	1.8	1.9
Central Terai	44	2.7	23	4.3	48	6.9	3	4	33	3.4	2.7
Western Mountain	61	3.4	38	3.3	24	4.6	12	2.3	10	2.1	1.5
Western Hill	32	2	35	4.3	46	3.2	4	1.7	28	2.3	1.6
Western Terai	39	2.9	49	4.9	57	5.3	19	3.8	53	3.8	2.3
Mid-western Hill	5	2.3	25	2.6	58	4.4	14	1.9	35	2.3	1.7
Mid-western Terai	48	3.2	22	2.3	69	11	23	3.1	25	3.1	2.1
Far-western Hill	-	-	-	-	74	4.6	10	1.9	27	2.3	2.2
Far-western Terai	52	2.5	35	2.6	83	5.6	4	1.5	36	2.6	1.7
Literacy											
Illiterate	38	3	25	3.3	39	7.3	6	3.2	24	3.2	2.4
Literate	42	2.8	34	4.6	49	5.4	10	2.1	31	2.8	2.2
Age											
<25 yr	33	3	20	1.8	43	4.7	10	2.3	14	2.1	2.4
25-39 yr	42	2.9	33	5.1	48	5.2	11	2	29	2.8	2.5
40-54 yr	41	2.8	35	4	47	5.8	8	2.4	31	3	2.1
55+ yr	41	2.6	21	3.6	45	6.8	9	3.1	28	3	2.3
Geographic area											
Urban	30	4.1	26	4.5	28	6.2	3	1.5	14	3	2.3
Rural	41	2.8	32	4.3	47	5.7	10	2.3	30	2.9	2.3
Time to closest HF											
<30 min	41	3	30	4.5	44	6.1	9	2.6	30	3.3	2.3
30-60 min	43	2.8	32	4.1	50	5.6	9	2.2	27	2.7	2.2
>60 min	38	2.7	34	4.4	47	5.4	10	2	32	2.7	2.2
NATIONAL	41	2.8	32	4.3	47	5.7	10	2.3	29	2.9	2.3

*Significant difference among domains p<0.05; †significant difference by literacy; ‡significant difference by age p<0.05; §p<0.05; ¶significant difference by residence p<0.05; *Only includes FCHVs who reported providing chlorhexidine in the 3 months prior to the survey to at least one pregnant woman/her family member; **only includes FCHVs who reported applying chlorhexidine in the 3 months prior to the survey to at least one baby at home

Annex 31. Percent distribution of all FCHVs recalling (unprompted) danger signs of newborn complications that require medical attention

Characteristics	Poor sucking or feeding ^{af}	Fever ^{af}	Fast or difficult breathing ^{aef}	Chest indrawin ^{gaef}	Cord infection ^{acbe}	Hypothermia ^{abcdf}	Difficulty to wake/lethargic/unconscious ^{ab}	Born very small ^{af}	Others ^{adf}	Don't know ^c
DENOMINATOR (N)	4,302									
Domains										
Eastern Mountain	82	66	63	49	34	42	25	20	11	2
Eastern Hill	81	64	61	42	57	57	27	20	8	2
Eastern Terai	75	72	67	58	51	51	30	24	8	1
Central Mountain	83	55	45	32	58	30	29	11	32	3
Central Hill	84	76	73	61	62	56	56	19	15	1
Central Terai	83	78	81	70	33	49	48	21	14	1
Western Mountain	80	70	54	48	65	52	40	17	17	3
Western Hill	79	67	58	50	48	45	34	11	19	1
Western Terai	84	79	76	68	47	50	37	23	8	1
Mid-western Hill	86	74	69	63	69	54	48	18	7	0
Mid-western Terai	100	90	84	72	80	81	75	39	3	0
Far-western Hill	91	80	69	69	78	74	69	21	9	1
Far-western Terai	90	78	74	63	75	60	50	8	8	1
Literacy										
Illiterate	80	70	70	56	42	41	36	21	13	2
Literate	83	73	67	58	57	55	44	18	13	1
Age										
<25 yr	79	68	66	58	50	48	33	18	10	4
25-39 yr	82	75	67	58	58	57	44	20	13	1
40-54 yr	84	71	66	58	53	52	42	18	13	1
55+ yr	82	71	72	55	48	44	43	19	14	0
Geographic area										
Urban	81	67	67	56	49	45	37	16	23	2
Rural	83	73	67	58	55	52	42	19	13	1
Time to closest health facility										
<30 min	84	74	71	61	50	53	44	19	13	2
30-60 min	83	73	67	58	55	52	41	20	12	1
>60 min	80	70	64	53	59	53	43	17	14	1
Districts implementing CB-NCP program										
No	80	66	65	48	53	43	37	15	16	1
Yes	84	77	69	64	55	59	46	21	11	1
NATIONAL	83	72	67	58	55	52	42	19	13	1

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05;

^eSignificant difference by time to closest health facility p<0.05; ^fsignificant difference between CB-NCP districts p<0.05

Annex 32. Average score of all FCHVs by level of agreement (+2 strongly agree, through -2 strongly disagree) on perceptions and satisfaction

Characteristics	Happy to be an FCHV	Family supports work as an FCHV	5 yrs from now will still be a FCHV	As compared to the past, my work burden as an FCHV has significantly increased	Communities appreciate FCHVs	Receive sufficiency support from supervisor	Treated fairly and respectfully by health workers at health facilities	Working as an FCHV contributed to greater respect in community	Regular supply of drugs & other supplies	Duties as an FCHV interferes with other important responsibilities	FCHVs are treated fairly by the gov't	Filling in forms or registers related to my FCHV duties is burden to me	Current provision of benefits is adequate for me to the services I provide to the community
DENOMINATOR	4,302												
Domain													
Eastern Mountain	1.9	1.8	1.8	1.8	1.6	1.7	1.6	1.5	1.3	0.7	0	-0.6	-0.4
Eastern Hill	1.8	1.9	1.7	1.9	1.7	1.7	1.7	1.6	1.4	0.7	0	-0.3	-0.8
Eastern Terai	1.9	1.9	1.8	1.8	1.8	1.8	1.7	1.6	1.5	-0.2	0.6	-1	-0.5
Central Mountain	1.8	1.9	1.7	1.9	1.8	1.7	1.7	1.8	1.3	0.2	0.5	-0.7	-0.1
Central Hill	1.9	1.9	1.8	1.7	1.8	1.8	1.8	1.8	1.6	0.3	0.1	-0.6	-0.2
Central Terai	1.9	1.8	1.8	1.9	1.6	1.6	1.6	1.6	1.3	0.4	-0.3	0.1	-1.1
Western Mountain	1.9	1.9	1.8	1.5	1.7	1.6	1.6	1.7	1.1	0.3	0.7	-0.1	0.1
Western Hill	1.8	1.9	1.7	1.8	1.6	1.7	1.7	1.5	1.6	0.2	0.1	-0.9	-0.2
Western Terai	1.9	1.9	1.8	1.8	1.8	1.8	1.7	1.7	1.5	0	0.9	-0.5	-0.4
Mid-western Hill	1.8	1.9	1.7	1.9	1.7	1.7	1.8	1.4	1.6	0.5	0.1	-0.6	-0.6
Mid-western Terai	2	2	2	1.9	2	1.9	1.8	1.9	1.8	0	-1	-0.8	-1.2
Far-western Hill	1.9	1.9	1.9	1.9	1.7	1.8	1.8	1.7	1.7	0.7	0.6	-0.7	-0.6
Far-western Terai	1.8	1.9	1.8	1.9	1.8	1.7	1.7	1.8	1.7	0.7	-0.3	-0.5	-0.8
Literacy													
Illiterate	1.9	1.8	1.7	1.8	1.7	1.6	1.6	1.7	1.4	0.2	0.4	0.3	-0.5
Literate	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.5	0.3	0.1	-0.7	-0.5
Age													
<25 yr	1.8	1.9	1.8	1.4	1.6	1.7	1.7	1.6	1.6	0.3	0	-1	-0.4
25-39 yr	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.5	0.3	0.2	-0.8	-0.5
40-54 yr	1.9	1.9	1.8	1.9	1.7	1.7	1.7	1.7	1.5	0.3	0.1	-0.4	-0.5
55+ yr	1.9	1.9	1.6	1.9	1.8	1.6	1.6	1.7	1.5	0.2	0.2	-0.1	-0.6
Geographic area													
Urban	1.9	1.9	1.9	1.6	1.8	1.5	1.6	1.6	1	0	-0.1	-1	-0.9
Rural	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.5	0.3	0.2	-0.5	-0.5
Time to closest HF													
<30 min	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.7	1.5	0.2	0.2	-0.5	-0.5
30-60 min	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.5	0.4	0.1	-0.6	-0.6
>60 min	1.8	1.9	1.7	1.8	1.7	1.7	1.7	1.6	1.5	0.5	0.2	-0.5	-0.4
NATIONAL	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.5	0.3	0.2	-0.5	-0.5

Annex 33a. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (happiness and intent to continue as FCHV)

DENOMINATOR (N)	Happy to be an FCHV ^e					5 yrs from now will still be a FCHV ^c				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	94	5	0	0	0	85	11	0	0	3
Eastern Hill	87	11	1	0	0	80	16	2	2	1
Eastern Terai	94	5	1	0	0	89	8	1	2	0
Central Mountain	85	13	2	0	0	82	13	3	1	1
Central Hill	92	7	0	1	0	87	9	2	1	1
Central Terai	92	6	1	1	0	88	9	1	1	0
Western Mountain	93	7	0	0	0	85	13	1	1	1
Western Hill	88	9	2	1	0	81	14	2	1	2
Western Terai	94	5	0	0	1	88	8	0	1	3
Mid-western Hill	81	17	1	1	0	79	17	1	1	2
Mid-western Terai	98	2	0	0	0	98	2	0	0	0
Far-western Hill	91	8	1	0	0	92	6	0	0	2
Far-western Terai	84	15	1	0	0	83	15	2	0	0
Literacy										
illiterate	92	6	1	0	0	83	12	3	1	1
literate	90	9	1	0	0	86	11	1	1	1
Age										
<25 yr	88	10	0	1	0	86	10	0	1	2
25-39 yr	90	9	1	0	0	88	10	1	0	1
40-54 yr	90	8	1	0	0	85	11	1	1	1
55+ yr	92	7	1	1	0	78	13	3	3	2
Geographic area										
Urban	91	9	0	0	0	90	9	0	0	1
Rural	90	8	1	0	0	85	11	1	1	1
Time to closest HF										
<30 min	91	7	1	0	0	87	10	1	1	1
30-60 min	91	7	0	1	0	85	11	1	1	1
>60 min	87	11	1	1	0	82	13	2	1	2
NATIONAL	90	8	1	0	0	85	11	1	1	1

^cSignificant difference by age p<0.05; ^esignificant difference by time to closest HF p<0.05

Annex 33b. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (community appreciation and FCHVs' sense of respect)

DENOMINATOR (N)	Communities Appreciate FCHVs					Working as an FCHV contributed to greater respect in community ^{bc}				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	65	31	3	1	1	84	13	3	0	0
Eastern Hill	70	27	1	2	0	90	10	1	0	0
Eastern Terai	78	15	3	3	0	92	6	1	0	0
Central Mountain	84	12	2	1	1	89	9	1	0	1
Central Hill	84	13	1	1	1	96	3	1	0	0
Central Terai	68	31	1	1	0	81	19	0	0	0
Western Mountain	73	24	2	0	1	90	9	1	0	0
Western Hill	63	28	6	1	1	91	8	1	0	0
Western Terai	79	19	0	1	1	92	7	0	1	1
Mid-western Hill	63	28	5	3	0	94	5	1	1	0
Mid-western Terai	96	3	0	0	0	96	4	0	0	0
Far-western Hill	77	20	2	0	0	92	8	0	0	0
Far-western Terai	79	20	1	0	0	88	11	1	0	0
Literacy										
Illiterate	71	26	2	0	0	85	13	1	0	0
Literate	73	22	3	2	1	91	8	1	0	0
Age										
<25 yr	65	28	1	1	4	93	6	1	0	0
25-39 yr	71	24	3	2	0	90	9	1	0	0
40-54 yr	75	21	2	1	0	91	8	1	0	0
55+ yr	75	21	3	1	0	87	11	1	0	1
Geographic area										
Urban	71	26	1	2	0	91	8	0	0	0
Rural	73	23	3	1	1	90	9	1	0	0
Time to closest HF										
<30 min	74	22	2	1	1	89	10	0	0	0
30-60 min	73	23	3	1	0	91	8	1	0	0
>60 min	72	23	4	1	1	91	8	1	0	0
NATIONAL	73	23	3	1	1	90	9	1	0	0

^aSignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05.

Annex 33c. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (family support and support from supervisor)

DENOMINATOR (N)	Family Supports work as an FCHV ^b					Receive sufficient support from supervisor ^c				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	84	13	3	0	0	72	25	3	0	0
Eastern Hill	90	10	1	0	0	73	26	1	0	0
Eastern Terai	92	6	1	0	0	85	11	3	1	0
Central Mountain	89	9	1	0	1	81	14	1	4	0
Central Hill	96	3	1	0	0	87	10	2	1	0
Central Terai	81	19	0	0	0	62	35	3	0	0
Western Mountain	90	9	1	0	0	67	28	3	1	2
Western Hill	91	8	1	0	0	80	17	2	1	0
Western Terai	92	7	0	1	1	83	14	1	2	0
Mid-western Hill	94	5	1	1	0	79	17	2	1	1
Mid-western Terai	96	4	0	0	0	91	8	0	0	0
Far-western Hill	92	8	0	0	0	85	12	2	1	0
Far-western Terai	88	11	1	0	0	75	24	1	0	0
Literacy										
illiterate	85	13	1	0	0	67	28	3	1	0
literate	91	8	1	0	0	80	17	2	1	0
Age										
<25 yr	93	6	1	0	0	79	18	2	1	1
25-39 yr	90	9	1	0	0	79	18	2	1	1
40-54 yr	91	8	1	0	0	77	20	2	1	0
55+ yr	87	11	1	0	1	73	23	2	2	0
Geographic area										
Urban	91	8	0	0	0	69	22	3	4	1
Rural	90	9	1	0	0	77	19	2	1	0
Time to closest HF										
<30 min	89	10	0	0	0	78	19	2	1	0
30-60 min	91	8	1	0	0	78	19	2	0	0
>60 min	91	8	1	0	0	75	20	2	2	0
NATIONAL	90	9	1	0	0	77	19	2	1	0

Annex 33d. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (adequacy of supplies and respectful treatment by health workers)

DENOMINATOR (N)	Regular supply of drugs & other supplies ^{bcd}					Treated fairly and respectfully by health workers at health facilities ^{bd}				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	49	42	8	2	0	66	29	4	0	1
Eastern Hill	56	36	5	2	0	72	26	1	1	0
Eastern Terai	71	19	6	4	0	86	9	3	2	0
Central Mountain	66	20	9	5	0	81	14	3	2	0
Central Hill	75	17	5	3	1	88	9	2	1	0
Central Terai	52	41	6	2	0	63	34	2	0	0
Western Mountain	49	32	13	6	1	69	27	1	1	1
Western Hill	75	21	4	1	0	78	19	2	0	1
Western Terai	71	22	5	3	0	80	15	1	1	2
Mid-western Hill	75	19	4	2	1	83	13	1	1	2
Mid-western Terai	81	18	2	0	0	87	12	1	0	0
Far-western Hill	79	17	4	0	0	86	12	1	1	0
Far-western Terai	73	24	3	0	0	73	25	1	0	0
Literacy										
Illiterate	59	31	7	2	0	71	25	3	1	0
literate	68	24	5	2	0	79	18	2	1	1
Age										
<25 yr	69	26	2	2	1	76	19	3	1	1
25-39 yr	67	25	6	3	0	78	19	1	0	1
40-54 yr	67	25	6	2	0	78	19	2	1	1
55+ yr	62	32	5	2	0	73	22	3	2	0
Geographic area										
Urban	53	25	10	12	0	73	20	4	1	2
Rural	66	26	5	2	0	77	19	2	1	1
Time to closest HF										
<30 min	67	26	5	2	0	78	19	2	1	0
30-60 min	66	25	6	2	0	79	18	2	1	1
>60 min	65	26	6	3	0	75	21	3	1	1
NATIONAL	66	26	6	2	0	77	19	2	1	1

^aSignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05

Annex 33e. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (adequacy of benefits and fair treatment by government)

DENOMINATOR (N)	Current provision of benefits is adequate for me for the services I provide to the community ^{acd}					FCHVs are treated fairly by the gov ^{tabc}				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	18	21	23	36	2	21	29	15	28	8
Eastern Hill	10	20	20	49	1	17	33	23	25	3
Eastern Terai	22	15	17	46	0	52	13	8	24	3
Central Mountain	24	25	20	30	1	38	24	17	17	5
Central Hill	14	32	23	30	1	29	22	20	23	6
Central Terai	4	20	18	57	1	17	29	11	40	3
Western Mountain	19	38	14	25	3	34	36	13	12	6
Western Hill	24	23	12	39	2	26	22	13	26	13
Western Terai	12	31	8	45	4	38	36	4	7	14
Mid-western Hill	14	21	16	45	4	21	24	16	22	18
Mid-western Terai	5	13	18	64	0	6	20	16	58	0
Far-western Hill	12	22	19	45	1	38	27	14	14	7
Far-western Terai	13	16	22	49	0	9	27	29	24	11
Literacy										
Illiterate	14	25	18	42	1	31	32	13	20	4
Literate	15	23	17	43	2	27	24	15	26	8
Age										
<25 yr	11	29	15	36	9	17	32	16	24	11
25-39 yr	15	24	17	43	2	28	25	15	24	8
40-54 yr	16	23	17	44	1	28	25	13	27	7
55+ yr	13	22	20	44	1	28	29	16	23	4
Geographic area										
Urban	10	18	19	53	0	22	23	14	34	7
Rural	15	24	17	43	2	28	26	14	25	7
Time to closest HF										
<30 min	15	23	18	43	2	28	26	13	26	7
30-60 min	14	24	16	46	1	28	25	15	26	6
>60 min	16	24	18	40	2	27	26	14	23	10
NATIONAL	15	24	17	43	2	28	26	14	25	7

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05

Annex 33f. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (conflict with other responsibilities and difficulty of completing forms)

DENOMINATOR (N)	Duties as an FCHV interferes with other important responsibilities ^e					Filling in forms or registers related to my FCHV duties is burdensome to me ^{abc}				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	26	50	15	8	1	6	30	22	42	0
Eastern Hill	28	50	9	12	0	13	33	23	31	1
Eastern Terai	20	32	7	41	0	8	22	9	62	0
Central Mountain	25	35	9	31	0	10	26	10	54	0
Central Hill	15	52	14	19	0	10	26	18	46	0
Central Terai	18	50	16	15	1	13	44	23	20	0
Western Mountain	27	35	17	21	1	21	29	15	32	2
Western Hill	24	37	15	24	0	6	21	16	56	0
Western Terai	23	33	6	37	1	15	24	4	51	5
Mid-western Hill	23	49	11	17	1	11	26	17	47	0
Mid-western Terai	5	56	11	27	0	4	30	12	53	0
Far-western Hill	28	50	9	13	0	10	23	14	51	2
Far-western Terai	27	51	10	12	0	9	21	44	25	0
Literacy										
Illiterate	20	42	13	24	0	26	38	14	21	2
Literate	22	44	12	21	0	7	26	17	49	0
Age										
<25 yr	21	42	15	20	1	6	16	19	54	4
25-39 yr	23	44	12	21	0	7	25	16	51	0
40-54 yr	22	44	11	22	0	12	31	17	40	0
55+ yr	19	44	15	22	0	20	31	16	31	2
Geographic area										
Urban	16	41	12	30	0	5	21	13	61	1
Rural	22	44	12	22	0	11	28	17	43	1
Time to closest HF										
<30 min	18	43	13	25	0	10	31	17	41	1
30-60 min	23	45	11	21	0	11	27	16	46	1
>60 min	25	44	13	18	0	12	27	18	43	1
NATIONAL	22	44	12	22	0	11	28	17	44	1

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^esignificant difference by time to closest HF p<0.05.

Annex 33g. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (health worker performance and adequacy of service provision)

DENOMINATOR (N)	At our local health facility, we have a problem with certain health workers who are not available at work when they should be ^{abc}					There have been problems at our health facility with services not being provided properly ^{abc}				
	4,302					4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain										
Eastern Mountain	12	45	18	25	0	14	39	17	30	1
Eastern Hill	8	30	30	32	1	6	29	30	34	1
Eastern Terai	5	23	12	60	1	5	21	12	61	0
Central Mountain	20	30	10	39	0	16	29	11	44	0
Central Hill	10	17	24	48	0	10	16	22	52	0
Central Terai	6	41	22	31	0	9	38	22	32	0
Western Mountain	21	39	15	23	2	19	35	18	26	2
Western Hill	7	18	15	58	1	7	19	14	60	1
Western Terai	6	20	11	58	5	6	19	9	61	5
Mid-western Hill	6	21	19	53	1	7	17	17	59	1
Mid-western Terai	1	31	5	63	0	2	32	3	63	0
Far-western Hill	4	16	16	62	1	4	16	15	64	1
Far-western Terai	4	10	56	29	0	3	9	56	31	0
Literacy										
Illiterate	9	33	19	37	1	11	30	19	39	1
Literate	8	25	19	48	1	8	23	18	50	1
Age										
<25 yr	12	23	22	38	4	12	20	22	42	4
25-39 yr	10	24	19	46	1	9	23	18	49	1
40-54 yr	7	27	18	47	1	7	25	18	49	1
55+ yr	7	32	19	41	1	9	28	19	44	1
Geographic area										
Urban	7	26	16	49	2	8	23	16	50	3
Rural	8	26	19	46	1	8	25	18	48	1
Time to closest HF										
<30 min	7	27	18	47	1	8	25	17	49	1
30-60 min	8	27	18	46	1	8	25	18	48	1
>60 min	10	25	21	44	1	10	23	19	47	1
NATIONAL	8	26	19	46	1	8	25	18	48	1

^aSignificant difference among domains p<0.05; ^bsignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05.

Annex 33h. Percent distribution of all FCHVs by job satisfaction and perceptions, nationally and by background characteristics (increase in work burden as FCHV)

DENOMINATOR (N)	As compared to the past, my work burden as an FCHV has significantly increased ^{de}				
	4,302				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Domain					
Eastern Mountain	86	11	0	1	1
Eastern Hill	88	10	0	1	1
Eastern Terai	85	13	0	1	1
Central Mountain	89	9	0	1	1
Central Hill	78	17	1	2	2
Central Terai	89	10	0	1	0
Western Mountain	68	23	1	5	3
Western Hill	88	9	0	0	2
Western Terai	86	11	1	1	1
Mid-western Hill	92	7	0	1	0
Mid-western Terai	91	9	0	0	0
Far-western Hill	92	7	0	1	0
Far-western Terai	90	9	0	0	0
Literacy					
Illiterate	85	13	0	1	0
Literate	86	11	0	1	1
Age					
<25 yr	63	22	1	2	12
25-39 yr	85	12	0	1	1
40-54 yr	89	9	0	1	0
55+ yr	87	12	0	1	0
Geographic area					
Urban	77	16	3	3	1
Rural	86	11	0	1	1
Time to closest HF					
<30 min	83	14	1	1	1
30-60 min	87	10	0	1	1
>60 min	89	9	0	1	1
NATIONAL	86	11	0	1	1

^dSignificant difference by residence $p < 0.05$; ^esignificant difference by time to closest HF $p < 0.05$.

Annex 34a. Percent distribution of all FCHVs by perceptions regarding motivation, nationally and by background characteristics (new knowledge and respect from community)

DENOMINATOR (N)	Opportunity to obtain new knowledge or skills					Respect and recognition from others in the community				
	4,302					4,302				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Domain										
Eastern Mountain	96	4	0	0	0	85	13	1	0	0
Eastern Hill	99	1	0	0	0	94	6	0	0	0
Eastern Terai	98	2	0	0	0	95	3	1	0	1
Central Mountain	97	3	0	0	0	89	10	1	0	0
Central Hill	99	1	0	0	0	94	6	0	0	0
Central Terai	99	1	0	0	0	84	16	0	0	0
Western Mountain	95	5	0	0	0	82	17	1	0	0
Western Hill	97	2	0	0	0	88	11	1	0	1
Western Terai	95	4	1	0	0	94	6	0	0	0
Mid-western Hill	99	1	0	0	0	91	8	0	0	0
Mid-western Terai	99	1	0	0	0	99	1	0	0	0
Far-western Hill	97	3	0	0	0	92	8	1	0	0
Far-western Terai	99	0	0	0	0	97	3	0	0	0
Literacy										
Illiterate	97	3	0	0	0	88	11	1	0	0
Literate	98	2	0	0	0	90	9	0	0	0
Age										
<25 yr	97	2	1	0	0	88	11	0	0	1
25-39 yr	97	2	0	0	0	90	10	0	0	0
40-54 yr	98	2	0	0	0	91	8	1	0	0
55+ yr	97	2	0	0	0	90	9	0	0	0
Geographic area										
Urban	98	2	0	0	0	91	9	0	0	0
Rural	98	2	0	0	0	90	9	0	0	0
Time to closest HF										
<30 min	98	2	0	0	0	89	10	0	0	0
30-60 min	98	2	0	0	0	91	9	0	0	0
>60 min	97	3	0	0	0	90	9	1	0	0
NATIONAL	98	2	0	0	0	90	9	0	0	0

Annex 34b. Percent distribution of all FCHVs by perceptions regarding motivation, nationally and by background characteristics (interesting work and contribution to family income)

DENOMINATOR (N)	Enjoyable, stimulating, and/or interesting activities e.g., program exposure visits or tours etc. ^b					Contribution to family income ^{bcde}				
	4,302					4,302				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Domain										
Eastern Mountain	81	15	3	0	0	41	25	21	13	0
Eastern Hill	86	13	1	0	0	42	31	19	7	0
Eastern Terai	85	11	3	1	1	48	23	18	11	0
Central Mountain	84	11	4	1	1	52	33	9	6	0
Central Hill	87	7	4	1	0	50	20	19	11	0
Central Terai	80	18	1	0	1	52	34	10	4	0
Western Mountain	74	23	2	1	0	38	28	15	16	2
Western Hill	84	15	0	0	1	43	26	20	10	0
Western Terai	90	9	1	0	0	71	19	6	4	1
Mid-western Hill	94	6	0	0	0	60	25	14	1	0
Mid-western Terai	95	5	0	0	0	43	33	18	6	0
Far-western Hill	86	5	7	2	0	42	28	19	10	1
Far-western Terai	96	3	1	0	0	48	18	20	13	1
Literacy										
illiterate	78	19	3	0	0	51	31	12	5	1
literate	86	11	2	1	1	48	26	17	9	0
Age										
<25 yr	89	8	3	0	1	50	23	16	9	3
25-39 yr	85	11	2	0	1	46	27	18	9	1
40-54 yr	85	12	1	0	0	50	26	15	8	0
55+ yr	80	16	3	1	0	51	29	14	7	0
Geographic area										
Urban	89	10	1	0	0	47	19	22	11	0
Rural	85	12	2	0	0	49	27	16	8	0
Time to closest HF										
<30 min	84	13	2	1	0	50	28	14	7	1
30-60 min	86	11	2	0	0	48	26	15	9	0
>60 min	84	13	2	0	0	47	25	19	9	0
NATIONAL	85	12	2	0	0	49	27	16	8	0

^aSignificant difference by literacy levels p<0.05; ^csignificant difference by age p<0.05; ^dsignificant difference by residence p<0.05; ^esignificant difference by time to HF p<0.05.

Annex 34c. Percent distribution of all FCHVs by perceptions regarding motivation, nationally and by background characteristics (improving community health and religious or community duty)

DENOMINATOR (N)	People in your community can be healthier					As a religious duty (dharma) or opportunity to serve the community				
	4,302					4,302				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Domain										
Eastern Mountain	87	12	0	0	0	86	12	2	0	0
Eastern Hill	87	13	0	0	0	95	5	1	0	0
Eastern Terai	96	3	0	0	0	98	2	0	0	0
Central Mountain	94	5	1	0	0	88	11	1	0	0
Central Hill	100	0	0	0	0	96	4	0	0	0
Central Terai	90	10	0	1	0	94	5	0	1	0
Western Mountain	88	12	0	0	0	87	13	0	0	0
Western Hill	94	6	0	0	0	85	14	1	0	0
Western Terai	95	4	0	0	1	90	9	0	0	1
Mid-western Hill	99	1	0	0	0	92	7	1	0	0
Mid-western Terai	98	1	0	0	0	100	0	0	0	0
Far-western Hill	95	5	1	0	0	96	4	0	0	0
Far-western Terai	99	1	0	0	0	99	1	0	0	0
Literacy										
Illiterate	92	8	0	0	0	94	6	0	0	0
Literate	94	6	0	0	0	92	7	0	0	0
Age										
<25 yr	94	5	0	0	1	92	7	1	0	1
25-39 yr	94	6	0	0	0	91	8	0	0	0
40-54 yr	94	6	0	0	0	92	7	0	0	0
55+ yr	93	7	0	0	0	96	4	0	0	0
Geographic area										
Urban	95	5	0	0	0	93	7	0	0	0
Rural	94	6	0	0	0	92	7	0	0	0
Time to closest HF										
<30 min	93	6	0	0	0	93	7	0	0	0
30-60 min	94	6	0	0	0	93	6	0	0	0
>60 min	94	6	0	0	0	91	9	1	0	0
NATIONAL	94	6	0	0	0	92	7	0	0	0

Annex 35. FCHV quantitative survey

SECTION I: IDENTIFICATION

S.N.	Questions	Responses	Codes
101	Domain Name		<input type="text"/> <input type="text"/>
102	District Name		<input type="text"/> <input type="text"/>
103	Name of VDC/Municipality		<input type="text"/> <input type="text"/> <input type="text"/>
104	Ward Number	<input type="text"/> <input type="text"/>	
105	Type of FCHV	Ward based Population based	1 2
106	How many households are there in your catchment area? Please ensure it is number of households and not the population.	Number of Households Don't know	<input type="text"/> <input type="text"/> <input type="text"/> 998
107	Surname of FCHV		
108	What is your caste/ethnicity? For caste/ethnic group code, refer to CBS list.		<input type="text"/> <input type="text"/>

SECTION 2: SOCIO-DEMOGRAPHIC INFORMATION

First of all, I will ask you some questions about you.

S.N.	Questions	Responses	Code	Go To
201	How old were you on your last birth day? Please record in completed years	Years <input type="text"/> <input type="text"/>		
202	Have you ever attended school?	Yes No	1 2 →	204
203	What is the highest grade you have completed? If less than grade 1, write "0" Write completed grade 1 to 9 in the given box or add the relevant codes listed.	Grade <input type="text"/> <input type="text"/> SLC passed Intermediate/+2 Bachelors Masters Others 203_a Please specify others.	10 11 12 13 96	<i>If highest grade is 6 or above go to Q.N. 206</i>
204	Now I would like you to read out loud as much of this sentence as you can? Show card to respondent. If respondent cannot read whole sentence, probe: Can you read any part of the sentence?	Cannot read at all Able to read part of the sentence Able to read whole sentence No Card with required language 204_a Please specify language.	1 2 3 4	
205	Please write down "My country is Nepal". Give paper and pen to respondent. Verify with her whether it is written correctly or not.	Able to write correctly Able to write partially Unable to write at all	1 2 3	

206	What is your mother tongue?	Nepali Maithili Bhojpuri Awadhi Newari Hindi Tamang Magar Tharu Others	1 2 3 4 5 6 7 8 9 96	
		206_a If others please specify.		
207	What is your marital status?	Currently married Unmarried Divorced/Separated Widow	1 2 3 4	209
208	Where does your husband stay?	Stays together at home Stays elsewhere (within country Stays elsewhere (abroad) Missing	1 2 3 4	
209	What type of family do you live in?	Nuclear Family Joint Family Extended Family Others	1 2 3 96	
		209_a If other please specify		

210	Besides FCHV work, in what type of income generating occupation/activities you are involved? Probe : Major occupation	Agriculture	1	
		Teaching	2	
		Other Services	3	
		Petty Business	4	
		Business	5	
		Daily Wage labor	6	
		Not involved in any occupation	7	
		Others	96	
		210_a If other please specify		

SECTION 3: WORK PROFILE

Now I will ask you some questions regarding activities performed by you as an FCHV.

S.N.	Questions	Responses	Code	Go To
301	How many years have you worked as an FCHV? Record response in completed years. If less than one Year record '0'.	<input type="text"/> <input type="text"/> years		
302	What are the activities you perform as an FCHV? (Multiple responses possible) Probe: Any others?	<ul style="list-style-type: none"> Antenatal care related Postnatal care related Neonatal care related Support in Immunization Clinic Support in PHC/ORC Family Planning Services and counselling IMCI related Nutrition counselling Conducting Health mothers group meeting Referral services Others 	<ul style="list-style-type: none"> 1 2 3 4 5 6 7 8 9 10 96 	
		302_a If other please specify.		
303	In the last week, what were the activities you performed as an FCHV? (Multiple responses possible) Probe: Any others?	<ul style="list-style-type: none"> Antenatal care related Postnatal care related Neonatal care related Support in Immunization Clinic Support in PHC/ORC Family Planning Services and counselling IMCI related Nutrition counselling Conducting Health mothers group meeting Referral services Others 	<ul style="list-style-type: none"> 1 2 3 4 5 6 7 8 9 10 96 	
		303_a If other please specify.		

304	In the last week how many days did you work as an FCHV? Record '0' if she has not worked in the last week. Please ensure that the activities conducted by FCHVs are only related to health.	<input type="text"/> days		
305	When you are working as an FCHV, how many hours do you usually work in a day? Record '0' if worked less than 1 hour. If only one answer please note same digit in both boxes	305_a minimum hours <input type="text"/> 305_b maximum hours <input type="text"/>		
306	On an average, on the days you work as an FCHV, how much time a day do you spend working as an FCHV? If answer is provided in hours, please convert to minutes and record	Minutes <input type="text"/> <input type="text"/> <input type="text"/>		
307	Considering your work as an FCHV and the time you spend working for it, would you be interested in spending the same amount of time, more time or less time as an FCHV?	Same amount of time More time Less time	1 2 3	
308	Do you live in the ward where you work as FCHV or you live outside the ward?	Lives in ward working as FCHV Lives outside the ward	1 2	
309	In last month, how many times did you visit to your HF? Record '0' if did not visit in the last month.	Number of times <input type="text"/> <input type="text"/>		
310	Which mode of transportation do you use generally to reach your HF you report to?	Walking Cycle Motorcycle Bus/Jeep/Van Others	1 2 3 4 96	312

311	On an average, how much money (if any) do you spend to reach the HF per month?	NRs. <input type="text"/> <input type="text"/> <input type="text"/>		
312	At present how much time generally does it take for you to reach your HF you report to from your home? If answer is provided in hours, please convert to minutes and record	Minutes <input type="text"/> <input type="text"/> <input type="text"/>		
313	Generally from which place do you provide services to the clients?	At own residence At residence of client Any other place	1 2 3	
314	Do you use mobile phone?	Yes No	1 2 →	317
315	Whom does that mobile phone belong?	Own Family member's Friend's	1 2 3	
316	On an average, how much money do you spend on mobile phone for FCHV work per month?	NRs. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
317	What are your sources of information on health issues? (Multiple responses possible) Probe: Any others?	Radio FCHV meetings/trainings Health workers Other FCHVs Television Newspaper Poster & Flip Charts Mobile phone (Text message) Others	1 2 3 4 5 6 7 8 96	
		317_a If other please specify.		

SECTION 4: SUPPORT RECEIVED

Now I will ask you some questions related to trainings received and meetings attended as FCHV.

S.N.	Questions	Responses	Code	Go To
401	Have you received FCHV Basic training?	Yes No	1 2	
402	When is the last time you went to the HF for an FCHV meeting? <i>(Note: If the response is the number of days/weeks/months/year then select the respective code and record the number in the given box below).</i>	Days Weeks Months Year Meeting never taken place Don't know Number <input type="text"/> <input type="text"/>	1 2 3 4 97 98	
403	When was the last time you participated in a 2-day review meeting at your HF?	Less than 6 months ago 6-12 months ago One year ago Don't Know/ Don't Remember	1 2 3 98	
404	Who supervises your FCHV work? <i>Note: Earlier working as VHW and MCHW are upgraded to AHW and ANM at present.</i>	H.A./Sr. AHW/AHW Staff Nurse/Sr. ANM/ANM AHW (Upgraded VHW) ANM (Upgraded MCHW) Other HF Staff Others 404_a If other please specify.	1 2 3 4 5 96	

405	When was the last time your supervisor contacted you? (Note: If the response is the number of days/weeks/months/year then select the respective code and record the number in the given box below).	Days Weeks Months Year Never contacted Don't know	1 2 3 4 97 98	407
		Number <input type="text"/> <input type="text"/>		
406	Where did your supervisor contact you to talk about your work last time?	Home of FCHV Immunization Clinic PHC/ORC Health Mothers Group Meeting Health Facility Mobile Phone Others	1 2 3 4 5 6 96	
		406_a If other please specify.		
Now I would like to ask you some questions about the incentives you receive as FCHV.				
407	Did you receive dress allowance in the last year?	Yes No	1 2 →	409
408	If Yes, how much rupees did you receive?	NRs. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Don't Remember	9998	
409	In the last year, did you receive any monetary or non-monetary incentives or anything other than dress allowance?	Yes No	1 2 →	412
410	Who had provided the incentive? (Multiple responses possible) Probe-ask if anything else	Health Facility VDC/Municipality Others	1 2 96	
		410_a If other please specify.		

411	What incentives did you receive? <i>(Multiple responses possible)</i> <i>Probe-ask if anything else</i>	Money Shawl Sari Bag Box (Tin) Umbrella Torch Light Cycle Radio Mobile phone Mobile Sim card Recognition/Appreciation letter Others	1 2 3 4 5 6 7 8 9 10 11 12 96	
Now I will ask some questions about your work in the community as FCHV and support received from them				
412	In the last 3 months, have you conducted health mothers group meeting in your ward?	Yes No	1 2 →	415
413	In the last 3 months, how many times have you conducted the health mothers group meeting? <i>Record from register. If not conducted record '0'.</i>	Number of Times <input type="text"/> <input type="text"/> Register submitted to Reporting HF Incomplete for 3 months record No register	94 95 99	
414	In the last 3 months, how many places did you conduct the mothers group meeting?	Number of Places <input type="text"/>		
415	In your district are there any active FCHV network/ association?	Yes No Don't know	1 2 98 } →	417
416	Are you associated with any organization or association dealing with FCHVs benefits?	Yes No Don't want to disclose	1 2 99	
417	Are you involved in any of the other local committees/groups?	Yes No	1 2 →	420

S.N.	Questions	Responses	Code	Go To
418	Which committee/group are you involved? (Multiple responses possible) Probe: Any others?	VDC/DDC committee Community forest Agricultural group HFOMC School Management Committee Water and Sanitation Political Group Ward Citizens' Forum Saving and credit cooperatives Women Development Committee Others 418_a If other please specify.	1 2 3 4 5 6 7 8 9 10 96	
419	What was the basis of your selection in that committee? (Multiple responses possible) Probe: Any others?	FCHV Women Ethnic group Political Affiliation Educational background Active participation Don't Know Others 419_a If other please specify.	1 2 3 4 5 6 98 96	
420	Do you have FCHV Fund in your VDC?	Yes No Don't Know	1 2 98	501
421	How much money is in the Fund at present?	Less than NRs. 50,000 NRs. 50,000 to NRs. 1,00, 000 More than NRs. 1,00,000 Don't Know	1 2 3 98	
422	Have you used money from FCHV Fund in last 1 year?	Yes No	1 2	

SECTION 5: WORK ACTIVITIES

Now I will ask you some questions about major activities conducted in the community as FCHVs.

S.N.	Questions	Responses	Code	Go To
PHC/ ORC				
501	Has a PHC outreach clinic ever been conducted that covers your ward/catchment area?	Yes No Health Facility delivers service Don't Know	1 2 3 98	505
502	In the last 3 months, how many PHC/ORCs were conducted that covers your ward/catchment area?	Number: <input type="text"/>		
503	Out of all those conducted in last 3 months, in how many of them did you provide support?	Number: <input type="text"/>		If '0' go to Q.No. 505
504	What is your role as an FCHV in this PHC/ORC? <i>(Multiple responses possible)</i> <i>Probe: Any others?</i>	Refer clients to clinic Attend the clinic to help Others 504_a If other please specify.	1 2 96	
Immunization				
505	Has an EPI clinic ever been conducted that covers your ward/catchment area?	Yes No	1 2 →	509
506	In the last 3 months, how many immunization clinics were conducted in your catchment area?	Number: <input type="text"/>		
507	Out of the immunization clinics conducted in last 3 months, in how many of them did you provide support?	Number: <input type="text"/>		If '0' go to Q.No. 509
508	What is your role as an FCHV in the immunization clinic? <i>(Multiple responses possible)</i> <i>Probe: Any others?</i>	Refer clients to clinic Attend the clinic to help Others 508_a If other please specify.	1 2 96	

S.N.	Questions	Responses	Code	Go To
Distribution of Vitamin A/Deworming tablets				
509	Did you participate in the most recent vitamin A/ Deworming tablet distribution in Baisakh/Kartik of this year?	Yes No	1 → 2	511
510	What was the reason for not being involved?	Sickness Out of place/village Vitamin A not in stock Others 510_a If other please specify.	1 2 3 96	
Family Planning				
511	In the last 3 months, to how manydid you provide counselling on family planning? (Read one by one) Record number in the box. If not remember record '998'. If not given service record '0'			
A	Pregnant Woman		<input type="text"/> <input type="text"/> <input type="text"/>	
B	Postnatal Woman		<input type="text"/> <input type="text"/> <input type="text"/>	
C	Newly Married Couple		<input type="text"/> <input type="text"/> <input type="text"/>	
D	Woman Undergone Abortion		<input type="text"/> <input type="text"/> <input type="text"/>	
E	Adolescent		<input type="text"/> <input type="text"/> <input type="text"/>	
F	Returnee Migrant		<input type="text"/> <input type="text"/> <input type="text"/>	
G	Other Adult Male		<input type="text"/> <input type="text"/> <input type="text"/>	
H	Other Adult Female		<input type="text"/> <input type="text"/> <input type="text"/>	

512	What are the Family Planning methods you know? (Multiple answers possible)	Condom Pills Depo/Sangini IUD/Copper T Norplant/Implant Permanent Sterilization (male) Permanent Sterilization (female) Natural methods Emergency Contraceptives	1 2 3 4 5 6 7 8 9	
513	In the last 3 months, how many condoms did you distribute? (Refer to the register for the record) (If not distributed record '0')	Number <input type="text"/> <input type="text"/> <input type="text"/> Register submitted to Reporting HF Incomplete for 3 months record No register	994 995 999	
514	In the last 3 months, how many cycles (strips) of contraceptive pills did you distribute? (Refer to the register for the record) (If not distributed record '0')	Cycles (Strips) <input type="text"/> <input type="text"/> <input type="text"/> Register submitted to Reporting HF Incomplete for 3 months record No register	994 995 999	
515	In the last 3 months, how many couples did you refer for family planning services? (Refer to the register for the record) (If none referred record '0')	Number <input type="text"/> <input type="text"/> <input type="text"/> Register submitted to Reporting HF Incomplete for 3 months record No register	994 995 999	
516	In the last 1 year, how many men and women did you refer for permanent sterilization? (If not referred record '0')	Men <input type="text"/> <input type="text"/> <input type="text"/> Women <input type="text"/> <input type="text"/> <input type="text"/> Don't Know/ Do not Remember	998	

S.N.	Questions	Responses	Code	Go To
Nutrition Related Activities				
517	In the last 3 months, record the number of people you provided the following nutrition related activities (Read one by one) If service not given , record '0', if don't know the number record '998'			
A	Distributed Balvita to children (Ask only in Balvita Implementation Districts & refer to register)	<input type="text"/> <input type="text"/> <input type="text"/>		
B	Weight measurement of child (Ask only in CBNCP Implementation Districts & refer to register)	<input type="text"/> <input type="text"/> <input type="text"/>		
C	Counselling pregnant woman on nutrition	<input type="text"/> <input type="text"/> <input type="text"/>		
D	Providing nutritional education on breastfeeding	<input type="text"/> <input type="text"/> <input type="text"/>		
E	Counselling on infant and young child feeding complementary feeding	<input type="text"/> <input type="text"/> <input type="text"/>		
F	Health Education on Sanitation	<input type="text"/> <input type="text"/> <input type="text"/>		
Child Health Related Activities				
518	In the last 3 months, how many malnourished children did you provide counselling or referred for care? (If not referred record '0')	Number <input type="text"/> <input type="text"/> <input type="text"/> No malnourished child Don't Know	993 998	
519	In the last 3 months, how many children suffering from diarrhea did you distribute ORS? (Refer to the register for the record) (If not distributed record '0')	Number <input type="text"/> <input type="text"/> <input type="text"/> No child suffering from diarrhea Register submitted to Reporting HF Incomplete record for 3 months No register	993 994 995 999	

520	<p>In the last 3 months, for how many children suffering from diarrhea did you distribute zinc tablet? (Refer to the register for the record) (If not distributed record '0')</p>	<p>Number <input type="text"/> <input type="text"/> <input type="text"/> No child suffering from diarrhea Register submitted to Reporting HF Incomplete for 3 months record No register</p>	<p>993 994 995 999</p>	
521	<p>In the last 3 months, how many children did you examine for cough and cold? (Refer to the register for the record) (If not distributed record '0')</p>	<p>Number <input type="text"/> <input type="text"/> <input type="text"/> No child suffering from cough/cold Register submitted to Reporting HF Incomplete for 3 months record No register</p>	<p>993 994 995 999</p>	
522	<p>In the last 3 months, how many children did you provide Cotrimoxazole for possible pneumonia cases? (Refer to treatment/referral slip or tally it) (If not distributed record '0')</p>	<p>Number <input type="text"/> <input type="text"/> <input type="text"/> No child suffering from pneumonia Register submitted to Reporting HF Incomplete for 3 months record No register</p>	<p>993 994 995 999</p>	

S.N.	Questions	Responses	Code	Go To
Maternal and Child Health				
523	In the last year, how many pregnant women were in there in your catchment/ward area?	Number <input type="text"/> <input type="text"/> <input type="text"/> Don't know / Do not remember	998	If '0' go to Q.No. 525
524	In the last 3 months, for how many pregnant women did you provide information, advice or services about pregnancy? (If the response is no, then write '0')	Number <input type="text"/> <input type="text"/> <input type="text"/> Don't know / Do not remember	998	
525	Generally, where do you provide service or information to the pregnant women?	At own residence At residence of pregnant woman Any other place	1 2 3	
526	What is the advice that you provide to pregnant women about pregnancy care? (Multiple responses possible) Probe: Anything else?	ANC checkup Injecting tetanus Having iron tablets Related to night blindness Related to deworming tablets Related to dangerous signs Related to giving birth at an HF Making arrangements for transportation in case of emergency and saving money Eating nutritious food Family planning Don't know Others 526_a If other please specify.	1 2 3 4 5 6 7 8 9 10 98 96	

527	<p>What is the advice that you provide to pregnant or recently delivered women about postnatal care?</p> <p>(Multiple responses possible)</p> <p>Probe: Anything else?</p>	<p>Eating nutritious food Early and exclusive breastfeeding Using chlorhexidine for cord care Using Matri Surakshya Chakki to prevent bleeding after delivery Family planning Don't know Others</p> <hr/> <p>527_a If other please specify.</p>	<p>1 2 3 4 5 98 96</p>	
528	<p>What are the danger signs of pregnancy complications that require medical attention?</p> <p>(Multiple responses possible)</p> <p>Probe: Is there anything else?</p>	<p>Severe headache Fits and unconsciousness Blurred vision Swelling of hands and face Severe lower abdominal pain Any vaginal bleeding Don't know Others</p> <hr/> <p>528_a If other please specify.</p>	<p>1 2 3 4 5 6 98 96</p>	
If services for pregnancy test not given by FCHV, go to Question no. 531 (refer to list)				
529	<p>How do you confirm pregnancy?</p> <p>Multiple response possible</p>	<p>Use of test kit Refer to HF Based on women's history Others</p> <hr/> <p>529_a If other please specify.</p>	<p>1 2 3 96</p>	
530	<p>In last 3 months, how many women did you tested for pregnancy?</p> <p>Write '0' if not tested any women</p>	<p>Number <input type="text"/> <input type="text"/></p> <p>Don't know</p>	<p>98</p>	

S.N.	Questions	Responses	Code	Go To
531	In the last 3 months, for how many women did you inform about the listed institution for safe abortion? If no women were informed write '0'.	Number <input type="text"/> <input type="text"/> Don't know	98	
If Matri Surakshya Chakki intervention is not implemented in the district, go to Question no. 533 (refer to list)				
532	In the last 3 months, for how many pregnant women have you provided Matri Surakshya Chakki? (Refer to the register for the record) Write '0' if MSC not distributed to anyone.	Number <input type="text"/> <input type="text"/> <input type="text"/> Not any pregnant women Register submitted to reporting HF Incomplete for 3 months record No register	93 94 95 99	
If Chlorhexidine intervention is not implemented in the survey district, go to Question no. 535 (refer to list)				
533	In the last 3 months, to how many pregnant women/her family member have you provided chlorhexidine? If not provided to anyone, write '0'.	Number <input type="text"/> <input type="text"/> <input type="text"/> Not any pregnant women Don't know/ Do not remember	993 998	
534	In the last 3 months, how many babies born at home have applied chlorhexidine? (Refer to the register for the record) If not provided to anyone, write '0'	Number <input type="text"/> <input type="text"/> <input type="text"/> No home delivery Register submitted to Reporting HF Incomplete for 3 months record No register	993 994 995 999	
535	During the last 3 months, for how many pregnant women have you provided iron tablets? (Refer to the register for the record) If not provided to anyone, write '0'	Number <input type="text"/> <input type="text"/> <input type="text"/> Not any pregnant women Register submitted to Reporting HF Incomplete for 3 months record No register	993 994 995 999	

536	In last 6 months, how many live births occurred in your catchment area? <i>Include Home as well as HF based delivery</i> <i>If not born, write '0'</i>	Number <input type="text"/> <input type="text"/> <input type="text"/> Don't Know/ Do not Remember	998	
537	In last 1 year how many newborns died (within 28 days of birth) in your catchment area? <i>If there are no deaths, write '0'</i>	Number <input type="text"/> <input type="text"/> <input type="text"/> Don't Know/ Do not Remember	998	
538	Do you go to the home of recently delivered women to provide counseling and check the status of the newborns?	Yes No	1 2 →	540
539	In the last 3 months, how many recently delivered women and newborn have you visited in their homes? <i>If not visited from anyone record '0'</i>	Number <input type="text"/> <input type="text"/> <input type="text"/> Don't Know/ Do not Remember	998	
540	In the last 3 months, were you called by any family at their home when their newborn got sick?	Yes No	1 2	

S.N.	Questions	Responses	Code	Go To
541	<p>What are the danger signs in a newborn indicating need for immediate care-seeking?</p> <p>(Multiple responses possible) Probe: Anything else?</p>	<p>Poor sucking or feeding</p> <p>Fast or difficult breathing</p> <p>Chest indrawing</p> <p>Hypothermia</p> <p>Fever</p> <p>Difficulty to wake /lethargic / unconscious</p> <p>Pustules on skin/severe umbilical infection and redness of skin around the cord/foul smelling discharge or bleeding from the cord</p> <p>Born very small</p> <p>Don't Know</p> <p>Others</p> <hr/> <p>541_a If other please specify.</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>98</p> <p>96</p>	
542	<p>During the last 3 months, how many newborns you referred for danger signs?</p> <p>If none record '0'</p>	<p>Number <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Don't Know/ Do not Remember</p>	<p>998</p>	
543	<p>What special care is needed for low/very low birth weight newborns?</p> <p>PROBE: Anything else? (Multiple responses possible)</p>	<p>Regular breastfeed (day/night)</p> <p>Keep baby skin to skin contact</p> <p>Kangaroo mother care</p> <p>Refer to HF</p> <p>Don't Know</p> <p>Others</p> <hr/> <p>543_a If other please specify.</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>98</p> <p>96</p>	

SECTION 6: RECORDING

S.N.	Questions	Responses	Code						
601	Usually are you capable of recording and your work related information on your own or do you require assistance from others?	Usually, I record on my own Usually, I need assistance of others	1 2						
602	On an average, how much time do you spend on recording of your services in a month? <i>If answer is provided in hours, please convert to minutes and record</i>	<table border="1" data-bbox="1144 408 1391 512"> <tr> <td colspan="3" data-bbox="1144 408 1391 456">Minutes</td> </tr> <tr> <td data-bbox="1144 456 1227 512"></td> <td data-bbox="1227 456 1310 512"></td> <td data-bbox="1310 456 1391 512"></td> </tr> </table>	Minutes						
Minutes									

SECTION 7: PERCEPTIONS

S.N.	Questions	Responses	Code
701	I am happy to be an FCHV.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
702	Five years from now, I expect to still be working as an FCHV.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
703	My community recognizes and appreciates the services I provide.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
704	Working as an FCHV has contributed to receiving greater respect in my community.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
705	My family supports my work as an FCHV.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5

S.N.	Questions	Responses	Code
706	I receive sufficient support from my supervisor at the HF.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
707	There is regular supply of the required drugs and other supplies that I require (without stock-outs).	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
708	I feel I am treated fairly and respectfully by the health workers at the HF.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
709	Current provision of benefits is adequate for me to the services I provide to the community.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
710	I feel that FCHVs are treated fairly by the government.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
711	My duties as an FCHV interfere with other important responsibilities (e.g. other work or care for my family, agriculture, business etc.).	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5

S.N.	Questions	Responses	Code
712	Filling in forms or registers related to my FCHV duties is burden to me.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
713	At our local HF, we have a problem with certain health workers who are not available at work when they should be.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
714	There have been problems at our HF with services not being provided properly. <i>For e.g.: health facilities not opened in regular time, health workers not behaving properly, PHC-ORCs and EPI clinic not conducted regularly.</i>	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
715	As compared to the past, my work burden as an FCHV has significantly increased.	Totally Agree Somewhat Agree Somewhat Disagree Totally Disagree Unsure	1 2 3 4 5
Now I will read some statements about your perceptions regarding motivations for FCHV work. Please let me know if you think the following are very important, somewhat important, somewhat unimportant, not important at all or unsure.			
716	Opportunity to obtain new knowledge or skills	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5
717	Respect and recognition from others in the community	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5

718	Enjoyable, stimulating, and/or interesting activities e.g. program exposure visits or tours etc.	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5
719	Contribution to family income	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5
720	People in your community can be healthier	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5
721	As a religious duty (dharma) or opportunity to serve the community	Very Important Somewhat Important Somewhat Unimportant Not Important At All Unsure	1 2 3 4 5

SECTION 8: CHECKLIST FOR COMMODITIES

Now I would like to observe supplies and other items that you use to provide health services. This information should be obtained through observation.

S.N.	Name of the Commodities (Unit of assessment)	Record if the commodity/material is available? If not available, circle code 2 and ask for next commodity /material		Total quantity in stock	Number of date expired commodities		
		2				3	4
		Yes	No				
Commodities							
A	Condom (pieces)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
B	Contraceptive Pills (Number of Cycles)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
C	ORS packet (Number of Packet)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
D	Zinc tablets (Number of Strip)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
E	Cotrimoxazole-Pediatric (Number of Strip)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
F	Iron tablets (Number of Tablet)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
G	Vitamin A capsule (Number of Capsule)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
H	Navi Malam- Kawach (Number of Tube)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
I	Matri Surakshya Chakki (Number of Strip)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
J	Balvita (Number of Sachet)	1	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		

K	Pregnancy test kit (Piece)	1	2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Recording and Reporting Register					
L	FCHV ward register (71/72)	1	2		
M	FCHV ward register (Old)	1	2		
N	ARI treatment book (50 no. book)	1	2		
O	Iron Distribution register	1	2		
P	Vitamin A register	1	2		
Q	FCHV Identity Card (with number distributed by Family Health Division)	1	2		
Equipment (functioning)					
R	Timer (ARI)	1	2		
S	Iodine Test Kit	1	2		
T	Blue Plastic Cup	1	2		
Job Aid					
U	ARI classification card	1	2		
V	Cotrim card	1	2		
W	Zinc card	1	2		
X	Home therapy card	1	2		
Y	Chlorhexidine/Kawach card	1	2		
Z	Chlorhexidine doll	1	2		
AA	Basic flip chart	1	2		
AB	FCHV sign board	1	2		
AC	FCHV Manual	1	2		
AD	BPP flip chart	1	2		
AE	BPP action card (to pregnant women)	1	2		

Annex 36. List of researchers from HERD who participated in the 2014 FCHV Survey

Quantitative Survey	Qualitative Survey
Padam Darji	Rima Devi Bhattarai
Kundan Chaudhary	Tola Kumari Pathak
Rosani Pun	Srijana Banjade
Susmita KC	Radhika Sapkota
Dhurba Koirala	Bipul Pokharel
Asmi Pandey	Tejendra Prakash Regmi
Prem raj Joshi	
Joshanna Shrestha	
Vivek Khanal	
Rohit Acharya	
Rekha Rawal	
Jharana Neupane	
Suvekshya Ghimire	
Mahesh Subedi	
Sudesh Chaudhary	
Aaksh Kapali	
Jaynendra Sah	
Rekha Lama Tamang	
Ashraya Manandhar	
Sandhya Paudel	
Meera Thapa	
Krishna KC	
Binod Kumar Pokharel	
Rajiv Mahato	
Bipana Shrestha	
Dikshya Bhattarai	
Gopal Bajgain	
Sudip Aryal	
Saugat Raj Basnet	
Chetendra Raj Joshi	

Rekha Sah	
Usha Adhikari	
Ashok Kumar Joshi	
Bal Kumar Ojha	
Binod Pant	
Jeewan singh	
Ganesh Bahadur Khati	
Sudeep Khatri	
Sushil Kumar Thapa	
Sarmila Gautam	
Anita Khadka	
Jay Krishna Neupane	
Jayas Nepal	
Bimala Dangi	
Ishu Karki	
Suresh Subedi	
Upendra Chand	
Pooja Sharma	
Karuna Bhattarai	
Maya Chetri	
Bimal Giri	
Sanjay Bhandari	
Nirmal Kushwaha	
Anil Kadariya	
Dipendra Kumar Mandal	

Annex 37. Additional analysis on newly defined urban areas conducted by Save the Children

Percent distribution of FCHVs by education and literacy

	Attended School	Highest grade attended in school, among those who have attended					Literacy (%)
		1-5	6-10	SLC pass	Intermediate	BS/MS	
Denominator (N)	4302	2876					4302
Residence							
New Urban	72	26	48	17	5	4	83
Old Urban	89	11	40	38	7	5	98
Rest rural	65	37	44	13	4	2	81
Total	67	35	45	14	4	3	82

Percent distribution of all FCHVs by years of experience

Residence	Years of FCHV experience					Mean (years)	Median (years)
	<1 yr	1-5 yr	6-10 yr	11-15 yr	16+ yr		
Denominator (N)	4302						
New Urban	2	18	16	12	53	14.7	16
Old Urban	1	13	21	22	43	13.7	14
Rest rural	3	17	21	13	45	13.7	14
Total	3	17	21	13	46	13.9	14

Percent distribution of all FCHVs according to number of days involved in FCHV activities last one week and average hours per day

Residence	Number of days worked in last week				Average working hour per day				
	0	1-3 days	4+ days	Mean days	<1 hr	1 hr	2 hr	3+ hr	Mean Hours
Denominator (N)	4302								
New Urban	12	62	25	2.4	2	12	26	60	3.1
Old Urban	18	58	25	2.3	0	12	18	70	3.5
Rest rural	12	69	19	2.2	1	13	27	59	3.1
Total	12	68	20	2.25	1	13	26	59	3.1

Percent distribution of all FCHVs according to average hours per week and willingness to devote amount of time in future

Residence	Average working hour per week					Time willing to devote in future		
	<2	2.1 4 hr	4.1 6 hr	6.1+	Mean	Same amount of time	More time	Less time
Denominator (N)	4302							
New Urban	20	18	15	48	7.6	17	79	4
Old Urban	24	11	14	52	8.0	19	79	2
Rest rural	21	20	17	42	7.1	23	74	3
Total	21	20	16	43	7.2	22	75	3

Percent distribution of all FCHVs with commodity available

Residence	Condoms	Pills	ORS Packet	Zinc Tablet	Cotrimoxazole	Iron	Vitamin A	Chlorhexidine
Denominator (N)	4302							
New Urban	60	63	80	55	40	62	51	55
Old Urban	51	50	66	36	16	43	42	23
Rest rural	59	57	74	53	50	66	45	51
Total	59	58	75	53	49	65	46	52

Percent distribution of all FCHVs who have participated in meeting

Residence	Last time at the HF for the FCHV meeting				
	<1 week	2 4 wks	1 month to 1 yr	>1 yr	DK/no meeting
Denominator (N)	4302				
New Urban	23	57	15	3	2
Old Urban	19	42	22	5	13
Rest rural	25	53	18	3	2
Total	25	53	18	3	2

Percent distribution of all FCHVs who report involvement in different health activities over the 3 months prior to the survey

Residence	Immunization activities	Distributed condoms	Distributed OCPs	Distributed Chlorhexidine	Treating diarrhea by ORS	Treating diarrhea by Zinc	Examined children for cough and cold	Provided cotrimoxazole for suspected pneumonia cases	Counselling for complementary feeding	Counselling for breast feeding	Provided Iron tablets
Denominator (N)	2549	2664	2661	2626	4302						
New Urban	92	71	73	30	58	51	47	21	93	95	47
Old Urban	93	64	63	13	42	28	29	8	84	90	28
Rest rural	91	67	66	25	51	43	44	25	88	91	47
Total	91	68	67	25	52	45	44	24	89	92	47

Percent distribution of FCHVs who reported on involvement with network/association and other local committees/groups

Residence	Involved with local association working on FCHV benefits		
	An active FCHV network/association in the district (4302)	Among who said that there is present of active association in the district, Associate with an active FCHV network/association (870)	Involved in any other local committees/groups
Denominator (N)	4302	870	4302
New Urban	26	64	65
Old Urban	36	64	65
Rest rural	17	51	61
Total	19	54	61

Percent distribution of all FCHVs by level of agreement

Residence	Happy to be an FCHV					5 years from now, expect to still be an FCHV				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	92	7	0	1	0	86	11	1	1	1
Old Urban	91	9	0	0	0	90	9	0	0	1
Rest rural	90	9	1	0	0	85	11	2	1	1
Total	90	8	1	0	0	85	11	1	1	1

Percent distribution of all FCHVs by level of agreement

Residence	Community appreciates FCHVs					FCHV work contributes to greater respect in community				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	81	18	1	1	0	77	20	2	1	0
Old Urban	80	18	1	0	1	71	26	1	2	0
Rest rural	76	21	1	1	1	72	23	3	1	1
Total	77	20	1	1	1	73	23	3	1	0

Residence	Family supports work as FCHV					FCHV duties interfere with other important responsibilities				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	91	9	0	0	0	19	42	13	26	0
Old Urban	92	8	0	0	0	16	41	13	30	0
Rest rural	90	9	1	0	0	22	45	12	21	0
Total	90	9	1	0	0	22	44	12	22	0

Residence	Burden has increased					Receives adequate support from supervisor				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	9	25	16	50	0	79	18	2	1	0
Old Urban	5	21	13	61	1	69	23	4	4	0
Rest rural	11	29	17	42	1	77	20	2	1	0
Total	11	28	17	44	1	77	19	2	1	0

Residence	Regular supply of drugs and supplies					Treated fairly by HWs				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	63	30	4	3	0	79	19	1	1	0
Old Urban	53	25	10	12	0	73	20	4	1	2
Rest rural	67	25	6	2	0	77	19	2	1	1
Total	66	26	6	2	0	77	19	2	1	1

Residence	Treated fairly by government					Provision of benefits is adequate				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	29	26	12	26	7	14	25	16	45	1
Old Urban	22	23	14	34	7	10	18	19	53	0
Rest rural	27	26	15	25	7	15	23	17	43	2
Total	28	26	14	25	7	15	24	17	43	2

Residence	Problem at HF with health workers not available at work when they should be					Problems with services at HF not being provided properly				
	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure	Totally agree	Somewhat agree	Somewhat disagree	Totally disagree	Unsure
Denominator (N)	4302									
New Urban	7	25	16	51	1	8	23	17	52	0
Old Urban	7	26	16	49	2	8	23	16	50	3
Rest rural	8	27	19	45	1	8	25	18	47	1
Total	8	26	19	46	1	8	25	18	48	1

Residence	Opportunity to obtain new knowledge/ skills					Respect and recognition from others in the community				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Denominator (N)	4302									
New Urban	98	2	0	0	0	92	7	1	0	0
Old Urban	99	1	0	0	0	91	9	0	0	0
Rest rural	98	2	0	0	0	90	10	0	0	0
Total	98	2	0	0	0	90	9	0	0	0

Residence	Enjoyable, stimulating, and/or interesting activities					Contribution to family income				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Denominator (N)	4302									
New Urban	89	9	1	0	1	49	25	16	10	0
Old Urban	89	10	1	0	0	47	19	22	11	0
Rest rural	84	13	2	1	0	49	27	16	8	1
Total	85	12	2	1	0	49	27	16	8	0

Residence	People in your community can be healthier					As a religious duty (dharma)				
	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure	Very important	Somewhat important	Somewhat unimportant	Not important at all	Unsure
Denominator (N)	4302									
New Urban	94	5	1	1	1	94	5	0	1	0
Old Urban	95	5	0	0	0	93	7	0	0	0
Rest rural	94	6	0	0	0	92	8	0	0	0
Total	94	6	0	0	0	92	7	0	0	0

Advancing Partners & Communities

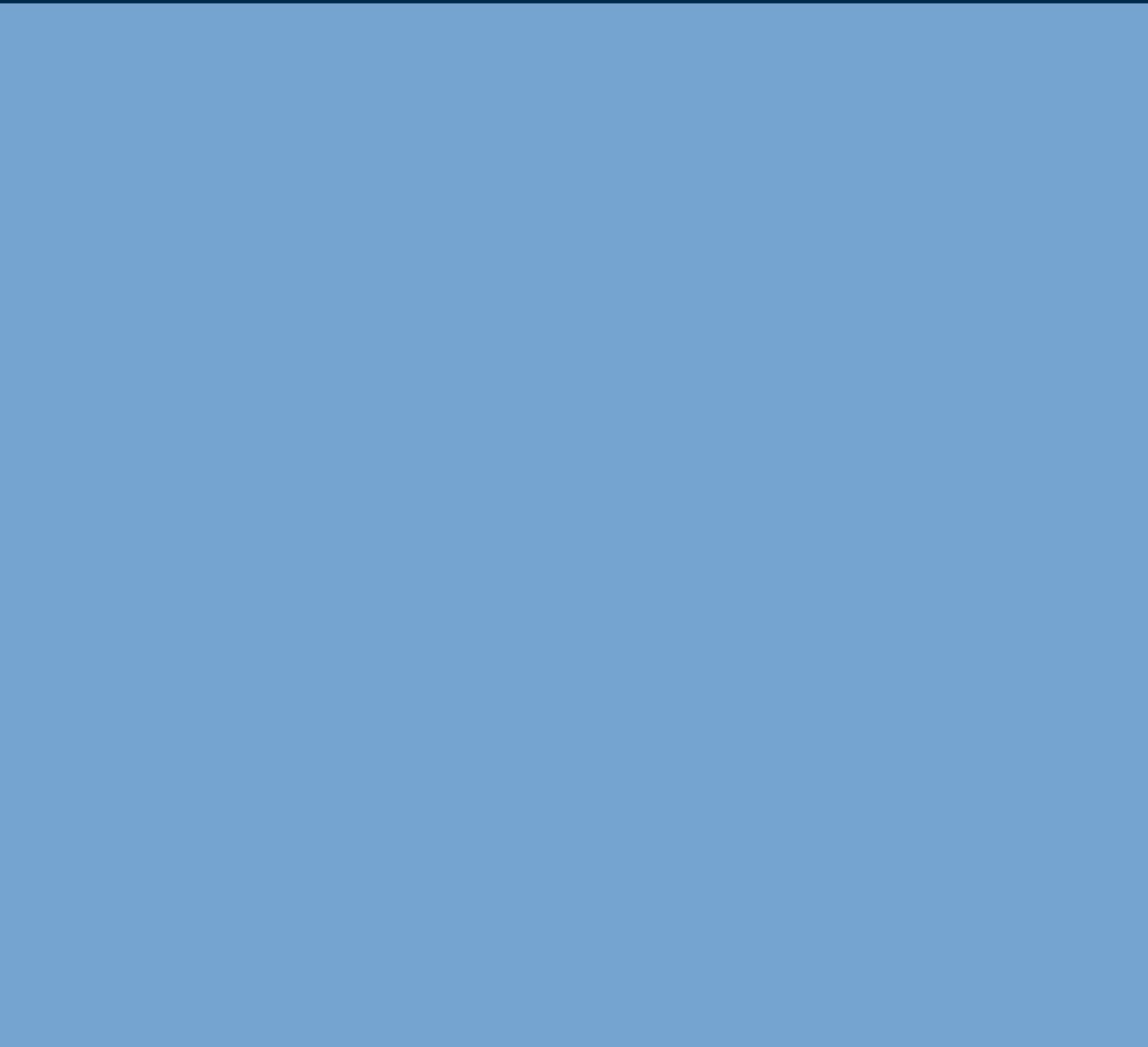
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