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**SAVE THE CHILDREN  
NEPAL FIELD OFFICE  
CHILD SURVIVAL 3  
SOCIAL MARKETING PROJECT  
FINAL EVALUATION REPORT**

**Agency for International Development**

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***Please note that this document is divided into two volumes.***

***Volume 1 contains the final evaluation report based on project objectives, conducted by Carrie Osborne, team coordinator, Dr. Philip Dayal, Ms. Pancha Kumari Manandhar, and Mr. Subarna Thapa.***

***Volume 2 contains the K&P Final Evaluation Survey Report and the sustainability questions per the AID final evaluation guidelines. Annexed to this volume are various reports that have been compiled over the past year.***

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## LIST OF ABBREVIATIONS

CDD	Control of Diarrheal Diseases
CHV	Community Health Volunteer
CPR	Contraceptive Prevalence Rate
CRS	Nepal Contraceptive Retail Sales Company Ltd.
CS	Child Survival
CYP	Couple Years of Protection
DIP	Detailed Implementation Plan
DPHO	District Public Health Office(r)
FDA	USA Food and Drugs Administration
FE	Final Evaluation
FP	Family Planning
HMG	His Majesty's Government (Nepal)
IEC	Information, Education, Communication
JJ	Jeevan Jal
JSI	John Snow International
MCH	Maternal and Child Health
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NFE	Non-formal Education
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts/Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
Rs.	Rupees (Nepalese currency)
SA	Sales Agent
SC/US	Save the Children Federation
SOMARC	Social Marketing for Change
SSNCC	Social Services National Coordination Council
TBA	Traditional Birth Attendant
UMN	United Mission to Nepal
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WIF	Worldview International Foundation
WHO	World Health Organisation

## SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

This is a summary of the main conclusions and recommendations of the Final Evaluation Team. The numbers in brackets refer to the appropriate paragraphs in the text which give further details.

1. This rural social marketing project's outcome and process objectives have had high achievement levels. Most of the outcome objectives were accomplished beyond their targets by the end of the project (3.1, 3.2). This is a good achievement given the very difficult mountainous terrain in the project area, and impressive in light of the fact that rural communities have been considered conservative in their health choices and in purchasing health care products.

2. The major success of the project is that awareness about family planning and the need for child spacing, and knowledge about diarrhea as the major killer of children, are high among all communities in the project area (3.1.1, 3.2.1). This has been achieved through a well-planned social marketing strategy. In addition communities realize the importance of family planning, child spacing, and use of oral rehydration salts (ORS) and are hence prepared to buy contraceptives and ORS (3.1.2, 3.2.2). Product recognition has risen well (3.2.6).

3. The main failure of the project is the inability to achieve a phase-over of key project activities to Contraceptive Retail Sales Ltd, (CRS) or to any other institution, to ensure future sustainability (2.1, 2.2, 2.4, 3.3.7, 4.C, 4.F).

4. The community-level activities of the project should be continued after the Child Survival project funds cease. It is particularly important to ensure that regular users of contraceptives have an uninterrupted supply. There are 700 regular users in the project area and many more potential users. This may be too few to be a viable commercial market for CRS but the credibility of both CRS and Save the Children/US in the project area is at stake.

5. The activities of the existing network of Sales Agents should continue for a few more years, although the current incentive plan seems unnecessarily complicated and should be reviewed and simplified. Attempts should be made to replace cash incentives with product incentives, and to encourage complementary commercial activities. In addition, more shopkeepers and drug-store owners should be encouraged and trained to stock contraceptives and Jeevan Jal; Women's Groups should be further encouraged to educate the community about diarrhea management and family spacing and, in areas where Sales Agents are not active, to sell the products.

6. Sales of Jeevan Jal had risen well (3.1.4) but were unfortunately affected by a sudden price rise which was beyond

the control of the project. The FE team agrees with the community that the price rise was too great, too soon. The price of Rs.1 per packet was affordable in the project community whereas that of Rs.3 is not. Social marketing is difficult if products cannot be provided at a cost that the community can afford.

7. The FE team appreciates the dilemma of promoting home-based fluids whilst also selling oral rehydration salts, but feels that more emphasis needs to be given on explaining the cause of dehydration and on the use of home-based fluids in case Jeevan Jal is unavailable or unaffordable (3.1.1). The myth that Jeevan Jal cures or treats diarrhea should be corrected and the concept of rehydration should be reinforced. The use of home-based fluids should be taught in accordance with national Control of Diarrheal Disease policies. Dependence on a single product, Jeevan Jal, as the only means of preventing dehydration is inadvisable.

8. The "generally poor image of contraceptives in this area" as seen by the Mid Term Evaluation has been overcome by the enthusiastic and skilful use of focus group discussions and mass media promotional activities by the project team (3.2.1). The community have been desensitized about contraceptives and family spacing. The FE team noted that villagers were able to talk freely about limiting family size and using contraceptives, even in group situations. This is a major achievement.

9. Sales of both pills and condoms through the project have increased throughout the project period. However, the rate of increase of sales declined as Depo Provera was made more available by the Ministry of Health (3.2.2). Since Depo Provera is increasingly becoming a method of choice for family planning, not only in the project area but throughout Nepal, future family spacing activities should include its promotion and distribution.

10. Contraceptive prevalence has increased significantly over the project period, although this is partly due to the use of Depo Provera (3.2.4.).

11. The project has achieved good contraceptive continuation rates, with regular use (i.e. of more than three months) exceeding the targets set (3.2.3) reflecting the product quality and that of the Sales Agents' follow-up (3.2.5). However, there is evidence that some women do not continue to use pills when their husbands are away from home. More counselling is required to ensure that pill use is effective or a different contraceptive is recommended.

12. 12. The FE team highly commends the project staff on their promotional efforts and educational activities which were well planned and respected the social mores of the communities. Drama was found to be the best and most effective means of mass communication in the communities of the project

area. Promotional activities, especially the use of drama, needs to continue. The variety of information, education and information materials (leaflets, charts, manuals, posters, flipcharts, films, videos, audio cassettes) that have been developed and collected during the life of the project is excellent (3.3.2). These materials should be shared with other agencies and groups in Nepal.

13. The school health education program is good and should continue (3.3.2). In addition to diarrhea management, education in schools should include basic family planning messages for older high school students.

14. The distribution system of products works well. The project has ensured a regular supply of products to Sales Agents and consumers (3.3.3). Further training is required on the storage of products.

15. The FE team agrees with the Mid Term Evaluation team in its view that "the project staff and sales agents are capable, committed and energetic." They should be congratulated in achieving many successes with this challenging and diffuse project in difficult terrain. It is a measure of their commitment that most staff have stayed through the whole project period. All project staff were well trained, although this occurred late in the project as needs were assessed in the light of project experience (3.3.1, Appendix 5).

16. Save the Children/US has amassed unique information about organizing a social marketing project in rural Nepal (3.3.5). It is essential that the information collected by SC/US during this project is shared with other agencies, both within and outside Nepal.

17. Though difficulties have been experienced with Contraceptive Retail Sales Ltd. (CRS) regarding hand-over of the project, relationships at middle-managerial level have been excellent. CRS has provided training for Child Survival staff and Sales Agents, advertising materials, timely distribution of products and useful marketing advice.

18. All the recommendations made by the Mid-Term Evaluation have been addressed (4.1,4.2), and many have been achieved.

19. The start up costs of a social marketing project are high in an area where people are not familiar with social marketing. In particular, costs have to be incurred for staff training, liaison with other agencies and in gaining the support and interest of the community. In contrast the recurrent costs are low (4.B).

20. Efforts should be made to reach the poorest of the poor who at the time of the evaluation were seen to be still underserved by the project services (3.2.4.). Sales Agents from underserved communities should be recruited.

## **1. INTRODUCTION TO THE FINAL EVALUATION**

### **1.1 Structure and Activities of the Final Evaluation Team**

The Final Evaluation of the Save the Children US "ORS and Temporary Contraceptives Social Marketing Project" took place from Tuesday 5th May to Friday 15th May 1992.

The Final Evaluation Team consisted of:

- \* Philip Dayal, Health Consultant, USA
- \* Pancha Kumari Manandhar, Family Planning and Health Adviser, National Planning Commission, Nepal
- \* Carrie Osborne, Primary Health Care Consultant, UK, (Team Leader)
- \* Subarna Jang Thapa, Assistant General Manager, Nepal Contraceptive Retail Sales Company (Private) Ltd., Nepal.

Brief biodatas are given in Chapter 4. K.2.

It had been planned that the team would also include Andrew Pillar, Resident Advisor with the SEATs Project for John Snow Inc., Papua New Guinea. Unfortunately he was unable to attend at the last minute.

The Evaluation took place in Kathmandu and Gorkha district. In Kathmandu the work comprised both meetings and a literature review. The review covered background documents on health and family planning in Nepal, the project proposal, detailed implementation plan (DIP), annual reports, mid-term evaluation (MTE) and survey reports; a list of documents reviewed is given in Appendix 1. Having devised interview checklists to ensure comparability of information, the team members held meetings and interviews with staff from USAID, CRS, MOH, Nepal Red Cross Society, and SC/US.

In Gorkha, the team divided into two groups of two, accompanied by Project staff, to visit all three Ilakas of the project area and interviewed 15 consumers, 15 Sales Agents (SA), 5 shopkeepers, 2 wholesalers, 7 community leaders, 3 women's groups, 1 teacher. (See Appendix 2 for List of Persons and Organizations Interviewed.) The area being inaccessible by car, the team walked on foot. Two members of the team had visited other areas of the project site on previous occasions. (See Appendix 3 for the Final Evaluation Team's Diary of Activities.)

## 1.2 Terms of Reference

The terms of reference from SC/US were discussed with the project staff and the Country Director. SC/US were keen for the Team to:

- review the original objectives,
- provide an overall assessment of the project's successes and failures,
- comment on the feasibility of proposed extension of project activities,
- answer the USAID final evaluation sustainability questions.

In the view of the Final Evaluation team and the project staff, the restriction of the Final Evaluation to answering sustainability questions (set in 1991) only would be insufficient to enable the donor (USAID), the PVO (Save the Children/US), the project staff or the community readily to assess whether the project achieved its objectives. In addition, the team felt that it was unfair to the PVO only to assess the project on sustainability. The project had been proposed and formulated when the sustainability issue was not paramount in the minds of donors.

In the past, CS project Final Evaluation teams have been asked by USAID to estimate overall accomplishments of the Child Survival grant funding as follows:

- primary focus and use of funding,
- PVO organizational development,
- improvement in project design and implementation plans,
- effectiveness/impact of services,
- PVO/host government cooperation,
- sustainability strategies,
- project finances,
- lessons learned,

and including "a comparison of the project objectives with documented achievements, assessing which strategies worked and which did not", commenting "on why certain things happened or did not happen." (letter from USAID to PVOs July 5th 1990) This approach gives a more balanced view of the project than do the sustainability questions alone. This evaluation looked at a number of the issues of the project normally undertaken on a final evaluation and these are discussed in this report.

The team completed the Project Sustainability Assessment (Chapter 4) in accordance with the sustainability guidelines developed for final evaluations contained in the letter sent by USAID to PVOs on July 12th 1991. However, after the field work for the final evaluation had been carried out, the Nepal Field Office of SC/US received USAID's latest "Final Evaluation Guidelines for Child Survival Projects terminating in FY92". These Guidelines were then received by the Final Evaluation Team Leader in August 1992 and she agreed to try to modify the Final Evaluation Report to incorporate the questions. Some of the latest questions were not contained in the previous guidelines and were therefore not addressed by

the team: these either have not been answered or have been answered by the Team Leader alone (as noted in the text of the report). In the view of the Team Leader the latest guidelines given by USAID are an improvement over those of 1991 - it is unfortunate that they were not received by the PVO in a timely manner.

The team felt that they had a very tight schedule and had underestimated the amount of time necessary to complete the evaluation given the complexity of the project, the terms of reference and the difficult terrain. As much of the evaluation as possible was completed, and omissions are noted in the text.

The format of the report is as follows: after a description of the project (Chapter 2), there follows an analysis and discussion of the successes and failures of the project and other issues (Chapter 3), and the USAID Project Sustainability Assessment (Chapter 4). Conclusions and recommendations are given in the text and the main ones are summarized at the beginning of this report.

## **2. DESCRIPTION OF THE CHILD SURVIVAL PROJECT**

### **2.1. The Project**

The Nepal Field Office of Save the Children/US (SC/US) has been operating an integrated rural development program in parts of Gorkha district since 1981. Primary health care and family planning activities have formed a major component of this program. In 1988, SC/US was awarded a Child Survival (CS III) grant from USAID to start an Oral Rehydration Salts and Temporary Contraceptives Social Marketing project in a few selected Ilakas of Gorkha District. The project was to be a part of the SC/US programme but be managed separately as future handover to the Nepal Contraceptive Retail Sales Company (Private) Ltd. (CRS) was expected.

The Project intended to focus on the social marketing of two child survival interventions, contraception and oral rehydration, based on an assessment of the main causes of child mortality and morbidity in the area: poor child spacing and diarrheal disease. It was proposed that these interventions be carried out in seven of the nine Ilakas of Gorkha District.

As a result of focus group discussions, surveys and a pilot project in Pandrung, it was decided that only one type of ORS, Jeevan Jal (locally produced pre-mixed and packaged salts), would be promoted. Sugar was not readily available in the project area and cereal-based solutions were not yet advocated by the government. Jeevan Jal was available free from MOH health posts but the "Annual supplies are usually exhausted within three days of the start of the diarrheal season". (DIP, page 29).

Prior to the project, temporary contraceptive methods were neither very popular nor easily available, and data measuring family planning achievement were based solely on numbers of new acceptors, without regard for continuation rates. This project decided to go beyond distribution alone and focus on two major temporary family planning problems:

- i) ongoing sales and use of products,
- ii) consumer use and satisfaction.

Project success was to be measured by changes in knowledge, awareness, use and sales as indicated by a set of diarrhea management and family planning objectives; institutional development was to be encouraged by process objectives. These objectives are fully discussed in Chapter 3. The outcome of these objectives was measured through sales data, staff reports and three surveys: a Baseline Survey, End of Year 2 Sales Survey, and an End of Year 3 Sales Survey (Final Survey). These surveys differed as detailed in Appendix 4.

The project activities now cover three Ilakas of the district, (as recommended by the MTE, see 2.3) covering a total population of 106,000, including an estimated 23,500 eligible

couples. Most of the terrain in rural Gorkha is hilly and not accessible by road. Sales, supervision, promotional and follow-up activities have to be done on foot, including the provision of supplies which must be carried in by porters. Some villages are more than a two-day walk (over 100kms) from the district headquarters and road head in Gorkha Bazaar.

Four products are marketed under the Project. These are Nilocon and Kanchan (oral contraceptives with estrogen and progestin), Dhaal (condoms), and Jeevan Jal (oral rehydration salts). These products are supplied by CRS, a local social marketing firm. The contraceptives are supplied to CRS by USAID and packaged by CRS. The chemicals and the foil packaging for the Jeevan Jal are supplied by UNICEF to the government-owned Royal Drugs Company Ltd. who sell the Jeevan Jal to CRS who supply SC/US. Prior to this project these CRS products had not been available for purchase in the CS project areas.

Sales of the products began in October 1988 in Ilaka 1. In March and May of 1989 sales activities expanded into Ilakas 7 and 4 respectively. Sales Agents were recruited among literate and motivated women and men from communities in the area. Selection of sales agents was made with the participation of community members and local leaders.

There are currently 87 active Sales Agents in the project area. They are supervised and their work monitored by four Ilaka supervisors, one each for Ilakas 1 and 7 and two for Ilaka 4 which covers a larger geographic area. Three senior staff coordinate the project and two others assist with promotion and follow-up.

In addition, 33 shopkeepers have been trained by CRS with SC/US assistance. Three Women's Groups have also been trained to educate about and sell the products.

A variety of promotional activities have been carried out. Detailed information has been gathered about all projects activities and outcomes.

## 2.2. Relationship with the Contraceptive Retail Sales Company

This is a key issue and so a detailed history is given. Contraceptive Retail Sales Company (CRS) is a Nepal-based company that has expertise in social marketing. The company originally started out in 1977 as a government-owned enterprise with funding from USAID. Over the course of the past few years it has been moving towards privatization, under direction and with technical assistance from USAID, its major donor.

CRS had been successful in marketing contraceptives and ORS in urban areas, and has also been gradually expanding its market into three small rural areas. SC/US and CRS had already been working cooperatively on an informal basis to test rural social marketing of Jeevan Jal in Pandrung, Gorkha. With SC/US already working in rural Gorkha, and CRS's technical expertise in social marketing, it was decided after exhaustive discussions and planning, that this project would be a collaborative effort between the two agencies.

One objective of this social marketing collaborative effort was to develop a model or system that could be phased into CRS's rural distribution and monitoring systems. It was expected that at the end of the grant period, the project, through the sales agents and promotional activities, would generate enough regular sales to make it worthwhile for CRS to take over the market developed. The whole focus of the project was to create a sustainable marketing system that would be continued by CRS after the project period. Experiences gained in this project could also be applied by CRS to their other rural social marketing activities.

A Memorandum of Understanding was signed between SC/US and CRS in March/April 1988. This memorandum states that SC/US's activities would be directed towards developing a program that would be attractive to and absorbed by CRS at the end of SC/US's implementation activities. It was agreed that whereas SC/US would be responsible for carrying out all activities as described in the USAID project proposal, CRS would provide all technical backstopping during the project life.

In the proposal, specific activities were drawn up for both SC/US and CRS. The wholesale and retail prices of the product would be determined by CRS. The products marketed in this project would be those distributed by CRS, and would be procured locally through CRS. The distribution system would start in Gorkha Bazaar (which was CRS's last drop-off point) and would be built upon the existing CRS system. Supervision and monitoring was to be intensive during the life of the project, but designed to fit into the CRS systems. To complement CRS's activities and information in other districts, SC/US was to look closely at using networks of women as distributors and sales agents. SC/US would assemble and make available to CRS information concerning product improvements that were suggested during project

implementation. Since the project proposed high levels of supervision which could not be maintained by a company such as CRS or by the government, SC/US would attempt to find a reasonable balance of supervisors to field activities that could be integrated into a CRS-type system after project completion. Some Kathmandu-based personnel supervisory costs to CRS were anticipated in the event that integration with the CRS company was achieved.

Up to 1990 the project continued with CRS involvement, and discussions regarding the hand-over looked positive. A number of priority activities were agreed to by SC/US and CRS to ensure CRS involvement in the project. These included monthly working group meetings, provision of an Assistant Coordinator by CRS to act as the liaison between SC/US and CRS, frequent and effective technical support in rural social marketing, provision and distribution of adequately tested promotional materials, sales agent trainings, sharing of reporting and monitoring systems to compare rural social marketing projects in other districts, reliable supply of good quality price-tested products and phase-over to CRS management and implementation in the fifth year of the project.

The cooperative agreement between CRS and USAID signed in July 1990 emphasized rural social marketing activities and collaboration with SC/US in Gorkha district. According to a previous agreement, CRS had appointed one officer-level person as a resident Assistant Project Coordinator. However, at about this time, intensive discussions were also going on between CRS and USAID about the future of the CRS company. USAID was asking for a greater control of the company to be in the hands of the private sector. Since no mutual agreement could be reached, CRS was defunded by USAID, and for the next several months CRS was not functional. Consequently, CRS was unable to continue to provide the position of Assistant Project Coordinator. As a result, this position was absorbed by the CS project. The project Mid-Term Evaluation (MTE) took place in November 1990 and detailed the difficulties and uncertainties. In 1991, when funding of CRS by USAID was resumed, the focus and priority of CRS changed to establishing and sustaining itself as a private company. Initially cooperation with the SC/US project looked positive: supplies were regular, CRS provided technical backstopping and training. However, as a result of a review of CRS's sustainability, which indicated that it should concentrate on its more easily cost-recoverable urban program and keep its own rural social marketing experiment small, CRS informed SC/US in October 1991 that it would not take over the rural social marketing in Gorkha. All communication in this regard was verbal and informal.

### 2.3 Recommendations of the Mid Term Evaluation

The Mid-Term Evaluation, conducted in November 1989, commended the project achievements, and made three major recommendations to support the program efforts in meeting its objectives.

These were:

1. The project should work on strengthening the program in the three Ilakas in which the SC/US social marketing program was currently operational, and not expand into the additional four Ilakas as originally proposed in the project proposal and the DIP. It was felt that this would allow the program "to build on its gains to develop a model social marketing program for rural Nepal."
2. In order to build on the credible reputation of SC/US, the ORS and contraceptive social marketing project should integrate more fully with other SC/US sectors. This would improve the image of sales agents and products. In particular, the Child Survival activities should be functionally integrated with the successful non-formal education (NFE) program.
3. Since there were delays in project implementation caused by factors outside SC/US's control, it was recommended that SC/US should secure a one year extension of the CS grant funding.

### 2.4 Key Changes Made Following the Mid Term Evaluation

Based on these recommendations, revisions to the DIP were worked out by SC/US and a number of modifications in the project design and implementation were made:

- The project activities were consolidated in the three Ilakas, 1, 4 and 7.
- The project activities were continued for another year within the limits of the original budget. No additional funding was requested.
- Integration with the SC/US health sector was achieved as follows:
  - i) SC/US health staff and Female Health Motivators became involved in the supervision of Sales Agents and follow up of consumers in the SC/US impact areas,
  - ii) consumers of pills experiencing side-effects were referred to the SC/US impact area health posts,
  - iii) some SC/US health staff became involved in drama performances and other promotional campaigns with the CS staff; for the last two years an experienced SC/US staff member was seconded to the project as community educator; the health staff provided technical advice to the CS staff,

iv) the SC/US staff and Female Health Motivators referred potential consumers to the local Sales Agents for purchase of products instead of distributing products free, except in an emergency,

v) the Sales Agents were encouraged to attend mobile MCH clinics in their area and provide health education and sell their products to consumers during clinic time.

- Integration with the SC/US non-formal education sector was achieved as follows:

i) many Sales Agents began regularly to attend the NFE classes to sell their products and provide health education. They used the flip charts at the classes and emphasized and explained the messages in "Learn and Understand", the workbook produced by the CS and NFE staff jointly for NFE participants. They were informed by the NFE facilitators and the CS staff when they should come,

ii) a large number of Women's Groups were given the opportunity to learn about family planning and diarrhea management and about selling the products.

- Integration of CS staff into the regular SC/US program has taken place as follows:

i) CS staff were provided with pay and benefits according to SC/US staff guidelines, which CS staff agree has brought them into a closer working relationship with the rest of the SC/US staff. Initially project staff had been on different and inconsistent rates of pay and benefits which led to uncertainties, grievances and a sense of separateness from SC/US,

ii) many staff meetings comprised both CS project staff and SC/US management and field staff to plan coordination of activities - this did not always work as well as hoped but a good attempt was made.

### 3. ANALYSIS AND DISCUSSION OF THE SUCCESSES AND FAILURES OF THE PROJECT

#### 3.1 Diarrhea Management Objectives

As recommended by the MTE, the diarrhea objectives were rewritten to be achieved by the end of the third year of selling products instead of by the end of the third year of the project activities.

##### 3.1.1 Objective 1.

A 90% awareness (modified to 80% by MTE) of Jeevan Jal in women with children age 0-5 was planned by end of year 2.

The baseline survey showed that 63% had heard of Jeevan Jal and 36.1% recognized the JJ packet. At the end of the second year of sales, awareness of JJ had already reached 95.1% and package recognition 92% which was above the original expected outcome. The final survey conducted at the end of the third year of sales showed that the awareness of JJ was 94.7%. Packet recognition was not asked for.

Increase in awareness of Jeevan Jal exceeded the original project objectives. This is an excellent achievement and reflects the hard work put into the various promotional activities. Villagers understood that diarrhea is a major killer of children.

The focus on trying to improve sales of CRS products and the non-availability of sugar in the project area has meant that little emphasis has been placed on home fluids for managing diarrhea. In the event of unavailability or unaffordability of Jeevan Jal, the communities are unaware of alternatives. However the project's plans and documentation clearly discuss this. The Ministry of Health had, in the last two years, reduced its education programme about home-based fluids because of the danger, found by WHO and JSI, of wrong proportions of salt in the solution. The Government of Nepal seems still uncertain as to what type of ORT it is going to encourage.

The Team also felt that many consumers understood Jeevan Jal to be a treatment for diarrhea. The message that Jeeven Jal was a replacement for the loss of fluids during diarrhea was not clearly understood by all the consumers interviewed. When asked what they would do in the event that Jeevan Jal was either unavailable or unaffordable, they said they would return to herbal remedies. The project's school health coordinator has done a very good job in reaching the schools and students in the area. School children interviewed by the FE Team demonstrated a strong knowledge of use and preparation of Jeevan Jal. The FE Team felt that the project had shown that awareness can be raised by a well-planned social marketing strategy.

### 3.1.2 Objective 2. 2.

The revised project planned to achieve a Jeevan Jal usage rate of 20% of diarrhea episodes in under-five year old children by the end of the third year of selling.

To measure usage rate, sales of JJ were regularly tracked against the expected number of cases. In addition, surveys were done to determine the number of packets sold, number of JJ acceptors, number of cases of diarrhea in 0-5 year olds treated with JJ, and number of women 15-44 with 0-5 year old children who used JJ. The baseline survey indicated a usage rate of 8.3%; by the end of the second year of sales, use had risen to 26.9%, with the usage rate reaching 30% in under-two year old children in the final survey. It is suggested by the CS staff that the final rate would be proportionately higher in under-five year olds than in under-two year olds as small babies rarely drink water (a major source of pathogens).

This was a good achievement, exceeding targets set. Use of Jeevan Jal is very high, (30% usage rate compared to the target of 20%), but still low in comparison to the level of awareness created in the communities by the project.

Deaths from diarrheal dehydration have been reduced to a minimum and in one village the FE Team members were told by a community leader that he had "not seen a child die of diarrhea in the last two years", whereas before the project activities, he had seen as many as 10 children die each year due to diarrhea. The community knew how to use ORS and also when to take a child to the health post.

A minor observation by one team member was that empty Jeevan Jal packets are often to be seen as garbage around the villages - not previously a problem!

### 3.1.3 Objective 3.

Knowledge of proper preparation of JJ was also used as an indicator of project success. At least 50% of the users should be able to correctly mix and administer the Jeevan Jal by the end of year 3 of sales.

This was determined by taking a sample of users and seeing how many of them mixed JJ correctly using a predesigned checklist. Initially only 12.2% of all mothers of children under five knew how to correctly mix Jeevan Jal. At the end of year 2, correct use had surpassed the target at 56.7% of JJ user households.

The MTE had recommended that a system be set up for routinely testing the proficiency of sales agents and consumers in the proper mixing and use of ORS. Surveys to assess correct mixing by consumers were carried out in September 1990 (32.1% correct), June 1990 (34.8% correct) and June 1991 (56.7%

correct) but were not repeated due to pressure of other survey work. Surveys of Sales Agents were carried out regularly at bimonthly meetings in years 3 and 4 and was discontinued in year 5 because of "near-perfect" performance. (Information received from Ann Frederick).

This was a commendable performance.

#### 3.1.4 Objective 4.

Sales of Jeevan Jal were to increase by 25% annually.

From the number of sales each year, it was calculated that by the end of year 2 the sales had increased by 39.8%. However, by the end of the third year sales had fallen by 25.2% from the previous year.

Sales of Jeevan Jal are good but have fallen in all Ilakas since the price rise (by Royal Drugs Ltd.) from Rs.1 to Rs.3 per packet in mid 1991. Discussions with consumers and community leaders suggested that JJ was still purchased for diarrhea but that fewer packets per episode were bought. Earlier the consumers bought five packets for Rs.5, whereas now the same Rs.5 only buys them one packet. Therefore, most consumers now only purchase one packet at a time. This will presumably have a subsequent effect on the morbidity and mortality due to dehydration. The community members, Sales Agents and leaders all feel that the rise in price of Jeevan Jal was too much, too suddenly.

The FE Team felt that sales had risen well and they agreed with the community that the price rise was too great, too soon. It would seem that the price of Rs.1 per packet was affordable in the project community but that of Rs.3 is not. Social marketing is difficult if products cannot be provided at a cost that the community can afford. It would be very useful to continue to collect data on sales and use of JJ, and diarrhea morbidity in this area to see whether they are affected by the price.

### 3.2 Family Planning Objectives

As recommended by the MTE, the family planning objectives were also rewritten to be achieved by the third year of selling the products instead of by the end of the third year of the project activities.

#### 3.2.1 Objective 5.

Awareness of two temporary methods of family planning among eligible couples was to reach 90% by end of year 3. The baseline survey showed two measures of awareness. Unprompted awareness was only 6.9%, but when respondents were prompted, awareness reached 30%. By the end of year 2, these figures had risen to 51.6% and 85.5% respectively. At the end of year 3 unprompted awareness had increased to 59%.

The increase in awareness of temporary methods was significant, though lower than hoped for. Awareness about family planning and the need for child spacing is very high in the project area. Communities have been desensitized to family planning issues. They are able to talk freely about limiting family size and using contraceptives, even in groups. The FE Team found that during discussions with Sales Agents and consumers others in the village would assemble and join in the conversation on use of oral contraceptives and condoms.

This is a major achievement. The MTE stated that "Social marketing of temporary contraceptives in rural Nepal is ambitious in and of itself". Two of the FE team members, Pancha Kumari Manandhar and Subarna Thapa, have extensive experience in discussing family spacing and contraceptive use in Nepal and both they and the other team members were greatly surprised by the openness and understanding of the issues by consumers, sales agents and village leaders.

#### 3.2.2 Objective 6.

Annual sales of temporary contraceptives were expected to increase by 25% for pills and 30% for condoms each year.

From the start of the project to the end of year 2, the sales of pills had increased by 39.0% and of condoms by 53.6%. At the end of year three the sales had increased by a further 16.1% for pills and 27.1% for condoms.

Not only is the awareness high, but consumers are hence prepared to buy the products. Sales have risen each year, though the sales of pills had not increased as much as hoped in the third year. The reduction in increase in pill and condom sales coincides with an increase in availability, popularity and use of Depo Provera, the injectable contraceptive for women. Depo Provera was introduced to the project area in 1990, provided free of charge by the Ministry

of Health and distributed by SC/US-trained MOH and SC/US staff. Women receive their first injections from health posts, mobile clinics and SC/US impact area offices. Subsequent injections can be provided by visiting female health motivators and village health workers. (See Objective 8).

Sales of condoms were nearer targets set and reflected well the salesmanship of the, mostly female, Sales Agents, the promotional work in overcoming the 'dirty' image of the condom, and the success in ensuring their continuous supply.

### 3.2.3 Objective 7.

It was planned that 23% of pill users and 40% of condom users would be regular users.

After the first year of sales 32.9% of pill users and 40.9% of condom users were already regular users. Regular pill use went up to 55.1% by the end of second year and to 57.2% by the end of year three. Similarly the increase in regular condom use reached 57% and then 63.3%. There are about 700 regular users of the projects temporary contraceptives in the project area.

These are excellent results. Continuation rates were high among pill and condom users and rose each year. They reflect the close follow-up of users by the Sales Agents and project staff and the easy availability of the products.

Although side effects from pills are reported, the project has addressed this problem by close follow-up of consumers by Sales Agents and the Assistant Project Program Coordinator. As a result, discontinuation rates due to side effects are low.

The number of regular users of pills and condoms has continued to increase in the three Ilakas over the four years of the project. Consumers interviewed by the FE Team were concerned about how product availability would be affected by the termination of the project funds.

There was some evidence from interviews to indicate that Sales Agents do not adequately screen pill users before selling them pills.

A significant number of husbands are away from home for long periods of time, thus wives feel it is unnecessary or inconvenient to use pills on a daily basis. This is discussed in the End of Year Two of Sales Survey Report. The message that pills are not necessarily effective in the first month of use should be reinforced to the Sales Agents and consumers. Women should be instructed that they need to use Dhaal in addition to the pills during this initial month and that taking pills only during a husband's short vacation at home may not be an effective means of contraception. If they know when their husbands plan to visit, women should be taught to start pills one month in advance.

### 3.2.4 Objective 8.

Contraceptive prevalence (i.e. current use) of pills and condoms was to reach 3% each by the end of three years of sales.

At the time of the baseline survey, the prevalence rate was 1.6% for pills and 1.0% for condoms among married, non-pregnant, non-sterilized women. By the end of year 2, current pill-use was 2.9% and condom-use was 1.3%. There was another increase by the end of 3 years to 3.6% for pills and 2.0% for condoms (but, as noted in Appendix 4, this survey only included women with children under 2 years, who, in Nepal, rarely use contraception other than natural methods as they are still breast feeding). Depo Provera use rose from 1% at baseline to 5.6% at the end of Year 2, falling to 2.9% at the end of year three as the MOH had run out of supplies.

Current use of pills among eligible couples surpassed expected rates. Though condom use did not reach 3%, it may have been underreported in the interviews with women in the final survey as this is a common occurrence in Nepal.

Focus group research by Bharat Mani Sharma and the surveys appear to show that the higher castes (such as Brahmin and Chhetri) are more likely to use contraceptives; that the occupational castes are less likely to use contraceptives, and if they do are more likely to use Depo Provera as it is easy and free. More emphasis needs to be put on reaching the poorest groups in the project area.

Use of Depo Provera rose during the project period; its use was actively promoted by the project staff as recommended by the MTE. Users of CRS products are switching to Depo Provera from project products (see End of Year Two Survey). However, during the three months up to the Final Evaluation there had been no Depo Provera available from the DPHO. Consumers, health workers and community leaders discussed this issue with the FE Team, noting the difficulty of relying on government supplies and appreciating the regular supply of CRS products.

The FT team felt that use of contraceptives is low, though awareness is high. There has certainly been an increase in the use of pills, condoms and Depo Provera in the project area. Nevertheless, there is still a 'KAP-gap'. This is not surprising given the temporary contraceptive prevalence rate in rural Nepal found to be less than 1% by the 1986 National Fertility Survey.

It seems that although the follow-up of pill users is good, women still prefer injectables or free pills.

### 3.2.5 Objective 9.

Regular use of each product was to increase by 10% annually.

In fact, increases in both pills and condoms went far above any expectations. At the end of second year of sales, regular use of pills increased by 136.9% and use of condoms by 131.9%. From the second to the end of the third year of sales, increase in regular use was still high at 37.5% for pills and 69.1% for condoms.

The superior quality of the CS project products may explain the high regular condom use increase rate. For example, one condom user in Ilaka 1 said he preferred the quality of CRS condoms to those distributed by Red Cross, and hence was willingly buying rather than accepting them free.

### 3.2.6 Objective 10.

It was expected that product recognition by eligible couples would increase by 25% each year for each product. At the time of the baseline survey Gulaf was recognized by 9.9% of those surveyed, but this product (a high-dose oral contraceptive) was never sold by the project because of its side effects. Product recognition for Nilocon (initially the only pill sold) was 7.2% in the baseline survey, which rose to 10.3% at the end of the second year of sales and finally jumped to 30.7% by the end of the third year of sales.

Kanchan was introduced in September 1990. In the survey of June 1991 (End of Year Two of Sales) 21.5% of those interviewed mentioned Kanchan by name without any prompting. This awareness dropped to 15.3% by the end of Year 3.

For the condom, Dhaal, product recognition was 13.8% at the baseline, 36% at the end of year 2 of sales and peaked at 38.8% by the end of the third year of sales.

Increase in product recognition was excellent for Nilocon, surpassing the objectives. It was also good for Dhaal considering that the survey interviewed women only. It may have been higher for pills generally had Kanchan been introduced earlier in the project. When Kanchan was introduced there was heavy mass media advertising by CRS.

### 3.2.7 Objective 11.

It was expected that 75% of regular users would have accurate knowledge of pill use by the end of three years of sales.

This was measured only in the survey at the end of the second year of sales, and indicated by regular users' understanding

of what to do if one or two pills were missed: almost half the users knew what to do if one pill was missed, only 14.6% had accurate knowledge of what to do if two pills in succession were missed.

Accurate knowledge of pill use was below the project objective. This objective was introduced after the MTE, as indicated on page 3 of the 1990 Annual Report. It suggests that more effort needs to be focused on educating pill users. The educational materials produced by the project addressed this issue well, but were only distributed in July 1991, after the year 2 survey. Had the Sales Agents had the flip charts earlier, and had they had the leaflets to give to all consumers, the knowledge of pill use may have been higher. The Sales Agents and CS staff were well trained in contraceptive use, but again they reached proficiency only late in the project. (See Objective 12.)

The project team was unable to repeat the users' survey at the end of year 3 as it was very time-consuming and expensive to find a sufficiently large sample of users. Apparently the End of Year 2 Users' Survey took 35 days to cover 300 consumers. This is another example of the great difficulties faced by this project's staff in covering the project area with its steep and isolated terrain.

### 3.3 Process Objectives

#### .3.1 Objective 12.

All levels of staff were to be trained in the process of social marketing, use of Jeevan Jal and in child spacing and temporary contraceptives.

The FE Team found that all CS staff were adequately trained during the life of the project in the process of social marketing, in ORT, especially Jeevan Jal usage, and in child spacing and temporary contraceptives, and in communication and management. In-service training was a regular part of the social marketing activities. The team were particularly impressed with the effort to give Sales Agents the opportunity to visit the participating agencies in Kathmandu.

Because of the pioneering nature of this project it was, perhaps, not clear at the start what the staff training needs would be. Hence in many cases staff were initially weak in an area of their job performance. Trainings should have been provided earlier to improve their skills. More chance should have been given to junior staff, such as the Ilaka supervisors, to be exposed to other programs in the country. (See Appendix 5 for list of training given to staff.)

The Team felt that more training needed to be given on the storage of products.

#### 3.3.2 Objective 13.

The project intended to develop, pretest, print and disseminate advertising and education materials for each product.

The FE team found that there has been excellent development and use of a wide variety of information, education and communication (IEC) materials and methods. Many advertising and educational materials were produced on ORS, pill and condom use. The flip charts are colorful and attractive and were well pretested. The card on pill counselling and side effects, for Sales Agents to use as a memory aid, was very good.

The film shows introduced in 1989 were appreciated by the community and organized well. The staff should be commended for their energy in organizing this. Film shows were held in 67 locations to audiences totalling over 26,000.

The team appreciated that the CS staff understood that the exact messages required for the project were not available on film and hence developed the drama shows. The project staff, who were trained by a professional street theater group, performed attractive dramas which combined humor with family planning and diarrhea management messages. The messages

learned from the drama by the communities were convincing. To date there have been 42 drama performances, attended by nearly 27,000 people. The Year 2 Survey showed that 68% of those who saw the dramas remembered both of the topics up to six months later. The FE Team found that people were asking for repeat performances of the drama in their communities and those who had not seen them wanted the project to bring the drama to their villages. This very popular communication strategy can be used to give new messages as the program changes and evolves. With the elimination of mid-level staff, Sales Agents, government health workers and other regular SC/US staff could now be encouraged and trained to perform dramas.

There has been good use of opportunities available for promotion, e.g. festivals, markets, NFE groups, VDC meetings and schools.

The school health program has taught about diarrheal prevention and management and distributed Jeevan Jal pamphlets in the schools of the three Ilakas. There have been competitions for school children, including one to design a suitable family spacing poster, a winning design of which was subsequently used in promotional materials. An essay competition was popular amongst the secondary school children. I.E.C. materials were pretested thoroughly and were designed to be easily understood by the communities in the project area.

### 3.3.3 Objective 14.

To develop a distribution system for products from Gorkha Bazaar.

An effective distribution system was established by 1990. The project manages a central storehouse in Gorkha Bazaar and four sub-stores in the field. Generally CRS carry supplies to Gorkha though at times stocks are carried by SC/US from Kathmandu. Supplies are carried by porters to the sub-stores regularly, from where Sales Agents pick up their stock on a bimonthly basis or as needed. Occasionally Ilaka Supervisors carry stocks to Sales Agents during visits. To date Sales Agents have not reported any supply shortages. The project should be commended for ensuring that supply continued during the time that CRS was not functioning.

Although the storage of products at the Ilaka level is good, the FE Team observed that storage in the homes of the Sales Agents requires improvement. It was found that household and personal items such as clothing were being stored alongside products in the storage box.

The Team also looked at the date of manufacture of the pills and condoms. Although the pills had a date on them, the condom packets did not. Given that these pills are good for five years from the date of manufacture, it was seen that many

products were close to the date of expiry. The Supervisors had no records of these dates and hence could not tell when a certain product stocked by a Sales Agent needed to be replaced.

The Sales Agents need training in storage of products. The Ilaka Supervisors should keep records of the dates of manufacture of the products distributed to all Sales Agents. This will help the supervisors to remind the Sales Agents to bring unused products in for exchange during their next bimonthly meeting. The Sales Agents need to be taught to sell the products on a 'first in, first out' basis. The storage and dates of manufacture of the products of all Sales Agents should be checked by the Ilaka Supervisors on a regular basis when visiting for supervision and support. They should carry a small supply of the product with them in case products need to be replenished or exchanged.

#### 3.3.4 Objective 15.

A supervision system was to be developed and implemented for all levels of staff.

The FE Team found that a supervision system was in place as per the 1990 Annual Report. The Ilaka Supervisors are energetic individuals who walk long distances and maintain frequent contact with their Sales Agents and consumers. The system of bimonthly meetings for Sales Agents was patchy in the first year, but staff then realized the value of these meetings and ensured that they were paramount in the yearly plans and other activities were planned around them. Senior CS staff were involved in promotional activities and regularly attended the bimonthly meetings. Senior staff met on a quarterly basis, often with the health staff and program managers.

The FE Team interviewed the project field staff separately and they all highly appreciated the work of each other - they seemed to make an excellent team. Although there was unresolved conflict between the Project Coordinator and the Assistant Project Coordinator throughout the project, it reflects well on the maturity of the persons concerned that this conflict did not extend to the level of field activities and hence did not affect the functioning of the project work.

The original project proposal set the staffing structure for a vertical project under the SC/US Country Director, but separate from SC/US's main staff structure, in order to allow easy phase-over to CRS. This caused many managerial difficulties, particularly in integrating the project activities with those of the SC/US regular program following the recommendations of the MTE. It also caused confusion among mid-level staff about identifying the person to whom they should report. Furthermore, this led to a sense of

separateness from SC/US among the project staff. Some staff said that they "were treated as second class citizens". However, the FE Team commends the SC/US management in rectifying this problem by incorporating the CS staff into the SC/US personnel structure, leading to a greater sense of ownership of the CS project by SC/US.

Project staff and SC/US managers (both in Nepal and Westport) seem to have been rather dilatory in responding to reports and letters written. The FE team recommend that greater emphasis is placed on responding to written reports and letters, giving comments and providing encouragement and advice.

The FE Team observed that some senior SC/US management both in Westport and in Nepal have only recently been fully convinced of the nature and need for the project, as a result of its achievements, and have subsequently been more supportive and encouraging. Senior management at Save the Children should review their supervisory roles to ensure a more positive and supportive approach to projects and project staff. Achievements should be praised and criticism should be given constructively.

The change of expatriate project advisers (four in five years) does not seem to have affected the project activities. Project staff reported that each adviser brought different areas of expertise to the project. However, the time taken for each adviser to settle and learn about the project was potentially wasteful and disruptive.

The supervision of contraceptive users was good. The Assistant Project Promotions Coordinator followed up 65% of pill users, which was a remarkable achievement given the fact that many users live many hours' and sometimes days' walk from Gorkha Bazaar.

### **3.3.5 Objective 16.**

To develop an information system for monitoring and evaluating the project.

As indicated in the First Annual Report, 1988, the reporting system was modelled according to the recommendations of the JSI evaluation of the reporting system of CRS. The CS project has developed a very impressive monitoring system for feedback of grass-roots level activities and sales data. Sales record keeping by Sales Agents and project staff is excellent and accurately reflects the realities in the field. The set of surveys was well designed, providing a simple yet professional measurement of project performance.

The research undertaken by the project team is good, covering all aspects of project activities and issues. Both qualitative and quantitative results have been well documented in annual reports and other project papers. The annual reports are

comprehensive and well describe all activities, successes, failures and changes.

The DIP reviewers were concerned that the sales agents may not be accurate in their data collection. The close supervision of the Sales Agents by the Ilaka Supervisors, the bimonthly meetings and the follow-up of consumers enabled them to be reliable data collectors.

From the information system the project team are able to track many of the indicators used to evaluate the impact of Social Marketing programs. (See "Methodologies for Evaluating the Impact of Contraceptive Social Marketing Programs" published by SOMARC.)

The team would encourage SC/US to publish its findings on awareness, sales and use of products, training needs, I.E.C. materials (particularly the use of drama), supervision and management of a project in such difficult topography.

### 3.3.6 Objective 17.

To coordinate and cooperate with other relevant agencies and workers.

Coordination with other agencies has been reasonably strong. Regular contact/communication has been maintained with Nepal Red Cross Society, CRS and the DPHO office in Gorkha. Meetings have taken place between project staff and these agencies to coordinate efforts, reduce duplication and avoid overlapping of activities.

Although some coordination between SC/US and the Red Cross has occurred, the continued free distribution of contraceptives by Red Cross has resulted in lower sales in the overlap areas. The DPHO agreed that government health workers in the three project Ilakas would not distribute contraceptives free of charge through CHVs or VHWS.

There appears to have been very loose coordination between SC/US, CRS and USAID in planning for long term sustainability of the CS project. (See 2.2) Very little documentation was seen by the FE Team on the progress of the takeover by CRS. Even at the time of evaluation, there was no clear letter or document from SC/US asking CRS to honor its commitment, and no definite reply from CRS saying what their difficulties are in merging this model into their infrastructure. Issues concerning this were discussed with the three parties.

The health programs of SC/US with MOH (mobile MCH clinics) were found to be working in the same area as the CS project but independently of each other. Whereas the CS project was selling oral contraceptives (Nilocon and Kanchan) and was unable to sell Depo Provera because it had not been approved by the FDA, the MCH clinics were encouraging women to use

various contraceptives emphasizing injectable contraceptives (Depo Provera). This was to the detriment of the CS project as women used Depo Provera and stopped buying pills.

### **3.3.7 Objective 18.**

The key long-term sustainability objective was to develop a social marketing system that could be phased into and integrated with the CRS distribution and monitoring system.

The project developed a social marketing system that raised awareness for and sold CRS products in a rural hilly area that had no previous sales of these products. The success of this system has been documented by data collected in surveys, product sales reports, the mid-term evaluation, annual reports and as indicated by outcome objective achievements. This system has not, however, been integrated into CRS and the difficulty for the future is twofold:

- i) the number of sales are too low to support a profit-making market through the Sales Agents,
- ii) CRS and USAID have now 'moved the goal posts' as CRS now has to plan its work towards making a profit and not take on non-profit making areas of work (see 2.2 and 4.D).

### **3.3.8 Objective 19.**

A new objective introduced after the MTE was to assist the DPHO to train female Sales Agents (if chosen by the community) as community health volunteers by July 1991.

This objective was added after the introduction by MOH of community health volunteers in 1989. By 1991 half of the Sales Agents had also been trained as CHVs. The intention had been that CHVs would receive a nominal payment from MOH, supplemented with profits from sales. However they have not been paid, MOH's support to CHVs has been limited and their future is in doubt. In the SC/US project area they are encouraged and assisted to function.

### **3.3.8 Objective 20.**

Another new objective was introduced in 1990 following the MTE in the hope that project activities may be carried out by CHVs: to assist the DPHO to train all CHVs in the project area to educate and assist the community in the management of diarrhea, population issues and family spacing.

The CS staff have completed this training for the CHVs, and it is reported that those CHVs who are active do educate the people about these issues.

### **3.3.9 Objective 21.**

To encourage the involvement of the NFE program, an objective was introduced following the MTE: to increase the awareness of 50% of NFE class participants in diarrhea management, population issues and family spacing.

CS project staff trained NFE supervisors in focus group discussions and the facilitators in birth spacing, temporary contraceptives and diarrhea management. The coordination and integration with the NFE activities is very good. Sales Agents attend classes as participants and as facilitators to share information with the group. The concept of "Learn and Understand" was used and applied by the Sales Agents. The "Learn and Understand" manual for neo-literates, written jointly by SC/US education and project staff, is a creditable publication that seems to be highly appreciated by facilitators, participants and other agencies.

According to SC/US education staff, awareness of the project issues by NFE class participants has risen substantially.

### **3.3.10 Objective 22.**

The last objective, again introduced after the MTE to promote the project, planned to train all government health and other NGO staff in Gorkha district in diarrhea management, population issues, family spacing, promotional and educational activities by July 1992.

This objective has been completed in part. There has been constant change of staff at district level which has hindered liaison and training. The project arranged for all health post in-charges to have communication skills training by SCF(UK). SC/US works closely with the government health staff in its project area.

## **3.4 Sales Agents**

Many of the Sales Agents are excellent. Sales Agents have increased awareness of temporary contraceptives and use of Jeevan Jal within the project area.

Culturally and socially, women are more acceptable as Sales Agents than men. Men tend to sell condoms only and their sales of pills are minimal. Female Sales Agents, on the other hand, appear to sell both condoms and pills.

Sales Agents are highly motivated and committed to their communities; many have a remarkable desire to help those less fortunate or educated. Some even provide free products out of their own meagre income to those in need. Sales Agents have

difficulties in receiving cash payments from the consumers due to problems with cash flow at the village level. Therefore, payment sometimes has to be received in kind and at times written off completely due to close working and personal relationships between the Sales Agent and the consumers. In kind payments received by the Sales Agents have included eggs, fuel wood and certain man-hours of labor. Some Sales Agents have admitted that in-kind payments sometimes exceed the actual value of the product sold. According to the report "Credit System in Practice" by Bharat Mani Sharma only half the consumers pay immediately they purchase the products.

The credibility and status of the Sales Agents in the community has markedly improved since the MTE as a result of mass promotional activities, focus group discussions, their work in the NFE classes and mobile clinics, and because 50% of them are CHVs. Some are NFE facilitators and TBAs.

The Sales Agents have gained knowledge and skills that will stay in the communities and may continue to be applied after the project is completed. The project successfully empowered women at the grass-roots level with communication skills and knowledge on key issues affecting their health, and encouraged them to be agents of social change and improvement of health.

A number of negative points have also been observed, however. More than half of the Sales Agents are Brahmin/Chhetri. These Sales Agents tend only to serve their own communities while neglecting the lower castes in their wards. Due to this ethnic bias, certain communities in the area are left unserved.

Some Sales Agents are unable to cover their total assigned areas due to the long distances involved.

#### 4. PROJECT SUSTAINABILITY ASSESSMENT

Please refer to para. 1.2 for the views of the FE Team on the Sustainability Assessment. Refer to Chapter 3 for the analysis of the achievements and failures of the project measured against its objectives.

Sustainability as the major goal is questionable for a project in a country with communities as poor as in Nepal. Donors looking for long-term sustainability need to provide long-term funding for developing strategies leading to sustainability.

##### A. Sustainability Status

##### A1. At what point does A.I.D. funding for child survival project activities end?

July 31st 1992.

##### A2. At what point does the organization plan to cease child survival project activities?

This has not yet been decided. The original plan was to hand over the key project activities to CRS (see 2.2 and 3.3.7) to be integrated into their social marketing program before July 1992. Since that plan did not materialize, various options are being considered to continue the social marketing activities after that date.

The Final Evaluation Team, after completing the field work of the FE, recommended that community level activities should continue. SC/US has therefore committed itself to funding the activities of the Sales Agents and Ilaka Supervisors through the SC/US MCH program to the end of 1992 until further funding can be sought and plans developed to continue supply of the products into the project area.

##### A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

Major project responsibilities and control have not been phased over to local institutions, for reasons described in para. 2.2 and below. As a result, SC/US program staff have responsibility and control of the project activities and are exploring options for the future.

The favoured plan is for SC/US, with assistance from CRS, to continue training Women's Groups and shopkeepers to educate the community about diarrhea and family spacing and to sell the products. It is planned that they will gradually take over most of the sales from Sales Agents unless there is sufficient funding for the Sales Agents to continue their activities. CRS has agreed to continue to supply the products to Gorkha. There is still not a clear plan and schedule as future activities will require further funding.

## B. Estimated Recurrent Costs and Projected Revenues

B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

These are:

- the provision of good quality temporary contraceptives and ORS in the project area through local respected persons (such as the Sales Agents/CHVs/womens groups/shopkeepers) with good supervision,
- promotional activities and focus group discussions to continue to raise awareness and change attitudes about the use of temporary contraceptives and ORS,
- good follow-up of pill users.

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

The recurrent costs that will be needed after CS funding ends are: product purchase; training, incentives and meetings for Sales Agents, women's groups and shopkeepers; administrative and IEC material costs; salaries for 4 Ilaka Supervisors, part salaries for senior managers; possibly one contraceptive counsellor; and promotional activities/campaigns.

Recurrent costs for one year of project activities will be as follows (some figures taken from "Budget for Continuation of Essential Social Marketing Activities in the original three Ilakas of Gorkha District", Ann Frederick, April 1992, others estimated by the FE Team Leader):

Product Costs	=	Rs.	35,775
S.A. incentives: Rs. 130/mo x 86 x 12 mos	=	Rs.	134,160
Bimonthly meetings/training	=	Rs.	20,000
Administration	=	Rs.	20,000
IEC materials	=	Rs.	10,000
Supervisors' salaries/allowances/benefits	=	Rs.	142,588
SC/US managers' part-salaries	=	Rs.	60,000
Contraceptive Counsellor's salary, allowance/benefits	=	Rs.	98,000
Promotional Campaigns	=	Rs.	110,000

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TOTAL = Rs. 630,523  
@47.50 = \$ 13,274

(approximately 59 cents per eligible couple or 12 cents per capita of the population per year).

B3. What is the total amount of money in US\$ the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

The FE Team Leader estimates that the total amount required per year to sustain the minimum of project benefits is \$8,895 (as B2. above minus contraceptive counsellor and promotional campaigns), whereas the total amount required per year to continue key activities is \$13,274 (as B2. above)

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

Analysis of these costs must take into consideration: the poverty and social attitudes of the people; the vast and difficult terrain that the Sales Agents and consumers have to cover on foot; the level of awareness and use; and the level of sales. In the light of these factors, these costs seem very reasonable.

B5. What are the projected revenues in US\$ that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?

The internal revenues (from sale of products) will be negligible, as many products are paid for in kind (see para. 3.4.1 and I1).

SC/US are investigating other external sources of funding.

B6. Identify costs which are not likely to be sustainable.

All those in B2. above, with the possible exception of partial product cost recovery.

B7. Are there any lessons to be learned from this projection of costs or revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

The lessons learned may be applicable only to other social marketing child survival projects in poor rural areas. They are:

- The costs of continuing the project are very low in comparison with the costs incurred in setting it up.
- The revenues likely to be received are negligible.

## C. Sustainability Plan

### C.1 Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

All nine of the full-time project staff were interviewed (see Appendix 2). None of them were involved in the original project proposal. The Project Coordinator and Assistant Coordinator were closely involved in the development of the DIP. All project staff were closely involved in subsequent project design, implementation and monitoring. All staff contributed to the evaluation and took full opportunity for discussion with the FE Team.

All those members of SC/US Nepal Field Office management who were part-paid by this project were interviewed (see Appendix 2). Of them, the Country Director was involved in all stages of the project, and the others were involved in implementation and monitoring.

(In addition, 15 Sales Agents and 5 shopkeepers were interviewed, who were involved in implementation and monitoring.)

### C.2 Briefly describe the project's plan for sustainability as laid out in the DIP or other relevant A.I.D. reports.

It is not possible to describe the plan briefly: it is a very complex issue. (See paragraphs 2.2 and 3.3.7.)

The plan in the DIP was that, by working out a social marketing system that coordinated closely with the CRS company, the project might still be continued by CRS after SC/US's inputs had been completed. It was expected that at the end of the grant period, the project, through the Sales Agents and promotional activities, would generate enough regular sales to make it worthwhile for CRS to take over the market developed. It was felt that if a viable market was developed in Gorkha district, distribution, monitoring and training would continue. The villages themselves would be left with well-trained, motivated individuals who would continue to serve their own communities (DIP, Page 29). As the project proposal and the DIP were prepared by SC/US in close collaboration with CRS, it was felt at that time by both parties that signed contracts were unnecessary (interview with Hem Hamal, then General Manager of CRS). Alternative strategies were not worked out in the DIP in the event that the original plan to integrate with the activities of CRS did not work.

In the 1988 Annual Report, it was stated that much time was put into designing a system of supervision and incentives that would facilitate a phase-over of the project to the CRS

company in the fourth year of the project. "There will be no attempt to integrate the management of the program into the SC/US program as this program must sustain itself through the CRS company at the end of four years". (Annual Report, 1988, 4.iii)

A memorandum of understanding was signed between SC/US and CRS in March/April 1988. This memorandum stated that SC/US's activities would be attractive to and absorbed by the CRS company at the end of SC/US's period of involvement. (Contractual Agreement with CRS, 1988).

By the time of the MTE, CRS's viability was in doubt. The MTE made a number of recommendations to help achieve sustainability including confining the project only to the three Ilakas in which the project was then active (rather than expanding to all seven Ilakas mentioned in the original proposal), integrating better with other SC/US sectors, coordinating with the MOH CHV program, exploring alternative sources to CRS, trying new products, increasing market research and diversifying to other family planning methods not provided by CRS (Fitzler et al., 1989 Pages 25-30).

The MTE also stated that sustainability depended on a number of key factors: (numbering added)

- "i) Appropriate Sales Agents must be recruited, trained and supported,
- ii) ORS and temporary contraceptive products must be easily available and promoted to increase public awareness, acceptance and repeated use,
- iii) Cultural resistance to contraceptives, such as seems true for condoms in many places, must be recognized and ameliorated, through increased literacy and education,
- iv) Products must themselves be trouble-free and desirable;
- v) Prices must be acceptable (tested),
- vi) Distribution must be consistent and supply and quality reliable,
- vii) Staff must be trained and employed to monitor and supervise the project,
- viii) Non-SC/US indigenous institutional structures must be developed and phased-in to manage the process when the project withdraws,
- ix) Product sales must generate sufficient income to recover some or all of the costs of the program,
- x) Marketing education (literacy and development education) should be pursued,
- xii) The product must remain good.

With these minimum elements in place, a market may be established, with consumer demand generating a self-sustaining system. Self-supporting economies of scale may be reached."

The 1990 Annual Report (para.VII A. page 25) outlined the renewed hopes for sustainability as CRS was refunded by USAID: namely for CRS to take on the Ilaka Supervisors, incentives to Sales Agents, bimonthly meetings and distribution of products. Promotional activities and follow-up of consumers would be

continued to a lesser extent by government health workers and SC/US staff. It also advocated training Sales Agents as CHVs and vice versa.

The 1991 Annual Report addressed the fact that CRS had then become unable to take over any project activities other than to continue product distribution to Gorkha. A number of new strategies were developed in the last year:

- providing incentives to Sales Agents related to their number of regular users and visits to NFE classes and mobile clinics,
- recruiting shopkeepers to sell the products on a profit basis rather than on an incentive basis,
- selling through NFE classes and women's groups, giving the profit to the groups as an incentive.

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

The project has attempted to implement all aspects of its sustainability plans (as summarized in C2). These are examined in C4.

It appears that incentives for Sales Agents to attend NFE class and mobile clinics introduced in 1991 are unnecessary and burdensome: although Sales Agents in Ilaka 1 were given performance-based incentives to attend NFE classes and mobile clinics on a trial basis for six months, Sales Agents in Ilakas 4 and 7 were also reported to have attended NFE classes and mobile clinics despite the fact they received no incentives.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

**Aspects of the sustainability plan implemented satisfactorily:**

- The PVO satisfactorily set up the project's working system in such a way that it could have been taken over by CRS. It also attempted to increase sales so that CRS would take it over. (In fact, CRS did not take it over because the level of sales achieved did not satisfy its revised profit-orientation.)
- The project was confined to only three Ilakas.
- Integration of the CS project with the other SC/US sectors, as recommended by the MTE, was achieved.
- Alternative sources of products were explored after the MTE. Discussions were held with Royal Drug for the supply

of ORS. Discussions were held with USAID Local Mission and the Ministry of Health concerning sources of contraceptives. These options were not pursued because CRS was refunded by USAID.

- Sales Agents were recruited, trained and supported. The profit from product sales alone was intended to provide enough incentive to keep Sales Agents active: to date, however, the level of sales by most Sales Agents is not high enough, though it is important to remember that many Sales Agents sell as a social contribution to the community and not for the money.
- Meetings with Sales Agents were carried out on a regular bimonthly basis and proved to be an important source of support and supervision and hence helped to sustain their work.
- Coordination with MOH for Sales Agents to become CHVs has taken place. Over 50% of Sales Agents are also CHVs.
- Market research was increased.
- Awareness rose, attitudes have changed, demand for and use of ORS and temporary contraceptives have increased.
- Cultural resistance to contraceptives was tackled well through promotional activities and non-formal education of women. The communities were 'desensitized' about contraceptives and were happy to have full and frank discussions about contraceptives and family spacing. This was a major achievement in such a rural conservative community.
- The quality of the ORS and temporary contraceptives was good.
- Staff were trained and employed to supervise the project.
- Coordination with other agencies occurred.

**Aspects of the sustainability plan never initiated:**

- A suggestion by the MTE and project staff that Sales Agents could be taught how to administer Depo Provera and hence sell this popular contraceptive, was rejected when the USAID local mission indicated that USAID would not approve the sales of Depo Provera as it had not been accepted by the US FDA.
- The suggestion in the MTE to develop non-SC/US indigenous institutional structures (other than CRS) was not initiated.

**Unplanned activities contributing to the sustainability:**

- Recently shopkeepers have been trained about diarrhea and family spacing and to sell the products. To date 33 shopkeepers have been trained; those interviewed by the FE Team felt that they would stock the products because of the demand from customers and as a social contribution, and felt that they may not make a profit but could do so on the other products sold to customers.
- Women's groups have had similar training.

C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make any financial commitment to sustain project benefits? If so, have these commitments been kept?

CRS did make a financial commitment (covering subsidized contraceptives, a staff member, delivery of products to Gorkha, marketing advice and assistance with training) and was due to absorb the marketing of products. At the time of the Mid-Term Evaluation, there was doubt whether CRS would take over the project, due to difficulties such as its lack of technical expertise in rural social marketing, its inability to supply products reliably and its uncertain future (as discussed in para 2.2). After refunding, it seemed that CRS would sustain the project; in October 1991, four years after the project started, CRS finally withdrew its major commitment to the project.

CRS did honor its commitment to provide contraceptives at 25-50% discount to the Child Survival project, delivery, marketing advice and training assistance except when it was defunded by USAID. It also provided a staff member to the program during 1989 who was withdrawn in 1990 due to the defunding. This position was absorbed by the CS project until the project's end.

Additionally, CRS agreed to provide ORS at a suitable price. CRS purchases ORS from Royal Drugs Ltd., which tripled the price in 1991. CRS was therefore not able to provide ORS at a price-tested cost that consumers could easily afford. This led to a reduction in sales of ORS and consequent loss of sustainability. Royal Drugs Ltd. has sometimes been unable to supply ORS to CRS in sufficient quantity to supply to the project.

The MOH also made a commitment. Following the recommendations of the MTE, the project obtained agreement with the DPHO in Gorkha that CHVs could be trained to be Sales Agents and that suitable existing Sales Agents could be trained as CHVs. This would have encouraged Sales Agents to continue to work even if CRS could not supervise them. However the MOH has reneged on its commitment to CHVs, is no longer giving them a stipend of

Rs.100 per month nor providing adequate supervision and training and hence the work of CHVs is minimal except where encouraged by the SC/US MCH program.

**C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?**

**Contraceptive Retail Sales Ltd.**

In 1990 CRS faced difficulties in funding from USAID. Subsequently, when the funding was resumed, there was a clear change in USAID's policy to CRS and hence in the priorities of CRS toward privatization and profit making. As a result CRS was not in a position to take on additional rural social marketing projects such as this one. See 2.2 and 3.3.7.

**Supply of ORS by Royal Drug Ltd.**

The decision by Royal Drugs Ltd. to raise the ORS price per packet to consumers from Rs.1 to Rs.3 (which is beyond the purchasing capacity of most members of the community in Gorkha), caused a reduction in sales of ORS as discussed in para 3.1.5. Royal Drugs Ltd. is a public sector company in which HMG owns 50% of the shares. In the past it has received technical advice and grants for machinery and spare parts for the production of ORS and aluminium foil for packaging from UNICEF. It also received funding from Japan Jaycees for an IEC officer. This funding has now ceased and Royal Drugs Ltd. needs to avoid making a loss on the production and sale of ORS. At a manufacturer's cost of Rs.2.5 it will break even. It is now subsidizing the hospital price of Rs.2.15 by the wholesale price of Rs.2.58, consumer price of Rs.3.

Royal Drugs Ltd. does not have the capacity to produce all the ORS required in Nepal; the requirement forecast for 1992 is 12 million packets (2 packets/diarrhea episode/child <5), whereas Royal Drugs Ltd. can make only 6-7 million packets per year. Hence it is not always able to ensure adequate supplies to CRS for its social marketing projects.

**Ministry of Health**

The government does not seem to have either the funds or the capacity to support CHVs as originally intended.

**D. Monitoring and Evaluation of Sustainability**

**D1. List the indicators the project used to track any achievements in sustainability output and/or outcomes.**

- i) contraceptive prevalence rate
- ii) ORS usage rate
- iii) Social marketing product prevalence rate
- iv) shifts in public attitude towards contraception and diarrhea management
- v) product recognition



of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

The PVO did receive feedback on the DIP from technical reviewers who considered the DIP to be outstanding - "a very strong project that is well designed with potential for replication". A number of issues were raised with relevance to sustainability and replication:

- The review asked for a detailed financial analysis in the First Annual Report in terms of expected revenues per sales agent - this was estimated in the Fourth Annual Report.
- The PVO was asked to continue to question and document the feasibility of this approach to improving access to ORS - this they have done in detail in each Annual Report.
- The reviewers questioned whether the Sales Agents would be successful in selling ORS and contraception - the project has shown that sales are rising, albeit slowly. The FE Team interviews showed that consumers are pleased with the system of Sales Agents because it enables them to purchase products close to their home from people they know and trust. This occurred both in the areas where SC/US have worked in community development for some years and in those areas where only the CS project was active.
- The reviewers suggested that a workshop be held for other PVOs and the MOH to observe and discuss the SC/US project design. A number of PVOs and members of the National Planning Commission have visited the project area to observe the project activities. A presentation of the project was given to the members of a Government of Nepal and World Bank health and population team at the National Planning Commission in 1991.
- The reviewers considered the drop-out rate of sales agents as a useful indicator of sustainability of the approach. The drop-out rate reported in the Third Annual Report was less than 10%, and it seems to have been less than 30% for the project period as a whole, including those Sales Agents who moved away from the area and those who were terminated because of being ineffectual. This shows a remarkable commitment to the project activities.
- The reviewers suggested that the project leadership should consider the issue of social equity, as market forces do not work for some areas and for poor people. The MOH continued to provide ORS and contraceptives free of charge from health posts though there was frequently a shortage of supply. Some consumers interviewed by the FE Team preferred to pay for supplies from Sales Agents as they knew that the products would always be available,

rather than to travel long distances to health posts only to find that there was no stock. As mentioned in I3 the Sales Agents were the key persons making the decision as to whether a consumer could afford the cost of the products and often gave the products freely or for payment in kind.

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation? If not, why not?

Yes, see C2 to C4.

#### E. Community Participation

E1. Please identify community leaders interviewed and indicate which group(s) they represent.

The FE Team interviewed several community leaders, Women's Group Presidents and prominent individuals (see Appendix 3).

E2. Which child survival activities do community leaders perceive as being effective at meeting current health needs?

All of the community leaders said that the promotional activities and the availability of products through the project were definitely meeting the health needs of the community and had had a major effect in promoting use of oral rehydration salts and family spacing. In some places they indicated that there was not a single death from diarrhea in the village in the past few years due to widespread use of Jeevan Jal for diarrhea management.

E3. What activities did the PVO carry out to enable the communities to better meet their basic health needs and increase their ability to sustain effective child survival project activities?

- The PVO raised awareness in the community about family spacing and diarrhea management, trained community members, especially women, and provided products to the community.
- The project trained NFE supervisors (who are members of the community) in diarrhea management, family spacing, research and communications.

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

- Meetings with community members and community leaders ensured that the Sales Agents were fairly selected by their communities.
- The village development committees discussed various aspects of the social marketing project and provided feedback to SC/US but there did not seem to be extensive involvement by these committees in the continuing organization of the project.
- The communities participated in focus group research to develop marketing strategies and in pretesting of IEC materials.
- Community leaders have been important in promotional activities and in the raising of the status of the Sales Agents.

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

This project does not work through health committees. There are village development committees (formerly panchayats) which meet regularly. Members are democratically elected.

E6. What are the most significant health issues being addressed by these health committees?

Not known to the FE Team.

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

The communities are not in a position to provide anything to this project except to pay for the projects' marketed products. Many members of the community are not even able to pay for those. To date, sales profits from products is not sufficient to sustain the Sales Agents and hence the project activities. The FE Team was not aware of any other financial commitment or contribution from the community.

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Not known to the FE Team.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities.

F1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.

Several key staff of local institutions (CRS, the Nepal Red Cross Society and MOH) were interviewed by the FE Team regarding the Child Survival Project activities. See Appendix 2.

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Did these linkages involve any financial exchange?

The DPHO and the Child Survival Project arranged regular coordination meetings. These were to plan training for the health post in-charges, other district health staff and the Community Health Volunteers (CHVs) in communication skills, family spacing and ORT.

The CS project was integrated with the SC/US program activities; SC/US has recently expanded its community development activities to cover the three Ilakas.

IEC materials were obtained from several sources including Nepal Red Cross Society, FP/MCH project, CDD program, UMN, WIF and SSNCC.

CRS provided supplies at a discounted rate, trainings and technical backstopping for the project staff.

The project enabled SC/US to improve its national-level linkages with all the major agencies working in diarrhea management, family planning, training and surveys at national level, such as the National Planning Commission, WIF, UNFPA, UNICEF, SCF (UK), Royal Drugs Ltd., CDD Program, FP/MCH Project, Public Health Division, New Era, JSI. The only financial exchange was the provision of costs for those attending trainings and meetings, which were met by the Child Survival project.

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

CRS and MOH, see C5.

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

All of them praised the effectiveness of Child Survival project work in Gorkha district. They all agreed that the awareness about family planning and diarrhea management was very high and that the Sales Agents were highly motivated and committed individuals. They also praised the promotional campaigns, IEC materials, and the increased availability of products in the area.

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once A.I.D. funding terminates?

The project and SC/US regular staff trained various local MOH personnel in diarrhea management, family spacing and communication skills.

It was proposed that a senior officer-level person be hired by CRS and trained by the Child Survival project to manage the project activities in Gorkha. This person was to continue as a staff member of CRS after the project ended. This staff member (Meera Rana) was hired by CRS for a few months only and then was taken on by and received considerable training from SC/US when CRS was defunded as described earlier.

In the absence of CRS take-over the project, SC/US's regular health and education program staff have been trained in the project issues and briefed about project activities.

F6. What is the current ability of MOH or other relevant local institutions (financial, human and material resources) to sustain project activities once CS funding ends?

MOH is unable to take on the project activities. It was never intended that the MOH would sustain the activities after the CS funding ends. However many CHVs, who are part of the MOH health care system, are Sales Agents of the CS project and thus have the knowledge and expertise to pass on to the communities. Similarly, the VHWs, who are MOH personnel, will continue to supervise Sales Agents who are CHVs as part of their regular work. even after the project ends.

CRS will provide products to selected shopkeepers and dealers at a bulk buyer rate. The present discount on products is available only for NGOs and not for shopkeepers and individuals. CRS may be able to continue to supply its products at the present discounted rates to SC/US for the Sales Agents and Women's Groups in Gorkha district if SC/US can continue supporting them. CRS will continue to provide promotional materials.

The effective close follow-up of pill users by experienced health workers was expensive in terms of manpower and time. In

theory, the MOH village health workers and health post staff have the skill to do this and have it as part of their job description. However, these cadres are often already over-stretched or not in-post.

**F7. Are there any project activities that counterpart Organizations perceive as effective?**

Both CRS and MOH consider the promotional activities (particularly drama), the selection, training and supervision of Sales Agents, the follow-up of contraceptive users and the information system of the project to be effective.

**G. Project Expenditures**

**G1. Attach a pipeline analysis of project expenditures**

The latest pipeline analysis is attached by SC/US Head Office.

**G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?**

The planned and actual expenditures for each year of the project have been explained in the project's Annual Reports and in annual budget revisions:

- Year 1 was underspent in all categories except consultants due to the slow start up of this difficult project. Time was needed for focus group research and the baseline survey before Sales Agents were recruited and major project activities carried out. The equipment budget was spent on two Zenith laptop computers which have been used for the project information system and reporting.

- Year 2 was again underspent, particularly on personnel, consultants and equipment. In years 2 and 3 funds were shifted, with approval from USAID, to pay for the expatriate adviser from the consultants line rather than personnel.

- After the MTE the project was extended to five years and the remaining annual budgets were revised within the fixed total budget. Year 3 was a little underspent, though excess expenditure occurred in Travel due to underestimating the costs of the promotional campaigns.

- In Year 4 Travel and Supplies were over budget due mainly to the promotional campaigns and further development of IEC materials. Year 4 total expenditure was 100.1% of revised budget.

- The FE was carried out before the end of project activities so the FE Team were unable to examine the final expenditures at the end of the project, but the indications were that the Supplies line would be overspent due to bills for IEC material preparation and end of Year 2 of Sales survey costs being sent in late. It seemed unlikely that the project would be overspent in either program or procurement.

G3. Did the project handle the finances in a competent manner?

In the view of the FE Team Leader who examined the budgets the project costs have been monitored moderately well, budget revisions have been made and details of expenditure given in Annual Reports. Difficulties have been experienced by the Nepal Field Office accounting department due to: the USAID financial year differing from that of SC/US; budget amendment procedures being "time-consuming and tedious"; misunderstandings concerning head office expenditure; long delays in receiving receipts for expenditure from the field.

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

It should be noted that the information system for project monitoring itself formed a costly part of the project: but it was a component essential to enable the PVO both to ascertain whether the project achieved its objectives and to complete USAID's Annual Reports, ISTI questionnaires and evaluation reports (see 3.3.5).

It would be helpful to the PVO if USAID could ensure that all reporting requirements are received by the PVO prior to the end of the project funding, as staff may no longer be on the payroll to complete the reports.

More help needs to be given by USAID to PVOs on understanding budgets and USAID reporting procedures.

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

The Project used locally recruited staff wherever possible and staff from SC/US's other health programs for training and research. Promotional activities, even dramas, were done by the staff of the Child Survival project rather than hiring professionals. The Project have recently trained Women's Groups and Shopkeepers to sell products without giving

incentives. Hence field level activities were carried out economically.

As the project progressed it soon became clear that it would be difficult and inefficient to attempt to cover the full geographical area (seven ilakas) originally planned. This was confirmed by the MTE and so the project confined its activities to the three original ilakas. Although this reduced the size of the target population it maximized the efficient use of the project's resources and staff.

Promotional campaigns organized by the CS project were designed to reach all sectors of the population and all geographical areas. The campaigns, especially drama, seem expensive, particularly on manpower, until it is appreciated that the average cost for performing dramas was Rs.4 (8 cents) per member of the audience.

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

Overall the project management's priority was to achieve the project's objectives. In pursuing that priority there is no reason to believe that the questions of productivity and efficiency were neglected. In particular the strategies outlined in H2 appear to have been appropriate and successful. The cost of extending the project by another year to five years was offset by not extending the project into the other four Ilakas.

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

Disproportionate amounts of senior management time were spent on the reports required by USAID. Simpler, clearer guidelines issued to PVOs in good time would reduce this inefficiency.

#### I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

The Project recovered the cost of the products through product sales by the Sales Agents who are provided with a supply of products on a bimonthly basis. At each meeting a fixed amount is deducted from their incentives depending on how many of each product or CYPs they have sold. This amount only covers

the basic cost of the product, and does not offset any project expenditures.

T-shirts produced for staff and Sales Agents for promotional activities were sold on an experimental basis to attempt to recover some costs. This was unsuccessful as sales were not sufficient to cover costs.

No other mechanisms were developed for the recovery of project costs. Research by project staff has shown that many people in this community were unable to afford the products at any cost - it is not feasible to expect much cost-recovery in these circumstances.

The supervisors managed the product-cost recovery during their bimonthly meetings with Sales Agents. They reported to the Project Coordinator who in turn gave the information to the accounting assistant for the project. No health staff were involved and thus no health services were affected.

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

The amount was not available to the FE but it would seem that the recovery was minimal and was just enough to cover the cost of the products. No extra funds were actually used to implement this cost recovery mechanism as it was part of regular bimonthly meetings.

I3. What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

The PVO's reputation in the community was not effected by the cost recovery since this took place between the Sales Agents and Supervisory staff of the Child Survival project. The project did not charge the communities directly for any services provided. Cash exchanges took place between the Sales Agent and the consumer only. The Sales Agents and their customers decided between themselves whether the payment would be made in cash or in kind. Some Sales Agents even admitted that the value of the in-kind payment was higher than the direct cash price.

On the other hand, in some cases products were actually given out free when a consumer was too poor to afford the price. The cost recovery, therefore, did not result in any service inequities. The minimal profit that the Sales Agents made from the sales was kept by them.

I4. What are the reasons for the success or failure of the cost recovery activities of this project?

The cost recovery activities were never intended to recover a major part of project costs but only to recover the cost of the products sold by Sales Agents. However, each Sales Agent was given 10 packets of JJ free at each bimonthly meeting as an extra incentive which offset the recovery costs for JJ.

The cost recovery mechanism comprises a set amount deducted from each Sales Agent's incentive at each bimonthly meeting. The amount deducted is dependent on the CYPs sold. Some products cost more than the amount deducted, some less. (See the incentive plan as detailed in the Second Annual Report)

This scheme was developed because Sales Agents were unable to give cash for the products received, as many consumers paid in kind rather than cash, and some were too poor to buy the products. Hence, subtracting the cost from the bimonthly incentive was an effective means of recovering product costs. Unfortunately this scheme will present a problem when trying to switch to a profit-based system.

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.s support strategy?

It is unrealistic to plan for cost-recovery in poor communities such as those in rural Nepal

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

No household income-generation activities were started by the CS project. SC/US's regular program in Gorkha incorporates many income-generating activities and loans.

J2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income generating activity of the project.

Not applicable.

J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

The revenues from product sales contributed minimally to the costs of the family planning and ORS products.

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.s support strategy?

No.

#### K1. Sustainability Summary

This project has many accomplishments: it has helped to identify activities that are viable and to pioneer strategies; it has built up local expertise and confidence; it has raised awareness and highlighted choices available to communities; it has raised the status of women. As this evaluation shows, however, there are many variables affecting such a project's sustainability: in particular, the poverty and social conditions of rural Nepal militate against the financial sustainability of social marketing projects.

The majority of the objectives have been achieved: the project has demonstrated that ORS and temporary contraceptives can be distributed in rural Nepal through locally chosen and trained sales agents, and can be sold to some couples for cash or kind. Awareness of family spacing and diarrhea management has been significantly improved through the various IEC activities, literacy classes and womens' groups.

The project has implemented its sustainability activities competently, despite being hampered by various factors, notably the changes in the relationship with CRS during the project period. However, subsequent to the final decision that CRS would not be taking over the project, the continuation of the project's activities after July 1992 has not been adequately addressed.

Many project staff, and the FE Team, feel that the duration of the project was not long enough to raise awareness and hence to bring about and sustain a substantial change in attitudes and practices, and hence to achieve high levels of regular sales.

Some lessons learned from this project relevant to USAID's support to other child survival projects are:

- the costs of continuing the project are very low in comparison with the costs incurred in setting it up,
- the revenues likely to be received from a rural social marketing project in Nepal are negligible,
- the information system for project monitoring itself formed a costly part of the project: but it was a component essential to enable the PVO both to ascertain whether the project achieved its objectives and to complete USAID's required reports (see 3.3.5),

- 50
- disproportionate amounts of senior management time were spent on the reports required by USAID. Simpler, clearer guidelines issued to PVOs in good time would reduce this inefficiency.

K2. List of all members of the final evaluation team and institutional affiliation

BRIEF BIODATA OF FINAL EVALUATION TEAM MEMBERS

**Dr. Philip Dayal,**  
Kathmandu,  
Nepal.

**Qualifications:** Ph.D in Sociology from the Punjab University in 1982. Also in 1982 he was awarded the Commonwealth Scholarship for Postgraduate studies in Health Planning and Administration at Leeds University in England. In 1986 he completed his Masters degree in Public Health from Harvard University.

**Experience:**

He has worked in the area of primary health care for a number of NGOs in India and the United States over the past fifteen years, including a research project with Harvard University with a grant from the Rockefeller Foundation. He has travelled to Haiti, Guatemala, India, Nigeria, and Ghana to do long-term follow-up of selected projects in these countries. His article "Long term follow-up of Eight Successful Primary Health Care Projects" appears in the book 'Why Things Work' published by Rockefeller Foundation (1990). Presently he is based in Nepal and works as an International Consultant in Health.

**Ms. Pancha Kumari Manandhar,**  
National Planning Commission,  
Kathmandu,  
Nepal.

**Qualifications:** Masters degrees in Public Health in Population Planning and Development Policies, in Health Education and Communication Strategies and in Economics.

**Experience:**

Worked for 14 years for the Ministry of Health, Nepal as District Health Officer, Senior Planning Research and Evaluation Officer, and then Training Division Chief. Has worked for the National Planning Commission for 9 years and is presently the Adviser to the National Planning

Commission, Population Division for the women and NGO sectors. Has been a board member of CRS for eight years. She has vast experience in the field of family planning and in the integration of population and overall development.

**Ms. Carrie Osborne,  
The Old Vicarage,  
Alstonefield,  
Ashbourne,  
Derbyshire DE6 2FX,  
U.K.**

**Qualifications:** Registered General Nurse 1974, BSc Human Biology 1978, Further Education Teachers Certificate 1980, MSc Community Health in Developing Countries 1985 (with a scholarship from ODA).

**Experience:**

Worked in health and education in UK for ten years, then in community health in developing countries since 1982. She has worked in Canada, Zambia, Nepal and Pakistan. Formerly training adviser to SCF/UK, Nepal and Primary Health Care Adviser to Meals for Millions, Nepal and SC/US, Nepal, responsible for the management of this Child Survival Project from 1990-91. She is experienced in planning and managing primary health care projects, human resource development and training, and evaluation. Presently a free-lance Primary Health Care consultant based in UK and vice-chair of AHRTAG (Appropriate Health Resources and Technologies Action Group).

**Mr. Subarna Thapa,  
Contraceptive Retail Sales Company (Private) Ltd,  
Kathmandu,  
Nepal.**

**Qualifications:** Masters degree in Commerce

**Experience:**

Eighteen years of professional work experience in health and family planning in Nepal. Worked as Health Educator for the Ministry of Health, Nepal, and in communication planning, audio-visual production and community-based distribution. Since 1977 has been involved in the development of CRS, together with Westinghouse Health Systems. Has been involved in every aspect of the development of CRS from the FP/MCH project to it becoming a private company. He has extensive experience of marketing, sales promotion, product launching, sales force development, training and development of field personnel and project administration skills.

Has been involved in defining long and short term goals, policy formulation, performance monitoring, liaison with collaborators and participation in inter-institutional committees and meetings at the Ministry of Health and National Planning Commission.

CHILD SURVIVAL III: NEPAL

BUDGET VS. ACTUALS FOR YEAR 5 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT \*

	YEAR 5: EXPENSES VS. PLANNED BUDGET *									LIFE OF GRANT: CUMULATIVE EXPENSES VS. TOTAL GRANT *			
	YEAR 1 EXPENSES	YEAR 2 EXPENSES	YEAR 3 EXPENSES	YEAR 4 EXPENSES	EXPENSES	PLANNED	BALANCE	% EXPENDED	PLANNED BUDGET	CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET	BALANCE	% OF TOTAL GRANT EXPENDED
					07/31/92	RIDGET			YEAR 6				
Personnel	4,330.92	18,142.74	24,654.03	60,919.55	50,954.98	50,465.45	(489.53)	101.02	0.00	159,002.22	158,512.69	(489.53)	100.33
Travel	1,860.23	10,859.86	12,419.90	16,699.15	7,739.24	6,300.85	(11,438.39)	122.82	0.00	49,578.38	48,139.99	(11,438.39)	103.02
Other Direct	2,303.76	5,710.11	5,362.39	3,465.51	9,621.98	9,055.55	433.57	95.21	0.00	25,463.75	25,897.32	433.57	98.33
SUBTOTAL	8,494.91	34,712.71	42,436.32	81,094.21	67,316.20	65,821.85	(11,494.35)	102.31	0.00	234,044.35	232,550.00	(11,494.35)	100.62
Consultants	13,872.14	8,899.86	30,321.80	2,548.21	7,940.79	24,451.79	16,511.00	32.52	0.00	63,582.80	80,093.80	16,511.00	79.42
Supplies	2,686.50	4,093.43	7,587.77	13,253.63	8,779.99	1,725.54	(17,054.45)	508.82	0.00	36,401.32	29,346.87	(17,054.45)	124.02
Equipment	4,390.00	719.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,109.33	5,109.33	0.00	100.02
SUBTOTAL	20,948.64	13,712.62	37,909.57	15,801.84	16,720.78	26,177.33	9,456.55	63.92	0.00	105,093.45	114,550.00	9,456.55	91.72
TOTAL	29,443.55	48,425.33	80,345.89	96,896.05	84,036.98	91,999.18	7,962.20	91.31	0.00	339,137.80	347,100.00	7,962.20	97.72

\* Field Office, Home Office and Overhead through: 07/31/92

\*\* Reflects Revised Planned Budgets Years 3 and 4, per Amendment No. 3.

\*\*\* Year 4 & 5 Planned Budgets per FO's Annual Report

- 1 = Aug. 1, 1987 - July 31, 1988
- 2 = Aug. 1, 1988 - July 31, 1989
- 3 = Aug. 1, 1989 - July 31, 1990
- 4 = Aug. 1, 1990 - July 31, 1991
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August 1st 1989 to July 31st 1990", Save the Children Federation Nepal.

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21. Stevens, Carl M; "AID Health Projects: Comments on the Sustainability Issue", Resources for Child Health/REACH, JSI, Boston, February 1987.
22. Valley Research Group, Kathmandu; "Comparative Study of Acceptability and Actual Use Breakage Rates of Two Latex Condoms", Family Health International, P.O.Box 13950, Research Triangle Park, NC 27709, USA, September 1991.

## **Appendix 2 LIST OF PERSONS AND ORGANISATIONS INTERVIEWED**

### **Save the Children/US:**

#### **Child Survival Project Staff:**

- \* Ilaka Supervisors - Yam Nath Bhatta
  - Gun Raj Devkota
  - Sanak Gurung
  - Chanda Mani Sharma
- \* Community Educator - Renuka Gurung
- \* Assistant Project Promotions Officer - Meera Rana
- \* Assistant Project Coordinator - Charles Pradhan
- \* Project Coordinator - Padmavati Singh
- \* Public Health Adviser (since April 1991) - Ann Frederick

#### **Health Field Staff:**

- \* MCH Coordinator - Dhana Malla
- \* Health Officer - Rabindra Thapa

#### **Kathmandu-based Staff**

- \* Country Director - Keith Leslie
- \* Assistant Director - Krishna Sob
- \* Program Director - Bharat Devkota
- \* Public Health Coordinator - Chanda Rai
- \* Women's Development Coordinator - Sashi Rijal
- \* Education Officer - Udaya Manandhar

### **Contraceptive Retail Sales (Private) Ltd**

- \* General Manager - Rajendra Singh
- \* Director of Marketing - Rajiv Satyal
- \* Assistant Director, Rural Social Marketing - Surendra Rayamajhi
- \* Ex-General Manager - Hem Hamal, now at Urban Planning Project

### **Royal Drug:**

- \* Sales Manager - Shanti Raj Joshi

### **USAID:**

- \* Technical Officer, Office of Health and Family Planning - Matt Friedman

### **Nepal Red Cross Society:**

- \* Project Director - H.K. Lovely Shrestha
- \* Secretary, Gorkha - Dil Bahadur
- \* Member, Gorkha - Badri Maskey

### **District Public Health Office:**

- \* Assistant DPHO, Gorkha - Hari Krishna Saha
- \* Village Health Worker, Gorkha - Mohan Kumar

Women's Groups:

- \* Lakribot, Ward 10, Ilaka 4, Chairperson - Mrs Durga Gurung and 12 other members
- \* Dhadan gaun, Ward 8, Ilaka 7, Chairperson - Mrs Sushila and 8 other members
- \* Phinam, Secretary - Mrs Chini Maiya Bailkati

Non-Formal Education Teachers:

- \* Arukot - Tika Data Gimire

School Teachers:

- \* Dhuwakot - Bhim Prasad

Consumers:

- \* Dhuwakot - Mah Kumari Thapa
  - Nan Kumari Katri
  - Sumitra Baniya
  - Mangal B. Bailkuti
  - Kamal Bahadur Thapa
  - Sree Upreti
  - ?
  - ?
- \* Takukot - Lalit Man Shrestha
  - Dal Kumari Shrestha
- \* Das Kilo - Dhana Nath
  
- \* - Buddha Kumari
- \* - Phil Maya Gurung
- \* - Kumari Gurung

Community Leaders:

- \* Takukot, VDC Chairman - Lila Paneru
- \* VDC Chairman - Chanda Bir Gurung
- \* politician - Prem Chanda Shrestha
- \* Lamachaur, politician - Harich Shrestha
- \* Phinam - Rudra Bahadur Baniya
  - Kamal Thapa
- \* Dhuwakot - Dev Raj Walia

Sales Agents:

- \* Lamachaur - Nunu Kumari Shrestha
- \* Arbang - Thanu Maya Gurung
- \* Kuwapani, Gyampisal - Kal Pana Baniya
- \* - Dil Maya Gurung
- \* Baluwa Dhara - Lok Bahadur Gurung
- \* - Ek Maya Gurung
- \* Arukot Thok - Dama Kumari Ghimire
- \* Panchkuwa Deurali - Lek Narayan Shrestha
- \* Takukot - Nir Kumari Shrestha
- \* Deurali Takukot - Januka Bhatta
- \* Taranagar - Mano Maya
- \* - Chanchela Gyawali
- \* Dhuwakot - Buddha (Putali) Maya
- \* Phinam - Bhakta Bahadur Khatri
- \* - Yagya Kumari Khadka

Shopkeepers:

- \* Arle, Taple, Medical Shop - Hira Lal Bohira
- \* Koke, Keorani, Medical Shop - Tek Bahadur Katri
- \* Baluwa Dhara, General Store - Padham Prasad Wagle
- \* Banewara, Medical Shop - Janek Bahadur Bhatta
- \* Nareswar, Medical Shop - Ganesh Bahadur Thapa

Wholesalers:

- \* Gorkha - Badri Maskey
- \* - Dil Bahadur

Appendix 3 FINAL EVALUATION TEAM DIARY OF ACTIVITIES

Tuesday May 5th

Evaluation Team Planning  
Meetings with SC/US staff

Wednesday May 6th

Documentation review  
Meeting at CRS  
Meeting at Royal Drug

Thursday May 7th

Meeting at USAID  
Meeting with Hem Hamal  
Meeting at the Nepal Red Cross Society  
Review of project I.E.C. materials, viewing of  
promotional campaign video.

Friday May 8th

Travel to Gorkha  
Presentation by project staff

Saturday May 9th

Group 1 (Carrie Osborne, Subarna Jang Thapa, Ann  
Frederick, Meera Rana) Gorkha to Ghyampesal

Group 2 (Philip Dayal, Pancha Kumari Manandhar, Padmavati  
Singh) Gorkha to Phinam

Sunday May 10th

Group 1 Ghyampesal to Aarupokhari  
Group 2 Phinam to Gorkha, Gorkha bazaar

Monday May 11th

Group 1 Aarupokhari to Lakuribot  
Group 2 Gorkha to Dhuwakot and back

Tuesday May 12th

Group 1 Lakuribot to Gorkha  
Group 2 Gorkha to Taranagar and back  
All meet with SC/US project and health staff

Wednesday May 13th

Interviews with SC/US staff

Thursday May 14th

Interviews with SC/US staff  
Discussion of findings.

Friday May 15th

Discussion of findings  
Presentation of findings to SC/US, UNFPA, USAID, CRS.

#### APPENDIX 4 SURVEY DESIGNS

The present project adviser, Ann Frederick outlined the various differences in the survey designs as follows:

**Baseline:** The survey used a thirty-cluster sampling methodology, with a total of 1047 households. There were three questionnaires - a household roster, an eligible women questionnaire, and an under-5 child questionnaire. For the eligible women questionnaire all women in the chosen households who had ever been married were interviewed, in the project's anticipated working area of seven ilakas. To get a sample comparable with the Year 2 and Final surveys, a subset consisting of currently married women 15-49 who live in the project's three ilakas was chosen -412 women. For the diarrhoea management objectives, those women with children under five were picked -238 women. For family planning findings, those who were not sterilised at the time of the survey were picked -304 women.

**Year 2:** This survey used a random sampling methodology, in the project's present three ilaka working area. Only women 15-49 who were currently married and not sterilised were interviewed, and only one in each household. If there were more than one eligible woman in one household, the one with the youngest child was picked. A total of 554 women were interviewed.

**Final Survey:** This survey came under the design guidelines for CS projects devised by Johns Hopkins University. Staff from SC/US and the CS project attended a workshop in Ahmedabad in March 1992. A number of additional questions were added on literacy, women's groups and future use of contraceptives. The most serious deviations from the baseline and Year 2 surveys were the inclusion of only women with children under two, which may have made both ORS and contraceptive use lower as the average age of the youngest child was 10 months. The survey used the thirty-cluster sampling technique, an all 23 VDCs of the project's three ilakas. Currently married women 15-49 with a child under 2 years old were interviewed, one per household. The women with the youngest child were picked if there were more than one eligible women per household. A total of 300 women were picked, 10 in each cluster.

## **APPENDIX 5            TRAINING GIVEN TO STAFF DURING THE PROJECT**

- All CS staff attended workshops on focus group training (1988), communication skills (1989), management and promotional programs (August 1989), health education and communication materials (March 1990), problem-based supervision, pretesting I.E.C. materials, pills and their promotion (June 1990). They all received Drama for Community Development training (February 1991), and survey training (June 1991).

In addition:

- The Project Coordinator attended a marketing workshop in Kathmandu, (1988), Advanced Training of Trainers in Bangkok (August 1990), Report Writing (August 1991)

- The Assistant Project Coordinator attended a Social marketing Seminar at the Asian Centre in Thailand, (1988), Report Writing training (August 1991), and attended an Organisation and Management training (September 1991).

- The Assistant Promotions Coordinator attended a Training of Trainers (January 1991), Report Writing workshop (August 1991).

- The Ilaka supervisors were trained in CRS products and marketing (July 1990), Training of Trainers (1991),

- One Ilaka supervisor and the Community Educator received Communication Skills training (August 1991).

- Sales Agents were trained on a regular basis during bimonthly meetings (in communication skills, social marketing, the products, diarrhoea management, family planning and contraceptive use in 1989), use of flip charts (March 1991), follow up and counselling of users (May 1991) and CRS also provided training for Sales Agents. The Sales Agents were all given the opportunity for observational tours - visiting Royal Drugs, CRS, the ORT centre at Kanti children's hospital, the government's main Family Planning clinic, and SC/US head office. The FE team felt that this was an excellent opportunity for the Sales Agents, helping to raise their credibility and authority in the community.

(Source of data: Annual Reports)

134 82341

Volume 2

# **K & P FINAL EVALUATION SURVEY REPORT**

**Child Survival III Social Marketing Project**

**Save the Children**

**Gorkha District, Nepal**

**April 1992**

**Agency for International Development  
Grant # OTR-0535-A-00-7215-00**

**Report prepared by:**

**Ann Frederick, Project Advisor**

**Save the Children  
54 Wilton Road  
Westport, CT 06880**

**July 1992**

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## ACKNOWLEDGMENTS

The author of this report thanks the staff of Save the Children who postponed other work to be supervisors and learn about this survey methodology. Thanks also go to those who were hired to work on this survey, and to all the village women who took time from their busy schedules to answer the questions. And a special thanks to statistician Dr. Bhatta for the hours he spent checking the formulae.

### Survey Trainers:

Charles Pradhan  
Meera Rana  
Padmavati Singh  
Ravindra Thapa

### Data Entry:

Subha Upadhyay

### Graphs:

Sita Bista

### Supervisors:

Yamnath Bhatta  
Gunraj Devkota  
Dirgha Gandhari  
Sanak Gurung  
Krishna Lamsal  
Biswoshanti Malla  
Chandramani Sharma  
Anjana Thapa  
Ravindra Thapa  
Raghu Thapaliya

### First Draft of Chapters I, II, and III-B:

Charles Pradhan

### Advice on Sampling Formulae and Limits of Certainty:

Dr. Krishna Dev Bhatta

### Interviewers:

Saraswati Marhatta  
Lakshmi Devi Khanal  
Sirjana Shrestha  
Chhabi Maya Gurung  
Sarita Shrestha  
Kalpana Devkota  
Khemkala Gurung  
Shakuntala Koirala  
Hira Devi Panday  
Krishna Maya Baramu

Savitri Neupane  
Sharada Ghimiri  
Kamala Shrestha  
Sunita Acharya  
Ismira Malla  
Lilawati Paneru  
Yasoda Neupane  
Goma Paneru  
Indra Maya Gurung  
Sumitra Shrestha

## EXECUTIVE SUMMARY

### Introduction

The CSIII USAID-sponsored project in Gorkha District, Nepal, is an experiment in social marketing carried out by Save the Children/US (SC/US). The project's two main interventions are the promotion of birth spacing and diarrhea management. Temporary contraceptives and packaged oral rehydration solution (Jeevan Jal) are marketed in an attempt to create a sustainable system for dealing with several of the worst health problems in Nepal. When project activities began in 1988, only 15% of the women could name any temporary contraceptive, and a mere 3.4% were using temporary methods. Usually the treatment of diarrhea involved withholding fluids, and only 8.3% had used Jeevan Jal for their child's last diarrhea episode.

Sales agents are the project's grass-roots workers who visit the targeted couples of reproductive age and mothers of young children in their homes. The sales agents explain the need for birth spacing and the use of ORS, sell the products and make follow-up visits to assure they are used properly. Awareness and use of family planning and ORS have increased through the project's intensive promotional and educational activities, including drama, films, flip charts, pamphlets, posters, and advertisements, backed up by the sales agents' door-to-door visits.

### Summary of Findings

#### Family Planning

Three surveys have measured the progress of the population with regard to the family planning and diarrhea management interventions. Now most of the women regard one child of each sex as ideal, and wish to space their children more than two years apart. 79% can name at least one temporary method, and 8% are using a temporary method. 49% name the sales agent as a nearby source of family planning methods, and 82% want to use family planning in the future.

But much remains to be done. Though 92% of the women do not wish another child within 2 years, only 15% are currently using contraception. 82% of the non-users say they wish to use some type of contraception in the future, but only 59% can name two or more temporary methods.

#### Diarrhea Management

Jeevan Jal is known by 95% of the mothers and is considered the preferred treatment for diarrhea by 72%. 30% used Jeevan Jal to treat their child's last diarrhea episode, and over half bought it from the sales agents.

The population has accepted Jeevan Jal more readily than contraception, for they see how it can save lives. Still, there is a large gap between 95% awareness and 30% use of Jeevan Jal. The connection between diarrhea and death from dehydration has been taught throughout the project, yet only 1/3 of the mothers gave more fluids than usual during their child's recent diarrhea episode, and only 8% know the signs of dehydration.

### Recommendations

Traditional beliefs and behaviors die hard. Three years of promotion and sales is too short a period for people who had not even heard of temporary contraception and oral rehydration solution to understand and whole-heartedly adopt them. For this reason, Save the Children's Nepal Field Office is taking over the project's main activities until another funding source can be found.

A follow-up to this project would do well to:

1. Reinforce the primary messages that have been taught so far about family planning:
  - a. Reasons for spacing and limiting children
  - b. Advantages and disadvantages of each spacing method
  - c. Proper use of condoms
  - d. What to do when pills are missed
  - e. Appropriateness of sterilization as limiting method
  
2. Reinforce all that has been taught so far in diarrhea management:
  - a. Routes of diarrheal disease transmission
  - b. Progression from diarrhea to dehydration to death
  - c. Signs of dehydration
  - d. Types of oral rehydration solution
  - e. Proper mixing of Jeevan Jal

3. **Maintain the product supply channels that exist and develop new ones that are ultimately sustainable:**
  - a. Continue the most effective sales agents and their incentives as long as there are no alternative sources of supply in their area
  - b. Continue to encourage the rural shopkeepers trained under this project, and recruit others
  - c. Continue to support the women's groups who are now selling products, and recruit others
  - d. Explore the possibility of selling Depo-provera through medical shops and government clinics
  
4. **Use Operations Research to develop new strategies to reach the goals of increased child survival and lowered fertility:**
  - a. Operations research into removing ethnic-specific barriers to diarrhea management and birth spacing
  - b. Diarrhea prevention strategies, such as latrine building accompanied by a health campaign teaching proper hygiene
  - c. Operations research to test alternatives to packaged ORS
  - d. Operations research to test ethnic-specific strategies for increasing women's age at marriage
  - e. Qualitative, ethnic-specific research into the pathways to increase women's status in the family and community, giving alternatives to bearing many sons

## LIST OF ABBREVIATIONS

CHV	Community Health Volunteer
CSIII	Child Survival III
CSSP	Child Survival Support Program
CRS	Contraceptive Retail Sales Company
IEC	Information, Education and Communication
FP	Family Planning
JHU	Johns Hopkins University
JJ	Jeevan Jal (ORS sold by the CSIII project)
MOH	Ministry of Health
NFE	Non-Formal Education
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
PVO	Private Voluntary Organization
SA	Sales Agent
SC/US	Save the Children/US
USAID	United States Agency for International Development
VDC	Village Development Committee

## I. INTRODUCTION

### A. Background

In 1987 the Nepal Field Office of Save the Children/US (SC/US) was awarded a USAID Child Survival (CS III) grant to start a rural social marketing project in Gorkha, a hill district to the west of Kathmandu. The project covers three of the district's nine ilakas (sub-districts). The project area has a total population of 106,000 and about 23,500 couples of childbearing age. The terrain is rough, and the farthest villages are over two days' walk from district headquarters at Gorkha Bazaar. The major interventions of this project are birth spacing and diarrhea management. Equal emphasis has been given to each of these interventions.

Nepal is one of the poorest countries in the world, and rates among the world's worst on child and maternal health indicators. Nepal's maternal mortality is estimated at 830/100,000 live births, one reason why Nepal is one of the two remaining countries of the world where women's life expectancy is less than men's (the other is Bhutan, Nepal's neighbor -- UNICEF 1992, p. 84). High maternal mortality is due to the interaction of several factors including inadequate health facilities, poor nutritional status, and spacing births too closely together. Although the government of Nepal has emphasized temporary contraceptive methods for over five years, before the CSIII project began only 15% of Gorkha's women could name any spacing methods and a mere 4% were using them.

From 40,000 - 45,000 Nepalese children under five die every year from diarrhea and related diseases. Before the project began, in one part of the project area in Gorkha, 70% of child deaths were found to be diarrhea-related. The traditional practice of withholding fluids during diarrhea causes dehydration and death. At the beginning of the project only 15% of child diarrhea cases were treated with ORS (8% with the Jeevan Jal packaged solution sold by the project).

#### 1. CSIII Project Structure and Activities

The social marketing project has trained local women and a few men as sales agents who visit each home and educate the villagers on the concepts of birth spacing and diarrhea management. There are currently 87 sales agents trained in population education, diarrhea management, communication skills and the promotion and use of the products. This project markets four products: Nilocon and Kanchan, both oral contraceptives containing estrogen and progesterin, Dhaal condoms and Jeevan Jal oral rehydration salts. Sales began in October 1988. The contraceptives themselves are provided by USAID, and are packaged by Nepal's Contraceptive Retail Sales Company (CRS). Jeevan Jal is made locally.

Four supervisors monitor the sales agents' work. Other project personnel are a coordinator, assistant coordinator, a counsellor for pill users, a school health educator, and an expatriate project advisor. As most of Gorkha is inaccessible by road, all project activities such as supervision, counselling, home visits, training and provision of supplies are done on foot. Recently, rural shopkeepers and women's groups have been trained to sell the products as an experiment in long-term sustainability.

## 2. Promotional and Educational Activities

When the social marketing project began, there was much resistance to use of the products. For Hindus, a son is essential for performing the father's death ritual, and bearing more may assure that at least one will survive. Reasons for not using contraception include fear of upsetting the gods, fear that interference with the sexual process will obstruct one's life energy flow, and fears about side effects--some based on fact, some fanciful and biologically impossible. Understandably, the rural farming families of the hills need manpower in the form of more offspring to work the fields. But here birth spacing, in effect waiting to see if older children survive before having more, can work well for people short of resources. The difficulty lies in convincing them of this.

Resistance to the use of ORS comes from the observation that diarrhea often appears to worsen when fluids are given. Because of this, the traditional practice was to withhold all liquids. Initially, the local villagers had much more confidence in traditional healers and modern antibiotics and anti-diarrheal medication than in ORS. Through this project, ORS has become popular and old beliefs are fading away.

The project has developed many IEC (Information, Education and Communication) and promotional activities to raise awareness of ORS and family planning spacing methods, and to overcome local resistance to the use of contraception and ORS. Materials were developed to assist the illiterate and barely literate sales agents and their clients in learning about population problems and diarrhea management, and in remembering specific details about product use.

One of the project's most innovative and successful features is the promotional campaigns. During a promotional campaign, the entire social marketing staff travel as a group from village to village. The first such campaigns used tape recorded messages about family planning and ORS. The staff would frequently stop the tape to discuss and reinforce the messages. Films were then used in the same

way, reinforced with staff-audience discussion. But the activity the villagers appreciate the most is the drama show consisting of two humorous but informative plays, one on diarrhea management, the other on birth spacing.

## **B. Research Activities**

Research has been incorporated into every aspect of the social marketing project. Qualitative research has provided a way for the community to give their input at every stage of each project activity. Qualitative research has included focus groups and individual interviews guided by questionnaires and checklists. Most qualitative research was conducted by the CSIII staff. The final evaluation focus groups, however, were conducted by a consultancy team hired for the purpose. Quantitative research has provided information on the project's ability to meet its stated objectives. There have been three surveys. The three surveys differed as follows:

### **1. Baseline Survey, April 1988**

This survey used a cluster sampling methodology, with 50 households per cluster in 21 clusters (three clusters in each of the seven anticipated working area ilakas). There were three questionnaires -- a household roster (1047 cases), an eligible women questionnaire (1026 cases), and an under-5 child questionnaire (805 cases). For the eligible women questionnaire, all women in the chosen households who had ever been married and were available for the interview were interviewed. To get a sample comparable with the Year 2 and Final Surveys, a subset consisting of currently married women 15-49 who live in the project's 3 ilakas was selected from all the cases entered in the computer -- 412 women. For some family planning tables, those who were not sterilized at the time of the survey were picked -- 304 women. This survey asked many questions not repeated in either the Year 2 or Final Survey.

**Advantages:** Thoroughness. Many details of socioeconomic status and health and hygiene practices, as well as morbidity and mortality data were included, and have nothing for comparison in the two more recent surveys.

**Disadvantages:** Unwieldiness -- too many variables to deal with, the fact that information is in three non-parallel files, and the inclusion of divorced, widowed, under and over-age women. Also, some variables not thought of until the Year 2 survey were not included.

**2. Year 2 Survey, June 1991**

This survey used a random sampling methodology, in the project's present three-ilaka working area. In each of the three ilaka three VDCs were chosen, and in each VDC two wards were chosen, for a total of 18 wards. The sample was self-weighted, meaning that the ilaka with the least population had the fewest respondents. Only women 15-49 who were currently married and not sterilized were interviewed, and only one in each household. If there were more than one eligible woman in a household, the one with the youngest child was interviewed. There were a total of 554 completed questionnaires.

Advantages: Ease of coding in field, entering in computer, and handling in computer. The questionnaire was designed in three columns, the first with space for full verbatim answers (for enumerators), the second with codes for the supervisors to choose among and enter in the third column, which was the only column the data entry person needed to look at (yet the full information was available for checking). The results of the Baseline survey were used to pre-code the Year 2 survey so the two were as compatible as possible given the limited scope of the Year 2 Survey.

The Year 2 Survey also included the only survey of users. These were all the ever-users of 20 of the sales agents, picked so their coverage matches the randomly chosen survey areas. The data from the Users' Survey are unique, for the number of users found in a sample survey is too small to subdivide by asking further questions.

Disadvantages: The main drawback with this sample is that the total number of married women (including sterilized) had to be extrapolated from the household roster, where the number of married women 15-49 in each household was given, and then the number of these women who were not sterilized. This means that both the proportion of sterilized to all married women and of permanent to temporary users are not as reliable as if we had actually interviewed the sterilized women. Also, a Final Survey was to be designed to match the Baseline's thoroughness. The Year 2 was to be an intermediate survey, streamlined to get the most essential information.

**3. Final Survey, April 1992**

AID now requires all PVOs managing child survival grants to conduct 30-cluster baseline and final evaluation surveys using a standardized questionnaire developed by the Johns Hopkins University (JHU) Child survival Support Program (CSSP). To train grant management staff in the theory and practice of doing such surveys, JHU and CARE/India jointly

organized a workshop in March 1992 in Ahmedabad, India. Three staff from the SC/US Nepal field office attended the workshop. The questions to be asked and the sampling technique for the social marketing project's final survey were decided upon at that time, by the SC/US staff in consultation with the JHU experts.

This survey used the WHO thirty-cluster sampling technique, a cluster here being a ward. Since the population of the VDCs was listed by ward, and each cluster was chosen by dividing the total population by 30 clusters to get the sampling interval, this is also became a self-weighted sample. At least one ward was sampled from each VDC. Currently married women 15-49 with a child under two years old were interviewed, one per household. The woman with the youngest child was picked if there were more than one eligible woman per household. A total of 300 women were interviewed, 10 in each cluster.

**Advantages:** The methodology. The use of more teams, close supervision of interviewers, and a shorter time period, worked well. And the hand-tabulation exercise, with group analysis of findings was a fun and expedient way to give feedback to each of the SC/US sectors involved.

**Disadvantages:** The fact that only women with under two-year-old children were selected leads the sampled mothers and children to be younger than those of the other two surveys. The average age of the woman's youngest child is only 10 months, meaning that many women had not begun ovulating after childbirth and did not consider themselves to be in need of contraception. Similarly, there must be a difference between ORS use in under-2s and under-5s. And this was not the thorough survey that was expected to provide a final comparison with baseline data.

One last disadvantage is that the author of this report, the project advisor, was not at the Ahmedabad workshop and so did not have an opportunity to discuss the reasons for choices of questions, sample size, and eligibility of women. It is thus difficult to justify some of the decisions made, for example, why mothers of under-2s were interviewed instead of under-5s when the project's objectives and previous surveys use under-5s. Or why family planning method awareness was not prompted as well as unprompted, to match the previous surveys.

### C. Final Survey Objectives

1. For AID Washington: The social marketing project funding ends in July 31, 1992, and AID requires a final evaluation survey for each CS project. The survey results on the progress made regarding the use and knowledge of ORS and temporary contraceptives will be used as part of the project's final evaluation for AID. These data also will become part of a database of CS project information worldwide.
2. For Save the Children: The main objective of the survey for both SC's home office and the Nepal Field Office is also to provide information about the knowledge and use of ORS and temporary contraceptives. Progress toward the project's stated objectives is of main interest. But cross-tabulation with ethnicity, literacy, and women's income generation are also important. The social marketing project exists within SC's community-based rural development program, so information concerning these other sectors is also included in this report.

### D. Schedule of Survey Activities

March:	Ahmedabad CARE-JHU workshop; Preparation for the survey -- choice of 30 random cluster sites, selecting supervisors and interviewers, determining costs and logistics for conducting the survey.
April 1-11:	Questionnaire pretesting, rechecking final printing of questionnaire in Nepali. Training hall arrangement.
April 12:	Preparation for survey training.
April 13-16:	Training of supervisors, survey teams, field test.
April 17-24:	Implementation of survey in thirty clusters (wards) of the three project area ilakas of Gorkha.
April 25-26:	Hand tabulation of survey results.
April 27:	Discussion of survey findings with project staff, health staff, and other SC staff in Gorkha.
May 1992:	Feedback by CS project staff to sales agents in sales agent meetings (community); Computer entry of data and consistency checks
June-July:	SPSS table output and report writing

II. FINAL SURVEY METHODOLOGY

A. The Questionnaire

Forty-three questions were included, to be asked of mothers with children under 24 months of age. The SC/US Nepal field office staff modified JHU's standardized survey questionnaire in Ahmedabad with the assistance of the international experts sent to the conference. Several additional questions were included about literacy classes and women's groups for cross-tabulation with the ORS and family planning questions. More detailed questions were also asked about family planning knowledge and practice than were in the standard questionnaire.

The questionnaire is divided into three parts:

- 1. Social, demographic, and other background information, including literacy class and women's group attendance;
- 2. Diarrhea Management Variables
- 3. Family Planning Variables

(See Appendices B and C for full questionnaires in English and Nepali).

B. Determination of Sample Size

1. Limits of confidence for previous survey variables

When values for key variables exist, as from previous surveys, the first step is to figure out the limits of confidence of the previous survey's variables. Formula 1 is the formula for limits of confidence.

FORMULA 1:

$$L = 2 \sqrt{\frac{C (\sum y_i^2 - 2p \sum x_i y_i + p^2 \sum x_i^2)}{(C-1) (\sum x_i^2)}}$$

Where:

C = Number of clusters

$\sum y_i^2$  = The sum of the square of the number of respondents in each cluster with the key value to the key variable

- $p$  = The proportion of all respondents with the key value to that variable
- $\sum x_i y_i$  = The sum of the product of the number of respondents in each cluster with the key value, and the total number of respondents in each cluster
- $\sum x_i^2$  = The sum of the squares of the number of respondents in each cluster
- $\sum x_i$  = The sum of the number of respondents in each cluster

Two variables from the Year 2 survey have been picked, one representing each of the two major project interventions, diarrhea management and family planning. In the Year 2 Survey, 26.9% of the children <5 who had diarrhea in the preceding two weeks used Jeevan Jal. The denominator for this variable is 234, the number of children with diarrhea. For the family planning variable, we chose the use of pills. Of all 554 women interviewed, 2.9% were currently using pills. The denominator here is the total sample of 554 women.

For the Year 2 Survey limits of certainty of Jeevan Jal use among children who had diarrhea in the past 2 weeks,

$$C = 18$$

$$\sum y_i^2 = 289$$

$$p = 0.269$$

$$\sum x_i y_i = 911$$

$$\sum x_i^2 = 3,837$$

$$\sum x_i = 235$$

$L = 0.07661$ . This means that the actual value of Jeevan Jal use in the population of children with diarrhea lies between 0.19239 and 0.34561, or 19.2% and 34.6%.

For the Year 2 Survey limits of certainty of pill use among all non-sterilized married women aged 15-49,

$$C = 18$$

$$\sum y_i^2 = 48$$

$$p = 0.029$$

$$\sum x_i y_i = 515$$

$$\sum x_i^2 = 20,170$$

$$\sum x_i = 554$$

$L = 0.02201$ . This means that the actual level of pill use in the population of married women who are not sterilized lies between 0.00699 and 0.05101, or 0.70% and 5.10%.

## 2. Minimum sample size for Final Survey

Now we have two values for  $L_1$  so we can figure what the sample size of the present survey should be, with respect to those two variables. The formula used to find the present survey's minimum sample size follows.

### FORMULA 2:

$$N_2 = \frac{L_1^2 N_1}{(|P_1 - P_2| - L_1)^2} \times \frac{P_2 (1 - P_2)}{P_1 (1 - P_1)}$$

Where:

$N_2$  = Sample size desired for second survey (Final Survey)

$N_1$  = Sample size used in first survey (Year 2 Survey)

$p_1$  = Prevalence rate found in the first survey

$p_2$  = Prevalence expected in this survey

$L_1$  = Limits of certainty calculated for the first survey

For the Jeevan Jal usage variable, the minimum sample size needed to give the same limits of certainty as in the Year 2 Survey is calculated with the following values:

$$L_1 = L = 0.07661$$

$$N_1 = 235$$

$$|P_1 - P_2| = 0.031$$

$$P_2 = 0.3$$

$$1 - P_1 = 0.731$$

$$P_1 = 0.269$$

$$1-p_2 = 0.700$$

$$N_2 = 708.06, \text{ or } 709.$$

So, for the limits of certainty to be the same for the Jeevan Jal use variable, the sample size for the Final Survey would need to be 709. But this sub-sample, the children with diarrhea, was only 43% of the Year 2 survey, so the figure needs to be multiplied by 100/43, or 2.32558. This makes it about 1647.

For the pill usage variable, the minimum sample size needed to give the same limits of certainty as in the Year 2 Survey is also calculated, using the following values:

$$L_1 = 0.02201$$

$$N_1 = 554$$

$$|p_1 - p_2| = 0.001$$

$$p_2 = 0.03$$

$$1-p_2 = 0.97$$

$$p_1 = 0.029$$

$$1-p_1 = 0.971$$

$$N_2 = 628.3093, \text{ or } 629.$$

So, for the limits of certainty to be the same for the pill use variable, the sample size for the Final Survey would need to be 629.

### 3. Final Survey Limits of Certainty

Because of cost and time limitations it was not possible to have a sample size of 1647, or even 649. The JHU survey trainers have advised that a sample of 300, with 10 respondents per cluster, is the maximum allowed with this methodology. Given this restriction on sample size, the survey proceeded. Now that the results are in, the first formula is again used, this time with the values found in the second survey. For these same two variables, the limits of certainty calculated are:

Jeevan Jal use

$$\begin{aligned}
 C &= 30 \\
 \sum y_i^2 &= 110 \\
 p &= 0.300 \\
 \sum x_i y_i &= 235 \\
 \sum x_i^2 &= 775 \\
 \sum x_i &= 143
 \end{aligned}$$

$L = 0.08855$  or 8.9%, meaning that actual use is between 21.1% and 38.9%.

Pill use

$$\begin{aligned}
 C &= 30 \\
 \sum y_i^2 &= 30 \\
 p &= 0.030 \\
 \sum x_i y_i &= 85 \\
 \sum x_i^2 &= 2633 \\
 \sum x_i &= 279
 \end{aligned}$$

$L = 0.03207$  or 3.8%, meaning that actual use is between 0% and 6.8%.

**C. Selection of Sample**

The sample consisted of 300 women with children 0-23 months of age in the three project area ilakas of Gorkha District. Ten women were selected in each of the 30 randomly selected wards (clusters) following the process described in the EPI Coverage Survey Training Manual (WHO, 1988). In Gorkha, a ward may contain 2 or more villages, and these villages may cover considerable terrain. Therefore, once the survey team reached the designated ward, the first task was to ask how many villages there were. If there were more than one village, the village to be surveyed was randomly selected, and the people of the village were asked to show the center of the village. At the center, the supervisor spun a bottle and the team walked in that direction to

the edge of the village, numbering each house with chalk. The first household to interview was chosen randomly from among the houses marked. The next household to interview was the nearest house to the first house, and so on, in any direction.

#### **D. Training of Supervisors and Interviewers**

Ten supervisors and twenty interviewers were selected to make ten survey teams. The entire training was conducted by SC/US health staff and CS project staff, all of whom had either attended the preparatory workshop in Ahmedabad, or had participated in the CS7 Baseline Survey in Siraha District. A participatory training technique was used. The training included the following topics:

- (a) Purpose and objectives of the survey
- (b) Selection of the sample
- (c) Selection of the starting household and survey direction
- (d) Calculation of confidence limits
- (e) The roles of the supervisors and interviewers, and
- (f) The meaning and coding of each question of the questionnaire

For the field test, the group was divided into ten teams of one supervisor and two interviewers each. Communities from 15 minutes to one hour's walk from Gorkha Bazaar were chosen as field test sites. Each of the new interviewers completed at least two questionnaires, and each of the experienced ones completed at least one. The completed questionnaires were checked, and the mistakes were tallied. A feedback session was held to discuss the problems.

On the last day of the training, the supervisors acted the part of village women, and the interviewers each completed one questionnaire. The supervisors had been instructed to answer in such a way that the main problems of the field test the day before would have to be dealt with. One of the problems identified in the field test was interference of other family members and villagers. The CS staff members who were not to be supervisors circulated around the training hall, simulating meddling villagers, to see if the interviewers could manage to handle the disturbance in a polite yet firm manner.

Though role plays usually precede field tests, the trainers and trainees felt this to be an appropriate final training exercise. The ideal way would be for the first role play to be staff-staff, showing good and bad interview techniques. Then the interviewers role play with each other to gain confidence and familiarity with the questionnaire (this part was missing in our training). Then the field test, then the interviewers interview the supervisors. For there is no better way for a supervisor to be made aware of the difficulties his/her supervisees are having than to become the object of the supervisee's work.

### E. Conducting the Interviews

There were ten teams, with one supervisor and two interviewers per team. The thirty clusters were divided among the teams according to travel time. The closest clusters were assigned four to a team, and the farthest two per team, but to reach the farthest clusters took two days of walking. Those clusters in the middle, with about one day of walking each way, were assigned three to a team. The total field survey took 8 days, from April 17th to 24th.

The supervisor of each team was responsible for the selection of the actual village surveyed, as well as the starting household. The supervisors observed at least one complete interview conducted by each interviewer each day. The two weakest interviewers were sent with the two female supervisors so they could be closely supervised without disrupting the interviews. They quickly came up to standard. The supervisors checked each questionnaire before the survey team left the survey area, so the interview could be repeated if data were missing or contradictory.

Because of past experience of villagers' not knowing their own age, a local calendar was developed, listing major events like earthquakes, major landslides, and years when local bridge and school construction was completed. This calendar was distributed to every interviewer. The interviewers were trained to probe for information the informant actually did not know (such as age) or was sensitive about (such as contraceptive knowledge and use).

Each interview took 20-30 minutes. One cluster required 4-5 hours, though in some places it took all day because of the time needed to walk from one house to another, up and down the hills. The closest house may not take the least time to reach, for between the two may be ravines, steep slopes, or recently ploughed fields.

A consent form was distributed to every interviewer, which she then read to each respondent. This is an unusual procedure in Nepal. It worked well, for the women felt they had a choice in the matter, and were assured that their responses would be held confidential. No woman refused to be interviewed.

### F. Data Analysis and Dissemination of Results

As each team returned from the survey, all of the questionnaires were rechecked by CS project staff. When all the teams had returned, hand tabulation was done by the survey supervisors and trainers at SC/US' Goraha office. After the two days of hand tabulation, all tables were checked by the survey trainers. Findings were represented in percentages and all the results were

copied on sheets of newsprint for discussion. Each question's results were discussed one by one in a group and conclusions were made. This was a lively session, and all agreed that the participatory discussion method of analyzing survey results is useful, fun, and has the potential for bringing out more perspectives on the data than if one person were responsible for analysis. It is also good to include those involved in the survey for they are close to the data and can clear up any confusion.

Each of the project's Ilaka Supervisors took the hand-tabulated results to their next scheduled sales agent meeting, and interpreted the findings to the sales agents at these meetings. Because the sales agents are the grass-roots level workers of the project, they were picked as appropriate recipients of the survey information. Key members of SC/US's health, education, and women's development sectors were also present at the initial discussion of findings at district headquarters.

Because of the additional objectives of this survey that involve cross-tabulation between variables, the data were also entered in computer, using dBASE IV. The dBASE data were checked with a consistency program, and corrections were made by referring to the original questionnaires. After these corrections were entered in dBASE, a printout was taken of all the data, and each entry was checked with the original codes on the questionnaires. These corrections were entered in dBASE, and the consistency program was run again. Satisfied that all corrections had been made, the dBASE file was translated to SPSS for labeling, recoding, selection of subsamples for comparison with the other surveys, then output in the form of frequencies, cross-tabulations and means. dBASE and SPSS were selected over EpiInfo because data from the previous two surveys were in SPSS.

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### III. FINAL SURVEY FINDINGS

Rather than compare the findings from all three surveys immediately, Final Survey findings are first given separately in this chapter. Some variables only exist for this survey, so cannot be compared. Also, this is the only report where the Final Survey findings are described, and so each variable needs to be addressed. In later chapters selected data from the Final Survey are compared with the previous surveys' data.

The Final Survey findings are presented in three categories, according to their order in the questionnaire:

1. Social, demographic, and other background information, including literacy class and women's group attendance;
2. Diarrhea management variables; and
3. Family planning variables

#### A. Demographic and Social Background Variables

##### 1. Introduction

This section contains demographic and social variables. Tables 1 through 5 show in different ways the age of the respondent, her age at marriage, number of children ever born and now surviving, and ideal number of children. Table 6 gives respondents' religion and ethnicity, and the remaining five tables present respondents' literacy and income generating activities.

##### 2. Demographic Variables

From Table 1 a noteworthy finding is that the mothers' age at marriage varies from 5 to 35. The majority of women were married before their 20th birthday, and, predictably, the ones to marry youngest are the Brahmins (not shown in table). It is also not surprising that by age 30 nearly 3/4 of the women have borne at least three children; none of the women over 40 have borne less than three children. Clearly any future program hoping to decrease fertility must find ways to increase the women's age at marriage, as well as working on spacing and limiting births. Merely making the span between generations longer will decrease overall fertility, and the health status of mothers and children will improve when teenagers are no longer bearing children.

Survival rates for children (Table 1) are interesting but cannot be translated into infant and child mortality rates for we do not know the age of the child at death. About 20% of Nepal's children die before their 5th birthday, and over 10% before 12 months, so this survey's rates for all children's deaths (around 11%) seem low. There is often

underreporting of deaths with a retrospective survey, and this is a young sample, whose children have had less exposure to the risk of death. Girls are known to be hardier than boys, which is the case here, with 91.5% of girls surviving, and only 86.4% of boys surviving. We do not know their ages, however, and the numbers are so small that a 5% difference has less significance.

Table 2, mothers' age and number of children born, gives few surprises, for we know that rural Nepalese women have many children. We hope, however, that the younger ones will stop at 2-3 children.

Tables 3 through 5 show how the respondents' actual and stated ideal number of children differ. The most frequently stated ideal was two sons and one daughter, though some respondents stated that their actual number of children was ideal for them, explaining most of the larger "ideal" numbers, especially of girls. The actual situation is more complex, showing modes for both boys and girls at one child, but individual families are not so evenly balanced and may have many children of one sex and one or none of the other.

### 3. Social Variables

Predictably, Table 6 shows that most of the population is Hindu, though this masks the actual situation in which many of the Mongolian ethnic groups practice some Buddhist rites. They may, for example, be married by a Hindu priest yet have a Buddhist lama do their parents' death rituals. The national census does not list population by ethnicity, so we do not know how ethnically representative this sample is. There is a good distribution across the ethnicities, which eliminates one fear of using the cluster sampling methodology, that the sample will not vary enough. Chapter IV compares this sample to the previous two surveys' samples with respect to social and demographic variables.

Table 7 shows the level and source of the respondents' schooling. There is a higher proportion of literate women than expected (33%). Though 89 women attended literacy classes, 37 of them did not learn to read, probably due to not completing the class. Still it is admirable that 50, or half of those women who are literate list the literacy class as the source of their literacy. Most attended SC/US literacy classes. But women's secondary school attendance, at only 6.7%, is abysmal. Perhaps the young women who attend literacy classes will insist that their daughters continue through secondary school.

If school attendance is prolonged, so is the age at marriage. But so often a girl's education is neglected. It is considered a useless investment for someone who will soon

belong to another family, and spend all her days in house and field work. Table 8 attempts to prove that literacy leads to lower fertility and greater child survival. But the woman's age, and therefore her child's age and exposure to the risk of death, must be taken into consideration.

In SC/US's integrated community development program, literacy classes are the entry point for other activities. Women who have passed the advanced literacy class are invited to form income-generating groups, and are given a small amount of money to use in their revolving loan fund. Table 9 gives women's income generating activities and women's group attendance. Only one-third of the women have separate income generating activities of their own (the same proportion as are literate), and less than one-tenth attend a women's group.

Of the income generating activities, the most popular is livestock raising, for it fits in well with the farming routine. Likewise, selling agricultural products and working as a laborer on others' land are popular because they are familiar and require no new skills. Very few of the women sell handicrafts, probably due to a combination of lack of skills and distance from the market. The greatest proportion of women's group members attend SC/US women's groups.

Table 10 shows how ethnicity influences literacy and income generating activities. To allow comparisons to be made between ethnic groups, three large ethnic groupings were made. The "high castes", or Brahmins and Chhetris, are here joined by the Newars, the merchant town-dwellers, for they all share a relatively privileged status. The middle group is made up of the Mongolian-origin tribal groups. The last are the occupational castes, the former "untouchables", to whom other less-privileged groups have been added here.

Education is certainly a privilege enjoyed most by the higher castes, though the early age at marriage does not allow many to complete secondary school. Nearly the same proportion of occupational caste women as Mongolian tribal women are now literate (see Chapter IV for a comparison with earlier surveys -- this was not always the case).

Though a greater proportion of occupational caste women generate their own income, the activities they engage in are most likely to be low-status occupations. They must work as field laborers for wealthy landowners and as porters carrying others' goods. Most of the shopkeepers are Newars, though some of the occupational caste women also have shops. Livestock raising is an activity suited to the housewife role high-caste women are restricted to in traditional society, and is the preferred source of income for the women of the upper and middle ethnic groupings. The occupational

caste women have yet to be fully reached by SC/US's programs in literacy, income generation, health and family planning.

#### 4. Conclusion

These demographic and social background variables are used primarily to compare with the previous survey samples, and to cross-tabulate with key FP and ORS variables. Taken on their own, these variables confirm the need for SC/US' involvement in Gorkha:

- a. Women have far more children than they would prefer to have, which is both a cause and result of many offspring dying
- b. Few women go to school, and very few continue to secondary school. This is linked with early marriage (cause and result), and early marriage in turn causes high fertility in each generation as well as short gaps between generations.
- c. SC/US's literacy classes and women's groups are helping to deal with the situation, and there is a cause-effect link, here tentatively proven between literacy and child survival. The major ways in which this is hypothesized to work, eventually leading to lower fertility, are:

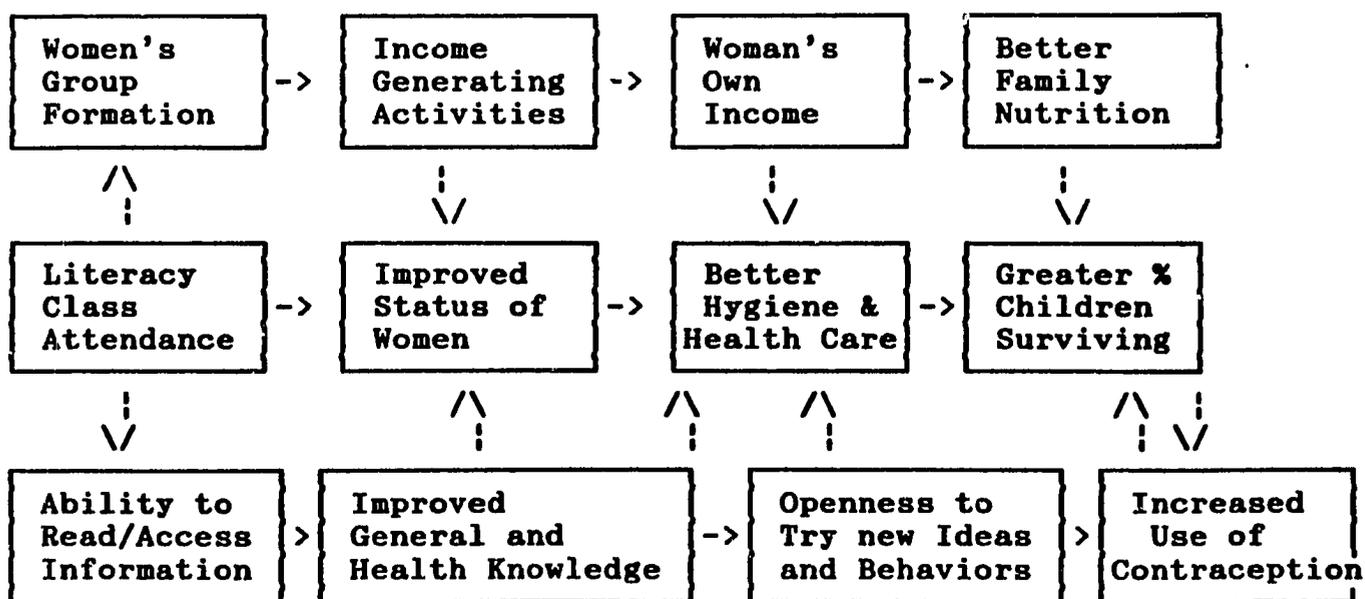


TABLE 1: MEANS OF KEY DEMOGRAPHIC VARIABLES

	Mean	Standard Deviation	Minimum Value	Maximum Value
Mother's Current Age	27.1	6.63	15	47
Mother's Age at Marriage	16.7	3.96	5	35
Number of Boys Born Alive	1.6	1.45	0	8
Number of Girls Born Alive	1.6	1.44	0	8
Number of Boys Surviving	1.4	1.20	0	8
Number of Girls Surviving	1.5	1.30	0	7
Percent of Boys Surviving	86.4%			
Percent of Girls Surviving	91.5%			
Age of Youngest Child in Completed Months	10.3	6.97	0	23
Number of Children Ever Born	3.2	2.13	1	11
Number of Children Now Surviving	2.8	1.71	1	9
Percentage of Children Now Surviving	88.8%			

**TABLE 2: MOTHER'S AGE IN FIVE-YEAR AGE GROUPS  
AND NUMBER OF CHILDREN EVER BORN**

AGE	MOTHERS		CHILDREN EVER BORN		Minimum	Maximum
	Freq.	Percent	Mean	% with > 2		
15-19	24	8.0	1.25	-	1	2
20-24	104	34.7	1.78	21.2	1	4
25-29	71	23.7	3.13	71.9	1	6
30-34	47	15.7	4.34	89.4	1	9
35-39	34	11.3	5.21	91.2	1	9
40-44	17	5.7	6.88	100.0	3	11
45-49	3	1.0	9.00	100.0	8	10
ALL	300	100.0	3.20	55.4	1	11.

**TABLE 3: FREQUENCIES OF CHILDREN EVER BORN  
and NOW SURVIVING**

Number	CHILDREN EVER BORN		CHILDREN NOW ALIVE	
	Freq.	Percent	Freq.	Percent
1	76	25.3	80	26.7
2	58	19.3	66	22.0
3	55	18.3	61	20.3
4	52	17.3	48	16.0
5	18	6.0	25	8.3
6	15	5.0	8	2.7
7	8	2.7	5	1.7
8	9	3.0	5	1.7
9	6	2.0	2	.7
10	1	.3	-	-
11	2	.7	-	-
N	300	100.0	300	100.0

TABLE 4: LIVE BIRTHS AND SURVIVING CHILDREN BY SEX

	NUMBER OF LIVE BIRTHS				NUMBER NOW ALIVE			
	BOYS		GIRLS		BOYS		GIRLS	
	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent
0	61	20.3	67	22.3	67	22.3	72	24.0
1	121	40.3	107	35.7	126	42.0	107	35.7
2	53	17.7	56	18.7	61	20.3	64	21.3
3	30	10.0	36	12.0	26	8.7	33	11.0
4	23	7.7	24	8.0	16	5.3	19	6.3
5	8	2.7	6	2.0	3	1.0	2	.7
6	1	.3	1	.3	-	-	1	.3
7	2	.7	2	.7	-	-	2	.7
8	1	.3	1	.3	1	.3	-	-
	300	100.0	300	100.0	300	100.0	300	100.0

TABLE 5: IDEAL NUMBER OF SONS AND DAUGHTERS FOR A HYPOTHETICAL COUPLE

NUMBER	SONS		DAUGHTERS	
	Frequency	Percent	Frequency	Percent
None	3	1.0	21	7.0
One	165	55.0	232	77.3
Two	117	39.0	38	12.7
Three	9	3.0	5	1.7
Four	6	2.0	4	1.3
TOTAL	300	100.0	300	100.0

TABLE 6: RELIGION AND ETHNICITY

<u>RELIGION</u>	Frequency	Percent
Hindu	279	93.0
Buddhist	19	6.3
Muslim	2	.7
	300	100.0
<u>ETHNICITY</u>	Frequency	Percent
Brahmin	77	25.7
Chhetri	45	15.0
Newar	24	8.0
TOTAL UPPER CASTES	146	48.7
Gurung	64	21.3
Magar	14	4.7
Baramu	6	2.0
Tamang	3	1.0
TOTAL MONGOLIAN GROUPS	87	29.0
Kami-Sunar	11	3.7
Sarki	24	8.0
Damai	7	2.3
Kumal	18	6.0
Jogi	2	.7
Musalman	2	.7
Other	3	1.0
TOTAL OCCUPATIONAL CASTES AND OTHERS	67	22.4
TOTAL	300	100.0

TABLE 7: WOMAN'S LITERACY AND SCHOOLING

WOMAN'S LITERACY	Frequency	Percent
Illiterate	201	67.0
Literate	99	33.0
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>
LEVEL OF WOMAN'S EDUCATION	Frequency	Percent
No Class-Cannot Read	160	53.3
No Class-But Can Read	5	1.7
Literacy Class-Cannot Read	37	12.3
Literacy Class-Can Read	50	16.7
Primary-Can't Read	4	1.3
Primary-Can Read	24	8.0
Post-Primary	20	6.7
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>
MOTHER ATTENDED LITERACY CLASS	Frequency	Percent
No	211	70.3
Yes	89	29.7
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>
WHICH LITERACY CLASS	Frequency	Percent
SCF Basic Class Not Completed	60	67.4
SCF Basic Class Completed	19	21.3
SCF Advanced Class Completed	2	2.2
Non-SCF Class Attended	6	6.7
Not Sure which Class Attended	2	2.2
<b>TOTAL</b>	<b>89</b>	<b>100.0</b>

Note: Two women who attended literacy classes went on to attend school, so are included in the school-attending percentage above.

TABLE 8: CHILD SURVIVAL BY LITERACY STATUS AT MARRIAGE

	LITERATE AT MARRIAGE		ILLITERATE AT MARRIAGE		ALL
	PRESENT AGE=<25	PRESENT AGE >25	PRESENT AGE=<25	PRESENT AGE >25	
MEAN NUMBER OF CHILDREN EVER BORN	1.66	3.00	1.89	4.66	3.20
MEAN NUMBER OF CHILDREN ALIVE	1.60	2.86	1.81	4.00	2.84
PERCENT CHILDREN SURVIVING	96.4	95.3	95.8	85.8	88.8
MEAN AGE OF MOTHER	21.1	29.0	22.2	32.6	27.1
N	50	7	100	143	300

Note: Age groups and mean age are given because the literate are younger.

TABLE 9: WOMEN'S GROUP ATTENDANCE AND SOURCE OF INCOME

WOMAN'S INCOME SOURCE	Freq.	Percent
None	201	67.0
Raises Livestock for Sale	43	14.3
Sells Agricultural Products	15	5.0
Works as Agricultural Laborer	14	4.7
Works as Shopkeeper	14	4.7
Works as Non-Agricultural Laborer	10	3.3
Sells Handicrafts	5	1.7
Has Other Source of Income	4	1.3
Works for Salary	3	1.0
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>
WOMEN'S GROUP ATTENDANCE	Freq.	Percent
No Group Attended	272	90.7
SCF Women's Group	21	7.0
Government Women's Development	5	1.7
Other Women's Group	2	0.6
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>

**TABLE 10: WOMAN'S INCOME GENERATING ACTIVITIES, LITERACY AND AGE AT MARRIAGE BY ETHNIC GROUPING**

SOURCE OF INCOME:	BRAHMINS CHHETRIS NEWARS	GURUNGS MAGARS BARAMU	OCCUPAT- IONAL CASTES	ALL
Handicrafts	2.7	-	1.5	1.7
Agricultural Products	7.5	3.4	1.5	5.0
Agricultural Labor	-	3.4	16.4	4.7
Non-Agricultural Labor	0.7	2.3	10.4	3.3
Shopkeeper	6.8	1.1	4.5	4.7
Salaried Worker	1.4	-	1.5	1.0
Livestock Raising	15.8	17.2	7.5	14.3
Other Source	1.4	2.3	-	1.3
<b>GENERATE OWN INCOME - TOTAL</b>	<b>32.2</b>	<b>28.7</b>	<b>40.3</b>	<b>33.0</b>
<b>DO NOT GENERATE OWN INCOME</b>	<b>67.8</b>	<b>71.3</b>	<b>59.7</b>	<b>67.0</b>
<b>ATTEND WOMEN'S GROUP</b>	<b>12.3</b>	<b>11.5</b>	<b>-</b>	<b>9.3</b>
<b>LITERATE</b>	<b>51.4</b>	<b>16.1</b>	<b>14.9</b>	<b>33.0</b>
<b>MEAN AGE AT MARRIAGE</b>	<b>15.6</b>	<b>18.4</b>	<b>19.9</b>	<b>16.7</b>
<b>N:</b>	<b>146</b>	<b>87</b>	<b>67</b>	<b>300</b>

**Note:** The percentage of women who have income from the various sources total more than "Generate own Income-total" because some women have several sources of income.

## B. Diarrhea Management Variables

### 1. Introduction

Seventeen questions were asked about diarrhea management. The first was whether or not the youngest child had diarrhea in the preceding two weeks. Those respondents whose child had had diarrhea answered the next eight questions regarding the treatment for that episode of diarrhea. The following two questions were also on diarrhea treatment but were asked of all respondents, as was the question on awareness of Jeevan Jal (the packaged ORS brand sold by the project). The amount of water to mix with one packet was asked of recent users, ever users, and never users who had heard of Jeevan Jal.

### 2. Treatment of children with diarrhea

Of all the respondents, 140 or 46.7% reported that their youngest child had had diarrhea in the two weeks preceding the survey. This shows that personal hygiene practices are poor, partly a result of the scarcity of clean water in Gorkha. This is the situation all over Nepal in pre- and early monsoon, the "diarrhea season".

Table 11 shows the feeding practices for the children who had diarrhea. This table indicates that, though mothers tend to breast-feed at least as much as usual when their child has diarrhea, other fluids and food are not given in adequate amounts. The message that food should be continued, given frequently in small amounts, and that fluids should be increased when the child has diarrhea, must be reinforced.

Table 12 shows that many of the mothers did not treat their child's diarrhea at all. This is due in part to the fact that diarrhea is considered a normal phenomenon, occurring too frequently to pay it much attention. Also, the diarrhea season coincides with planting season, when mothers are busy in the fields and have the least time to spend on their children. Less than half of the mothers gave oral rehydration solution to their children. And the fact that 24% of the mothers gave their child anti-diarrheal medicine is worrisome. SC/US's regular health program and the social marketing project are both teaching mothers to first rehydrate the child, and only in severe or prolonged cases to give medication. This finding indicates that even after four years of project activities, IEC messages about the management of diarrheal diseases still need to be continued.

In Table 13 it is seen that 55% of the mothers who gave Jeevan Jal to their child bought the packets from Social Marketing Project sales agents. This is rewarding, and

leads us to think that, especially with sales of Jeevan Jal having decreased (due to a tripling in price), the sales agents should continue to provide the products for several more years to assure that the present rates improve. Table 14 shows again that most women were not worried about their child's diarrhea. But of those who did consult someone, just as many sought advice from the project's sales agents as from their own friends and relatives.

Table 15 reports answers to the question "What symptoms would lead you to seek advice about your child's diarrhea". This was only asked of mothers who did seek advice for their child's recent case of diarrhea. Most women did not mention the most severe symptoms, the signs of dehydration, though half or more said that prolonged duration and fever would lead them to seek advice. This shows a great need for future health campaigns to focus on signs of dehydration.

### 3. Awareness of Jeevan Jal

It is a very positive finding that 72% of the mothers said that they should give Jeevan Jal to a child with diarrhea (Table 16). This means that the project was successful in spreading its main diarrhea management message: "A child should be given Jeevan Jal when he/she has diarrhea".

Ninety-five percent of the respondents had heard of Jeevan Jal (Table 17 -- the denominator is 285, or 95% of 300). The greatest success of this project is found in the increase in awareness of ORS and family planning methods. Other sources, such as national radio and the government's health program have helped, but we can confidently say that this project played the major role in making rural inhabitants of Gorkha aware of Jeevan Jal.

Teaching the correct amount of water to mix with a packet of Jeevan Jal is one of the major interventions of this project. That only 4/5 of the mothers who used Jeevan Jal for their child's recent diarrhea episode were able to give the correct amount of water is distressing, but that this figure is reduced to less than 2/3 of the total number of mothers who had heard of Jeevan Jal shows that no matter how simple it seems, the amount of water to use must still be reinforced in future educational campaigns.

Table 18 shows the actions women think should be taken when someone is recovering from diarrhea. To portray the concept of needing to treat someone who is recovering -- even to translate the word "recovering" into Nepali -- was difficult. In a poverty situation where child deaths are common, the family is relieved and ceases to worry as soon as the child appears to be out of danger.

"High-calorie food" and "more food" may be beyond the means of many, especially in the diarrhea season, which is also the lean time when grain supplies are dwindling, awaiting the post-monsoon harvest. Clearly the respondents would like to have high-calorie food to give. They do not seem to know that small, frequent feedings would help the child.

#### 4. Conclusion

Nearly half of the respondents reported that their child had had diarrhea in the two weeks preceding the survey, and very little was done to treat this diarrhea. With half of the children down with diarrhea at a time, that is no wonder! There is awareness that children should be given Jeevan Jal (72%) but only 30% actually gave the child Jeevan Jal, and 9% gave a homemade solution. Less than half of the women increased either breast-feeding or other fluids.

The CSIII project sales agents were the source of over half of the Jeevan Jal used for these recent diarrhea cases, and tied with relatives and friends as most often sought sources of advice for these cases.

Several topics for future diarrhea management educational campaigns have been identified:

1. Symptoms of severe dehydration
2. Increasing fluids, especially breast-feeding
3. Giving small, frequent feedings; and
4. The amount of water to mix with a packet of Jeevan Jal

TABLE 11: FEEDING PRACTICES IN CHILD'S RECENT DIARRHEA EPISODE

	BREAST MILK	FLUIDS OTHER THAN MILK	SOLID AND SEMI-SOLID FOODS
More than Usual	41.4 %	33.7 %	11.9 %
Same as Usual	40.0 %	22.7 %	23.8 %
Less than Usual	16.4 %	32.7 %	49.5 %
Stopped Completely	0.7 %	11.9 %	14.8 %
Not Breast-Fed	1.4 %	-	-
Exclusively Breast-Feeding	-	(27.9 %)	(27.9 %)
N	140	101	101

Note: The first column's percentages are of the 140 mothers of children <2 who had had diarrhea in the past two weeks, and for whom we have answers to this question; the last two columns' are of the 101 mothers of children with diarrhea who are not exclusively breast-feeding.

TABLE 12: TREATMENT OF CHILD WITH DIARRHEA

TREATMENT	NUMBER OF CHILDREN	PERCENTAGE
No Treatment	45	32.1
Jeevan Jal	42	30.0
Nun-Chini Pani	13	9.3
Other Fluids	12	8.6
Anti-Diarrhea Medicine	34	24.3
Other Treatment	27	19.3
TOTAL: Children who had had Diarrhea in Past 2 Weeks	140	(>100% due to Mult. Responses)

TABLE 13: SOURCE OF JEEVAN JAL USED IN RECENT DIARRHEA EPISODE

SOURCE	N	PERCENTAGE
Sales Agent	23	54.8
Medical/General Shop	16	38.1
Hospital	8	19.0
Health Post	4	9.5
Private Clinic/Doctor	2	4.8
Women's Group	2	4.8
Other Source	2	4.8
TOTAL:	42	(Totals >100% due to Mult. Respon.)

TABLE 14: ADVICE SOUGHT FOR CHILD WITH DIARRHEA

SOURCE OF ADVICE:	N	PERCENTAGE
No Advice Sought	109	77.9
Sales Agent	12	8.6
Relative or Friend	12	8.6
Medical/General Shop	8	5.7
Hospital	7	5.0
Health Post	3	2.1
Private Doctor/Clinic	1	0.7
Traditional Birth Attend.	1	0.7
Dhami/Jhankri (Shaman)	1	0.7
Other Source of Advice	4	2.9
TOTAL: Children who had had Diarrhea in Past 2 Weeks	140	(>100% due to Mult. Responses)

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**TABLE 15: SYMPTOMS THAT WOULD LEAD MOTHER  
TO SEEK ADVICE FOR CHILD'S DIARRHEA**

SYMPTOM	N	PERCENTAGE
Prolonged Duration	22	68.8
Fever	16	50.0
Vomiting	8	25.0
Loss of Appetite	7	21.9
Weakness/Tiredness	7	21.9
Sunken Fontanel, Dry Eyes, Decreased Urine Output	4	8.0
Blood in Stool	1	3.1
Other Symptom	3	9.4
N: Mothers who Sought Advice for Child's Diarrhea	32	(>100% due to Multiple Answers)

**TABLE 16: ACTIONS THAT SHOULD BE TAKEN IF  
A CHILD HAS DIARRHEA**

ACTION	N	PERCENTAGE
Give Jeevan Jal	217	72.3
Take to Hospital	94	31.3
Give Nun-Chini Pani	60	23.0
Don't Know	13	4.3
Take to Sales Agent	17	5.6
Give More to Drink	6	2.0
Give Small Freq. Feedings	4	1.3
Stop all Fluids	3	1.0
Other Action	45	15.0
TOTAL: All Respondents	300	(>100% due to Mult. Responses)

**TABLE 17: ACTIONS TO BE TAKEN WHEN A CHILD IS RECOVERING FROM DIARRHEA**

ACTION	N	PERCENTAGE
Give High-Calorie Food	131	43.7
Give Small Freq. Feedings	45	15.0
Give More Food	39	13.0
Don't Know	62	20.7
Other Answers	37	12.3
<b>TOTAL: All Respondents</b>	<b>300</b>	<b>(&gt;100% due to Mult. Responses).</b>

**TABLE 18: AMOUNT OF WATER TO MIX WITH JEEVAN JAL BY USE OF JEEVAN JAL**

	JEEVAN JAL USED FOR DIARRHEA IN PAST 2 WEEKS	JEEVAN JAL USED IN PAST OR NEVER	ALL RESPONDENTS WHO ARE AWARE OF JEEVAN JAL
Correct Amount of Water	80.9	60.5	63.5
Incorrect Amount or "Don't know"	19.1	60.5	36.5
N	42	243	285

02

## C. Family Planning Variables

### 1. Introduction

There were 14 family planning-related questions. The FP variables include pregnancy status and whether the woman wants another child within 2 years, awareness and use of contraception, future use plans, known sources of temporary contraception, and reasons for not planning to contracept in the future.

### 2. Pregnancy and Desire for More Children

Table 19 shows respondents' pregnancy status, current number of children, and desire for more children. The proportion of women who are pregnant is low, probably due to sampling only women with a child under 2. Most women do not want another child in the next two years (83%), or within two years of the birth of the child they are now carrying (93%) -- some spacing messages at least have been heard. But 35% of the pregnant women already have at least three living children, as do 51% of all respondents. There is some consolation in the fact that none of the pregnant women who wish to have another child within two years of this birth already have three children. And only 6% of the non-pregnant women who wish another child within two years already have three children.

### 3. Awareness and Use of Contraceptive Methods

Table 20 shows the respondents' self-mentioned awareness of specific contraceptives. Awareness was not prompted in this survey. It is encouraging that the awareness of pills is as great as that of either male or female sterilization for until recently sterilization was synonymous with family planning. But the proportion who are aware of at least two temporary FP methods is even slightly lower than that of pills, showing that most women are not aware of the full range of methods. Self-mention of the two brands of pills sold by the project is also low, showing that women identify the pills generically, not by name. Brand recognition is not obtainable for condoms, the other contraceptive sold, because the brand name *Dhaal* has become the commonly used word for condoms. Half of the women are aware of Depo-provera, the three-month injectable which proved to be more popular than either pills or condoms in the Year 2 Survey.

Table 21 shows the respondents' currently used method. The greatest difficulty with this sample is, as has been mentioned, that this sample includes only women with children under 2. This means contraceptive use particularly is low because many of the women of the final survey have

not yet ovulated after their last birth. Within the table, however, we see that male and female sterilization are still the most popular methods, and remain the most appropriate methods for couples who have completed their desired family size. The present survey shows pills and Depo-provera to be nearly equal, but this may be due to the temporary lack of supply of Depo in Nepal. Depo is very popular, and is the easiest temporary method available for these rural women.

#### 4. Source of Supply of Contraceptives

The fourteen women who are current users of condoms or pills were asked where they obtain their supplies (Table 22). That ten of the fourteen buy from our project's sales agents is a positive finding, and one that encourages SC/US to continue with the sales agents at least until alternative sources of supply are found.

Even more encouraging is the mention of sales agents as sources of temporary family planning methods by nearly half of all respondents (Table 23). The question asked for sources near the respondent's home. Only 19% do not know of any source; the rest are aware that near their home either the sales agent or a health post, hospital, medical shop or clinic can provide contraceptives. Eventually contraceptive supplies can be provided by shops and clinics, but as yet the sales agents are the best-known source so will be retained after grant funding ends.

#### 5. Future Use of Contraception

In Table 24, respondents were divided into those currently using and not using contraception. Most of the women interviewed wish to use some method in the future. The most popular method both for those not currently using and for those wishing to switch methods is female sterilization. Closely following for the non-current users is Depo-provera, then pills, when all brands are added together. Only 2% of the women consider using condoms, but women often forget about condoms and men were not interviewed, so condom future and present use are both underestimated. Norplant was chosen by 9 women, but it is not yet available in Gorkha District. Organizing camps for inserting Norplant would not be difficult, but there is no backup service for dealing with complications and removal.

Over half of the current users are apparently content with their method, for they are not thinking of switching methods. Again, it is appropriate for temporary method users to switch to permanent methods when they are sure the children they have are sufficient and are likely to survive. More of the current users would switch to pills than would

switch to Depo-provera, perhaps influenced by the current shortage of Depo-provera.

Those women who said either they that would not use or that they were not sure if they would use contraception in the future were asked their reasons. Table 25 shows that most of the women who will not use contraception want to have another child. The second most often-cited reason is fear of side effects, followed by husband's absence. There are 31 women (52.5%) who are at risk of pregnancy, meaning they neither say they are infertile nor that their husband is away, and yet they do not wish to have a child, and do not plan to contracept. Of these 31, 15 are afraid of side effects, 4 list family opposition, and the rest do not give any reason for not using contraception. It has been projected that if those women who wish to stop having children do not use contraception, they will conceive at the rate of 20% each month (Bongaarts, pp. 293-313).

## 6. Conclusion

Awareness, both of methods of contraception and of the need to space children more than 2 years apart, is far higher than practice. Most women do not want another child within the next 2 years (91%) yet only 16% of the non-pregnant women are using contraception, leaving 75% of these women unprotected yet not wanting a child.

Of all methods, sterilization is still the most popular, with pills and Depo-provera the most popular temporary methods. Most women (82% of the non-users) say they will use FP in the future, but side effects and social pressure prevent half of the remaining women from considering FP. Future educational campaigns would do well to focus on educating women about a variety of methods. In this way, their own or a friend's negative experience with one method can be offset with positive knowledge about another. The sales agents are well known as a source of contraceptive supplies. The present practice of having sales agents visit women soon after they give birth should be given even more emphasis -- this young, fertile sample should know more about FP.

TABLE 19: PREGNANCY AND DESIRE FOR MORE CHILDREN

	Frequency	Percent	PERCENT WITH 3 OR MORE CHILDREN ALIVE
<b>RESPONDENT NOW PREGNANT</b>			
No	272	90.7	53.0
Yes	23	7.7	34.8
Not Sure	5	1.7	40.0
<b>TOTAL</b>	<b>300</b>	<b>100.0</b>	<b>51.3</b>
<b>PREGNANT WOMEN'S DESIRE FOR ANOTHER CHILD WITHIN 2 YEARS OF THIS BIRTH</b>			
No	19	82.6	42.1
Yes	4	17.4	0.0
<b>TOTAL</b>	<b>23</b>	<b>100.0</b>	<b>34.8</b>
<b>NON-PREGNANT WOMEN'S DESIRE FOR ANOTHER CHILD WITHIN 2 YEARS</b>			
No	258	93.1	55.4
Yes	17	6.1	5.9
Don't know	2	0.7	4.3
<b>TOTAL</b>	<b>277</b>	<b>100.0</b>	<b>52.7</b>

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**TABLE 20: SELF-MENTIONED AWARENESS  
OF CONTRACEPTIVE METHODS**

<b>METHOD</b>	<b>Frequency</b>	<b>Percent</b>
<b>Any Pill</b>	<b>179</b>	<b>59.7</b>
<b>Generic Pills or Gulaf</b>	<b>145</b>	<b>48.3</b>
<b>Nilocon Pills</b>	<b>84</b>	<b>28.0</b>
<b>Kanchan Pills</b>	<b>41</b>	<b>13.7</b>
<b>Depo-Provera</b>	<b>149</b>	<b>49.7</b>
<b>Condoms - Dhaal</b>	<b>109</b>	<b>36.3</b>
<b>Norplant</b>	<b>35</b>	<b>11.7</b>
<b>Foaming Tablets - Kamal</b>	<b>32</b>	<b>10.7</b>
<b>IUD - Copper T</b>	<b>9</b>	<b>3.0</b>
<b>Abstinence</b>	<b>5</b>	<b>1.7</b>
<b>Coitus Interruptus</b>	<b>1</b>	<b>0.3</b>
<b>Other FP Method</b>	<b>3</b>	<b>1.0</b>
<b>AWARE OF AT LEAST 2 TEMPORARY METHODS</b>	<b>178</b>	<b>59.3</b>
<b>Female Sterilization</b>	<b>178</b>	<b>59.3</b>
<b>Male Sterilization</b>	<b>154</b>	<b>51.3</b>
<b>Not Aware of any Method</b>	<b>30</b>	<b>10.0</b>
<b>TOTAL</b>	<b>300</b>	<b>*</b>

\* Totals more than 100% because respondents were asked to list as many methods as possible. Brand names of pills are not counted as separate methods for the "awareness of at least 2 temporary methods".

TABLE 21: CURRENT CONTRACEPTIVE USE

	Freq.	Percent
No Method Used	256	85.3
Female Sterilization	11	3.7
Male Sterilization	10	3.3
Depo-Provera	8	2.7
Pills	9	3.0
Condoms	5	1.7
Vaginal Tablet	1	.3
TOTAL	300	100.0

TABLE 22: SOURCE OF CURRENTLY USED PILLS OR CONDOMS

SOURCE	Frequency
Sales Agent	10
Medical Shop	1
Hospital	2
Red Cross	1
TOTAL PILL AND CONDOM USERS	14

**TABLE 23: KNOWN SOURCES OF SPACING METHODS  
NEAR RESPONDENT'S HOME**

<b>SOURCE</b>	<b>N</b>	<b>PERCENTAGE</b>
<b>Sales Agent</b>	148	49.3
<b>Hospital</b>	49	16.3
<b>Medical Shop</b>	39	13.0
<b>SC/US Clinic/Office</b>	21	7.0
<b>Health Post</b>	20	6.7
<b>Red Cross</b>	14	4.7
<b>Private Doctor/Clinic</b>	5	1.7
<b>Women's Group</b>	2	0.7
<b>Other Source</b>	2	0.7
<b>Don't Know</b>	57	19.0
<b>TOTAL: All Respondents</b>	<b>300</b>	<b>(&gt;100% due to Mult. Responses)</b>

TABLE 24: CHOICE OF FUTURE METHOD

METHOD(S) CONSIDERED (Respondents were asked to list <u>all</u> methods considered)	NON-CURRENT USERS		CURRENT USERS
	N	PERCENT	N
No Method Considered (Current Users: No change)	45	17.6	23
Not Sure if Will Use	14	5.5	-
Will Use, but not sure of Method to Use	12	4.7	-
Female Sterilization	89	34.8	9
Male Sterilization	41	16.0	3
Depo-provera	56	21.9	2
Pills (Brand Not Mentioned)	30	11.7	2
Nilocon	9	3.5	3
Kanchan	5	2.0	1
Norplant	9	3.5	1
Condoms	5	2.0	-
Vaginal Tablets	2	0.8	1
TOTAL:	256	(>100% due to Multip. Responses)	44 (Percentages not given due to small denominator)

TABLE 25: REASONS FOR NOT USING CONTRACEPTION IN FUTURE

REASON(S)	N	PERCENTAGE
Side Effects	19	32.2
Want Child	21	35.6
Husband Away	11	18.6
Family Opposition	4	6.8
Infertile	4	6.8
Religious Reasons	1	1.7
Have Asthma	1	1.7
Don't know -- No reason	7	11.9
TOTAL: Respondents Who Are Not Current Users and Who Will Not Use in Future **	59	(Totals over 100% because of Multiple Responses)

\* Other reasons include various rumors, fears, and the woman's having reached menopause

\*\* Includes those not sure if will use in future

#### IV. DEMOGRAPHIC AND SOCIAL VARIABLES OF FINAL AND PREVIOUS SURVEYS

##### A. Introduction

The samples used for each of the three surveys should be similar -- if they are not, the findings may be biased in some way. The main purpose of this chapter, therefore, is to see if the samples are similar or not. In addition, some of the social variables should show some improvement, such as women's literacy and income generating activities. The major demographic variables, such as number of children ever born and now surviving, are not expected to evidence much change in the years since the previous surveys, especially since the Year 2 Survey was conducted only 10 months before the Final Survey.

##### B. Demographic and Social Background Variables

From Table A-1 it is seen that this year's sample is the youngest, closely followed by the Baseline women. The difference in the mean ages of Year 2 and Final Survey respondents is 1.8, or nearly 2 years. This is, as has already been mentioned, because of the Final Survey requirement that the woman have a child less than 2 years old. This is also the reason for so few representatives of the over-40 age groups in the Final Survey.

Despite their relative youth, however, this year's sample has the highest mean number of children, and the greatest proportion with over two children surviving (Table A-2). This finding is partly explained by the fact that only women with children were included, leaving out the sterile and subfertile women included in the previous surveys. The high child survival rate found for the final survey has already been explained by the relatively young age of the children in the sample.

The respondents' religion is overwhelmingly Hindu, though the Final Survey shows more Buddhist representation, and the only two Muslims found in all three survey samples (Table A-3). This is a minor difference and is unlikely to affect other variables. Table A-4 shows a similarly broadened ethnic representation for the Final Survey which, however, has the lowest proportion of occupational caste members. Sampling of the Mongolian groups is nearly equal for the later two surveys, though ethnicities within this broad grouping are unevenly represented. The Baseline Survey's Mongolian ethnic representation seems low.

The ethnic consideration most likely to affect the other variables is the proportion of high-caste to other respondents. The high caste women made up 59% of the Baseline, 43% of the Year 2, and 49% of the Final Survey sample. These women are known to be better educated and to have a better economic base than the others. In addition, health and family planning services have penetrated this group more thoroughly than the other ethnic groups.

### C. Literacy and other Dependent Social Variables

Literacy (Table A-5) is increasing markedly, though some of the increase can be explained by age and caste differences. The trend toward women's literacy must continue! Women's income generating activities (Table A-6) are increasing, though a broadening of the definition of "income generating" in the Year 2 Survey accounts for some of the increase for that survey's respondents.

Table A-7 shows the progress each of the major ethnic groupings has made in two women's confidence-raising activities -- literacy and income generating. The proportion of occupational caste women who are literate has nearly doubled in each survey, but they are still pitifully behind the high-caste women, half of whom are literate. The middle group appears to have regressed, but this is most probably due to the sampling of different ethnicities within the broad grouping in the Year 2 and Final Surveys.

Income generating activities are a bit more difficult to interpret, but this dilemma is in accord with the literature on status of women. If a woman is part of a poverty-stricken household, the income she generates may not be hers to dispose of. So the fact that 40% of the occupational caste women have their own source of income, already discovered in Chapter III to be primarily from labor for others, may not be a sign of progress at all. On the other hand, the women of the conservative higher castes' generating their own income does tend to promote the health and welfare of the family. The middle group has traditionally had less of a status problem, partly because the women have their own traditionally sanctioned business and handicraft ventures (See Acharya and Bennett, 1981).

Tables A-8 and A-9 show ideal family size and child survival for the broad ethnic groups. The proportion wanting two or less children has not increased, and surprisingly more of the lower caste women than the others want to stop at two children. This is an exact reversal of the case built by Acharya and Bennett, whereby the Indo-Aryan groups, the Brahmins, Chhetris and occupational castes, want the most children because the women have no alternative source of power than becoming mother to many sons.

Child survival for the Aryan groups is also higher than for the middle group. As has been mentioned, the children of the Baseline and Final Survey respondents are younger than those of the Year 2 Survey respondents. This accounts for much of the difference in child survival -- "child" here means merely offspring, for we do not have the ages of the older children. In other words, a 17-year-old child of a 35-year-old woman has had 15 more years of exposure to the risk of death than a 2-year old child of a 20-year-old woman.

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#### D. Conclusion

The three surveys' samples are basically similar. The only demographic variables that can be assumed to affect the other findings are mother's age and age of youngest child. FP use is definitely going to be lower among mothers of children less than 2 than among the general population of married women. It would have been interesting if this population had been studied from the start, for these women are the most fertile, the most in need of contraception, and also the most in need of ORS for their young children. But the fact that this sub-population was picked only for the final survey gives us problems.

Caste has a potential effect on the findings through cultural and economic pathways. For example, each ethnic group has different literacy rates, and, because literacy is our closest proxy for economic status, it follows that the economic situation also varies with ethnicity. And so, indirectly, the inclusion of varying proportions of upper-caste respondents means that the economic background also varies. The gap between literacy levels of the upper and the two lower caste groups is wider than ever now. We are thus relieved that the three samples are so similar in ethnic representation, especially of the group most different from the others, the upper castes.

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TABLE A-1: PROPORTION OF WOMEN IN EACH FIVE-YEAR AGE GROUPING

	BASELINE	YEAR 2	FINAL
15-19	12.8	9.6	8.0
20-24	31.6	24.0	34.7
25-29	20.7	24.5	23.7
30-34	13.2	15.7	15.7
35-39	8.6	11.2	11.3
40-44	9.2	8.8	5.7
45-49	3.9	6.1	1.0
N	304	554	300

TABLE A-2: PROPORTION OF CHILDREN SURVIVING

	BASELINE	YEAR 2	FINAL
MEAN NO. CHILDREN EVER BORN			
All:	3.0	2.6	3.2
Sterilized:	4.3	Not Avail.	3.8
Non-sterilized:	2.7	2.6	3.2
CHILD DEATHS PER 1000 LIVE BIRTHS	196	196	110
% WITH > 2 CHILDREN NOW ALIVE	31.9	45.1	51.3
% PREGNANT NOW (Of non-sterilized)	7.9	9.6	8.2
N	304	554	300

Note: All Final Survey respondents have at least one child, whereas 18.8% of Baseline and 11.7% of Year 2 Survey respondents had no children.

TABLE A-3: RELIGION -- FINAL AND PREVIOUS SURVEYS

	BASELINE	YEAR 2	FINAL
HINDU	98.7	94.9	93.0
BUDDHIST	1.3	5.1	6.3
MUSLIM	-	-	0.7
N	304	554	300

TABLE A-4: ETHNICITY OF RESPONDENTS IN EACH SURVEY

	BASELINE	YEAR 2	FINAL
BRAHMIN	32.9	24.7	25.7
CHHETRI	15.1	7.8	15.0
NEWAR	10.5	10.5	8.0
SUBTOTAL HIGH CASTES	58.6	43.0	48.7
GURUNG	11.2	4.2	21.3
MAGAR	1.3	17.0	4.7
BARAMU	-	6.5	2.0
TAMANG	-	3.1	1.0
SUBTOTAL MONGOLIAN GROUPS	12.5	30.8	29.0
OCCUPATIONAL CASTES	26.9	23.7	20.0
MUSLIMS	-	-	0.7
OTHERS	2.0	2.7	1.7
SUBTOTAL OCCUPATIONAL AND OTHER CASTES	28.9	26.4	22.4
N	304	554	300

TABLE A-5: WOMEN'S LITERACY AND EDUCATIONAL STATUS

	BASELINE	YEAR 2	FINAL
ILLITERATE	85.0	74.5	67.0
ATTENDED PRIMARY	4.8	7.5	8.0
ATTENDED SECONDARY	3.3	3.9	6.7
ATTENDED LITERACY CLASS, CAN READ	(Not asked)	11.0	16.7
STUDIED AT HOME, CAN READ	8.6 *	3.4	1.7
N	304	554	300

Note: Those women who attended literacy class or school but cannot read are counted as illiterate in this table.

\* Baseline women who are literate but did not attend school are put in the "studied at home" category, though they may have attended a literacy class.

TABLE A-6: WOMEN'S GROUP ATTENDANCE AND INCOME GENERATION

	BASELINE	YEAR 2	FINAL
OWN SOURCE OF INCOME	5.6	42.4	33.0
ATTEND WOMENS GROUP	*	*	9.3
N	304	554	300

\* Women's group attendance was not asked in the previous surveys.

TABLE A-7: WOMAN'S LITERACY AND INCOME GENERATION BY ETHNIC GROUPING  
-- ALL THREE SURVEYS

	BRAHMINS CHHETRIS AND NEWARS	GURUNGS MAGARS BARAMUS & TAMANGS	OCCUPATION- AL CASTES & OTHER GROUPS	ALL
<b>% LITERATE</b>				
BASELINE	24.2	10.5	4.5	16.8
YEAR 2	39.5	20.6	8.2	25.5
FINAL	51.4	16.1	14.9	33.0
<b>% WHO HAVE OWN INCOME SOURCE</b>				
BASELINE	3.4	7.9	6.8	4.9
YEAR 2	50.8	38.8	32.9	42.4
FINAL	32.2	28.7	40.3	33.0
<b>MEAN AGE AT MARRIAGE (Only available for Final Survey) FINAL</b>	15.6	18.4	19.9	16.7
BASELINE N	178 (58.6)	38 (12.5)	88 (28.9)	304 (100.0)
YEAR 2 N	238 (43.0)	170 (30.7)	146 (26.4)	554 (100.0)
FINAL N	146 (48.7)	87 (29.0)	67 (22.3)	300 (100.0)

TABLE A-8: IDEAL FAMILY SIZE BY ETHNIC GROUPING  
FOR YEAR 2 AND FINAL SURVEY

	BRAHMINS CHHETRIS AND NEWARS	GURUNGS MAGARS BARAMUS & TAMANGS	OCCUPATION- AL CASTES & OTHER GROUPS	ALL
<b>TWO OR LESS CHILDREN</b>				
YEAR 2	55.4	52.4	59.6	55.6
FINAL	58.9	47.1	61.2	56.0
<b>THREE OR MORE CHILDREN</b>				
YEAR 2 *	42.8	45.4	36.3	41.9
FINAL	41.1	52.8	38.8	43.9
BASELINE N	178 (58.6)	38 (12.5)	88 (28.9)	304 (100.0)
YEAR 2 N	238 (43.0)	170 (30.7)	146 (26.4)	554 (100.0)
FINAL N	146 (48.7)	87 (29.0)	67 (22.3)	300 (100.0)

Note: This question was not asked of Baseline respondents

\* Some Year 2 Survey respondents gave answers such as "it's god's will", or "don't know", which are not included in this table, so the totals do not add to 100.0 for the Year 2 Survey.

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TABLE A-9: CHILD SURVIVAL, BY ETHNIC GROUPING

	BRAHMINS CHHETRIS AND NEWARS	GURUNGS MAGARS BARAMUS & TAMANGS	OCCUPATION- AL CASTES & OTHER GROUPS	ALL
MEAN NUMBER OF CHILDREN BORN ALIVE				
BASELINE	2.72	3.29	2.47	2.72
YEAR 2	2.64	2.82	2.12	2.56
FINAL	2.97	3.80	2.90	3.20
MEAN NUMBER OF CHILDREN SURVIVING				
BASELINE	2.31	1.82	1.92	2.14
YEAR 2	2.07	2.14	1.48	1.94
FINAL	2.71	3.26	2.58	2.84
PERCENT OF CHILDREN SURVIVING				
BASELINE	85.1	55.2	77.9	78.7
YEAR 2	78.4	75.6	69.7	75.5
FINAL	91.2	85.8	89.2	88.9
BASELINE N	178 (58.6)	38 (12.5)	88 (28.9)	304 (100.0)
YEAR 2 N	238 (43.0)	170 (30.7)	146 (26.4)	554 (100.0)
FINAL N	146 (48.7)	87 (29.0)	67 (22.3)	300 (100.0)

## V. DIARRHEA MANAGEMENT FINDINGS FROM FINAL AND PREVIOUS SURVEYS

### A. Introduction

Chapters V and VI show the progress made through the four years of project activities, with respect to specific project objectives. Chapter V deals with ORS objectives and Chapter VI with FP objectives. Other comparisons are made through time, wherever the variables used in the three surveys are similar enough.

It is noteworthy that nearly half of the children in both the Year 2 Survey (44.7%) and the Final Survey (47.2%) had had diarrhea in the two weeks prior to the survey, compared to only 17.5% of the Baseline Survey children. The incidence of diarrhea is greatest during the hot months just before the monsoon (April and May), and at the beginning of the monsoon (June). The Baseline interviews covered the entire month of April, while the Final Survey was from April 17-24, and the Year 2 Survey was conducted in June. Though the Baseline and Final Surveys occurred in the same month, the spring of 1992 was a time of severe drought all over Nepal, and the quantity and quality of drinking water suffered in most areas. It is also a sad casualty of Nepal's population explosion that for many Nepalese, access to safe drinking water has decreased, not increased with time.

### B. Diarrhea Management Objectives

Table B-1 shows that all of the project's diarrhea management objectives except sales of Jeevan Jal have more than been met. All, in fact, were met after two years of sales. Awareness of Jeevan Jal has risen to 95%, and we are confident that this is primarily in response to the promotional and IEC activities of this project. The use of Jeevan Jal in children's diarrhea episodes the two weeks preceding the survey, though surpassing the three-year objectives even at the end of two years of sales, is still not as high as we would hope. Similarly, though the proportion who mix Jeevan Jal correctly exceeds the objective, 20% of the women who had used Jeevan Jal still do not know the correct amount of water to mix with the packet of salts. If the solution is any saltier than tears, it may worsen the dehydration rather than easing it -- this message needs reinforcement.

The decline in Jeevan Jal sales in the third year is a reaction to the tripling of price (from one rupee to three rupees, or U.S. \$.02 to \$.06) at the end of the second year of sales. This is a result of UNICEF's withdrawing their subsidy. Jeevan Jal supplies marked with the new price arrived in the beginning of the third year of sales. Consumers and sales agents complained

to the Final Evaluation team about this price raise. The sales agents said that just as many consumers buy Jeevan Jal as before, only each consumer buys fewer packets--this means there is less likelihood that packets will be on hand when they are needed.

### C. Social Factors Affecting Diarrhea Management

Ethnicity, literacy, and income generating are the main social variables cross-tabulated with the ORS variables. Table B-2 gives the ethnic variation in responses to ORS variables through time as measured by the three surveys. A far greater proportion of occupational caste children in the Final Survey had diarrhea than just ten months before, seen in the Year 2 Survey, whereas the other two ethnic groupings do not evidence such a change. Predictably, the highest castes had the lowest proportion with diarrhea, and the lowest castes had the highest proportion with diarrhea--this accords with economic status. The incidence of diarrhea is of great concern -- it is seen to be worsening rather than lessening, especially in the lower caste group.

Jeevan Jal was used for a greater proportion of the Brahmin-Chhetri-Newar diarrhea cases, and for a lower proportion of the occupational caste cases, but no group deviated more than 6 percentage points from the total sample use rate. Similarly, awareness is near-uniformly high, with the Gurung-Magar group slightly behind but not so far behind as in the Baseline Survey.

Clearly more of the upper castes than the other groups are receiving the social marketing messages, for when asked the preferred diarrhea treatment, there is about a 20-percentage point gap between the higher castes' mention of Jeevan Jal and all others, -- for both the Year 2 and Final Surveys.

Table B-3 and B-4 show that school attendance has more influence than either NFE class attendance or income generating on whether or not the child gets diarrhea in the first place, but that NFE class and income generating are both closely associated with the use of Jeevan Jal. Two potential confounders are here -- that of socioeconomic status with education, and of the subject matter used in the NFE classes (ORS and FP, among others) with literacy. Whatever the source of the messages, the essential point is that the women hear them and act on them.

### D. Conclusion

This project has succeeded in meeting all of its diarrhea management objectives except the sale of Jeevan Jal. Sales decreased in the third year when the price of Jeevan Jal tripled. Though only an increase of 4 cents U.S., this population found it difficult to keep a spare packet or two on hand at the new price. Nonetheless, use of Jeevan Jal for recent diarrhea episodes has continued to increase.

Nearly all of the population are aware of Jeevan Jal. For the next phase of the social marketing project, alternatives to Jeevan Jal should be promoted more than they have been so far. The concern at the beginning of the project that incorrect proportions of the ingredients would result from using a homemade sugar-salt solution is validated by the fact that 29% of consumers still do not know the correct amount of water, even after years of intensive IEC and promotional activities. But there need to be several alternatives for times when there are no supplies of Jeevan Jal, or when the price is unaffordable.

Another important focus for the future is prevention of diarrhea. Though the CSIII school health educator teaches children proper hygiene, less than 1% of project area households have latrines, so present defecation practices cannot help but spread disease. SC/US has recently begun a project to help the villagers build latrines. The agency provides the latrine pans and the villagers provide the labor and materials for the hut around the pan. A health campaign teaching about the spread of disease, how to keep the latrine clean, and the importance of handwashing and clean drinking water should be part of the latrine building project.

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TABLE B-1: DIARRHEA MANAGEMENT OBJECTIVES

DIARRHEA MANAGEMENT OBJECTIVES	BASELINE SURVEY FINDINGS	YEAR 2 SURVEY FINDINGS	FINAL SURVEY FINDINGS
1. 80% OF WOMEN WITH CHILDREN <5 WILL BE AWARE OF JEEVAN JAL BY END OF 3rd YEAR OF SALES	63.0% had heard of JJ 36.1% recognized JJ packet	95.1% had heard of JJ 92% recog. JJ packet	94.7% had heard of JJ (Packet recog. not asked)
2. JEEVAN JAL WILL BE USED FOR 20% OF <5s' DIARRHEA EPISODES IN PAST 2 WEEKS BY END OF 3rd YEAR OF SALES	8.3% (5 used JJ, of 60 with diarr, of total 343 children <5)	26.9% (63 used JJ, 234 had diarr, total of 544 children <5)	30.0% (42 used JJ, 143 had diarr, total of 300 children <2)
3. 50% OF JEEVAN JAL CONSUMERS WILL BE ABLE TO MIX JEEVAN JAL CORRECTLY BY END OF 3rd YEAR OF SALES  (In 1991 last mixing survey 56.7% of JJ consumer households mixed completely correctly)	Knowledge of JJ "completely correct" =17.1% of those who had heard of JJ	61.7% of those who had heard of JJ know correct amount of water  (69.4% of ever users of JJ know correct amount water)	71.3% of those who had heard of JJ know correct amount of water  (80% of ever users of JJ know correct amount water)
4. SALES OF JEEVAN JAL WILL INCREASE BY 25% EACH YEAR OF SALES	1st Year's Sales= 9857 Packets	2nd Year's Sales= 13,785 Packets  39.8% Increase	3rd Year's Sales= 10,314 Packets (Should be 15,402 for 25% increase/yr, or 17,231 for 25% increase from 2nd year)

**TABLE B-2: DIARRHEA MANAGEMENT VARIABLES BY ETHNIC GROUPING  
FOR ALL THREE SURVEYS**

	BRAHMINS CHHETRIS AND NEWARS	GURUNGS MAGARS BARAMUS & TAMANGS	OCCUPATION- AL CASTES & OTHER GROUPS	ALL
<b>% OF CHILDREN WHO HAD DIARRHEA IN PAST 2 WEEKS</b>				
YEAR 2	36.3	49.4	48.1	43.3
FINAL	39.0	49.4	64.2	47.2
<b>% WHO USED JEEVAN JAL TO TREAT DIARRHEA CASE OF PAST 2 WEEKS</b>				
YEAR 2	29.9	28.9	20.0	26.8
FINAL	35.1	27.9	23.3	29.4
<b>% WHO ARE AWARE OF JEEVAN JAL</b>				
BASELINE	64.0	28.9	46.6	54.6
YEAR 2	97.5	90.6	91.8	93.9
FINAL	97.3	92.0	94.0	95.0
<b>% WHO SAY "JEEVAN JAL" WHEN ASKED PREFERRED DIARRHEA TREATMENT</b>				
YEAR 2	85.3	65.3	63.7	73.5
FINAL	82.2	63.2	62.7	72.3
BASELINE N	178 (58.6)	38 (12.5)	88 (28.9)	304 (100.0)
YEAR 2 N	238 (43.0)	170 (30.7)	146 (26.4)	554 (100.0)
FINAL N	146 (48.7)	87 (29.0)	67 (22.3)	300 (100.0)

Note: Except for awareness of Jeevan Jal, this table does not include Baseline respondents, because ethnicity and most ORS variables are in separate, unlinked files.

**TABLE B-3: ORS VARIABLES BY WOMAN'S SOURCE OF LITERACY  
FOR YEAR 2 AND FINAL SURVEYS**

VARIABLE	SURVEY	ILLITERATE	NFE CLASS	SCHOOL	ALL
CHILD HAD DIARRHEA IN PAST 2 WEEKS *	YEAR 2	43.7	45.5	32.1	43.3
	FINAL	50.9	50.6	31.3	47.7
USED JEEVAN JAL FOR DIARRHEA *	YEAR 2	20.5	38.0	58.8	26.8
	FINAL	22.6	40.9	33.3	29.4
	YEAR 2 N	377	114	63	554
	FINAL N	165	87	48	300

**TABLE B-4: ORS VARIABLES BY WOMAN'S INCOME GENERATION  
FOR YEAR 2 AND FINAL SURVEYS**

VARIABLE	SURVEY	WOMAN HAS OWN INCOME SOURCE	WOMAN HAS NO INCOME SOURCE	ALL
CHILD HAD DIARRHEA IN PAST 2 WEEKS *	YEAR 2	44.9	42.0	43.3
	FINAL	53.5	44.8	47.7
USED JEEVAN JAL FOR DIARRHEA	YEAR 2	32.1	22.5	26.8
	FINAL	34.0	26.7	29.4
	YEAR 2 N	235	319	554
	FINAL N	99	201	300

## VI. FAMILY PLANNING FINDINGS FROM FINAL AND PREVIOUS SURVEYS

### A. Introduction

While Jeevan Jal has been fully accepted in the community for its ability to save lives, contraception has met with more opposition. For Jeevan Jal the issues are limited to price, the choice of traditional versus modern medicine and ORS versus antibiotics or antidiarrheals. The situation for contraception is more complicated. Oral contraceptives have undeniable side effects, and some serious complications. There are rumors of fanciful and physically impossible effects of condoms. Condoms have more of a reputation for breakage than has been proven, but this reputation prevents many couples from using them. They are also disliked for their interference in sex, and for the "dirty" image that has arisen from the practice of using condoms only with prostitutes.

There is general opposition to contraception for its being "against God's will", unnatural, and obstructing the body's vital energy flow, potentially causing physical and mental problems. Social reasons for having many children include the need for extra labor on the farm and the Hindus' need for sons to light the parents' funeral pyre to liberate their souls. High child mortality rates lead families to have extra children as insurance. One of the most difficult tasks of this project has been convincing the village women that spacing children further apart will increase the chances of survival of the ones already born.

### B. Family Planning Objectives

Table C-1 shows the three surveys' findings with respect to the family planning objectives. The three surveys' differences in sampling and choice of questions limits the comparability of some figures. It is clear, however, that awareness of temporary family planning has risen in the project area. Not having prompted awareness rates for the Final Survey means that we do not know if awareness of at least two temporary methods has actually reached the 90% level set in the objectives, but the fact that unprompted awareness has risen 7.7 percentage points since the Year 2 Survey, when prompted awareness was 85.5%, leads us to extrapolate prompted awareness to over 90%.

The use of pills has risen to 3.2%, which meets the level set in the objectives. Condom use, as discussed in Chapter III, is low, unrealistically so when sales records are compared with usage rates from the surveys. Product recognition is increasing, though recognition was not asked in the Final Survey.

Knowledge of product use was solicited during the Year 2 Users' Survey. The inability of consumers to remember what to do if either one or two pills are missed has been a problem throughout

the project. The message the women are supposed to have learned is if one day is missed, to take a pill when they remember the next morning and another in the evening. If two days' pills are missed, she should take one each morning and evening for two days and use condoms for the rest of the cycle. A flip chart is used by the sales agents to explain this to the consumers, and pamphlets are given to the consumers to give the illiterate women pictorial reinforcement of the message, but to little avail. The pill users' follow-up counsellor estimates that the knowledge today is little better than the level found in the Year 2 Users' Survey, which showed that 47% remembered the message for one, but only 15% for two days of missed pills.

Table C-2 shows the project objectives that deal with sales records. All the sales objectives have been met, and some have been far exceeded. The target for example, was for regular use to increase by 10% each year of sales, when in fact it increased by over 130% the second year, and over 60% the third year for each product.

Table C-3 shows how awareness and use of specific family planning methods has changed through the project years, with, of course, the same qualifications about the samples as have been mentioned before. The most spectacular increase in awareness is found for Depo-provera, the three-month injectable. It is disheartening that the 2 methods sold by the project show a decrease in awareness, though the decrease is slight. Other methods not available in most of Gorkha are better known than before, such as Norplant, as yet unobtainable in Gorkha, and the IUD, available sporadically in the two hospitals.

The relatively low usage rates for the Final Survey can only be explained by the fact that all of the respondents had given birth to their youngest child within two years of the survey -- it is unlikely that the temporary method usage rate in the population has decreased when sales have been increasing. Use of Depo-provera, however, the most popular temporary method in the second survey, is sure to have dropped due to the present lack of supplies of Depo in Gorkha. And the apparent drop in sterilization prevalence can be explained presuming that these women with very young children would not be interested in sterilization for some years.

### C. Social Factors Affecting Family Planning

Table C-4 shows how family planning awareness and use vary across the ethnic groups over time. The four row-wise categories are mutually exclusive and add to 100%, meaning that we can chart the population's movement through the stages from being first unaware of family planning, to being aware but never having used a method, to having used a method (perhaps for a short time), and then being continuing users. We would hope that the majority of

the women would be continuing users of some method after several more years of project activity. This table shows that the occupational caste women have progressed the farthest in this respect. The Brahmin-Chhetri group show good progress as well. The Gurung-Magar group are strangely lagging behind, most probably due to sampling differences (as was found with the literacy findings), for it cannot be that less of this group are aware now than last year. It is unfortunate that we do not have Final Survey data on past use, for we could have found the number of women who had been using Depo-provera but quit due to lack of supplies. The higher proportion who are totally unaware of family planning in the Final Survey must be due to the young sample, which reinforces the need for targeting these women.

Tables C-5 and C-6 show the association between family planning and literacy and income generating. As was found with ORS variables, the fact that a woman has been to school is closely associated with family planning use. There is less difference between the illiterates and the new-literates regarding use, but awareness of at least two temporary methods is far greater among the NFE class literates than among the illiterates. The mean ages of respondents have been included as age could be a confounding variable. In the Final Survey, income generating is seen to be associated with greater use and awareness rates (Table C-6).

#### D. Conclusion

This chapter would be far more complete if the sampling and variables of the three surveys were consistent. Nonetheless, some patterns are discernible. Awareness is increasing overall, with some irregularities seen for individual methods. Use of temporary family planning must be seen in light of the Final Survey sample's youth and recent childbearing, but pill use has attained its objective, and condom use most probably appears low due to interviewing only women. Sales objectives have all been met. There is a problem with the consumers of pills not remembering what to do if they miss a pill or two.

Literate women, especially those who attended school, and women who generate their own income are more likely than others to know about and to use contraception. The occupational caste women have moved the farthest through the years, from over half being totally unaware of family planning in the Baseline Survey, to having the greatest proportion of users found among any ethnic grouping in the Final Survey.

TABLE C-1: FAMILY PLANNING OBJECTIVES

FAMILY PLANNING OBJECTIVES	BASELINE SURVEY FINDINGS	YEAR 2 SURVEY FINDINGS	FINAL SURVEY FINDINGS
1. 90% OF ELIGIBLE COUPLES WILL BE AWARE OF AT LEAST 2 SPACING METHODS BY END OF 3rd YEAR OF SALES	Prompted plus Unprompted= 30.0% Unprompted= 6.9%	Prompted plus Unprompted= 85.5% Unprompted= 51.6%	(Awareness was not prompted) Unprompted= 59.3%
2. CURRENT USE RATES FOR PILLS AND CONDOMS WILL EACH BE 3% BY END OF 3rd YEAR OF SALES	Pills 1.6% Condoms 1.6% (of married, not sterilized)	Pills 2.9% Condoms 1.0% (of married, not sterilized)	Pills 3.2% Condoms 1.8% (of married, not sterilized with child <2)
3. PRODUCT RECOGNITION WILL INCREASE BY 25% EACH YEAR OF SALES FOR EACH PRODUCT	Gulaf 9.9% Nilocon 7.2% Dhaal 13.8% (Packet Seen)	Kanchan 30.5% Nilocon 43.9% Dhaal 54.2% (Packet Seen)	(Not Asked)
4. 75% OF REGULAR USERS WILL HAVE ACCURATE KNOWLEDGE OF PRODUCT USE BY END OF 3rd YEAR OF SALES	(Not Measured)	47.3% Know what to do if 1 Day of Pills Missed 14.7% Know for 2 Days Missed	(Not Measured)

Note: "Regular Use" means at least three months of continuous use.

TABLE C-2: FAMILY PLANNING OBJECTIVES (SALES)

FAMILY PLANNING OBJECTIVES (SALES)	FIRST YEAR OF SALES	SECOND YEAR OF SALES	THIRD YEAR OF SALES
5. ANNUAL SALES WILL INCREASE BY 25% EACH YEAR	1st Year: Pills 1763 Cycles Condoms 4281 Packets	2nd Year: Pills 2450 (39% Increase) Condoms 6575 (53.6% Increase)	3rd Year: Pills 2844 (16.1% Incr.) Condoms 8355 (27.1% Increase)
6. REGULAR USE WILL INCREASE BY 10% EACH YEAR OF SALES	Last 2 Months of 1st Year: Pills 71 Regular Users Condoms 113 Regular Users	Last 2 Months of 2nd Year: Pills 168 (136.7% Incr) Condoms 262 (131.9% Incr)	Last 2 Months of 3rd Year: Pills 271 (61.3% Incr) Condoms 443 (69.1% Incr)
7. 30% OF PILL USERS AND 40% OF CONDOM USERS WILL BE REGULAR USERS EACH YEAR OF SALES	Last 2 Months of 1st Year: Pills=71/216 = 32.9% Condoms=113/276 = 40.9%	Last 2 Months of 2nd Year Pills=168/305 = 55.1% Cond.=262/460 = 57.0%	Last 2 Months of 3rd Year Pills=231/404 = 57.2% Cond.=443/700 = 63.3%

Note: "Regular Use" for Pill users means at least three months of continuous use, and for Condom users means buying at least six packets of Dhaal.

TABLE C-3: FAMILY PLANNING AWARENESS AND USE--ALL THREE SURVEYS

VARIABLE	BASELINE SURVEY FINDINGS	YEAR 2 SURVEY FINDINGS	FINAL SURVEY FINDINGS
<b>METHOD AWARENESS (Unprompted)</b>			
Pills	15.0	61.9	59.7
Condoms	7.5	42.6	36.3
Depo-Provera	3.9	31.0	49.7
IUD	1.5	7.0	11.7
Norplant	-	2.2	3.0
Vaginal Tablets	1.5	9.0	10.7
Abstinence	-	-	1.7
Coitus Interruptus	-	-	0.3
Male Sterilization	13.3	64.3	51.3
Female Sterilization	13.1	64.1	59.3
N	412	554	300
<b>METHOD USE (Among Non-Sterilized)</b>			
Pills	1.6	2.9	3.2
Condoms	1.6	1.3	1.8
Depo-Provera	1.0	5.6	2.9
IUD	-	0.2	-
Norplant	-	-	-
Vaginal Tablets	-	0.2	0.4
Other Temp. Method	-	0.4	-
Any Temporary Method	4.2	9.7	8.3
N	304	554	279
<b>METHOD USE (Among All Married Women)</b>			
Pills	1.5	2.4	3.0
Condoms	1.2	1.1	1.7
Depo-Provera	0.7	4.7	2.7
IUD	-	0.2	-
Norplant	-	-	-
Vaginal Tablets	-	0.2	0.3
Other	-	0.3	-
Any Temporary Method	3.4	8.8	7.7
Male Sterilization	12.4	} 16.3	3.3
Female Sterilization	8.3		3.7
Any Method	24.1	25.1	14.7
N	412	662 (Extrapolated)	300

TABLE C-4: FAMILY PLANNING STATUS BY ETHNIC GROUPING  
FOR ALL THREE SURVEYS

	BRAHMIN, CHHETRI, OR NEWAR	GURUNG, MAGAR, BARAMU, OR TAMANG	OCCUPATION- AL CASTES or OTHER GROUPS	ALL
<b>% UNAWARE OF FP</b>				
BASELINE	36.0	78.9	53.4	46.4
YEAR 2	2.1	4.1	6.2	3.8
FINAL	6.2	10.3	6.0	7.3
<b>AWARE, NEVER USERS</b>				
BASELINE	55.1	18.4	42.0	46.7
YEAR 2	74.4	73.5	80.8	75.8
FINAL *	76.0	83.9	74.6	78.0
<b>PAST, NOT PRESENT USERS OF FP</b>				
BASELINE	2.8	2.6	2.3	2.6
YEAR 2	13.9	9.4	6.8	10.6
FINAL	-	-	-	-
<b>PRESENT USERS</b>				
BASELINE	6.2	-	2.3	4.3
YEAR 2	9.7	12.9	6.2	9.7
FINAL	17.8	5.7	19.4	14.7
<b>BASELINE N</b>	178 (58.6)	38 (12.5)	88 (28.9)	304 (100.0)
<b>YEAR 2 N</b>	238 (43.0)	170 (30.7)	146 (26.4)	554 (100.0)
<b>FINAL N</b>	146 (48.7)	87 (29.0)	67 (22.3)	300 (100.0)

\* There was no question in the final survey about previous family planning use, so the "never users" include past users in this survey only.

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TABLE C-5: FP VARIABLES BY SOURCE OF LITERACY - ALL THREE SURVEYS

VARIABLE	SURVEY	ILLITERATE	NFE CLASS	SCHOOL	ALL
CURRENT FP USERS (%)	BASELINE**	3.2		9.8	4.3
	YEAR 2	9.8	7.9	12.7	9.7
	FINAL ***	5.9	7.4	17.8	8.2
KNOW AT LEAST 2 TEMPORARY FP METHODS (%)	BASELINE	23.3		64.7	30.2
	YEAR 2	80.9	93.0	96.8	85.2
	FINAL	49.7	65.5	81.2	59.4
MEAN AGE	BASELINE	28.3		23.9	27.6
	YEAR 2	30.4	27.4	22.5	28.7
	FINAL	28.8	26.3	22.5	27.1
	BASELINE N	253		51	304
	YEAR 2 N	377	114	63	554
	FINAL N	165	87	48	300

Note: \* Baseline respondents' diarrhea management and literacy variables are in different files so cannot be cross-tabulated without much fiddling.

\*\* Baseline respondents were not asked about literacy class, only if they could or could not read. The figure between "literacy class and "school" is for total who can read.

\*\*\* For the Final Survey's current use, a subsample of 279 non-sterilized women was the denominator.

**TABLE C-6: FP VARIABLES BY WOMAN'S INCOME GENERATION  
FOR BASELINE, YEAR 2, AND FINAL SURVEYS**

VARIABLE	SURVEY	WOMAN HAS OWN INCOME SOURCE	WOMAN HAS NO INCOME SOURCE	ALL	
CURRENT FP USE	BASELINE	0.0	4.5	4.3	
	YEAR 2	11.5	8.5	9.7	
	FINAL **	13.0	5.9	8.2	
KNOW AT LEAST 2 TEMPORARY FP METHODS	BASELINE	26.7	30.4	30.2	
	YEAR 2	89.4	82.1	85.2	
	FINAL	79.8	54.2	59.4	
MEAN AGE	BASELINE	25.4	27.7	27.6	
	YEAR 2	28.1	29.5	28.7	
	FINAL	26.9	27.2	27.1	
	BASELINE	N	15	289	304
	YEAR 2	N	235	319	554
	FINAL	N	99	201	300

Note: \* Baseline respondents' diarrhea management and income generation variables are in different files so cannot be cross-tabulated without much fiddling.

\*\* For the Final Survey's current use, a subsample of 279 non-sterilized women was the denominator.

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## VII. CONCLUSION AND SUGGESTIONS FOR THE FUTURE

### A. Demographic and Social Variables

The samples of the three surveys were similar enough for the findings to be comparable. The only problematic difference between the three samples is the sampling of women with children under 2 in the Final Survey, whereas all married women aged 15-49 were sampled in the earlier surveys. The effect of caste is presumed to be minimal, and that due primarily to the differing proportions of high-caste respondents in each sample -- 59% in the Baseline, 43% in the Year 2, and 49% in the Final Survey.

Progress is being made in two women's self-confidence-raising activities -- literacy and income generation. Women's literacy has more than doubled in the four years since the Baseline Survey, and half of the Final Survey's literate women learned to read in a SC/US literacy class. Still, only 1/3 of the Final Survey women are literate, and only 6.7% attended any secondary school. One third of the women have their own source of income, mostly from farm-based activities.

One of SC/US's main development policies in Nepal is that women must become empowered so they can better work for the welfare of their family and the community. Some of the pathways to empowerment are through literacy, having their own income source, and through knowledge of health and family planning. The fact that SC/US uses an integrated approach to development means that this ORS and FP project is supported in the community by the education and productivity sectors, as well as by the other activities of the health sector.

### B. Diarrhea Management

All project objectives regarding diarrhea management have been met -- except for sales of Jeevan Jal. Jeevan Jal awareness is high, a tribute to the hard work of sales agents and project staff. Use is increasing, though still at only 30% of recent diarrhea cases. Sales actually decreased, a direct result of the tripling of the price of one packet of Jeevan Jal.

Though it is a positive finding that Jeevan Jal use and awareness are increasing, it is distressing that the incidence of diarrhea is also increasing. Nearly half of the children were found to have had diarrhea in the two weeks before the survey.

In summary, the project's diarrhea management successes and areas that need improvement as identified through the survey data are:

## 1. Successes in Diarrhea Management

- a. 95% of mothers have heard of Jeevan Jal.
- b. 80% of Jeevan Jal ever-users know the correct amount of water to mix with one packet.
- c. Jeevan Jal was used for 30% of children's diarrhea episodes in the two weeks preceding the survey.
- d. 55% of the Jeevan Jal used in these cases was bought from social marketing project sales agents.
- e. Sales agents are as frequently mentioned sources of advice as relatives/friends.

## 2. Areas for Future Project Focus

- a. Other types of ORS should be taught as alternatives to Jeevan Jal for when the price is unaffordable or supplies are not available.
- b. Diarrhea incidence of nearly 50% is too high, and it is increasing rather than decreasing. Prevention needs to become a major focus, with latrine building and teaching about how to prevent the spread of diarrheal disease.
- c. Messages to increase fluids during diarrhea need to continue -- only 41% gave more breast milk than usual, and only 34% gave more other fluids than usual in their child's last diarrhea case.
- d. Signs and symptoms of dehydration need to be taught again and again -- only 8% mentioned dehydration signs as reasons to seek advice for diarrhea.
- e. Though 80% know how much water to mix with a packet of Jeevan Jal, that still leaves 20% who do not know. The mixing demonstrations must continue, and new strategies for helping people remember must be devised.

## C. Family Planning

Most women think one child of each sex is enough, and most do not wish another pregnancy within two years -- these attitudes are at least in part due to project activities. Yet only 15% of the Final Survey women are using contraception. This proportion is certainly low because of the sample's youthfulness and the fact

that each has borne a child within the past 2 years. But this group does wish to use contraception in the future. The task left for the social marketing project to carry on is to close the "KAP-gap", the gap between awareness and use of contraceptives.

The next stage will need to utilize all of SC/US' strengths in the fields of women's productivity and literacy to help women raise their status in the home and the community. This will further their already-awakened desires to have small families and use contraception. The messages given thus far must continue to be reinforced, and the supply lines and referral system must be strengthened. In addition, new ethnic-specific strategies, new products and supply lines may be tried.

#### 1. Successes in Family Planning

- a. 59% of the women can spontaneously name two temporary family planning methods; as great a proportion of women are aware of pills as of sterilization.
- b. The objective of 3% of eligible couples using pills by the end of three years of sales has been met.
- c. Though packet recognition was not tested in the Final Survey, the rates in the Year 2 Survey were more than triple the rates of the Baseline Survey.
- d. Sales of pills and condoms have increased by an average of more than the targeted 25% per year.
- e. Regular use (at least 3 months of pill use, and at least 8 packets of condoms purchased) has increased far more than was targeted, and the proportion of all users who are regular users has also increased.

#### 2. Areas for Future Project Focus

- a. Teaching a wide variety of methods -- 40% of the Final Survey women know less than two temporary methods.
- b. Continuing to promote sterilization as the most appropriate method for couples who have their desired number of children.

- c. Reinforcing the messages taught pill consumers about missing one or two days of pills -- or perhaps the message could be simplified to "continue the pills but use condoms if any are missed"
- d. Assuring the supply of all products. Depo-provera is the second-best-known temporary contraceptive, and was the most popular in the Year 2 Survey. Now there are no supplies. The project should try to assure the supply of Depo-provera, and to sell it in medical shops. Consider having the mobile clinics sell Depo -- they now give it free.
- e. Testing of strategies developed for specific ethnic groups. The sales agents, the CSIII staff and the drama were oriented primarily to the upper castes.
- f. Work with the productivity and literacy sectors to improve the status of women and give an alternative to having many sons.

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**APPENDIX A**

## APPENDIX A: SURVEY COSTS

Cost in Nepali Rupees	
Printing (Questionnaires and Report) -	4,120.00
Travel - - - - -	2,875.00
Food - - - - -	11,402.30
Supplies - - - - -	3,818.00
Porters - - - - -	2,210.00
Supervisors' Salary - - - - -	3,750.00
Bus Fare - - - - -	82.00
Enumerators' Wages - - - - -	11,500.00
<hr/>	
TOTAL - - - - -	39,757.30 (\$ 837.00)

**APPENDIX B**

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Mother's Education/Occupation

5. Can you read? (Show questionnaire)

- a. Yes [ ]
- b. No [ ]

6. What was the highest educational level you attained?

- a. None, does not read [ ]
- b. Went to primary school but cannot read [ ]
- c. Went to primary school and can read [ ]
- d. Went past primary school - secondary or higher [ ]
- e. Can read - no school but studied at home or at friend's house [ ]
- f. Studied at literacy class [ ]
- g. Other specify \_\_\_\_\_ [ ]

7. Did you ever attend a literacy class?

- a. Yes [ ]
- b. No [ ] ----> go to 10

8. If 'Yes', which class?

- a. SCF's basic literacy class attended but not completed [ ]
- b. SCF's basic literacy class completed [ ]
- c. SCF's advanced literacy class completed [ ]
- d. Other literacy class attended (government or other project) [ ]
- e. Don't know [ ]

9. In which year did your class begin?

Year \_\_\_\_\_

10. Do you do any "income generating work"?  
(multiple answers possible; record all answers)

- a. Nothing [ ]
- b. Sewing, knitting, weaving, rugs, and other handicraft, etc. [ ]
- c. Selling agricultural products [ ]
- d. Agricultural labor [ ]
- e. Other casual labor [ ]
- f. Shopkeeper [ ]
- g. Salaried worker [ ]
- h. Raise/sell livestock (eg. sheep, goats, pigs, chickens) [ ]
- i. Other (specify) \_\_\_\_\_ [ ]

11. Are you a member of a women's group/mother's group/credit group?

- a. Yes [ ]
- b. No [ ]

12. If 'Yes', which and for how many months?

- a. SCF's (Months \_\_\_\_\_)
- b. Government women development (Months \_\_\_\_\_)
- c. Other specify \_\_\_\_\_ (Months \_\_\_\_\_)

Diarrheal Diseases

13. Has (name of child) had diarrhea during the last 15 days?

- a. Yes [ ]
- b. No [ ] -----> go to 23

14. During (name of child)'s diarrhea did you breast-feed \_\_\_\_\_  
(read the choices to the mother)..... (Name of Child)

- a. More than usual? or [ ]
- b. Same as usual? or [ ]
- c. Less than usual? or [ ]
- d. Stopped completely or [ ]
- e. Child already weaned? [ ]

15. During (name of child)'s diarrhea did you provide (name of child) with fluids other than breast milk .....  
(read the choices to the mother).....

- a. More than usual? or [ ]
- b. Same as usual? or [ ]
- c. Less than usual? or [ ]
- d. Stopped completely or [ ]
- e. Exclusively breast-feeding? [ ]

16. During (name of child)'s diarrhea did you provide (name of child) other food .....  
(read the choices to the mother).....

- a. More than usual? or [ ]
- b. Same as usual? or [ ]
- c. Less than usual? or [ ]
- d. Stopped completely or [ ]
- e. Exclusively breast-feeding? [ ]

17. When (name of child) had diarrhea, did you treat it in any way?  
(multiple answers possible; record all answers)

- a. Nothing [ ]
- b. Jeevan Jal [ ]
- c. Sugar-salt solution [ ]
- d. Other fluids [ ]
- e. Anti-diarrhea medicine or antibiotics [ ]
- f. Other specify \_\_\_\_\_ [ ]

(If Jeevan Jal is not mentioned, go to Question No. 22)

18. If answer is Jeevan Jal. From where did you get it?  
(Record all the multiple answers)

- a. Sales agent [ ]
- b. Shopkeeper [ ]
- c. Health post [ ]
- d. Clinic [ ]
- e. Hospital [ ]
- f. Women group [ ]
- g. Others (specify \_\_\_\_\_) [ ]

19. How much water did you mix with one packet of Jeevan Jal?

- a. 6 tea glasses of water [ ]
- b. 2 manas [ ]
- c. 1 litre [ ]
- d. Don't know [ ]
- e. Others specify \_\_\_\_\_ [ ]

20. When (name of child) had diarrhea, did you seek advice for the diarrhea?

- a. Yes [ ]
- b. No [ ] -----> go to 23

21. From whom did you seek advice for the diarrhea of (name of child)?

(multiple answers possible; record all answers)

- a. Sales Agent [ ]
- b. General hospital [ ]
- c. Health centre/clinic/post [ ]
- d. Private clinic/doctor [ ]
- e. Pharmacy [ ]
- f. Village health worker [ ]
- g. Traditional birth attendant [ ]
- i. Relatives or friends [ ]
- j. Dhami/Jhankri [ ]
- k. Other specify \_\_\_\_\_ [ ]

22. What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea?  
(multiple answers possible; record all answers)

- a. Doesn't know [ ]
- b. Vomiting [ ]
- c. Fever [ ]
- d. Dry mouth, sunken eyes, decreased urine output (dehydration) [ ]
- e. Diarrhea of prolonged duration [ ]
- f. Blood in stool [ ]
- g. Loss of appetite [ ]
- h. Weakness or tiredness [ ]
- i. Other (specify \_\_\_\_\_) [ ]

23. What important actions should you take if (name of child) has diarrhea?  
(multiple answers possible; record all answers)

- a. Doesn't know [ ]
- b. Sales Agent [ ]
- c. Take the child to the hospital/health center [ ]
- d. Give the child more to drink than usual [ ]
- e. Give the child smaller, more frequent feeds [ ]
- f. Give Jeevan Jal [ ]
- g. Give nun-chini-pani [ ]
- h. Withhold fluids [ ]
- i. Withhold foods [ ]
- j. Other (specify \_\_\_\_\_) [ ]

24. What are the important actions should a mother take when a child's diarrhea is lessening?  
(multiple answers possible; record all answers)

- a. Doesn't know [ ]
- b. Give child smaller more frequent feeds [ ]
- c. More food than usual [ ]
- d. Give food with high caloric content [ ]
- e. Other specify \_\_\_\_\_ [ ]

25. Have you ever heard of Jeevan Jal? (Mark "Yes" if Jeevan Jal mentioned in 19 or 25)  
(If Jeevan Jal is mentioned in both questions no. 17 & 23, skip to 30). (If Jeevan Jal is mentioned only in No. 23, go to 31).

- a. Yes [ ]
- b. No [ ]
- c. Don't know [ ]

26. What is it used for?

- a. To prevent dehydration [ ]
- b. For diarrhea cases [ ]
- c. Don't know [ ]
- d. Other specify \_\_\_\_\_ [ ]

27. Have you ever used Jeevan Jal?

- a. Yes [ ]
- b. No [ ] go to 29

28. How much water did you mix with one packet of Jeevan Jal?

- a. 6 tea glasses of water [ ]
- b. 2 manas [ ]
- c. 1 litre [ ]
- d. Others specify \_\_\_\_\_ [ ]

29. How much water do you mix with one packet of Jeevan Jal?

- a. 6 tea glasses of water [ ]
- b. 2 manas [ ]
- c. 1 litre [ ]
- d. Other (specify \_\_\_\_\_) [ ]

Birth Spacing

30. Are you pregnant now?

- a. Yes [ ]
- b. No [ ] go to 32
- c. Not sure [ ] go to 32

31. If pregnant now, do you want to have another child within two years of the birth?

- a. Yes [ ] go to 33
- b. No [ ] go to 33

32. Do you want to have another child in the next two years?

- a. Yes [ ]
- b. No [ ]
- c. Doesn't know [ ]

33. Do you know any kinds of methods to space or limit births?

- a. Yes [ ]
- b. No [ ] -----> go to 40

34. If 'Yes', what are they? (do not prompt, tick all methods known)

- a. Female sterilization [ ]
- b. Male sterilization [ ]
- c. Norplant [ ]
- d. Injections/Depo [ ]
- e. Pill/Gulaf [ ]
- f. Nilocon [ ]
- g. Kanchan [ ]
- h. IUD [ ]
- i. Condom/Dhaal [ ]
- j. foam/gel/vaginal tablet (Kamal) [ ]
- k. Abstinence [ ]
- l. Coitus interrupt [ ]
- m. Others specify \_\_\_\_\_ [ ]

35. Are you currently using any method to avoid/postpone getting pregnant?

- a. Yes [ ]
- b. No [ ] -----> go to 39

36. If 'Yes', what method are you or your husband using now to avoid/postpone getting pregnant?

- a. Female sterilization [ ]
- b. Male sterilization [ ]
- c. Norplant [ ]
- d. Injections/Depo [ ]
- e. Pill/Gulaf [ ]
- f. Nilocon [ ]
- g. Kanchan [ ]
- h. IUD [ ]
- i. Condom/Dhaal [ ]
- j. foam/gel/vaginal tablet (Kamal) [ ]
- k. Abstinence [ ]
- l. Coitus interrupt [ ]
- m. Others specify \_\_\_\_\_ [ ]

37. For how long have you been using this method?

Answer: \_\_\_\_\_ months

(If pill/Nilocon/Kanchan/Condom (Dhaal) not mentioned go to 39)

38. If answer 'Pill' (Nilocon/Kanchan) or 'Condom' (Dhaal) from where did you get it?

- a. Shop/Medical Shop [ ]
- b. Sales agent (name \_\_\_\_\_) [ ]
- c. Women's group [ ]
- d. Health Post [ ]
- e. Mobile clinic [ ]
- f. SCF office [ ]
- g. Hospital [ ]
- h. Red Cross volunteer (name \_\_\_\_\_) [ ]
- i. Others (specify \_\_\_\_\_) [ ]

39. Do you know where you can get spacing methods close to your home? (Tick all sources mentioned)

- a. No source known [ ]
- b. Shop/medical shop [ ]
- c. Sales agent (name \_\_\_\_\_) [ ]
- d. Women's group [ ]
- e. Health post [ ]
- f. Mobile clinic [ ]
- g. SCF office [ ]
- h. Hospital [ ]
- i. Red Cross volunteer (name \_\_\_\_\_) [ ]
- j. Others (specify \_\_\_\_\_) [ ]

40. Do you want to use FP in future?

- a. Yes [ ]
- b. No [ ]-----\
- c. Not sure [ ]-----/ go to 42

41. If 'Yes' which method (tick all methods considered)

- a. Female sterilization [ ]
- b. Male sterilization [ ]
- c. Norplant [ ]
- d. Injections/Depo [ ]
- e. Pill/Gulaf [ ]
- f. Nilocon [ ]
- g. Kanchan [ ]
- h. IUD [ ]
- i. Condom/Dhaal [ ]
- j. foam/gel/vaginal tablet (Kamal) [ ]
- k. Abstinence [ ]
- l. Coitus interrupt [ ]
- m. Others specify \_\_\_\_\_ [ ]

42. If 'No/not sure' why? (tick all that respondent lists)

- a. Side effects (bad effects on health) [ ]
- b. Want child [ ]
- c. Husband away [ ]
- d. Family opposed [ ]
- e. Other (specify \_\_\_\_\_) [ ]

43. How many children should a couple have?

Boys \_\_\_\_\_  
Girls \_\_\_\_\_

**APPENDIX C**

## सेभ द चिल्ड्रेन (यू. एस.)

पिभिओ बाल बचाउ ज्ञान तथा अभ्यास प्रश्नावली  
एससिएफ/नेपाल, सिएस III फाईनल सर्वेक्षण

दुई वर्ष भन्दा कम उमेरको ( २४ महिना भन्दा कमको) बच्चा भएको (१५ - ४९ वर्षको) आमालाई सोधिने प्रश्नहरू ।

अन्तरवार्ता मिति _____	पहिलो मितिमा नपाए वा नभ्याए दोश्रो अन्तरवार्ता मिति _____
अन्तरवार्ता लिने व्यक्तिको नाम : _____	
सुपरिवेक्षकको नाम : _____	

१. आमाको नाम \_\_\_\_\_

आमाको उमेर (पुरा भएको) \_\_\_\_\_

विवाह भएको बेलाको उमेर: \_\_\_\_\_ विवाह भएको कति वर्ष भयो ? \_\_\_\_\_  
(पुरा भएको वर्ष)

२. तपाईंले कतिजना जिवीत छोराछोरी जन्माउनु भयो ?

छोरा  छोरी

३. तपाईंको बच्चाहरू मध्ये हाल कतिजना बाँचेका छन् ?

छोरा  छोरी

४. दुई वर्ष मुनिका बच्चाहरु मध्ये सबैभन्दा सानोको नाम र उमेर

नाम : \_\_\_\_\_

जन्म मिति : . \_\_\_\_\_ गते \_\_\_\_\_ महिना \_\_\_\_\_ साल \_\_\_\_\_ उमेर \_\_\_\_\_ (महिनामा) \_\_\_\_\_

(खोप कार्ड हेरी पत्ता लगाउनु होस्)

इलाका : \_\_\_\_\_ गा.वि.स. \_\_\_\_\_ वडा नं. \_\_\_\_\_

गाउँको नाम : \_\_\_\_\_

जातीय समूह \_\_\_\_\_ धर्म \_\_\_\_\_

- |                                 |                           |
|---------------------------------|---------------------------|
| १. बाहुन                        | १. हिन्दु                 |
| २. क्षेत्री                     | २. बौद्ध                  |
| ३. नेवार                        | ३. इस्लाम                 |
| ४. गुरुङ्ग                      | ४. इसाई                   |
| ५. मगर                          | ५. अन्य उल्लेख गर्नु होस् |
| ६. तामाङ्ग                      |                           |
| ७. दमाई                         |                           |
| ८. कामी/सुनार                   |                           |
| ९. सार्की                       |                           |
| १०. बरामु                       |                           |
| ११. मुसलमान                     |                           |
| १२. कुमाल                       |                           |
| १३. जोगी                        |                           |
| १४. अन्य उल्लेख गर्नुहोस् _____ |                           |

५. के तपाईं पढ्न सक्नु हुन्छ ? (प्रश्नावलि देखाउने)

- क. सक्छु [ ]  
ख. सक्दिन [ ]

६. तपाईंले कति सम्म पढ्न भएको छ ?

- क. पढेको छैन/पढ्न आउँदैन [ ]  
ख. प्राथमिक कक्षा पढेको तर पढ्न आउँदैन [ ]  
ग. प्राथमिक कक्षा पढेको पढ्न आउँछ [ ]  
घ. माध्यमिक/निम्न माध्यमिक [ ]  
ङ. स्कूलमा पढेको छैन तर पढ्न आउँछ [ ]  
साथी/छिमेकी वा घरमा पढेको  
च. प्रौढ कक्षामा पढेको [ ]  
छ. अन्य \_\_\_\_\_ [ ]

७. के तपाईं कहिल्यै साक्षर कक्षामा जानु भएको छ ?

- क. गएको छु [ ]  
ख. गएको छैन [ ]

प्रश्न नं. १० मा जानुहोस्

८. यदि जानु भएको भए, कुन कक्षामा

- क. एस.सि.एफ.को आधारभूत साक्षर कक्षा गएको तर पुरा नगरेको [ ]  
ख. एस.सि.एफ.को आधारभूत साक्षर कक्षा पुरा गरेको [ ]  
ग. एस.सि.एफ.को उच्च साक्षर कक्षा पुरा गरेको [ ]  
घ. अन्य साक्षर कक्षामा गएको [ ]  
(सरकारी वा अन्य आयोजना) [ ]  
ङ. थाहा छैन । [ ]

९. तपाईंले साक्षर कक्षामा कहिले देखि जानु भयो ?

साल \_\_\_\_\_

१०. के तपाईले पैसा कमाउने कुनै काम गर्नु हुन्छ ?  
(एक भन्दा बढी उत्तर आए सबै उल्लेख गर्नुहोस्)

- |    |  |     |
|----|--|-----|
| क. | छैन (गर्दिन)                                     | [ ] |
| ख. | सिलाई बुनाई, हस्तकला                             | [ ] |
| ग. | कृषि उत्पादन बेच्ने                              | [ ] |
| घ. | कृषि सम्बन्धी ज्यालादारीमा काम गर्ने             | [ ] |
| ङ. | अन्य ज्यालादारीमा काम गर्ने                      | [ ] |
| च. | पसल थाप्ने                                       | [ ] |
| छ. | नोकरी  | [ ] |
| ज. | पशु पाल्ने/बेच्ने (भेडा, बाख्रा, सुँगुर, कुखुरा) | [ ] |
| झ. | अन्य (उल्लेख गर्नुहोस्) _____                    | [ ] |

११. के तपाई महिला समूह/आमा समूह/ऋण समूहको सदस्य हुनु हुन्छ ?

- |    |     |     |                          |
|----|-----|-----|--------------------------|
| क. | छु  | [ ] |                          |
| ख. | छैन | [ ] | प्रश्न नं १३ मा जानुहोस् |

१२. यदि हुनु हुन्छ भने, कुन अफिस/कहिले देखी ?

- |    |                             |     |             |
|----|-----------------------------|-----|-------------|
| क. | एस.सि.एफ.को                 | [ ] | महिना _____ |
| ख. | सरकारी महिला विकासको        | [ ] | महिना _____ |
| ग. | अन्य उल्लेख गर्नुहोस् _____ | [ ] | महिना _____ |

## भाडा पखाला

१३. तपाईंको (बच्चाको नाम) लाई आजभन्दा १५ दिन भित्र पखाला लागेको थियो ?

- क. थियो [     ]  
 ख. थिएन [     ] प्रश्न नं. २३ मा जानुहोस्

१४. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा आफ्नो दूध (अन्तरवार्ता लिनेले तल लेखेको सबै पढनुहोस्)

- क. सधै भन्दा बढी खुवाउनु भयो कि? [     ]  
 ख. सधै जति नै खुवाउनु भयो कि? [     ]  
 ग. सधै भन्दा कम खुवाउनु भयो कि? [     ]  
 घ. खुवाउन पूरै बन्द गर्नु भयो कि? [     ]  
 ङ. पहिले नै छुटाई सकेको थियो [     ]

१५. तपाईंले (बच्चाको नाम) लाई पखाला लागेको बेला उसलाई आफ्नो दूध वाहेक अरु केही फोल खानेकुरा (अन्तरवार्ता लिनेले सबै पढनुहोस्)

- क. सधै भन्दा बढी खुवाउनु भयो कि? [     ]  
 ख. सधै जति नै खुवाउनुभयो कि? [     ]  
 ग. सधै भन्दा कम खुवाउनु भयो कि? [     ]  
 घ. खुवाउन पूरै बन्द गर्नु भयो कि? [     ]  
 ङ. अहिले दूध मात्र खुवाइरहनु भएको छ ? [     ]

१६. तपाईंले (बच्चाको नाम) लाई पखाला लागेको बेला अरु खानेकुरा (अन्तरवार्ता लिनेले सबै पढनुहोस्)

- क. सधै भन्दा बढी खुवाउनु भयो कि? [     ]  
 ख. सधै जति नै खुवाउनु भयो कि? [     ]  
 ग. सधै भन्दा कम खुवाउनु भयो कि? [     ]  
 घ. खुवाउन पूरै बन्द गर्नु भयो कि? [     ]  
 ङ. अहिले दूध मात्र खुवाइरहनु भएको छ ? [     ]

१७. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा तपाईंले कुनै उपचार गर्नु भयो ?  
 (एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेखनुहोस्)

- क. केही गरेको छैन [     ]  
 ख. जीवन जल [     ]  
 ग. नून चिनी पानी [     ]  
 घ. अन्य फोल (उल्लेख गर्नुस्) [     ] \_\_\_\_\_  
 ङ. पखाला रोक्ने औषधीहरू [     ]  
 च. अन्य (उल्लेख गर्नुहोस्) [     ] \_\_\_\_\_

यदि, जीवनजल उत्तर आएन भने, प्रश्न नं. २३ मा जानुहोस्

१८. यदि उत्तर जीवन जल हो भने, तपाईंले कहाँबाट पाउनु भयो ?  
(एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेख्नुहोस्)

- |    |                         |     |
|----|-------------------------|-----|
| क. | बिक्री कार्यकर्ताबाट    | [ ] |
| ख. | पसलबाट                  | [ ] |
| ग. | स्वास्थ्यचौकीबाट        | [ ] |
| घ. | क्लिनिकबाट              | [ ] |
| ङ. | अस्पतालबाट              | [ ] |
| च. | महिला समूहबाट           | [ ] |
| छ. | अन्य (उल्लेख गर्नुहोस्) | [ ] |

१९. तपाईंले एक पुरिया जीवन जलमा कति पानी मिसाउनु भयो ?

- |    |                         |     |
|----|-------------------------|-----|
| क. | ६ थ्रिया गिलास पानी     | [ ] |
| ख. | २ माना                  | [ ] |
| ग. | १ लिटर                  | [ ] |
| घ. | थाहा छैन                | [ ] |
| ङ. | अन्य (उल्लेख गर्नुहोस्) | [ ] |

२०. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा कुनै सल्लाह लिने अथवा उपचार गर्ने काम गर्नु भयो ?

- |    |            |                               |
|----|------------|-------------------------------|
| क. | लिए/गराए   | [ ]                           |
| ख. | लिइन/गराइन | [ ] प्रश्न नं. २३ मा जानुहोस् |

२१. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा कसबाट सल्लाह लिने अथवा उपचार गर्ने काम गराउनु भयो ? (एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेख्नुहोस्)

- |    |                              |     |
|----|------------------------------|-----|
| क. | बिक्री कार्यकर्ता            | [ ] |
| ख. | अस्पताल                      | [ ] |
| ग. | हेल्य पोष्ट/स्वास्थ्य चौकी   | [ ] |
| घ. | प्राइभेट डाक्टर              | [ ] |
| ङ. | औषधी पसल                     | [ ] |
| च. | ग्रामीण स्वास्थ्य कार्यकर्ता | [ ] |
| छ. | परंपरागत सुडेनी              | [ ] |
| ज. | नातेदार/साथी                 | [ ] |
| झ. | धामी भक्ती                   | [ ] |
| ञ. | अन्य (उल्लेख गर्नुहोस्)      | [ ] |

२२. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा कस्तो कस्तो लक्षण देखा पर्दा तपाईं उपचार खोज्नु हुन्छ ? (एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेख्नुहोस्)

- |    |                                       |     |
|----|---------------------------------------|-----|
| क. | थाहा छैन                              | [ ] |
| ख. | बान्ता भएमा                           | [ ] |
| ग. | ज्वरो आएमा                            | [ ] |
| घ. | मुख सुक्नु, आँखा गद्गु, पिसाब कम भएमा | [ ] |
| ङ. | धेरै दिनसम्म पखाला लागि रहेमा         | [ ] |
| च. | दिसामा रगत देखा परेमा                 | [ ] |
| छ. | खाना नरुचेमा                          | [ ] |
| ज. | कमजोर अथवा थकित देखिएमा               | [ ] |
| झ. | अन्य (उल्लेख गर्नुहोस्)               | [ ] |

२३. तपाईंको (बच्चाको नाम) लाई पखाला लाग्यो भने तपाईंले के के गर्नु हुन्छ ?  
(एक भन्दा बढी उत्तरको सम्भावना छ सबै जवाफ लेख्नुहोस्)

- |    |                                      |     |
|----|--------------------------------------|-----|
| क. | थाहा छैन                             | [ ] |
| ख. | बिक्री कार्यकर्ता कहाँ संपर्क राख्छु | [ ] |
| ग. | स्वास्थ्य चौकी/अस्पताल लान्छु        | [ ] |
| घ. | बच्चालाई सधैको भन्दा बढी पिउन दिन्छु | [ ] |
| ङ. | बच्चालाई धेरै खानेकुरा घरीघरी दिन्छु | [ ] |
| च. | जीवनजल पिउनु दिन्छु                  | [ ] |
| छ. | नून, चिनी, पानी दिन्छु               | [ ] |
| ज. | भोल कुरा दिन्न                       | [ ] |
| झ. | खानेकुरा दिन्न                       | [ ] |
| ञ. | अन्य (उल्लेख गर्नुहोस्)              | [ ] |

२४. तपाईंले (बच्चाको नाम) लाई पखाला कम हुँदै गएको बेलामा के के कुरा गर्नु हुन्छ ?  
(सबै उत्तर लेख्नुहोस्)

- |    |   |     |
|----|---|-----|
| क. | थाहा छैन                                  | [ ] |
| ख. | बच्चालाई धेरै खाना धेरै पटक खुवाउनु पर्दछ | [ ] |
| ग. | सधैको भन्दा बढी खाना खुवाउनु पर्दछ        | [ ] |
| घ. | बढी शक्ति दिने खानेकुरा खुवाउनु पर्दछ     | [ ] |
| ङ. | अन्य (उल्लेख गर्नुहोस्)                   | [ ] |

२५. के तपाईंले जीवनजल बारे सुन्नु भएको छ ?

(यदि प्रश्न १७ र २३ मा उल्लेख भएको भए " छु " मा चिन्ह लगाउनु होस्,  
प्रश्न १७ मा र २३ दुवैमा जीवनजलको उत्तर आयो भने प्रश्न नं. ३० मा जानु होस्  
प्रश्न २३ मा मात्र जीवनजलको उत्तर आयो भने प्रश्न २९ सोध्नुहोस्)

- |    |          |     |
|----|----------|-----|
| क. | छु       | [ ] |
| ख. | छैन      | [ ] |
| ग. | थाहा छैन | [ ] |

२६. यो के को लागि प्रयोग गरिन्छ ?

- क. जलवियोजन रोक्नको लागि [ ]  
ख. पखाला लागेको बेला [ ]  
ग. थाहा छैन [ ]  
घ. अन्य (उल्लेख गर्नुहोस्) [ ] \_\_\_\_\_

२७. के तपाईंले कहिल्यै जीवनजल प्रयोग गर्नु भएको छ ?

- क. छ [ ]  
ख. छैन [ ] प्रश्न नं. २९ मा जानु होस्

२८. एक पुरिया जीवनजलमा तपाईंले कति पानी मिसाउनु भयो ?

- क. ६ चिया गिलास पानी [ ]  
ख. २ माना [ ]  
ग. १ लिटर [ ]  
घ. अन्य (उल्लेख गर्नुहोस्) [ ] \_\_\_\_\_

२९. एक पुरिया जीवनजलमा कति पानी मिसाउनु पर्छ ?

- क. ६ चिया गिलास पानी [ ]  
ख. २ माना पानी [ ]  
ग. १ लिटर पानी [ ]  
घ. अन्य \_\_\_\_\_ [ ]  
ङ. थाहा छैन [ ]

## जन्म अन्तर

३०. के तपाई हाल गर्भवती हुनु हुन्छ ?
- क. छु | |
- ख. छैन | | प्रश्न नं. ३२ मा जानुहोस्
- ग. थाहा छैन | | प्रश्न नं. ३२ मा जानुहोस्
३१. यदि हाल गर्भवती हुनु हुन्छ भने, के तपाई अर्को बच्चा २ वर्ष भित्र चाहनु हुन्छ ?
- क. चाहन्छु | | प्रश्न नं. ३३ मा जानुहोस्
- ख. चाहन्न | |
३२. के तपाई, आउँदो दुई वर्ष भित्र अर्को बच्चा जन्माउन चाहनु हुन्छ ?
- क. चाहन्छु | |
- ख. चाहन्न | |
- ग. थाहा छैन | |
३३. के तपाईलाई जन्म अन्तर वा गर्भ रोक्ने उपायहरू थाहा छ ?
- क. थाहा छ | |
- ख. थाहा छैन | | प्रश्न नं. ४० मा जानुहोस्
३४. यदि थाहा छ भने ती के के हुन् ?
- क. महिला बन्ध्याकरण | |
- ख. पुरुष बन्ध्याकरण | |
- ग. नरप्लाण्ट | |
- घ. सूई | |
- ङ. खाने चक्की/गुलाफ | |
- च. निलोकन | |
- छ. कंचन | |
- ज. लुप/कपरटी | |
- झ. कण्डम/ढाल | |
- ञ. फोम/जेल/कमल चक्की | |
- ट. संभोग नगर्ने | |
- ठ. विर्य बाहिर फाल्ने/पाखा फाल्ने | |
- ड. अन्य उल्लेख गर्नुहोस् \_\_\_\_\_ | |
३५. के तपाई हाल गर्भवती नहुनलाई कुनै परिवार नियोजनको साधन अपनाउनु भएको छ ?
- क. छ | |
- ख. छैन | | प्रश्न नं. ३९ मा जानुहोस्

३६. यदि छ भने, तपाईंले वा तपाईंको श्रीमानले गर्भ रोक्न/टाढा गर्नको लागि कुन उपाय अपनाई रहनु भएको छ ?

- |    |                                |  |  |
|----|--------------------------------|--|--|
| क. | महिला बन्ध्याकरण               |  |  |
| ख. | पुरुष बन्ध्याकरण               |  |  |
| ग. | नरप्लाण्ट                      |  |  |
| घ. | सूई                            |  |  |
| ङ. | खाने चक्की/गुलाफ               |  |  |
| च. | निलोकन                         |  |  |
| छ. | कंचन                           |  |  |
| ज. | लुप/कपरटी                      |  |  |
| झ. | कण्डम/ढाल                      |  |  |
| ञ. | फोम/जेल/कमल चक्की              |  |  |
| ट. | संभोग नगर्ने                   |  |  |
| ठ. | विर्य बाहिर फाल्ने/पाखा फाल्ने |  |  |
| ड. | अन्य उल्लेख गर्नुहोस् _____    |  |  |

३७. यी उपायहरू कहिले देखि प्रयोग गरिरहनु भएको छ ? (वर्षलाई महिना बनाउने)

उत्तर : \_\_\_\_\_ महिना

यदि निलोकन, कंचन र ढालको जवाफ नआएमा प्रश्न नं. ३९ मा जानु होस्

३८. यदि उत्तर " खाने चक्की " (निलोकन/कंचन) वा " कण्डम " ढाल हो भने कहाँबाट पाउनु हुन्छ ? (एक भन्दा बढी उत्तरको सम्भावना छ सबै जवाफ लेख्नुहोस्)

- |    |                                     |  |  |
|----|-------------------------------------|--|--|
| क. | पसल/औषधी पसलेबाट                    |  |  |
| ख. | विक्री कार्यकर्ताबाट (नाम : _____ ) |  |  |
| ग. | महिला समूह                          |  |  |
| घ. | स्वास्थ्य चौकी                      |  |  |
| ङ. | घुम्ती क्लिनिक                      |  |  |
| च. | एस.सि.एफ.को कार्यालय                |  |  |
| छ. | अस्पताल                             |  |  |
| ज. | रेडक्रस स्वयंसेवक (नाम : _____ )    |  |  |
| झ. | अन्य उल्लेख गर्नुहोस् _____         |  |  |

३९. तपाईंको घर नजिक जन्म अन्तर गर्ने साधन पाउने ठाउँ के तपाईंलाई थाहा छ ? (एक भन्दा बढी उत्तरको सम्भावना छ सबै जवाफ लेख्नुहोस्)

- |    |                                     |  |  |
|----|-------------------------------------|--|--|
| क. | थाहा छैन                            |  |  |
| ख. | पसल/औषधी पसलबाट                     |  |  |
| ग. | विक्री कार्यकर्ताबाट (नाम : _____ ) |  |  |
| घ. | महिला समूह                          |  |  |
| ङ. | स्वास्थ्य चौकी                      |  |  |

च.	घुम्ती क्लिनिक		
छ.	एस.सि.एफ.को कार्यालय		
ज.	अस्पताल		
झ.	रेडक्रस स्वयंसेवक (नाम : _____)		
ञ.	अन्य उल्लेख गर्नुहोस्		

४०. भविष्यमा परिवार नियोजनको साधन प्रयोग गर्नु हुन्छ ?

क.	गर्छु			
ख.	गर्दिन			प्रश्न नं. ४२ मा जानुहोस्
ग.	थाहा छैन			प्रश्न नं. ४२ मा जानुहोस्

४१. यदि " गर्छु " भने कुन तरीका (उल्लेख गरेको सबै उपायमा चिन्ह लगाउनुहोस्)

क.	महिला बन्ध्याकरण		
ख.	पुरुष बन्ध्याकरण		
ग.	नरप्लाण्ट		
घ.	सूई		
ङ.	खाने चक्की/गुलाफ		
च.	निलोकन		
छ.	कंचन		
ज.	लुप/कपरटी		
झ.	कण्डम/ढाल		
ञ.	फोग/जेल/कमल चक्की		
ट.	संभोग नगर्ने		
ठ.	विर्य बाहिर फाल्ने/पाखा फाल्ने		
ड.	अन्य उल्लेख गर्नुहोस् _____		

४२. यदि " गर्दिन/थाहा छैन" भने किन ? (उत्तरदाताले दिएको सबै कारणहरूमा चिन्ह लगाउनुहोस्)

क.	स्वास्थ्यमा प्रतिकूल असर		
ख.	बच्चा चाहिएको		
ग.	श्रीमान बाहिर भएको		
घ.	परिवारको विरोध		
ङ.	अन्य _____		

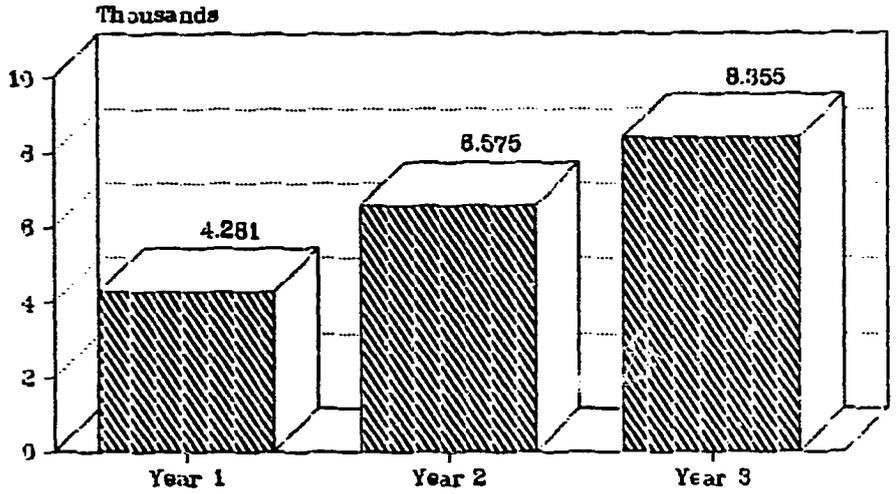
४३. एक दम्पतीको कति जना बच्चा हुनु पर्दछ ?

छोरा \_\_\_\_\_  
छोरी \_\_\_\_\_

**APPENDIX D**

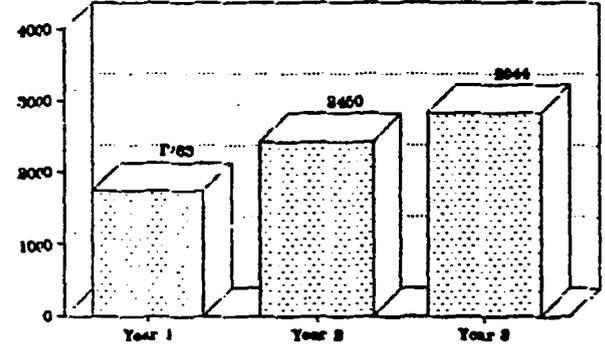
**APPENDIX E**

### Social Marketing Project Dhaal Sold (in Packets)

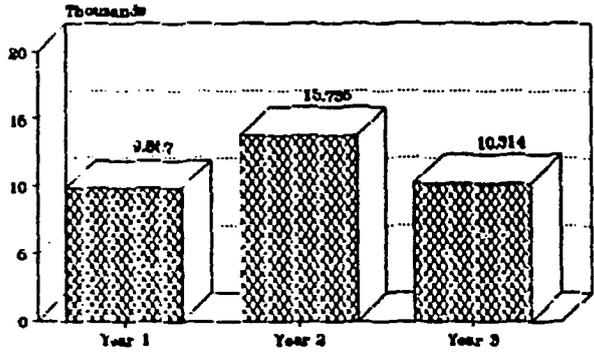


Haka 1 started selling in Karkit 2044  
Haka 4 started selling in Jetha 2044  
Haka 7 started selling in Chait 2044

### Pills Sold (in Cycles)



### Jeevan Jal Sold (in Packets)



## APPENDIX F

Labor and goods were used as payment by 5 consumers (6.9%). Three consumers (4.2%) paid in field labor, and two (2.8%) paid with millet, corn, or fish.

**SUMMARY TABLE: SALES AGENTS' AND CONSUMERS' VIEW OF THE CREDIT SYSTEM**

	SALES AGENTS' VIEW		CONSUMERS' VIEW	
	N	%	N	%
PAID IN FULL IMMEDIATELY	1844	50.1	27	37.5
NEVER PAID	152	4.1	6	8.4
TOOK CREDIT--TOTAL	1281	34.8	34	47.2
PARTIAL CREDIT	910	24.7	(NOT	(NOT
FULL CREDIT	371	10.1	ASKED)	ASKED)
TIME TO FULL PAYMENT				
<1 MONTH	124	3.4	8	11.1
1 MONTH	366	9.9	17	23.6
2 MONTHS	590	16.0	6	8.3
3 MONTHS	83	2.3	1	1.4
4 MONTHS	25	0.7	1	1.4
6 MONTHS	115	3.1	1	1.4
2 YEARS	3	0.1	-	-
PAID WITH LABOR OR GOODS	402	10.9	5	6.9
LABOR	337	9.2	3	4.2
GOODS--TOTAL	65	1.8	2	2.8
MILLET/CORN/EGG/	27	0.7	2	2.8
CHICKEN				
VEGETABLES	38	1.0	-	-
TOTAL	3679	100.0	72	100.0

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**APPENDIX G**

# CS III Project

## The Social Marketing Project

### Promotional Program



By

Padmawoti Singh

Save the Children, US  
Nepal Field Office

July, 1992

## The Social Marketing Project Promotional Program

### History:

In 1988 a rural social marketing project began in Gorkha District, sponsored by USAID's Child Survival program and implemented by Save the Children/US (SC/US). The aim of this project is to reduce child and maternal mortality by promoting oral rehydration treatment for diarrhea, and family planning methods to space births. In the beginning there was much ignorance and resistance in the community-- ignorance about the purpose of oral rehydration solution (ORS) and the existence of various types of temporary contraceptives, and resistance to the use of family planning. For this reason, the first task of the social marketing team was to design information, education and communication (IEC) and promotional strategies to inform the people and to begin to change their attitudes. The promotional program thus plays a very important role.

The promotional program in the Child Survival (CSIII) project was initiated in 1989, one year after the start of the project. Information from the Baseline Survey, focus group research and individual interviews was utilized to design the first promotional program. A promotion management workshop was organized for CS III staff to design appropriate promotional methods for the villagers and detailed plans for promotional programs. Various informative and educational activities were chosen to promote the products and the social marketing program in the rural areas of Gorkha District.

The CSIII program was first publicly promoted by the Inauguration graced by her Royal Highness Jayanti Shah, a gathering which gave publicity to the project. This in itself was a promotional event. In the history of the project promotional strategies have included meetings with local leaders and influential people, an inter-high school poster competition, exhibitions at local festivals, the Gaijatra program, video shows, a school health program and campaign-style promotional programs consisting of a sequence of activities: film shows, talk programs, group discussions and drama.

The project's drama program uses plays depicting the audience's own situation and have proven a very effective medium for motivating the rural audience. Among all promotional activities, drama has proven the best vehicle for carrying the desired messages and information to the villagers. This encouraged project staff to organize the program twice a year on a regular basis so as to cover every village of the project area. The promotional program in all its forms has become one of the major activities of the project and has become very popular with the rural audience.

## OBJECTIVES

The promotional program was carried out with the following objectives:

1. To create mass awareness on birth spacing and oral rehydration solution (ORS).
2. To propagate and disseminate information and education on temporary contraceptives and the use of ORS.
3. To motivate the target audience to accept birth spacing methods and ORS.
4. To overcome rumors about contraceptives.
5. To introduce sales agents and promote their image in their own community.

## ACTIVITY 1: Tape Recorder

The promotional program started with the project's supervisors carrying a tape recorder to each village playing songs, jingles and dramas on family spacing and oral rehydration solution to the group that gathered. 'Chautari' rest places in the hills of Nepal are natural gathering places. The people gathered in the chautari and listened to the songs and drama. Then the supervisors gave information on the need for and proper use of temporary contraceptives and oral rehydration solution.

## ACTIVITY 2: Traditional Media

The second activity is the 'Gai Jatra program' organized by the project on the occasion of the Gai Jatra festival when people can say outrageous things at a traditionally sanctioned time. On this special occasion people have true freedom of speech. They can engage in satire about politics, social behaviors, social norms and values. The people are disguised behind masks or painted faces like clowns. They sing, dance and roam in the street cracking satirical jokes. The CSIII team has participated in Gai Jatra in Gorkha Bazaar (Ilaka No. 1) and Palkhu Bazaar (Ilaka No. 4) every year from 1989 to 1991.

A promotional street drama was first designed by the Project Coordinator for performance at Gai Jatra. Local artists were hired. They performed a street drama highlighting the importance of birth spacing and use of temporary contraceptives and a traditional singer (Gaine) sang birth spacing and family planning songs. A huge crowd gathered at the festival from different parts of Gorkha Bazaar and observed the program. Approximately 6 to 10 thousand people have been informed about family planning through this medium every year. Promotional programs at local festivals have been very successful in familiarizing the people of particular areas with the project and giving information about the products through traditional media.

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**ACTIVITY 3: Exhibitions**

The dissemination of messages through exhibitions is a strategy also used by the project. The project has organized exhibition stalls on the occasion of Teej (the women's festival), Gaijatra and local festivals like 'Dhudeni Jatra' and 'Purnima Jatra'. The crowd gathers at the festivals for entertainment and socializing. The project staff give information on family spacing and ORS mixing through microphone-aided announcements and songs. At the same time, contraceptive and ORS posters and product samples were exhibited and leaflets containing information were distributed. The people who were interested to know about family planning and needed advice were given information and counselling. The proper mixing of Jeevan Jal was also demonstrated in the stall and education on diarrhoea management was given. Approximately 5 to 10 thousand people have been informed about birth spacing, family planning and the proper use of Jeevan Jal through the exhibition stalls set up at in local festivals.

**ACTIVITY 4: Video**

The project tried video as a mass communication medium to propagate family planning and diarrhea management messages in Ilaka No. 1. Ilaka No. 1 surrounds District headquarters and most areas are not far from the road. Therefore it was easy to carry the video equipment for the show. The program was organized on an experimental basis in four locations of Phinam and Nareshwor. A large crowd gathered to see the program but, due to the small screen, the masses could not see the films properly. So, though appropriate family planning, sanitation and diarrhoea management films were shown, they proved to be ineffective, reaching only 1/3 of the gathering. The project dropped the video program and moved to other, more effective strategies.

**ACTIVITY 5: Film Show**

Following on the lessons learned by the video attempt, the project developed a campaign-style promotional program consisting of a variety of educational activities such as film-shows, talk programs, group discussions and a school health program. The CS III staff travelled as a team from one village to another around the project area. This program was run at least four days in each village development committee. The preferred program venue was the center of each village in order to facilitate the people's participation in the program.

Film shows are found to be an effective medium for a promotional program. A good film can communicate the desired message to the people. Talk programs and school health education have also played an important role in dissemination of messages and education on family spacing and diarrheal disease, and demonstration of Jeevan Jal mixing.

All film-shows organized in the three Ilakas are given below with date, place and approximate audience size.

Altogether 76 film-shows accompanied by other promotional and educational activities were organized in the three Ilakas of the Project area, and were seen by a total of 26,660 rural people. The programme proved to be very effective in disseminating messages and information.

#### Plus points of the program

1. Equal participation by both males and females.
2. The masses were attracted to gather through the filmshow.
3. Announcements of timing of performances were conveyed through the students when they went home from school.
4. Sales agents were actively involved throughout the program.
6. Information was given in local dialects by the sales agents.
7. Demonstration of products was possible, at one time for a large group of people.
8. Songs and role plays also attracted crowds.

#### ACTIVITY 6: The promotional drama program

In the world of today, mass media play a significant role. In an area of this world where so much illiteracy and ignorance prevail, the media plays a still more important role. But the system of mass communication used must be an effective one. For the communication of health education like family planning and diarrhoea management, one of the most effective media is drama. The project's final and most successful activity was a drama programme.

The CSIII team launched the drama program in December 1991. The project has now conducted drama programs in all of the areas it covers. The objectives of the drama programme are to impart education on birth spacing, family planning, temporary contraceptives, management of diarrhoea and proper mixing of Jeevan Jal. First in October of 1991, actors were hired from Sarvanam, a well known street theatre group. Later the project staff decided to receive training so they themselves could continue the drama performances. A two-week long training program was organized jointly by SC/US and Sarvanam.

The two dramas taught in the training session were then staged in different parts of the project area. The first drama is about family planning emphasizing birth limiting and spacing. The messages conveyed in the story are well supported by entertaining and humorous events. The second drama was about the importance of rehydration during diarrhoea. The causes of diarrheal disease and its prevention were also dramatized. From both an entertainment point of view and also an educational point of view, the drama show became a very effective communication medium in the rural context. The stories are summarized in the following paragraphs.

Play # 1: YAMPURI MA EK DIN ("One Day In The Land Of Heaven")

In the Land of Death, people who have just died plead with Yamaraj, the Lord of Death, to give them another chance. Each death is linked to not practicing "Janma Antar"- birth spacing, which is closely linked to not appreciating daughters. Comic relief is provided when Yamaraj scolds one man: "Your wife is not a son-bearing machine!", and again when he tells a drunkard that a package of six condoms costs less than a glass of rakshi, he asks what he should do with the condoms - "Eat them?" The audience roars. A woman who died bearing a child conceived too soon after the others is given another chance--if she promises to use pills regularly. She has heard that pills have bad effects, but agrees to take them when assured that the side effects will diminish within 3 months, (as with a new pair of shoes, it takes time to adjust), and that spacing children further apart will ensure better health for each child. She agrees to tell her friends about birth spacing methods.

Play # 2: BHUTAHA KHOLA (The River Ghost)

A young couple's small daughter has had diarrhea since she went swimming in the river. The parents are confused, and the villagers all give different advice. The husband's best friend insists they feed the child water, but the village wise man says no. They spend 53 rupees on the jhankri (shaman), who says elaborate mantras to drive out the Ghost of the River whom he says is causing the problem, but is not able to cure the child. The parents see they have wasted their money. Then the project sales agent comes and shows everyone how to make Jeevan Jal. "One-two-three-four-five-six--how many glasses? Six!". The parents are desperate, and feed the baby Jeevan Jal. She improves--she's talking! Now she's even dancing! The jhankri, told that the ghost is really the polluted river, promises that he will do his best to promote Jeevan Jal.

LOCATIONS OF DRAMA

The drama show was held in 44 different locations of the three project area/ilakas from November 1990 to January 1991. The project staff travelled from one village to another performing every night until the early morning hours, for 20 to 25 days at a time. The locations were all center points for two or three villages. Every major ethnic group of the project area saw the plays. Nearly 30,000 people learned about family spacing and diarrhoea management through the program in their own village. Appendix B shows the dates, places and approximate audience size of the campaigns.

**Post-Drama Evaluation:**

The project staff conducted an evaluation of the drama program the day after each performance to understand how effective the show was in that location. A simple questionnaire was developed and individual interviews were held with males and females met along the way. There was no strict attempt at getting a random sample. All ages of people who were married were included in the interview, regardless of caste, race, sex or religion. The questionnaire is attached as Appendix C of this report.

**Results:**

23 males and 48 females of all age groups were interviewed. Preference was given to women because they are less exposed to other media than men. Women with small children are the main targets for ORS messages, and married couples are the targets for family planning messages. After the compilation of questionnaires, the data was tabulated and tables were prepared (see attached table).

**TABLE No. 1: Drama Evaluation Results**

S.No		Males	Females	Total	Percentage
1.	Respondents who said they liked the drama.	20	41	61	85.91
2.	Respondents who said they understood the drama	20	40	60	84.5
3.	Respondents who said drama is a good medium for teaching	18	38	56	78.87
4.	Respondents who saw the film	13	37	50	70.42
5.	Respondents who said they understood the film better than the drama.	1	3	4	5.63
6.	Respondents who said understood the drama better the film.	10	26	36	50.70
7.	Respondents who understood both film & drama equally well.	3	10	13	18.30
	<b>Total Number of respondents</b>	<b>23</b>	<b>48</b>	<b>71</b>	<b>100.0</b>

Survey at the End of Year 2 of Sales:

A survey was conducted at the end of the second year of sales, in June 1991. The questionnaire included some questions regarding the promotional program's film and drama shows. Here, we find that 33% of the respondents had seen the drama shown in their area. Even if only 1/3 of the entire three Ilakas' population have seen the drama by now, these viewers will have spread the message to their family and friends. Retention of the two drama topics after 6 months is very good. Drama is proven to be an excellent medium for rural Nepal. The following table taken from the Year 2 Survey Report gives the random sample survey responses to questions about the drama program.

Table No. 2: Year 2 Survey

SALES AGENT AND PROMOTIONAL CAMPAIGN INFORMATION BY ETHNICITY

	BRAHMIN CHHETRI	GURUNG MAGAR TAMANG BARAMU	NEWAR	DAMAI SARKI KAMI KUMAL	ALL
% WHO SAW DRAMA (where drama was shown)	32.7 (35)	26.6 (17)	57.1 (8)	34.7 (17)	32.9 (77)
% OF THOSE WHO SAW, WHO REMEMBER BOTH TOPICS	80.0 (28)	41.2 (7)	62.5 (5)	76.5 (13)	68.8 (53)
N--IN WARDS WHERE DRAMA WAS SHOWN	107	64	14	49	234

(Note: The drama had been shown in about half of the VDCs by time of the Year 2 Survey)

Users Survey:

The Users Survey at the end of the second year of sales tracked down 20% of the project's ever-users of pills and condoms. The questionnaire also asked some information about the promotional program. The users' survey was conducted in June 1991 at the same time as the Year 2 of Sales Survey of the general population.

Interviews were done only in the places where the drama and film were shown. Again, a statistical sampling methodology was not used, but we made an effort to choose both males and females and a variety of ethnicities and age groups. A total of 271 persons were interviewed, 105 males and 166 females.

**Major findings:**

Table 3 shows the respondents' understanding and opinion of the film and drama. It is found that 72.7% of the people could recall both of the topics of the film and 91% both topics of the drama.

People said they liked the drama better than the films. 53.1% said they liked the drama better, whereas only 18.6% preferred the film. Thirty-two of the viewers liked the drama and film equally well.

A greater proportion of males than females were able to remember the topics. 82.9% of the males said they understood the content, compared to only 66.2% of the females. The difference may be due to exposure. Men in the villages frequently visit district headquarters where entertainment like films and video are available. Also more men are literate and may have read materials relating to birth spacing and ORS.

**Table No. 3: Users' Survey**

**RESPONDENT'S UNDERSTANDING AND OPINIONS OF FILM AND DRAMA**

	Male	Female	
1. Total number of respondents who saw film (of those who were interviewed)	105	166	271
2. % who remembered both film topics: Family Planning and diarrhea Management	82.9% (87)	66.3% (110)	72.7% (197)
3. % who said film is a good way to teach the village people	95.2% (100)	89.2% (148)	91.5% (248)
4. Total respondents who saw drama (of those who were interviewed)	49	95	144
5. % who remembered both drama topics: Family Planning and Diarrhea Management	91.8% (45)	90.5% (86)	91.0% (131)
6. Total respondents who saw both drama and film (of those who were interviewed)	39	74	113
7. % who thought drama was better than film	53.9% (21)	52.7% (39)	53.1% (60)
8. % who thought film was better	23.1% (9)	16.2% (12)	18.6% (21)
9. % who thought them equally good.	23.1% (9)	31.1% (23)	28.3% (32)

**Discussion:**

Drama is seen to be more effective than film shows because only 72.7 remembered the film's messages where as 91% remembered the messages from the drama show. (but we must remember that the films were shown 6 months to a year before the drama). Clearly, drama is more popular than film. 53% said they liked the drama better than film where as only 18% thought the film was better than the drama. Therefore, we see the drama as the best communication medium for rural audiences in Gorkha.

**Cost of the Promotional Program:**

The cost of the promotional program seems very high if we only look at the total cost. The cost of each promotional program is about Rs. 35,000 per program of 20 days' duration, including staff per diem, porters and other expenses. An average of 600 people attend each show, if we divide the total cost by the total audience, it costs only Rs. 4/- per person to learn about birth spacing and Jeevan Jal. The program seems cost effective if we calculate in this way.

**Other Activities:**

Besides the above-mentioned activities, the project organized inter-high school poster and essay competitions to create awareness of the need for birth spacing. The first, second and third winners were awarded certificates and gifts.

**Conclusion:**

The project has tested many different promotional media to communicate messages about family spacing and diarrhea management to the rural people. Among all methods, the film-shows and drama proven to be the best media for rural audiences. The film-shows were organized in 76 locations and the drama in 42 locations and each was seen by approximately 1/3 of the population of the project area.

People understood the drama better than the film. In the Year 2 User's Survey, 72.7% of the people could recall both of the topics of the film and 91% both topics of the drama.

In conclusion, the promotional program, designed with community input and participation, has proven an effective way to reach the rural masses.

Appendix A  
FILM SHOWS: ILAKA NO. 7

Date	VDC	Place:	Approximate Audience Size
May 1990	Massel	Ghyampesal	500
"	"	Devisthan	300
"	"	Baguicha	600
"	Pandrung	Jarang	350
"	"	Jhalbarai	200
"	"	Gairichhap	325
"	Pachkuwa	Gyaji	300
"	Deurali	Deurali	400
"	"	Baluwadada	400
"	Aarupokhari	Pokhari	450
"	"	Dharapani	400
"	Aaruchanante	Churung	450
"	"	Phulpati	500
"	Dhawa	Aarutar	450
"	"	Baluwatar	300
"	"	Dhawa	1000
"	Tandrang	Chautara	650
"	"	Magnithok	400
"	"	Maithum	200
"	Baguwa	Tarakhase	400
"	"	Khanchowk	300
"	"	Shikhar	300
"	"	Dandada	750
"	Total	23 shows	9925

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**FILM SHOWS: ILAKA NO. 4**

<b>Date</b>	<b>Place</b>	<b>Approximate Audience Size</b>
December 3, 1990	MLB Health Post	500
December 4, 1990	Nareshwor Dada	300
December 5, 1990	Muchhok Ramche School	300
December 6, 1990	Malle	250
December 7, 1990	SMG Jhyawa School	400
December 8, 1990	Simjung School	500
December 9, 1990	Milim School	200
December 10, 1990	Ghyachhok School	300
December 11, 1990	Dhansira School	250
December 12, 1990	" to Goje Village	250
December 13, 1990	Barpak High School	1100
December 15, 1990	Pokhari School	600
December 16, 1990	Ranchok School	250
December 17, 1990	Jaubari School	400
December 18, 1990	SRP School	350
December 19, 1990	SWR Majhthar School	250
December 20, 1990	Ratmate School	300
December 21, 1990	Aaprik School	380
December 22, 1990	Wayak School	400
December 23, 1990	Alaiche School	280
December 24, 1990	Kalleri School	500
December 25, 1990	Takukot (KOT)	500
December 26, 1990	Dadagaon School	350
<b>Total</b>	<b>23 shows</b>	<b>8910</b>

**FILM SHOWS: ILAKA NO. 1**

Date	VDC	Place	Approximate Audience Size
Sept 3, 1990	Dhuwakot	Harahari Chautara	500
" 4, 1990	"	Ratemate	400
" 5, 1990	"	Sera	350
" 6, 1990	"	Pandebeshi	680
" 7, 1990	Deurali	Salyangiri	200
" 8, 1990		Hatia	400
" 9, 1990		Yankot	500
" 10, 1990	Taranagar	Kundur	700
" 11, 1990	"	13 Kilometre	200
" 13, 1990	"	Chhepetar	450
" 14, 1990	"	Birenchowk	500
" 15, 1990	Raniswara	Laxmi Bazaar	550
" 16, 1990	"	Kattel Dada	400
" 17, 1990	Gorakhkali	Reeb	300
" 18, 1990	"	Swara	300
" 19, 1990	Nareshwor	Bhogateni	300
" 20, 1990	"	Ghalang	300
" 21, 1990	Phinam	Kuwapani	500
" 22, 1990	"	Dhungagade	400
	<b>Total</b>	<b>19 Shows</b>	<b>7830</b>

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**FILM SHOWS: ILAKA NO. 4**

<b>Venue</b>	<b>No. of Participants</b>	<b>Date</b>
Kalleri	300	27/3/90
Alaiche	300	28/3/90
Arbang	400	29/3/90
Aprik	400	30/3/90
Kamthali	200	31/3/90
Kharchowk	300	1/4/90
Saurpani	500	2/4/90
Jaubari	300	5/4/90
Ranchok	350	6/4/90
Mandre	150	7/4/90
Barpak	900	8/4/90
Barpak	1100	9/4/90
Goje	200	10/4/90
Dhanshira	200	11/4/90
Ghyachowk	300	12/4/90
Millim	350	13/4/90
Shimjung	300	14/4/90
Sirandanda	400	15/4/90
Jhyawa	450	16/4/90
Kusunde	400	17/4/90
Muchhock	200	18/4/90
Majhlakuribot	400	19/4/90
Arukharka	100	20/4/90
Takukot	600	22/4/90
Dandagaon	300	23/4/90
<b>Total</b>	<b>9200</b>	<b>25 shows</b>

Appendix BTable No. 1**Drama Program: Ilaka No. 4**

<b>Date</b>	<b>VDC</b>	<b>Place</b>	<b>Audience</b>
March 1, 1990	Takukot	Dadagaun	350
" 2, 1990	"	Palkhu	1400
" 3, 1990	Swara	Majhthar	600
" 5, 1990	Arbang	Aarpik	400
" 6, 1990	"	Waiyak	300
Dec. 3, 1990	Majhlakuribot	Health Post	800
" 4, 1990	"	Nareshwor	600
" 5, 1990	Muchhok	Falpu School	500
" 6, 1990	"	Jhyawa	500
" 7, 1990	Simjung	Simjung School	500
" 8, 1990	"	Millim School	500
" 9, 1990	"	Ghyachowk	500
" 10, 1990	"	Dhanashira	500
" 11, 1990	"	Goje School	500
" 13, 1990	Barpak	Barpak School	1500
" 14, 1990	"	Ranchowk School	300
" 15, 1990	"	Jaubari School	300
" 16, 1990	Saurpani	Saurpani School	500
	<b>Total Shows</b>	<b>18 (Locations)</b>	<b>10,550</b>

Table No. 2

## Drama Program: Ilaka No. 7

Date	VDC	Place	Audience
March 7, 1991	Aaruchanaute	Phulpati Dada	800
" 8, 1991	"	Aarutar	800
" 10, 1991	Aarupokhari	Pokhari	1500
" 11, 1991	"	Baluwa	600
" 12, 1991	Pokkhuwa Bawalali	Churung	500
" 13, 1991	"	PKD School	700
" 14, 1991	"	Ghyaji	700
Sept 11, 1991	Massel	Ghyampesal	1500
" 12, 1991	"	Bindrawati School	1000
" 13, 1991	Pandrung	Jarang School	500
" 15, 1991	Tandrang	Tarakhase	650
" 16, 1991	"	Majinthok	800
" 17, 1991	Dhawa	Baluwatar	450
" 18, 1991	"	Dhawa School	950
" 20, 1991	Baguwa	Lamachaur	1200
	Total Shows	15 (Locations)	12,650

Table No. 3**Drama Program: Ilaka No. 1**

<b>Date</b>	<b>VDC</b>	<b>Place</b>	<b>Audience</b>
Nov 29, 1991	Dhuwakot	Harahari Chautara	300
" 30, 1991	"	Shera School	300
Dec 1, 1991	Deurali	Ram Shah School	350
" 2, 1991	"	Salyangiri School	350
" 3, 1991	Taranagar	Birenowk	500
" 5, 1991	Raniswara	Laxmi Bazaar	900
" 6, 1991	"	Dhungagade	400
" 7, 1991	Phinam	Phinam School	1000
" 8, 1991	"	Batasedada	600
	<b>Total Shows</b>	<b>9 (Locations)</b>	<b>4700</b>

The above three tables show that altogether 42 drama shows were organized in 42 locations of Ilakas no. 1, 4 and 7. Approximately 27,900 people observed the drama programs.

Appendix CDrama Evaluation Questionnaire:

Date:

Name:

Age:

VDC:

Village:

Ilaka:

Questions:

1. Did you see the drama program?
2. Did you like it?
3. Did you understand the messages of the drama?
4. Do you think drama can be used to teach the rural audience?
5. Did you see the film program?
6. Is drama more understandable or film?

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**APPENDIX H**

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# **CS III Project**

## **Pill User Follow-Up: A Report On Side Effects**



**By**

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**July, 1992**

## **I. INTRODUCTION:**

This report is a summary of 442 checklists collected during the pill user follow up program from January 1990 to April 1992. This report deals mainly with the side effects of pills.

Save the Children/US (SC/US) has been working in Gorkha District since 1981. SC/US has education, health and family planning, drinking water, resource conservation, agriculture, infrastructure, and women's development programs, which combine to form an integrated approach to community development.

The Social Marketing project is funded by USAID and was started in 1988. It covers 23 Village Development Committees (VDCs) of Gorkha District. The project aims to increase awareness of birth spacing and diarrheal management, and market contraceptives and ORS packets. Jeevan Jal ORS packets, condoms and two types of contraceptive pills are sold in the project area through sales agents. Project activities include group discussions, drama shows, film shows, talk programs, pills use follow-up, school health education, bimonthly sales agent meetings and trainings, and qualitative and quantitative research.

Among the various activities, regular pill user follow-up is one of the most important. Many pill users discontinue pills due to side-effects, bad rumours and having difficulty remembering to take pills every day. To reduce the defaulter rate, new users need close follow-up and counselling. Sales agents, supervisors and other project staff go to the pills users' homes in order to counsel and educate them. When they speak with the women, they fill up the checklists. This is a report prepared out of these checklists, and is mainly focused on side-effects.

## **II. Pill Users Follow-up Report Based on Side-effects:**

Objectives of pills user follow-up are as follows:

- To learn the level of each consumer's knowledge about pills;
- To counsel the consumers about pill-related problems;
- To learn the consumers' side effects from pills;
- To find out the real causes of discontinuation of pills;
- To raise the number of regular pill-users by encouraging them to continue;
- To solve problems faced by sales agents; and
- To promote pills, Dhaal and Jeevan Jal.

Two types of pills, the low-dose Nilocon and the medium-dose Kanchan are marketed by the project. Both pills have two different hormones, Estrogen and Progestin. Kanchan contains twice as much as Estrogen as Nilocon (1 mg. vs 0.5 mg.); otherwise they are the same. Side-effects may occur when there is an excess or a deficiency of one of these hormones in the body.

Excess of Estrogen may cause dizziness, headache, chloasma (or facial darkening), urinary problems, edema, visual changes, leg cramps, cyclic weight gain, nausea and vomiting, diarrhea, weakness, mouth odor, mouth ulcer, heavy bleeding with clots, leukorrhea and deep vein thrombosis (DVT).

Excess of Progestin may cause increase in appetite, depression, tiredness, non-cyclic weight gain, hypertension, acne (pimples), rashes and itching.

Estrogen deficiency may cause prolonged bleeding, spotting and nervousness. Progestin deficiency may cause break-through bleeding, dysmenorrhoea, heavy bleeding with clots, withdrawal bleeding, and monthly period delays.

#### Composition of the Pills marketed by the project:

Kanchan: Each green tablet contains Norethindrone 1 mg with Ethinyl estradiol 0.35 mg and each brown iron tablet contains Ferrous fumarate 75 mg.

Nilocon: Each blue tablet contains Norethindrone 0.5 mg. with Ethinyl estradiol 0.35 mg. Each brown iron tablet contains Ferrous fumarate 75 mg.

#### II. Methodology:

The study is based on primary data sources. The information was collected through interviewing pill users by means of structural checklists. To analyse the data, percentages and means are used.

There are many objectives for pill user follow-up, but this report is mainly concerned with the side-effects of pills. The total number of followed-up pill users is 442. All pill users are considered either new users, regular users or discontinuers, by their status at the time they were visited.

The term "New user" is used for those pill acceptors who have taken pills for less than three months.

The term "Regular user" is used for those who have been taking pills for more than three months regularly.

The term "Discontinuer/Defaulter" is used for an acceptor who had discontinued pills at the time of follow-up.

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Table No. 1 presents the types and numbers of pill users. According to the table, the number of regular pill users who were followed up is greater than that of new users and of defaulters.

TABLE NO. 1

Total Number of Followed-up Pill Users:  
New users, Regular users and Defaulters

TYPES OF USERS	NUMBER	PERCENTAGE
New Users	77	17.4
Regular Users	203	45.9
Defaulter	162	36.7
Total Number of followed-up users	442	100.0

Correct Knowledge about what to do if a day or two of pills is missed is very important. But it is difficult to find out how much they know. Pills must be taken regularly, at the same time each day to prevent side-effects. Irregular pill taking may cause some unpleasant side-effects like bleeding disturbances, weakness and dizziness due to imbalance of hormones in the body. The user may also become pregnant if the hormone levels fluctuate too much.

Table No. 2 shows the number and percentage of the users who know and don't know what to do if they miss pills. According to the table, 76.5 percent had knowledge of what to do if one day is forgotten, while only 14.2 percent had knowledge of what to do if two days are forgotten. Most of the consumers argue that they have never missed any pill, though they do know how to manage missed pills. During follow-up, it is generally found that new users and defaulters have the least knowledge on managing one and two missed pills. But even most regular users do not have proper knowledge of what to do if two days are forgotten.

TABLE NO. 2

Correct Knowledge on Taking Pills

ONE PILL MISSED	NUMBER	PERCENTAGE	TWO PILLS MISSED	NUMBER	PERCENTAGE
Proper Knowledge	338	76.5	Proper Knowledge	63	14.3
Lack of Knowlege	104	23.5	Lack of Knowlege	379	85.8
Total Number of followed up acceptors	442	100.0	Total Number of followed up acceptors	442	100.0

Out of 162 followed-up defaulters, 7 became pregnant and many had side-effects. Irregular pill taking may be the cause of both the side-effects and the pregnancies.

Age is also an important factor for pill acceptors. Generally, pills are given to women between the ages of 15 and 45. But those who smoke more than 15 cigarettes per day or are more than 35 years old may have a greater risk of cardiovascular disease, diabetes and high blood pressure because these are more common in old age, and pills may further increase the risk.

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Table No. 3 shows the pill users' age and the proportion reporting side-effects. According to the table, nearly half (48.8%) of the women taking pills are between 25 and 34 years, which shows correct targeting of young women. Only 1.6% are teen agers (15-19 years), though most rural Nepalese women marry before they are 20. There is no custom of waiting several years after marriage to have the first child.

The mean number of users' children rises with age. Many of the older women are taking pills after having their desired number of children because they become afraid to become sterilized or because they only have a few years to wait before menopause. Most village women give birth to two children before they become 20 years old, which is shown in Table No. 3 below.

Women of all ages are seen to have side effects. So, according to the table, there is no relationship between age and side-effects.

TABLE NO. 3

Pill Users Age Group By Number of Living Children and Side-Effects.

AGE GROUP	Number of Users	Percent of total Users	Mean No. of children	Percent with 2 or less children	Percentage with Side-Effect(s)
15-19	7	1.6	0.8	85.7	28.5
20-24	68	15.4	2.2	63.2	54.4
25-29	105	23.7	1.8	35.2	52.3
30-34	111	25.1	3.4	18.0	45.0
35-39	83	18.8	4.5	7.2	59.0
40-44	52	11.8	4.7	15.3	44.2
45-ABOVE	16	3.6	5.9	0.0	37.5
	442	100	3.3	442	442

Note: One respondent in the age group 15-19 has no baby. She is the only one found to want to delay her first child.

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The side effects found during follow-up have been categorized into four types:

Early pregnancy symptoms consist of dizziness, weakness, nausea, vomiting, weight loss, appetite loss and fainting.

Bleeding Disturbances consist of heavy bleeding, breakthrough bleeding, prolonged bleeding, spotting, and missed menses.

Potentially severe side-effects are unremitting headache, vision problems and leg pain thought to be deep vein thrombosis.

Other side-effects are reduced lactation, leukorrhoea, hot and cold sensations, hands and legs burning, back pain, sensations inside the stomach, burning urine, vagina itching, rash, stomach cramps, stomach swelling and weight gain.

Here we deal with the various types of side-effects in different kinds of users with the help of tables given below.

#### Side-effects in New Users of Kanchan and Nilocon

Table No. 4 compares side effects of Kanchan and Nilocon new users. The table has been divided into four sections, matching the four categories of side effects. Out of the total of 77 new users, 44 (57.1%) are Nilocon users, while 33 (42.8%) are Kanchan users.

There are 17 respondents who suffered from early pregnancy symptoms. Of them, 15 are Nilocon users and only two are Kanchan users. Among the 15 respondents who are Nilocon users, 10 experienced dizziness, 6 had weakness, 7 had nausea and 2 had vomiting. But only two Kanchan users suffered from dizziness and weakness. There are no cases of nausea, vomiting or weight loss found in Kanchan users.

A total of 5 respondents suffered from bleeding disturbances. Out of them 4 are Nilocon users and one is a Kanchan user. There are a total of four respondents suffering from potentially severe side effects - 3 are Nilocon users and 1 is a Kanchan user. They all suffered from headaches. There is only one case of reduced lactation, a Nilocon user and no such case was found for Kanchan.

In conclusion, out of 33 Kanchan users only 4 suffered from side-effects while out of 44 Nilocon users, 22 users had side effects. So 50 percent of Nilocon users suffered from side effects while only 12.1 percent of Kanchan users had side effects. Now we can conclude that a larger proportion of the new users had side effects from Nilocon than from Kanchan.

**Table No. 4**  
**Side effects in Kanchan and Nilocon New Users**

SIDE- EFFECTS	KANCHAN		NILOCON		TOTAL	
	No. OF RESPOND-ENTS	PERCENTAGE	No. OF RESPOND-ENTS	PERCENTAGE	No. of RESPOND-ENTS	PERCENTAGE
1. Early pregnancy symptoms total	2	5.0	15	34.4	17	22.0
A. Dizziness	1	3.0	10	22.4	11	14.2
B. Weakness	1	3.0	6	13.3	7	9.0
C. Nausea/vomiting	0		7	15.9	7	9.0
D. Weight loss	0		2	4.5	2	2.5
2. Bleeding disturbances total	1	3.0	4	9.9	5	6.2
A. Heavy bleeding	0		1	2.2	1	1.2
B. Prolonged bleeding	0		1	2.2	1	1.2
C. Spotting	1	3.0	2	4.5	3	3.8
3. Potentially severe side-effects:						
A. Headaches	1	3.0	3	6.8	4	6.2
4. Others:						
A. Reduced lactation	0	-	1	2.2	1	2.2
<b>Total Responses</b>	<b>4</b>	<b>12.1</b>	<b>33</b>	<b>75</b>	<b>37</b>	<b>48.3</b>
<b>Total New Users with side-effects</b>	<b>4</b>	<b>12.1</b>	<b>22</b>	<b>50</b>	<b>26</b>	<b>33.7</b>
<b>Total Followed-up New Users</b>	<b>33</b>	<b>42.8</b>	<b>44</b>	<b>57.1</b>	<b>77</b>	<b>99.9</b>

Note: Responses are not mutually exclusive so total more than the number of users with side effects.

Side-effects in Regular Kanchan and Nilocon Users:

Generally it is said that the side-effects of pills diminish after three months, but 45.7% of the regular users of Kanchan and Nilocon had side-effects after they had already been taking the pills for three months. It is difficult to tell whether all of the complaints are actually due to pills.

Table No. 5 presents the number and percentage of side-effects in regular users of Nilocon and Kanchan. The table shows that 47.8 percent of Kanchan regular users and 34.9 percent of Nilocon regular users had side-effects. Altogether more than 22 percent suffered from early pregnancy symptoms, mainly weakness and dizziness. 17 percent suffered from bleeding disturbances. Very few (7.3%) had potentially severe side-effects like headaches, and 6.8% had other side-effects like reduced lactation and weight gain.

This table shows slightly more side-effects in regular Kanchan users than in Nilocon users but Table No. 4 shows fewer new Kanchan users having side-effects than new Nilocon users. According to Table No. 5, side-effects like early pregnancy symptoms are found more in Nilocon than Kanchan users, bleeding disturbances are similar for both pills' users. Cases of potentially severe side-effects are limited to headaches and are found slightly more in Kanchan than Nilocon users, and the weight gain problem is not found in Kanchan at all.

In conclusion, nearly half of the regular users of both pills have side-effects. Kanchan for some reason shows side-effects at a later stage. Only 12.1% of new Kanchan users have side-effects while 47.8% experience side-effects after they have ben using pills three months or more.

**Table No. 5**

**Side effects in Kanchan and Nilocon Regular Users**

SIDE- EFFECTS	KANCHAN		NILOCON		TOTAL	
	No. OF RESPOND-ENTS	PERCENTAGE	No. OF RESPOND-ENTS	PERCENTAGE	No. of RESPOND-ENTS	PERCENTAGE
1. Early pregnancy symptoms total	22	30.9	49	37.1	71	34.9
A. Dizziness	13	18.3	33	25.0	46	22.6
B. Weakness	13	18.3	32	24.2	45	22.1
C. Nausea/vomiting	4	5.6	4	3.0	8	3.9
D. Weight loss	2	2.8	8	6.0	10	4.9
2. Bleeding disturbances total	12	16.8	22	16.6	34	17.0
A. Heavy bleeding	7	9.8	7	5.3	14	6.8
B. Prolonged bleeding	3	4.2	6	4.5	9	4.4
C. Spotting	2	2.8	9	6.8	11	5.8
3. Potentially severe side-effects:						
A. Headaches	7	9.8	8	6.0	15	7.3
4. Others:						
A. Reduced lactation	8	11.2	4	3.0	12	5.9
B. Weight gain	-	-	2	1.5	2	0.9
<b>Total Responses</b>	<b>59</b>	<b>82.8</b>	<b>113</b>	<b>85.3</b>	<b>172</b>	<b>84.6</b>
<b>Total New Users with side-effects</b>	<b>34</b>	<b>47.8</b>	<b>61</b>	<b>46.2</b>	<b>95</b>	<b>46.7</b>
<b>Total Followed-up New Users</b>	<b>71</b>	<b>34.4</b>	<b>132</b>	<b>65.5</b>	<b>203</b>	<b>99.9</b>

Note: Responses are not mutually exclusive so may total more than the respondent shown above.

### Reasons for Discontinuation of Pills:

The defaulters have given up pills due to various reasons. Here, defaulters are divided into three categories:

1. Discontinued taking pills and not at risk of pregnancy;
2. Discontinued taking pills and still at risk of pregnancy; and
3. Discontinued taking pills because of desire to become pregnant.

The number and percentage of discontinuers of pills are presented in Table No. 6. According to this table, 62.2 percent discontinued and are at risk of pregnancy, and out of them 56.7 percent had side-effects, 28.4 percent gave up taking pills and are not at risk of pregnancy. In this group, 12.3% of the defaulters switched to other methods, 14.8% gave up due to their husband being away from home and several discontinued due to menopause.

9.2% of the defaulters gave up pills due to accidental or intentional pregnancy. Among them, 4.3% of the defaulters become pregnant because they were taking pills irregularly and 3.7% of them were taking pills for spacing. 1.2% of the defaulters used pills in order to abort but this did not work and their babies are luckily in normal condition.

In conclusion, defaulters stop pills due to many reasons besides side-effects. Out of 162 who were followed up, 92 gave up pills mainly due to side-effects and 20 respondents stopped due to other reasons.

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Table No. 6  
Main Reasons for Discontinuing Pills

REASONS FOR DISCONTINUING	Number	Percentage
<b>Discontinued and not at risk of pregnancy:</b>		
Switched methods	20     (7)	12.3
Menopause	2	1.2
Husband Away	24	14.8
<b>Sub-Total</b>	<b>46</b>	<b>28.4</b>
<b>Discontinued and Still at risk of pregnancy:</b>		
Rumours	6     (4)	3.7
Family pressure	3     (2)	1.8
Side effects	92	56.8
<b>Sub-Total</b>	<b>101</b>	<b>62.3</b>
<b>Discontinued because of pregnancy and wanted to become pregnant:</b>		
Accidental pregnancy	7	4.3
Took pills for abortion	2	1.2
Desired child	6	3.8
<b>Sub-Total</b>	<b>15</b>	<b>9.3</b>
<b>Total -- Discontinuer Follow-up cases.</b>	<b>162</b>	<b>• 100.0</b>

Note: Figures in parentheses denote the number of respondents with side effects.

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### Users who Discontinued Taking Pills due to Side-Effects

Table No. 7 shows the number and percentage of defaulters who stopped pills. There were a total of 162 respondents, 128 Nilocon and 34 Kanchan users. Among the 128 Nilocon users 92 (71.8%) had side-effects while among 34 Kanchan users 18 (52.9%) had side-effects. In this case there were a higher proportion of Nilocon discontinuers with side-effects than Kanchan discontinuers.

Table No.6 shows a total of 92 defaulters whose main reason for discontinuing pills was side-effects, but Table No.7 indicates that a total of 110 defaulters had side-effects.

Table No.7 shows that the highest number of defaulters faced side-effects of early pregnancy symptoms, followed by bleeding disturbances, potentially severe symptoms and other side-effects. According to Table No. 7, out of the 84 early pregnancy symptoms, of them 73 are Nilocon users and 11 are Kanchan users.

Similarly, out of the total of 48 responses regarding bleeding disturbances, 42 cases were found to be Nilocon and 6 Kanchan users. There are 20 respondents who had potentially severe side-effects. Of them 15 were Nilocon and 5 in Kanchan users. Of the 24 responses received on other side-effects, 10 are from Nilocon and 10 are Kanchan users.

Side effects are similar for both pills. The 92 Nilocon users/defaulters who stopped due to side effects gave 217 responses while the 18 Kanchan defaulters gave a total of 63 responses.

SIDE-EFFECTS	KANCHAN		NILOCON		TOTAL	
	No. OF RESPOND-ENTS	PERCENTAGE	No. OF RESPOND-ENTS	PERCENTAGE	No. of RESPOND-ENTS	PERCENTAGE
1. Early pregnancy symptoms total	11	32.3	73	55.9	84	51.8
A. Dizziness	8	23.5	48	37.5	56	34.5
B. Weakness	11	32.3	54	42.1	65	39.3
C. Nausea/vomiting	5	14.7	12	9.3	17	10.4
D. Weight loss	5	14.7	14	10.9	19	11.7
E. Appetite loss	3	8.8	6	4.6	9	5.5
F. Become faint	1	2.9	0	0.0	1	0.6
2. Bleeding disturbances total	6	17.6	42	32.8	48	29.6
A. Heavy bleeding	5	14.7	21	16.4	26	16.0
B. Prolonged menses	2	5.8	13	10.1	15	9.2
C. Breakthrough Bleeding	4	11.7	5	3.9	9	5.5
D. Spotting	0	0.0	6	4.6	6	3.7
E. Stopped menses	0	0.0	1	0.7	1	0.6
F. "Black" Bleeding	0	0.0	1	0.7	1	0.6
3. Potentially severe side-effects total	5	14.4	15	11.7	20	12.3
A. Headaches	5	14.7	15	11.7	20	12.3
B. Vision problem	4	11.7	2	1.5	6	3.7
C. Leg pain	0	0.0	1	0.7	1	0.6
4. Others:						
A. Reduced lactation	2	5.8	2	1.5	4	2.4
B. Leukorrhea	0	0.0	3	2.3	3	1.8
C. Feel hot/cold	2	5.8	4	3.1	6	3.4
D. Hands/legs burn	2	5.8	1	0.1	3	1.8
E. Back pain	3	8.8	3	2.3	6	3.7
F. Sensation in-side stomach	0	0.0	1	0.1	1	0.6
G. Urine burns	0	0.0	1	0.1	1	0.6
H. Vagina itching	0	0.0	1	0.1	1	0.6
I. Rash	0	0.0	1	0.1	1	0.6
J. Stomach cramps	0	0.0	1	0.1	1	0.6
K. Stomach swell	1	2.9	0	0.0	1	0.6
L. Weight gain	0	0	2	1.5	2	1.2
<b>Total Responses</b>	<b>63</b>	<b>184.4</b>	<b>219</b>	<b>166.8</b>	<b>282</b>	<b>173.3</b>
<b>Total No. of respondents with side-effects</b>	<b>18</b>	<b>52.9</b>	<b>92</b>	<b>71.8</b>	<b>110</b>	<b>67.9</b>
<b>Total No. of defaulters followed up</b>	<b>34</b>	<b>20.9</b>	<b>128</b>	<b>79.0</b>	<b>162</b>	<b>99.9</b>

Note: Responses are not mutually exclusive so total more than the number of respondents with side effects shown above.

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A comparison of side effects among new and regular and past users of Kanchan and Nilocon:

Table No. 8 shows the number and percentage of ever-users experiencing side effects. Here the three types of pill users - new, regular and defaulters, are combined.

According to the table, 138 Kanchan users and 304 Nilocon users were followed up. Among the 138 Kanchan users, 56 (40.5%) had side effects while 175 (68.7%) of the Nilocon users had side effects. The table shows that all types of side-effects are more prevalent in Nilocon users than Kanchan users, except a few such as reduced lactation, breakthrough bleeding, headaches, vision problems and stomach cramps/swelling. Side effects only seen in Nilocon are stopped menses, "black" bleeding, burning urine, vaginal itching, weight gain, stomach cramps and burning sensation in the legs.

In conclusion both of the pills have similar side-effects but there are more effects found in Nilocon than Kanchan users. Kanchan's effects are seen later and are potentially more severe than those found in Nilocon users. These include headache and vision problems which can be life-threatening. The only case of probable deep vein thrombosis (leg pain) was found in a Nilocon user.

SIDE- EFFECTS	KANCHAN		NILOCON		TOTAL	
	No. OF RESPONDENTS	PERCENTAGE	No. OF RESPONDENTS	PERCENTAGE	No. of RESPONDENTS	PERCENTAGE
1. Early pregnancy symptoms total	35	23.3	137	45.2	172	68.5
A. Dizziness	22	15.9	91	29.9	113	25.5
B. Weakness	25	18.1	92	30.2	117	26.4
C. Nausea/vomiting	9	6.5	23	7.5	32	7.2
D. Weight loss	7	5.0	24	7.8	31	7.0
E. Appetite loss	3	2.1	6	1.9	9	2.0
F. Become faint	1	0.7	0	0.0	1	0.2
2. Bleeding disturbances total	19	17.3	68	22.3	87	19.5
A. Heavy bleeding	12	8.6	29	9.5	41	9.2
B. Prolonged	5	3.6	20	6.5	25	5.6
C. Breakthrough Bleeding	4	2.8	5	1.6	9	2.0
D. Spotting	3	2.1	17	5.5	20	4.5
E. Stopped menses	0	0.0	1	0.3	1	0.2
F. Black bleeding	0	0.0	1	0.3	1	0.2
3. Potentially severe side-effects total	13	9.4	26	8.5	39	8.8
A. Headaches	13	9.4	26	8.5	39	8.8
B. Vision problem	4	2.8	2	0.6	6	1.3
C. Leg pain	0	0.0	1	0.3	1	0.2
4. Others:						
A. Reduced lactation	10	7.2	7	2.3	17	3.8
B. Leukorrhea	0	0.0	3	0.9	3	0.6
C. Feel hot/cold	2	1.4	4	1.3	6	1.3
D. Hands/legs burn	2	1.4	1	1.3	3	0.6
E. Back pain	3	2.1	3	0.9	6	1.3
F. Sensation inside stomach	0	0.0	2	0.6	2	0.4
G. Urine burns	0	0.0	1	0.3	1	0.2
H. Vagina itching	0	0.0	1	0.3	1	0.2
I. Rash	0	0.0	1	0.3	1	0.2
J. Stomach cramps	0	0.0	1	0.3	1	0.2
K. Stomach swell	1	0.7	0	0.0	1	0.2
L. Weight gain						
<b>Total Responses</b>	<b>126</b>	<b>91.4</b>	<b>363</b>	<b>119.3</b>	<b>489</b>	<b>110.5</b>
<b>Total No. of respondents with side effects</b>	<b>56</b>	<b>40.5</b>	<b>175</b>	<b>68.7</b>	<b>231</b>	<b>52.5</b>
<b>Total No. of defaulters followed up</b>	<b>138</b>	<b>31.2</b>	<b>304</b>	<b>68.7</b>	<b>442</b>	<b>100.0</b>

Note: Responses are not mutually exclusive so total more than the number of

## CONCLUSION:

Many rural people have heard negative rumours about pills and think they are true. But this report has revealed that more than 50 percent of the current pill users have not had any side-effects. Many of the consumers are those who have the desired number of children and are afraid of sterilization or are waiting to make sure that their children survive. In this analysis and contrary to popular belief, there is no relationship between age and side-effects. Many consumers have knowledge about what to do if one pill is missed but very few on two pills missed. There is a negligible number of minor side-effects in new Kanchan users while 50 percent of Nilocon new users have side-effects. There are many cases of early pregnancy symptoms in Nilocon users which lessen within three months. A few Nilocon users also have problems with bleeding disturbances.

New users of Kanchan have very few side-effects while as many regular users of Kanchan have side-effects as Nilocon users. It seems that Kanchan produces late side-effects. Generally, side-effects such as early pregnancy symptoms and minor bleeding disturbances diminish within three months. In reality, it is not known if many of the side-effects are due to pills or just to poor diet and hard labour. Many rural women who take pills also look thin and weak, but their non pill-taking neighbours do as well. Both pills are associated with bleeding problems in regular users. Irregular pill users often suffer from heavy bleeding.

Defaulters have stopped using pills not only because of side-effects but also due to wanting to switch methods and having no need to continue pills. Many defaulters who had taken pills for a long time also gave up pills due to side-effects. In summary, 48.8% of the pill users did not have side-effects even though many pill users do have one or more side-effects. Both Nilocon and Kanchan exhibit side-effects associated with excess of Estrogen, even though Nilocon has a lower dose of Estrogen.

## PROBLEMS:

### 1. Side-effects of the pills.

- Most of the defaulters give up pills in the first three months due to minor side-effects;
- It is said that minor side-effects will lessen within three months, but many regular users also have such side-effects;
- There are more bleeding problems with regular users and defaulters than with new users;
- Heavy bleeding is found with irregular pills use.

It is difficult to say if all complaints are side-effects of the pills or not.

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2. Many pill users have not got proper knowledge on pill taking:
  - They choose the wrong starting day.
  - They have lack of knowledge on missing pills.
  - They take pills irregularly.
  - They do not take pills at the time of monthly period.
  - Some do not take iron tablets along with the pills.
3. A few users will not quit taking pills even though they have potentially severe side-effects.
4. It is difficult to identify if a woman is pregnant or not, and many want to start pills before menstruation.
5. Women have to take pills even if their husband is only home for a short period because many males do not like condoms.

#### RECOMMENDATIONS:

- Need of more follow-up for new users in order to solve their immediate problems.
- Consumers expect medicine and vitamins whenever we visit their homes. They should be advised to visit the SC Office, MCH clinic, health post or hospital if they have problems.
- Consumers who are suffering from life-threatening side-effects should be motivated not to use pills but to use Dhaal until they are ready to be sterilized.
- Women who are interested to start pills before their menses should be provided pills only after a pregnancy check at the MCH clinic, health post or hospital.
- Women who have no side-effects for a long period should be recognized as models of successful pill taking, "satisfied users". They should be invited to meet potential consumers time and again.
- Pill users should be properly screened in order to reduce the rate of side-effects.
- A promotional program is needed to raise knowledge on pills and to overcome rumours.
- Short-period pill users should be advised to use Dhaal rather than pills.
- New users should be followed up frequently to reduce the defaulter rate.

## PILL FAILURES: FOLLOW-UP ON SURVEY FINDINGS

Mira Maiya Singh Rana

### Introduction:

Twelve cases of apparent pill failure (becoming pregnant while taking pills) were found in the Two Years of Selling User's Survey, conducted by the Social Marketing Project in June, 1991. Out of the twelve cases, we only obtained the names of eleven women. Among them, one Buddhimaya Sarki, aged 42, could not be found. This left ten for interviewing.

A questionnaire was developed in order to find out if these were actual failure cases and, if so what the causes were. The ten women who reported pill failure in the Year 2 Survey (and were found) were again interviewed by project staff.

Out of the ten women, three said they had become pregnant even though they were taking pills regularly. One gave a confusing answer, one woman had never taken either Kanchan or Nilocon, the only pills sold by our project, and one said her monthly period temporarily stopped during the time of the Survey. Four others were sure that they became pregnant after giving up the pills. The ten respondents were divided into these five categories:

- Pregnant while using pills	-- 3
- Pregnant after discontinuing pills	-- 4
- Not sure if pregnant after or during last cycle of pills	-- 1
- Period late not pregnant	-- 1
- Never used pills	-- 1

-----  
Total: 10

### Findings:

#### A. Pregnancy During Pills Use:

Three women - Chet Kumari Shrestha, Man Maya Sunar and Purna Maya Magar became pregnant when they were taking birth control pills. Chet Kumari said that she had taken only two cycles of pills. She had never forgotten to take her pills. She also has proper knowledge of taking pills, except if two days are forgotten. Man Maya said that she became pregnant during her 14th cycle of pills. According to her, she had missed one day of pills and had then forgotten to take two pills the following day. So we cannot say this is a pill failure. Now she has again started taking pills after having her baby. The last respondent, Purna Maya said that said that she had felt the movement of a baby while she was taking her twelfth cycle of pills. She also said that she had sometimes forgotten to take pills and that she had no knowledge of what to do if two days are forgotten. She cannot remember if she had taken two pills the following day or not when she missed a pill. So we cannot call this a failure case either.

**B. Confusing Answer:**

Santa Kumari Baram said that she had given up pills in Shrawan after taking five cycles of pills. She also became pregnant in Shrawan. In this case, we cannot say it was a pill failure because she probably became pregnant after she gave up pills.

**C. Non User of Kanchan and Nilocon:**

One respondent, Mithu Maya Darji, whose name was included in our Users Survey gave the surprising answer that she had never used either Kanchan or Nilocon that are provided by our Sales Agents. She said that she had taken 4 cycles of free-distributed pills five years ago. But her husband occasionally used Dhaal provided by sales agent. It seems that her name was mistakenly given to the interviewer in the Users' Survey instead of her husband's.

**D. Monthly Period Stopped During Survey Time:**

One respondent, Dhana Maya Thapa, says that she was not pregnant at the survey time. During the survey her monthly period had stopped, so her name was mistakenly included in the pill failure list. Because her period was delayed, she thought she might be pregnant.

**E. Pregnancy After Pills Were Given Up:**

Four respondents said that they had become pregnant after they gave up the pill. Among them one said that she had become pregnant two months after she stopped using pills, another after four months, another after six months, and the last after one year.

**Conclusion:**

The villagers are all too conscious of the side-effects of birth control pills. In addition, there are many reports of method failures. This in-depth look at "failure" cases is a valuable means to counter such negativity.

Out of a total of ten respondents, one woman became pregnant when she was taking pills properly and two women had missed taking pills for one day and had forgotten to take two on the following day. One said she became pregnant in the month when she gave up the pills. One woman's monthly period was delayed at the time of the survey, and four others became pregnant some months after the pills were given up. The last woman had never even taken pills! She was left in the sample, to point out the vaariety of mistaken assumptions likely to be encountered in any such sample. Out of the total 226 followed-up pill users, for one to be an actual method failure gives a failure rate of 0.44%. This investigation shows that these cases of pill failure are less than one percent of the total users.

**Recommendations:**

1. We have learned that, before presuming a pregnancy to be a method failure much probing must be done into the circumstances surrounding the pregnancy.
  - A. Did she miss one or more day of pills?  
If so, what did she do? Some think they can use pills and condoms, only when their husband comes home.
  - B. Had she already stopped using pills?
  - C. Was she pregnant before she started taking pills (not seen here but during follow-up found cases of attempted abortion by taking pills). A check for this is to ask "On which day of your period did you start taking pills?" The answer should be "On the fifth day."
  - D. Even if she doesn't remember missing any pills, does she know what to do if she misses one day or two?
  - E. Does she take pills irregularly - stopping, starting again? In this way her body never becomes used to the pills.
2. Because so few pill users can remember what to do if two days are missed, we should consider changing the message so that it is easier to remember.
3. To decrease the misuse of pills, pill users must continue to be followed closely. Similarly, sales agents need frequent supervision to assure that they themselves are giving the correct messages.

**APPENDIX I**

**A Report**  
**on**  
**Street Drama Performed by SCF, USA**  
**in**  
**Gorkha District**

**by**  
**Puskar Gurung**  
**Mohan Mishra**  
**(SARWANAM)**  
**1992**

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# INTRODUCTION

## 1.1 Background

Nepal is one of the poorest of the poor countries in the world, with a very low per capita income and seriously alarming inequality in income distribution depict the existing level of People's living. A majority of the Nepalese are poor and backward. As most people dwell in rural areas, rural poverty is the crux of the problem. Many writers and authors say that the nature and the extent of the poverty in rural Nepal is proceeding unchallenged. Poverty is the main problem which has, created a vicious circle, where poverty happens to be the causes as well as consequence of all the problems like malnutrition, illiteracy, unemployment, indebtedness, hunger, disease. These things have a significant impact on the productivity in the agriculture sector resulting in less productivity of land, capital, labour etc. Economists seem to be pessimistic concerning the progress of the rural Nepal. The reason is that the existing problem could be solved if the people have complete knowledge on the activities or programmes being run or to be run. Not only this, if we can provide the rural people with some minimum knowledge on health education, like family planning, sanitation, and rehydration, many problems can be lessened at least. Thus, creating mass awareness is of top-most importance.

It goes without saying that survival, with minimum caloric requirement, clothing and shelter are the basic rights of every people. But most of the rural people do not know this fact, rather they take their problems as the will or curse of God and prefer to continue their life with the same problems intact. Although, Nepal's broad national plans have taken the objectives of uplifting the living condition of the people of Nepal in general and that of rural people in particular. But, because of the scarce resources on one hand and the program-lacking polices of the government on the other hand even a small portion of rural population could not have been incorporated in social-status uplifting project.

Nepal's own resources are extremely limited. It should be taken into consideration that if we want some immediate improvement there should be a direct attack on poverty, its causes and consequences which is not possible at a national level for Nepal. Thus, integrated area development projects are stressfully recommended for the resource lacking developing countries like Nepal. It is a matter of pleasure that many foreign countries and agencies are taking keen interest and are active in different integrated development projects. Those projects are located in different parts of Nepal, particularly Hill areas.

## 1.2 Save The Children Fund (SFC), U.S.A. and its role

As has been mentioned already different integrated development projects are functioning in different parts of Nepal. One of the notable examples is the project run by SCF, USA in Gorkha district of Western Nepal. As this agency specifically works for the children, in Gorkha the project has taken the objectives of uplifting the health conditions, education and the living of the people emphasizing the children. These objectives are consistent with the broad national objectives of Nepal.



Posters are is another communication which are less effective and costly, also their scope is quite limited. The reason is that posters are to be printed, taken to the required area, attached on walls, distributed, and read by the people their coverage is extremely limited; and their convincing power is very weak.

A recent and popular technique that is more and more used as a mass media in different countries is street drama. But the use of street drama as an effective device of communication is not possible unless and until there are drama groups, experienced artists, and experts. On the availability of these things, performing drama happens to be the most effective media. There are several reasons behind this. Firstly, in drama people can see a live program, live events and find themselves involved in the drama in some way. Secondly, dramas are performed in different localities, where people have varied customs, habits and languages, and dramas can be adjusted accordingly.

### **1.6 Street Drama in Gorkha**

SCF, USA recently concluded its drama program in all the wards of its coverage. The drama had the objectives of imparting the health education and family planning to the people, which is very much consistent with the objectives taken by National Plans. Thus, theoretically it is very encouraging that for the sake of the issue of national importance SCF, USA has adopted street drama for the mass communication. The present report endeavours to evaluate the drama done by SCF, USA.

### **1.7 Street Drama and Sarwanam**

In Nepal Street drama was done in 1982 for the first time by Sarwanam. Sarwanam is an intellectual group active on the stage. It is to Sarwanam's credit that it introduced street drama in Nepal. In the beginning, street drama was initiated with political motives. To protest against the Panchayat autocracy, the then political system, was the principle objective in mind. At the same time, imparting moral education through drama and contributing towards community development through drama were other objectives. In this connection, Sarwanam did many street dramas urging for political changes; and dramas were performed for child education as well as for community development. So far the areas covered by the dramas of Sarwanam in connection with community development are health education, sanitation, road preservation, environment conservation, birth spacing, birth control, immunization against disease, impartiality towards disabled and so forth.

With a great deal of experience Sarwanam knows all the techniques of making the drama effective and economical. In this way Sarwanam is a great name on the stage.

## **TWO: PERFORMANCE OF STREET DRAMA BY SCF, USA**

### **2.1 Background**

SCF launched street drama in its working area, Gorkha, in October-November, 1990. At that time all the artists were hired from Sarwanam, a street theater group of Nepal. Later on SCF decided to continue the performance of drama by giving training to its own staff. Accordingly a two-week long training programme was organized jointly by SCF, USA and Sarwanam. On the concluding ceremony the trainees presented two dramas which were later on staged in different locations of Gorkha.

### **2.2 Contents of Drama**

As has been mentioned already, two dramas were staged in different parts of Gorkha. The first drama was about family planning, which emphasized birth control and birth spacing. The sequence of the story was well supported by events, humour and full of entertainment. The second drama was about basic child health education in which rehydration during diarrhea was emphasized. Besides this, causes of disease and precautions were also dramatized. From entertainment point of view, people enjoyed drama quite a lot and understood the contents.

### **2.3 Quality of Drama**

The dramas were written by one of the noted play-writes of Nepal, Mr. Ashesh Malla. The contents of the dramas were to-the-point and they were well furnished with entertainment. Over and above this the artists participating were well disciplined and extremely concerned about their performance. Although the artists were rather inexperienced, the sense of learning in them, seriousness in doing rehearsals, and disciplined behavior during the staging of drama made them highly effective and successful.

So far as acting side has been concerned, some artists have surpassed imagination, in relation to the duration of their training period and experience. Some artists are doing modestly and, they have shown some improvement. It should be born in the mind that the quality of acting is directly related to the effectiveness of the drama. The artists should be capable of incorporating the audience in the drama in some way. And it is very much encouraging that this type of talent is present in them.

In this way, considering all the measuring rods for a high-quality drama, the dramas performed by SCF, USA staffs are in no way inferior. That have done excellently and are highly successful in accomplishing their task.

### **2.4 Selection of Locations**

It was found that most of the artists cum staff were local people of Gorkha. They had a complete knowledge concerning the gathering spots in the district. And they rightly selected those gathering spots for drama. While selecting the locations two factors are important; first, a large of audience should be accomodated and, secondly, there should be a minimum level of disturbances. Sometimes, these two factors contradict each

another. Thus the selection of the spots is another measuring rod of a high level of successful completion.

## 2.5 Use of Equipment and Costumes

Generally what is said is that street drama requires no lighting facility, costumes, make up and so on; only a non-disturbing gathering spot and artists. But the type of drama done for community development may not be street drama in its true sense. Thus, in order to increase the effectiveness of the drama the use of mikes, make-ups and some types of settings can be used. It cannot be denied that using these articles means increased effectiveness. From this point of view, the dramas were very good and performances of high standard.

## 2.6 Towards the artists

Over all, the drama played by SCF, USA staff-cum-artists was tremendous. The audience was well entertained and they were educated on child health care, family planning and sanitation. Regarding the performance of artists, Mr. Mim Prashad Ghmire, the comedian actor, played a vital role in giving life to the audience that they could not stop laughing during the whole drama. His flow of dialogue, movement, expression and action all were terrific.

In the drama called Yama Puri Ma Ek Din (one day in Yama Puri), Mr, Ghimire played the role of a drunkard, which the audience enjoyed very much. In another drama called Bhutaha Khola (stream of ghost), he played the role of Jhankri (shaman) and gave similar enjoyment. The message given by him was satirical, and hit the people who still hold old fashioned ideas. Sometimes he was found to be over-confident, by giving too much emphasis on humor, and less emphasis on the message. Still he was very successful.

The character role player Mr. Guna Raj Devkota was very impressive. In Yama Puri Ma Ek Din he was Yama Raj and showed his talent excellently. The audience appreciated him much in the other drama Bhutaha Khola in which he played the role of Baje. He is advised to control himself from his own laughing at sudden circumstances.

Mr. Charles Pradhan (Hari Babu in Bhutaha Khola) has done well. He was confident in delivering dialogues. Still, he spoke so fast that the audience sometimes could not follow him. He is advised to practice to deliver his dialogue little more slowly.

Mr Chandra Mani is an honest actor in the sense that he did his allotted part excellently, which was not expected during his training period. Mr Chandra Mani played the role of the Pagal (crazy man) in Yama Puri Ma Ek Din and the role of Mangale in Bhutaha Khola.

Mr. Yam Nath Bhatta has developed his talents as an actor which was also not expected during the training. He played the role of Yama Doot (the secretary of Yama Raj) in first drama and the role of Harke in the second drama. He needs improvement in order to make his role more effective. He should be more confident, more natural in his actions.

Appearing just in one occasion Mr. Sanak Gurung showed his talent as an artist. He can be given a bigger, better role in the future.

As a whole, all the artists have done their respective roles well. However, overlapping in dialogue delivery frequently created problems. This type of problem should be removed.

## **2.7 Success/ Completion**

Overwhelming support from all around and well disciplined behavior, supported by seriousness on the part of artists helped complete the dramas successfully in all the blocks of the project area. During this period many thousands of people saw the drama, learned many things, were entertained and so on. At the same time, the artists became experienced, highly productive and, over and above, SCF, USA got efficient manpower for its future venture of the drama.

## THREE: EFFECTIVENESS OF DRAMA

### 3.1 Background

The effectiveness of the drama not only depends upon the quality of the artists but it also significantly depends upon the quality or type of response on the part of audience. There are a couple of important questions concerning the effectiveness of the drama. First, how many people saw the drama and, secondly, how interested they were in drama. Since the drama contains messages as well as entertainment, there is a danger that the audience may forget the important side of the drama. In order to examine this possible danger a post-test is essential.

### 3.2 Size of Audience

As has been said already, natural gathering and quiet spots were rightly selected for the staging of drama. Therefore, the size of the audience happened to be always encouraging. Not only this, mouth to mouth advertisement always kept the audience increasing. Sometimes, in spite of the use of mikes, the uncontrollable gathering compelled the artists to revise the drama in order to control the crowd. When the evaluation team from Sarwanam went to Gorkha in order to watch the drama and mass behavior they found that the audience saw the drama with keen interest and, also they compared the events of the drama with their real life. They were seemed to have learned many things.

### 3.3 People's Reaction

The evaluation team found the audience reacting to the drama throughout the drama and after the drama. The evaluation team asked questions of people of varied ages concerning the effectiveness of the drama; and people responded differently. Most of the people who saw the drama said that they had already heard the messages contained in the drama but that they were convinced only after seeing the drama. Some people said that they learned many things from the drama and realized that their mistakes in their real life were because of their ignorance. Some people who missed the drama, or a part of the drama were remoursing for that. They want to see it as soon as possible. Any way, mouth-to-mouth communication has also been playing a vital role. A few comments are given below:

- |   |   |                        |  |         |
|---|---|------------------------|--|---------|
| 1 | 1 | Name:                  | Dhana Maya Basnet                          | Age: 30 |
|   | 2 | Address:               | Birendra Chowk                             |         |
|   | 3 | Marital status:        | Married with 4 children.                   |         |
|   | 4 | Did you see the drama? | Yes  |         |
|   | 5 | How did you like?      | Interesting.                               |         |
|   | 6 | What did you learn?    | I learned about treatments;                |         |
|   |   |                        | a) Rehydration treatment during diarrhoea. |         |
|   |   |                        | b) Trouble with more children.             |         |
|   |   |                        | c) Birth spacing.                          |         |
|   |   |                        | d) Sanitation.                             |         |

7 Any comment?

I already have 4 children. I want my husband to see this drama and prevent any more children.

2 1 Name: Harka Rana Magar Age: 55

2 Address: Birendra Chowk

3 Marital status: Married with 8 children.

4 Did you see the drama? Yes.

5 How did you like? Interesting.

6 What did you learn?

Actually the drama was educative for the new generation. I am an old man of age 55. Most of the things contained in the drama were known to me already. But in the drama I found those things much more convincing than before.

7 Any comment?

I suggest that the drama be continued. SCF, USA has done very commendable job by staging drama. I am confident that if the drama is staged continuously in this way, our new generation not only learn things but also do accordingly.

3 1 Name: Bacchu Ghimere Age: 21

2 Address: Tarangar

3 Marital status: Just married.

4 Did you see the drama? Yes.

5 How did you like? Interesting.

6 What did you learn?

I learned many things. Actually I am so convinced that I have decided not to have any child for four or five years. Again, only after four or five years of the first child there will be second. And not more than two.

7 Any suggestion?

I got convinced so easily, many people will learn from this drama. I strongly recommend it for its continuous presentation.

4 1 Name: Priti Duwal Age: 19

2 Address: Tarangar

3 Marital status: Unmarried.

4 Did you see the drama? Yes.

5 How did you like? Very interesting.

6 What did you learn?

I learned many things. I have seen many conservative people who hold rubbish ideas that they think the children are God gifts and they have a lot. Thus, this drama should be shown to them.

7 Any suggestion?

This is the most effective means of communication. I hope the villagers learned a lot from this drama. It will be great help if this can be performed again.

5 1 Name: Ram Chandra Karki Age: 38

2 Address: Dhunga Gade

3 Marital status: Married with 2 children.

4 Did you see the drama? Yes, I saw.

5 How did you like? I like very much.

6 What did you learn?

Most of the thing I already know. So, I have just two children and will not have any more. Any way, I hearty appreciate the task done by SCF, USA.

7 Any comment?

Unproductive ideas can be removed by showing this drama to the people of Gorkha District who are traditional.

### **3.4 Overwhelming Support**

Overwhelming support from all around created a favorable environment for the drama. From the very beginning the audience happened to be very much cooperative and helpful. Many people have said that they are interested to provide all help to stage the drama again in their localities. More interestingly, children in the localities where drama was performed were found to be imitating the dialogues from the drama. People suggested many points to the artists and accordingly the refinement and adjustment process was always on the way.

## FOUR: SUMMARY AND RECOMMENDATION

### 4.1 Summary

Because of the seriousness on the part of artists, the sense of learning in them, and the determination on the part of SCF, USA to make its programmes more effective, high quality street dramas were done in Gorkha district. The drama was scheduled for all the blocks was accomplished very successfully.

The drama was very effective in sending messages to the audience. People reacted very positively and took it as a very much glad to have a chance to see such a beautiful drama. Every effort was made to increase the dramas effectiveness. Continuous process of improvement and adjustment made the drama highly successful.

### 4.2 Recommendation

Considering the overwhelming support and positive reaction at this time it will be very much productive work to continue this type of program in the days to come. A few points can be suggested to the artists and to SCF, USA.

- 1 Artists have to maintain their sense of learning and seriousness in accomplishing their job and develop a feeling of confidence.
- 2 Artists should not give more importance to the entertainment aspect than to the message as there is danger of misinterpretation.
- 3 Artists should listen to comments patiently and without any reaction to whom who comments. And positive comments should be kept in mind.
- 4 SCF, USA is suggested to continue the performance of drama for mass communication in the days to come. It will be more productive to increase the frequency of the drama.
- 5 If one or two experienced artists could be hired from outside there will be a multiplier effect on the quality improvement and the effectiveness of the drama.
- 6 Last but not least, a system of collecting people's opinions should be established so that knowledge can be acquired concerning whether the target group has been benefited or not.

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7 Any comment?

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2 1 Name: Haika Rana Magar Age: 55

2 Address: Birendra Chowk

3 Marital status: Married with 8 children.

4 Did you see the drama? Yes.

5 How did you like? Interesting.

6 What did you learn?

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- 6 Last but not least, a system of collecting people's opinions should be established so that knowledge can be acquired concerning whether the target group has been benefited or not.

QUALITATIVE INVESTIGATION  
OF  
RURAL SOCIAL MARKETING OF  
TEMPORARY CONTRACEPTIVES AND ORS  
IN  
GORKHA DISTRICT  
-FOCUS GROUP DISCUSSION-

SUBMITTED TO:

SAVE THE CHILDREN FEDERATION, US  
NEPAL FIELD OFFICE  
KATHMANDU, NEPAL

SUBMITTED BY:

BHARAT MANI SHARMA

APRIL 1992

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## PREFACE

This qualitative study on Rural Social Marketing of Temporary Contraceptives and ORS in Gorkha district was commissioned by Save the Children/US, Nepal field office. This report is based on the findings from a total of 18 male and female focus group discussions conducted in nine village development committees of Gorkha district. This study was designed to complement the findings that come up in quantitative studies. An outside evaluation was preferred to one done by project staff to make the study more objective.

It is sincerely hoped that the findings from this study will provide valuable insights regarding consumers' thoughts and feelings, and be a guide for strategic and creative thinking in the future.

My heartfelt gratitude is extended to the SCF/US Country Director Mr. Keith Leslie and Project Adviser Ms. Ann Frederick for entrusting us to conduct this study, imparting encouragement and extending logistic support and resources without which this study would not have been possible. I am indebted to the Project Co-ordinator Ms. Padmawati Singh and her staff for their valuable suggestions and support for the study.

I would like to acknowledge Mr. Kavita Ram Shrestha, the study Consultant for his valuable technical input during different phases of the study.

Special appreciation goes to the field staff Mr. Balaram Banskota, Ms. Bhagwati Khadka, Ms. Bela Shrestha, Ms. Rajani Shrestha, Ms. Sangita Acharya, Mr. Yub Raj Shrestha and Mr. Sher Bahadur Pun for their hard work in the field.

Last but not least, on behalf of the study team I would like to acknowledge the full cooperation provided by the respondents, without whose patience and participation the study would not have been possible.

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### APPENDICES

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## CHAPTER II: OBJECTIVES

The objective of this qualitative study was to obtain community perceptions about the Rural Social Marketing Project and to ascertain the effect of the project on the community's Knowledge, Attitude and Practice (KAP) of ORS and family planning spacing methods. Specific objectives of the study were :

- to investigate the image of Sales Agents, quality of services provided, frequency and content of home visits by the sales agents;
- to investigate change in KAP of local people regarding diarrhoeal diseases and use of Jeevan Jal;
- to investigate changes in people's attitude towards spacing and use of contraceptives;
- to investigate the overall impression of pills and condoms in the community;
- to evaluate the effectiveness of different types of promotional campaigns used by the the project in the community;
- to explore the feasibility of marketing contraceptives and ORS through local shopkeepers in the village; and
- to assess project's coverage of different castes/ethnic groups, socio-economic groups and geographic locations.

## CHAPTER I : BACKGROUND

Save the Children Federation, US (SCF,US) has been conducting a Rural Social Marketing of Temporary Contraceptives and ORS (Oral Rehydration Salts) Project with grant assistance from the United States Agency for International Development (USAID) since 1987 in Gorkha district. The Project covers a population of approximately 106,000, in 23 village development committees (VDCs). About 100 Sales Agents (80% females) were imparted a short training to disseminate the idea of Family Planning (FP) and scientific anti-diarrhoeal measures. They were to provide knowledge of contraceptives including pills and condoms to the population. The contraceptives are donated by USAID and packed by Nepal Contraceptives Retail Sales Company (CRS). Jeevan Jal ORS is supplied by the Royal Drugs Limited Company. All of the Sales Agents are working in the area as semi-volunteers with a small monthly incentive.

Ilaka level Supervisors monitor the work of the Sales Agents. A Project Co-ordinator, an Assistant Co-ordinator, a Counsellor for pills users, a Community Educator and an expatriate Project Adviser are also directly involved in implementation and management of the project.

Various promotional campaigns have been launched in the area to create awareness and sales promotion through different communication media. Different studies have also been conducted by the social marketing project for program monitoring and evaluation.

Past studies show that there is a high level of awareness among the people but that the use of contraceptives is very low in the area and the use of Jeevan Jal, though having met project objectives, could be higher. Now, just as the project is to end it was decided to find out the reasons behind these and other issues so that future activities can be planned. For this, outside expertise was sought.

## Sample Distribution

Ilaka Number	Village Dev. Committee	Caste/Ethnic Group			Sex	
		Brahmin/Chhetri	Gurung	Occupational	Male	Female
1	Taranagar	X Mixed		X Kumal	X	X
	Gorakhkali	X Mixed		X Kami	X	X
	Phinam	X Chhetri		X Muslim	X	X
4	Majhlakuribot		X X		X	X
	Saurpani	X Brahmin		X Sarki	X	X
	Barpak		X X		X	X
7	Pandrung	X Brahmin	X		X	X
	Aarupokhari		X	X Sarki/ Damai	X	X
	Masel	X Mixed		X Sarki	X	X
Total	9	6	6	6	9	9

Selection of the Participants: Participants meeting the preset criteria for the group discussion were purposively selected with the help of local knowledgeable persons, school teachers and social workers. The participants were briefed about the purpose of the study and were requested to spare time for group discussion.

### CHAPTER III : METHODOLOGY

The study was conducted by focus group discussion (a social science research technique), as suggested by SC/US. A total of 18 focus group discussions were conducted in nine VDCs of Gorkha district.

Sample : There were nine male and nine female groups, consisting of 60 males and 64 females in totality. The sample was equally divided among the three ilakas, and among three broad ethnic groupings. Gorkha's main ethnic groups are the Brahmins, Chhetris, Newars, Gurungs, Magars, Baramus, Tamangs, Kamis, Damais, Sarkis and Kumals. In addition, the Muslims can be considered to be an ethnic group, for their customs and heritage are distinct from the others. In designing the sampling methodology for this study, the upper caste Brahmins and Chhetris were put in one group, joined by the Newars, though no Newars were interviewed. The Mongolian castes--Gurungs, Magars, Baramus and Tamangs were put in the second group, represented only by the Gurungs, the most populous group in northern Gorkha.

The occupational castes made up the last grouping to whom the Muslims were tentatively added because of their relatively low socio-economic status in Gorkha as suggested by SC/US. The focus group results show that this was erroneous--the Muslims need to be considered separately. One male and one female group discussion was conducted in each VDC (Appendix III). A total of 124 married male and female respondents meeting the following criteria were selected for the discussion.

#### Male

- Over 15 years of age
- Not sterilized
- Spouse not sterilized
- Having children under five years of age, or wife currently pregnant.

#### Female

- 15 to 45 years of age
- Not sterilized
- Spouse not sterilized
- Having children under five years of age, or wife currently pregnant.

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## CHAPTER IV : FINDINGS

### 1. Sales Agents

Most of the Brahmin/Chhetri, Gurung and Muslim caste/ethnic groups knew their Sales Agent if there were one in their village or in the adjacent area, and were content with his/her services. Occupational caste groups in general were less familiar with and were less likely to have been visited by the Sales Agents. The frequency of visits in the occupational communities was either low or nil. The occupational caste groups considered themselves to be the lowest priority of the Sales Agents as they were not considered to be potential consumers of the products owing to their low socio-economic status.

" They do not visit us because we are poor and lower caste people."

The Sales Agents serve those of their own gender better. The Sales Agents have become important extension agents in creating awareness of FP, spacing and the use of Jeevan Jal.

However, some of the villages did not have any Sales Agent assigned at all.

Sales Agents also have become a prominent source of FP contraceptives and ORS (Jeevan Jal) especially in the areas where health facilities are meager and the majority of the population lives under subsistence conditions. Suggestions received for better services of the Sales Agents were :

- The Sales Agents should pay more attention to regular door-to-door visits, motivation and group discussions.
- The Sales Agents should treat the poor and rich, and upper and lower castes in the community without discrimination.
- The Sales Agents, particularly in remote areas where health facilities are still rare, should be trained and well equipped with other medicines for simple maladies in order to enhance the image of the Sales Agents and promote sales.

Discussion Procedure: Group discussions were held in a quiet, informal situation. All participants for the group discussion were made to sit in a semi-circle in front of the moderator so that the moderator and participants could have eye contact. A non-participant observer sat behind the moderator, noted and recorded the responses on a micro-cassette recorder. The moderator prepared individual focus group discussion reports in the field with the help of the cassette, and prepared notes in consultation with the observer.

Discussion and Reporting Tools: A topic guide (Appendix II) for moderator's discussion was developed and was used to conduct the focus group discussions.

Training and Orientation for Study Team: A two-day orientation session on the nature and scope of the study was held in Kathmandu for the study team. A two-hour briefing session was held and a slide show was arranged in Gorkha bazaar at the SCF office by SCF staff.

Field Schedule: The field work started on 21st February and continued through 1st March, 1992.

Data Analysis: On the completion of the field work, data were analyzed with the help of transcripts, moderators' reports and the notes prepared by the observer.

Limitations: This study is qualitative in nature and does not attempt to put a quantitative value on the data.

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lack of proper motivation and services are hindrances mentioned by the groups.

People suggested that to change the attitudes of the population, it was essential to bring about motivation through person-to-person communication based on formal and informal discussions reinforced at the grass root level and with the facility for adequate supply of Jeevan Jal in the community. Still others opine that the Sales Agents should distribute Jeevan Jal free of cost, particularly to the poor who cannot afford to buy it.

They think that besides the project, the radio, Health post, Village Health Workers (VHWs), the Nepal Red Cross Society-run Primary Health Care and Family Planning Project, the regular Maternal Child Health (MCH) mobile clinic and health workers of SCF have also played an important role in creating awareness as well as in changing the knowledge, attitude and practices of rural people vis-a-vis diarrhoea and the use of Jeevan Jal and NCP.

### 3. Spacing

The Brahmin/Chhetri and Gurung groups both use and favour the use of spacing methods more than those of occupational castes. The methods they like best are pills, Depo-provera, and condoms. In addition some of the Brahmin/Chhetri groups were using IUDs and foaming vaginal tablets. The occupational castes mostly confined themselves to the use of Depo-provera as it was accessible and available free of cost. A segment of the young and educated Muslim populace was found to be using condoms surreptitiously because of their religious restrictions regarding family planning.

Varied factors played a significant roles in the motivation of consumers of contraceptives. More users of pills and condoms were found to be motivated by the Sales Agents, whereas more of the users of Depo-provera were influenced by SCF's MCH clinics, health posts and VHWs. In the areas where there were no Sales Agents, they were motivated by the VHWs and the radio.

Women prefer Depo-provera because they are afraid of sterilization and they do not want the bother of remembering to take pills everyday. Women chose pills because of lack of knowledge of other methods, ease with which they could be used only when their husbands were home, the fear of side effects of Depo-provera, and being advised to use pills by the health assistants.

The male proponents of condoms and foaming vaginal tablets chose these methods for their convenience, reliability, and lack of side effects. These men say that neither method hinders their sexual experience, in contrast to others of the groups who do not like condoms. As for foaming tablets, opposition from the males was also encountered for their short effective period, lack of patience on their part after full erection, the shyness of the females to insert the tablets in front of their spouse and the males' aversion to inserting the tablet themselves.

Many people in rural areas are averse to using pills because of various side effects such as bleeding, headache, backpain, giddiness, weakness, weight loss, fear of giving birth to twin babies or disabled children. Other problems are the bother of taking pills every day, probability of forgetting to use, fear of being exposed to the society as a user of pills, opposition from husbands, elders and cost.

Men do not like to use condoms owing to their unreliability (chances of bursting), fear of getting them stuck inside, irritation to the female during sexual intercourse, reduced sexual enjoyment, problems of disposal, refusal by wives, problem of keeping them out of the reach of children and other family members and social barriers (in rural areas a condom user is suspected of having an extra-marital relationship).

"Dhaal (condom) has made having extra-marital relations convenient for bad persons."

People in rural areas prefer sterilization as a permanent solution after having their desired number of children. It is a convenient and cheap method of FP.

"Sterilization is care-free, economic and reliable".

People do not like to use any contraceptives in rural areas due to several other reasons, like desire for children (particularly sons), infrequent sexual intercourse because of the husband staying far from home, traditional beliefs and faith in natural FP -- having sex during the safe period, and natural spacing. In rural areas the older generations and the occupational castes still hold the view that births should not be controlled as children are god-given. The children grow and survive according to their own fate and become helping hands for the family.

"Children are Gods' gift, we should accept them".

In some areas where there are no Sales Agents, the villagers wish to use contraceptives but they are unavailable.

"We would like to use contraceptives but who will provide them?"

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Suggestions received for the promotion of use of contraceptives were :

- There should be better extension, motivation, group discussions and communication and wider coverage by the Sales Agents of the rural areas.
- The importance of spacing for better maternal health and happy family life and the advantages of a small and disadvantages of a large family should be reinforced in the villages.
- Users should be used as an example for non-users as samples to convince and motivate them.
- There should not be any difference in approach between different agencies. Some agencies provide contraceptives and Jeevan Jal free of cost within the coverage area of this project, whereas the Sales Agents charge for them.

People think that the project has increased awareness regarding FP, spacing and the use of contraceptives among the rural population within its coverage area. People's attitudes and practice of using contraceptives have changed due to the project. However, there has been only a minor change in the occupational castes. They attribute this to Sales Agents' lack of motivational activities and services in these communities.

At the same time other factors like radio, Non Formal Education (NFE) classes, SCF regular MCH mobile clinics, health post, VHWS, Nepal Red Cross Society-run Project are also playing an important role in increasing FP awareness.

#### 4. Product Image (Condoms and Pills)

In rural areas people are not in favour of the use of condoms because of several reasons, including the decrease in sexual enjoyment, trouble to wives during sexual intercourse because of irritation, unreliability (chances of bursting), problems of getting stuck inside, problems of keeping them out of the reach of the children, and problems disposing condoms after use. People in the rural areas consider that condoms are only used for extra marital relations.

"Our Women complain that condoms break and do not give that much satisfaction".

People do not like to use pills because of side effects. They have themselves witnessed many women becoming the victims of side effects after the use of pills. Condoms and pills have an infamous reputation amongst a large portion of the population.

"Pills make user weak the woman needs better food".

"My husband brought pills for me but I threw them away because I was afraid that I would die". ( Occupational caste group-Massel)

## 5. Promotional Campaign

The Brahmin/Chhetris, Gurungs and Muslims were familiar with the different promotional activities of the project. However, very few of the occupational caste group members were familiar with the promotional activities. People had witnessed the drama and video shows, they were familiar with Jeevan Jal hanging cards, spacing posters and calendars, booklets, pamphlets on pills and condoms and flip charts. People were also motivated through person-to-person communication and group discussions by the Sales Agents. Very few of the occupational caste group members had been visited for FP motivation by the Sales Agents. The group discussions conducted in NFE classes, the services rendered by regular MCH mobile clinics and the health staff of SCF were complimentary promotional activities.

People view the drama shows and motivation through NFE classes as the most effective approaches for educational and promotional activities. The drama shows were able to depict the real picture of their day-to-day life and convince them of the advantages of a small family and difficulties of a large family, the importance of spacing for better mother and child health, the causes and effects of diarrhoeal disease and its treatment with Jeevan Jal. The individuals motivated through NFE classes further motivated their fellow men.

"The drama show taught us the importance of spacing for better health of mother and child, and a happy family life".

People say that none of the Information, Education and communication (IEC) activities were ineffective. However, some comments were made that pamphlets and booklets were less effective for illiterates because of their inability to understand them. The following suggestions were made to make these activities more effective in the future :

- Emphasis should be laid on person-to-person communication and motivation, and formal and informal group discussion in the community.
- Priority should be given to NFE classes for motivational and educational activities using different IEC materials.

- Drama and film shows should be emphasized for mass communication and motivation. However, the show has to be announced in advance and a convenient time should be scheduled for the shows.

#### 6. Provision for Supply of Products through Local Shopkeepers

When discussion was conducted with people from each of the three broad ethnic group as to how they would be managing contraceptives after the termination of the project, they (with the exception of some females who did not give their views) suggested that SCF should either arrange a small pharmacy in the village or depute Sales Agents for the supply of products and other medicines of day-to-day use. However, loyal female consumers belonging to Brahmin/Chhetri and Gurung caste groups spontaneously suggested that they would purchase the products from distant markets even if they had to face troubles and be able to spare some time.

"If we cannot get FP supplies from Sales Agents, we will go to Gorkha bazaar or Kathmandu."

They had a positive attitude towards providing services through local shopkeepers if they were located in an accessible location. They suggested that proper care should be taken while selecting such sellers. They should be cooperative and locally trusted. Sufficient training on product administration, motivation and communication should be provided to them. Further, local people should also be well informed about the availability of products and services in their shops.

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## 7. Coverage of the Project

People from Brahmin/Chhetri, Gurung and Muslim caste groups were better served by the project than the occupational castes. Some villages were completely uncovered by the project. Households far from the place of residence of the Sales Agents were the least served. The occupational caste group members feel that the Sales Agents are reluctant to visit their home both because of their low social status and because they have no money to pay for the products.

"This is not a service but a way to make money".

The suggestions received for better coverage were:

- to depute Sales Agents to all uncovered wards;
- to assure that Sales Agents visit the occupational caste communities even more than the other communities;
- to consider subsidizing the products for those who cannot pay; and
- to gear IEC materials to illiterates, specifically to occupational caste groups.

## CHAPTER V : SUMMARY OF FINDINGS

### Sales Agents :

- Most people of the project area were familiar with the Sales Agents. However, fewer of the occupational caste groups were familiar than those of the upper caste groups.
- Those who received services were satisfied with the Sales Agents.
- In some areas there were no Sales Agents.
- People have acquired knowledge about Jeevan Jal and FP through the Sales Agents.
- Sales Agents play an important role in motivating and educating the rural population on FP services and Jeevan Jal.

### Jeevan Jal and Treatment Practices :

- The Brahmin/Chhetri, Gurung and Muslim caste groups had more knowledge than the occupational castes about Jeevan Jal. The practice of using Jeevan Jal was greater among Brahmin/Chhetri Gurung and Muslim caste groups than among the occupational caste groups.
- Reasons for not buying Jeevan Jal included :
  - \* Use of NCP as a substitute
  - \* Traditional beliefs and practices (faithhealing, withholding liquids/water)
  - \* Not available when needed
  - \* Too costly
  - \* Less faith in Jeevan Jal
  - \* Too busy with household activities to do anything about the diarrhoea
  - \* Diarrhoea not considered serious
  - \* Free distribution of Jeevan Jal by other line agencies

**Spacing :**

- Brahmin/Chhetri and Gurung caste groups were more aware about spacing and the use of various spacing methods than the occupational caste groups.
- People prefer Depo-provera to pills as a convenient and costfree method of spacing.
- Some people of rural areas like to use contraceptives for spacing but because of lack of proper knowledge and services they are unable.
- Though birth control in the Islam religion is considered a religious crime, a few young and educated people have started using condoms secretly for spacing.
- Reasons for not buying the project's contraceptives included:
  - \* Side effects of Pills
  - \* Bother of taking Pills everyday
  - \* Depo-provera is preferred because of its reliability, convenience, and free availability
  - \* Preference for waiting until having desired number of children, than becoming sterilized
  - \* Traditional beliefs such as children are God's gift and fear of abnormal births
  - \* Bad image of FP contraceptives users in family/community
  - \* Expensive
  - \* Free distribution by other agencies
  - \* Condoms are unriable (brust)
  - \* Condoms are physically irritating
  - \* Lack of knowledge and motivation
  - \* No needed to use during the absence of husbands

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**Product Image :**

- In general, pills have a bad product image in the rural areas because of side effects like bleeding, weakness, giddiness, headache, back pain, and because of the bother of regular use and chances of forgetting.
- In general, condoms have a negative product image due to perceived unreliability, decreased sexual enjoyment, irritation caused to women during sexual intercourse and suspicion of having extra marital relations.

**Promotional Campaign :**

- People think that the drama shows and education through NFE classes were the most effective promotional activities of the project.
- Almost all promotional activities were effective means for motivating the rural people.
- Radio, health post, VHW, and Red Cross Field Workers were also playing an important role in creating awareness in the community.

**Provision for Supply of Products through local shopkeepers :**

- People suggested the establishment of either SC/US-run pharmacies or supply of products through trained local shopkeepers to provide Jeevan Jal, FP contraceptives and medicines of daily use after the termination of the Rural Social Marketing Project.
- People have a positive attitude towards providing contraceptives and Jeevan Jal through local shopkeepers in the future. They suggested that local shopkeepers should be cooperative and well trained to motivate and educate the local people.

**Coverage of the Project :**

- The Brahmin/Chhetri, Gurung and Muslim caste groups were better served than the occupational ones. The frequency of visits paid by the Sales Agents to the occupational caste groups was almost nil.
- People suggested that deputation of Sales Agents to the uncovered areas, intensive motivation of people staying in remote areas, particularly the women, and motivation and education through group discussions are required to provide services to the hitherto uncovered population.

## CHAPTER VI : RECOMMENDATIONS

It is found from the study that the most prominent fears in the minds of the people are the side effects of pills and the unreliability of condoms. In order to do away with these fears and counter the negative image of the products, it is recommended:

- to educate and motivate people about the importance of family planning through NFE, group discussions, local intellectuals, drama shows and SCF's mobile clinics;
- to show villagers satisfied users as a model;
- to screen potential users properly, and thereby reduce the possibility of serious complications;
- to let them know the proper method of using condoms so as to avoid bursting;
- to provide services to uncovered population Sales Agents should be recruited;
- Sales Agents should pay more attention to the occupational caste groups;
- to provide FP services in future locally trusted shopkeepers should be recruited and well-trained.

MB

Group 1

VDC: Phinam Date: Feb. 26, 1992  
 Ward No.: 5 Moderator: Bela Shrestha  
 Village: Phinam (Kuwapani) Recorder: Rajani Shrestha  
 Ilaka No.: 1 Location: Open Field  
 Group Composition: Chhetri/Female Time: 7:45 - 8:47 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Chhetri	30	Literate	4	2
2	Chhetri	30	Literate	3	1
3	Chhetri	37	Literate	2	1
4	Chhetri	45	Illiterate	5	1
5	Chhetri	24	Illiterate	3	3
6	Chhetri	30	Literate	3	2
7	Chhetri	22	Literate	1	1

Group 2

VDC: Pandrung Date: Feb. 23, 1992  
 Ward No.: 4 Moderator: Bhagwati Khadka  
 Village: Pandrung Recorder: Sangita Acharya  
 Ilaka No.: 7 Location: Private House  
 Group Composition: Brahmin/Female Time: 8:30 - 10:00 PM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Brahmin	29	Illiterate	2	2
2	Brahmin	20	Literate	1	1
3	Brahmin	18	Grade 7	1	1
4	Brahmin	26	Illiterate	4	1
5	Brahmin	35	Illiterate	6	1
6	Brahmin	30	Illiterate	2	2

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Group 3

VDC: Saurpani  
 Ward No.: 6  
 Village: Saurpani  
 Ilaka No.: 4  
 Group Composition: Brahmin/Male

Date: Feb. 26, 1992  
 Moderator: Balram Banskota  
 Recorder: Yub Raj Shrestha  
 Location: Conference Hall  
 Time: 9:35 - 10:15 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Brahmin	40	Literate	4	1
2	Brahmin	28	Grade 8	2	2
3	Brahmin	35	Literate	1	1
4	Brahmin	28	Literate	2	2
5	Brahmin	29	Literate	-	1
6	Brahmin	33	Grade 8	1	1

Group 4

VDC: Masel  
 Ward No.: 8  
 Village: Devasthan  
 Ilaka No.: 7  
 Group Composition: Brahmin/Chhetri/  
 Male

Date: Feb. 24, 1992  
 Moderator: Bharat M. Sharma  
 Recorder: Sher Bdr. Pun  
 Location: Open Field  
 Time: 8:45 - 9:45

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Brahmin	21	Literate	3	2
2	Brahmin	28	S.L.C.	2	2
3	Brahmin	21	Illiterate	2	2
4	Brahmin	22	S.L.C.	-	-
5	Brahmin	28	Literate	1	-
6	Chhetri	24	Literate	-	1
7	Brahmin	33	Literate	2	1

Group 5

VDC: Taranagar

Ward No.: 5

Village: Birendra Chowk (Okhle)

Ilaka No.: 1

Group Composition: Brahmin/Chhetri/  
Male

Date: Feb. 28, 1992

Moderator: Bharat M. Sharma

Recorder: Sher Bdr. Pun

Location: Open Field

Time: 10:10 AM - 11:05 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Chhetri	24	Literate	1	1
2	Chhetri	30	Grade 4	2	1
3	Brahmin	36	Grade 10	1	1
4	Chhetri	39	Grade 3	7	2
5	Brahmin	24	Grade 10	1	1
6	Chhetri	30	Literate	2	2
7	Brahmin	34	Grade 10	7	4

Group 6

VDC: Gorakhkali

Ward No.: 7

Village: Mandre Dhunga

Ilaka No.: 1

Group Composition: Brahmin/Chhetri/  
Male

Date: Feb. 29, 1992

Moderator: Bharat M. Sharma

Recorder: Sher Bdr. Pun

Location: Private House

Time: 6:30 - 7:00 PM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Brahmin	30	S.L.C.	1	1
2	Chhetri	51	Illiterate	3	1
3	Chhetri	28	Literate	2	1
4	Chhetri	25	Grade 9	2	2
5	Chhetri	25	I.Ed.	1	1
6	Chhetri	30	Literate	2	1

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Group 7

VDC: Barpak  
 Ward No.: 5  
 Village: Asnan  
 Ilaka No.: 4  
 Group Composition: Gurung/Male

Date: Feb. 27, 1992  
 Moderator: Balram Banskota  
 Recorder: Yub Raj Shrestha  
 Location: Private House  
 Time: 10:10 - 10:35 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	31	Literate	3	2
2	Gurung	36	Literate	2	1
3	Gurung	35	Illiterate	2	1
4	Gurung	51	Illiterate	5	2
5	Gurung	55	Illiterate	3	1
6	Gurung	51	Illiterate	4	2

Group 8

VDC: Pandrung  
 Ward No.: 6  
 Village: Gairichhap  
 Ilaka No.: 7  
 Group Composition: Gurung/Male

Date: Feb. 23, 1992  
 Moderator: Balram Banskota  
 Recorder: Yub Raj Shrestha  
 Location: Open Field (Bari)  
 Time: 1:35 - 2:10 PM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	44	Literate	3	2
2	Gurung	24	Literate	1	1
3	Gurung	48	Illiterate	2	1
4	Gurung	39	Literate	4	2
5	Gurung	41	Illiterate	7	3
6	Gurung	45	Illiterate	1	1

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Group 9

VDC: Majhlakuribot  
 Ward No.: 6  
 Village: Tarku Jhalla  
 Ilaka No.: 4  
 Group Composition: Gurung/Male

Date: Feb. 25, 1992  
 Moderator: Balram Banskota  
 Recorder: Yub Raj Shrestha  
 Location: Open Field (Bari)  
 Time: 8:40 - 9:20 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	30	I.A.	1	1
2	Gurung	50	Literate	7	2
3	Gurung	37	Literate	1	1
4	Gurung	38	Literate	5	2
5	Gurung	24	Literate	1	1
6	Gurung	44	Literate	4	2
7	Gurung	48	Literate	4	2

Group 10

VDC: Barpak  
 Ward No.: 7  
 Village: Barpak  
 Ilaka No.: 4  
 Group Composition: Gurung/Female

Date: Feb. 27, 1992  
 Moderator: Bhagwati Khadka  
 Recorder: Sangita Acharya  
 Location: Private House  
 Time: 2:30 - 3:30 PM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	40	Illiterate	5	2
2	Gurung	25	Illiterate	2	2
3	Gurung	48	Illiterate	6	1
4	Gurung	21	Illiterate	2	2
5	Gurung	30	Illiterate	5	2
6	Gurung	25	Illiterate	1	1

Group 11

VDC: Aarupokhari Date: Feb. 25, 1992  
 Ward No.: 1 Moderator: Bela Shrestha  
 Village: Gurung Gaun Recorder: Rajani Shrestha  
 Ilaka No.: 7 Location: Open Field  
 Group Composition: Gurung/Female Time: 4:50 - 5:55 PM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	22	Illiterate	1	1
2	Gurung	25	Illiterate	3	2
3	Gurung	32	Illiterate	5	1
4	Gurung	32	Illiterate	5	2
5	Gurung	33	Illiterate	4	1
6	Gurung	25	Illiterate	1	1
7	Gurung	32	Illiterate	4	1
8	Gurung	35	Illiterate	4	1

Group 12

VDC: Majhlakuribot Date: Feb. 25, 1992  
 Ward No.: 4 Moderator: Bhagwati Khadka  
 Village: Keraghari Recorder: Sangita Acharya  
 Ilaka No.: 4 Location: Open Field  
 Group Composition: Gurung/Female Time: 8:00 - 9:00 AM

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Gurung	30	Illiterate	3	2
2	Gurung	22	Illiterate	1	1
3	Gurung	26	Illiterate	2	1
4	Gurung	40	Illiterate	2	2
5	Gurung	28	Grade 3	2	2
6	Gurung	25	Literate	2	1
7	Gurung	32	Illiterate	4	2
8	Gurung	32	Illiterate	4	2

Group 13

VDC: Taranagar  
 Ward No.: 1  
 Village: Tianghare  
 Ilaka No.: 1  
 Group Composition: Occupationals

Date: Feb. 28, 1992  
 Moderator: Bela Shrestha  
 Recorder: Rajani Shrestha  
 Location: Open Field (Bari)  
 Time: 12:30 - 1:10 PM  
 (Kumal)/Female

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Kumal	25	Literate	1	1
2	Kumal	30	Illiterate	5	2
3	Kumal	29	Illiterate	4	3
4	Kumal	34	Illiterate	3	4
5	Kumal	24	Illiterate	2	1
6	Kumal	23	Illiterate	4	3
7	Kumal	23	Illiterate	2	1
8	Kumal	22	Illiterate	3	2

Group 14

VDC: Gorakhkali  
 Ward No.: 4  
 Village: Kamigaun  
 Ilaka No.: 1  
 Group Composition: Occupational

Date: Feb. 29, 1992  
 Moderator: Bela Shrestha  
 Recorder: Rajani Shrestha  
 Location: Open Field  
 Time: 5:40 - 6:15 PM  
 (Kam1)/Female

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Kami	30	Illiterate	3	1
2	Kami	18	Illiterate	1	1
3	Kami	36	Illiterate	3	2
4	Kami	25	Illiterate	1	1
5	Kami	36	Illiterate	4	1
6	Kami	35	Illiterate	6	1

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Group 15

VDC: Masel  
 Ward No.: 1  
 Village: Upallow Sarkigaun  
 Ilaka No.: 7  
 Group Composition: Occupational

Date: Feb. 23, 1992  
 Moderator: Bela Shrestha  
 Recorder: Rajani Shrestha  
 Location: Open Field (Bari)  
 Time: 12:05 - 1:15 PM  
 (Sarki)/Female

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Sarki	36	Illiterate	4	2
2	Sarki	32	Illiterate	4	2
3	Sarki	28	Illiterate	1	1
4	Sarki	26	Illiterate	2	1
5	Sarki	21	Illiterate	-	-
6	Sarki	22	Illiterate	1	1
7	Sarki	21	Illiterate	2	2

Group 16

VDC: Aarupokhari  
 Ward No.: 4  
 Village: Piple  
 Ilaka No.: 7  
 Group Composition: Occupational

Date: 25 Feb., 1992  
 Moderator: Bharat M. Sharma  
 Recorder: Sher Bdr. Pun  
 Location: Open Field (Bari)  
 Time: 2:00 - 2:40 PM  
 (Sarki/Damai)

Male

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Sarki	37	Literate	5	2
2	Sarki	52	Illiterate	5	-
3	Sarki	39	Illiterate	5	1
4	Sarki	45	Illiterate	6	1
5	Damai	24	Illiterate	1	1
6	Sarki	32	Illiterate	2	1
7	Sarki	36	Illiterate	4	2

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Group 17

VDC: Phinam  
 Ward No.: 1, 2  
 Village: Aaruswanra/Deragaon  
 Ilaka No.: 1  
 Group Composition: Occupationals

Date: 27 Feb., 1992  
 Moderator: Bharat M. Sharma  
 Recorder: Sher Bdr. Pun  
 Location: Resting Place  
 Time: 10:20 - 11:10 PM  
 (Muslims)/Male

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Muslims	35	Literate	5	1
2	Muslims	36	Grade 3	5	2
3	Muslims	40	Literate	4	1
4	Muslims	30	Literate	2	1
5	Muslims	20	Grade 7	1	1
6	Muslims	31	Literate	3	2
7	Muslims	35	Literate	2	1
8	Muslims	27	Grade 5	1	1

Group 19

VDC: Saurpani  
 Ward No.: 4  
 Village: Gyagi  
 Ilaka No.: 4  
 Group Composition: Occupational

Date: Feb. 26, 1992  
 Moderator: Bhagwati Khadka  
 Recorder: Sangita Acharya  
 Location: Yard of a House  
 Time: 8:00 - 9:00 AM  
 (Sarki)/Female

Participant's Profile

S/N	Caste	Age	Literacy	Number of Children	
				Total	< 5 Years
1	Sarki	24	Literate	1	1
2	Sarki	27	Illiterate	3	2
3	Sarki	21	Illiterate	2	2
4	Sarki	30	Literate	3	2
5	Sarki	22	Illiterate	1	1
6	Sarki	23	Illiterate	5	4
7	Sarki	38	Literate	3	1
8	Sarki	30	Literate	4	3

## Appendix II

### Rural Social Marketing of Temporary Contraceptives and ORS in Gorkha District, 1992

#### (Topic Guide for Focus Group Discussion)

#### I. Introduction and Warm up (Moderator's Opening) :

- Explain the purpose of your visit.
- Spend 5-10 minutes for warming up the group.
- Explain that they should feel free to give their frank and honest opinions. What they have to say is valuable to us : we are like brothers/sisters/ friends.
- Explain that this is not a test, therefore, there are no right or wrong answers. All comments, both positive and negative, are most welcome.
- Assure them that all comments will be kept confidential and be used for research purposes only.
- Introduce yourself and ask the participants to do the same. Collect basic information -- name, age, sex, caste, total number of children and children under 5 years.

#### II. Sales Agent :

- Do you know the Sales Agent? (the person who sells Jeevan Jal and FP contraceptives in your village).
- If yes, what dose she/he do? (sales, health/FP education and follow-up).
- Do you receive their services when you need them?
- If yes, how, when and how often?
- If no, why not?
- Do you gotten any benefit from their services?
- If yes, What?
- If no, why not?
- How could they provide better services to your community?

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III. Jeevan Jal :

- How do you treat a child with diarrhoea?
- If Jeevan Jal, why?
- If other treatments, what and why?
- We found that most parents know about JJ but they do not use Jeevan Jal. Why?
- Has any changes in thinking and practice come as a result of the project?
- If yes, what?
- If no, why not?

IV. Spacing :

- Are any of you using any spacing methods?
- If yes, what methods and who motivated you?
- Why are you using it?
- Would you like to continue or change to another method?
- If continue, why?
- If other method, why?
- If not using, why you are not using contraceptives?
- Do you know why many people do not like to use contraceptives (rumors, other reasons)
- Do villagers/you believe in these beliefs?
- Can you suggest how we could promote the use of these products?
- Has any change in thinking and practice come as a result of the project?
- If yes, what?
- If no, why not?

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V. Products :

- Why do people not use more condoms? (rumors, other reasons).
- Why do people not use more pills? (rumors, other reasons).

VI. Promotional Campaigns :

- What types of promotional campaigns and activities are being used by our field workers and Sales Agents in the village?
- What is the most effective educational activity in village? Why?
- What are the least effective educational activities in village? Why?
- What could be done to make these activities more effective in future to educate the people? How?

VII. Service through Local Shopkeepers :

- After termination of the project, how could these products be supplied in the village?
- Will people buy these products from local shopkeepers or not?
- If not, why not?

VIII. Coverage of the Project :

- Have all people been reached by this project?
- If not, who is left out?
- Which geographical location?
- Which socio-economic group?
- Which caste group?
- Others left out?
- What are your suggestions to provide services to these uncovered groups?