I
INTRODUCTION

1.1 General Background

Community health program has become one of the important means for the improvement of health condition of the people at local level especially in developing countries like Nepal. Today, many international organizations and agencies, including UNICEF and WHO have emphasized the importance of community involvement in health development through out the globe. As a means to improvement to improve community participation and enhance the outreach of health services through local women working voluntarily, the Female Community Health Volunteer (FCHV) program in Nepal was started by the Ministry of Health and Population in 1988.

Studies show that infectious diseases, maternal, prenatal and nutritional health problems continue to lead to half of Nepal's mortality, and most disability-adjusted life years (DALY) lost. The loss of DALYs suffered by women of reproductive age (15 – 44 years) is 26 percent higher than that of men, and children under five accounts for over 50 percent of all DALYs lost. Additionally, marginalized people suffer a disproportionate burden of ill health. The national infant mortality rate (IMR), for example, is 64 per 1000, but among Dalit children it is 116 (Bhatia and Jha, 2004).

The future implications of these current demographic trends on quality of life are significant, in terms of both health and poverty. In combination with mass people movement and displacement, disruptions to the environment, and the high proportion of children and youth, the health scenario today remains dominated by persistent, new and reemerging maternal and child infectious diseases – despite progresses made. As with other well-being indicators and proxies, health status varies greatly according to geographical area of residence, age and gender.

Health data suggest that public health programs should prioritize infectious and communicable diseases, and conditions affecting women of reproductive age, and their children. However, many factors affect access to health services, including socio-cultural, economic, religious, and geographical. Especially for women and children, often restricted to the 'private' sphere, seeking health care outside of home

and community, for conditions often not discussed, is a challenge. Bearing these factors in mind, and recognizing the importance of local women's participation in reducing the impact of disease on women and children, the Government of Nepal (GoN) initiated the Female Community Health Volunteer (FCHV) program in 1988 through the Family Health

Division (FHD), Department of Health Services (DoHS), and Ministry of Health and Population (MoHP). From an initial 27 districts, by 1993 it expanded (with donor support) to cover all 75 districts in Nepal, changing from a ward-based to population-based approach in selected districts. At present the cadre of FCHVs is nearly 50,000, promoting health seeking practices under the supervision of maternal and child health workers (MCHWs) and village health workers (VHWs) (RHDP, 2007).

The FCHV is a village based unpaid health volunteer, who works for the delivery of Primary Health Care service. This is the community level health service infrastructure of Ministry of Health. The FCHV is expected to promote the utilization of preventive health services made available in the communities and mobilize the mother group to initiate health actions side by side The existence of these human resources provides potential for further health development, learning, and experience, and because they are locally placed members of the geographical community, FCHVs fall within the scope of the Local Self Governance Act, which promotes decentralizing so as to make social systems more responsive to the specific needs of diverse and disadvantaged populations.

Since the inception of the program, FCHVs have served as frontline local health resource persons who provide community based health education and services in rural areas, with special focus on maternal and child health and family planning issues. Through their voluntary service, FCHVs contribute extensively to the health and well being of their communities. They have played a significant role in the semi-annual distribution of Vitamin A capsules and National Immunization Days and in providing community based treatment of acute respiratory infection (ARI) cases and referral to health facilities in program districts (MoH, 2003).

The present study attempts to explore the contribution of FCHVs for primary health care and their understanding and roles for the prevention of infectious and communicable diseases in the southern part of Parbat district including seven VDCs, viz. Hosrangdi, Sarangkhola, Huwas, Bhorle, Tribeni, Beulibas and Urampohkara.

1.2 Statement of the Problem

Local partner capacity building is improving the skills and confidences of government health personnel, traditional healers, school teachers, local beneficiary representatives and individuals, and FCHVs, for overall improvements in awareness and health empowerment, quality service demand and delivery, increased utilization, and improved effectiveness of health services, as evident from improvements to overall health status. An emphasis on women's groups, including the government sponsored Mother's Groups, has positively improved health seeking behavior, child and family health. Community based health programs have been focused on continue activities in order to increase FCHVs confidence and competency as local health promoters, and to provide trainings to FCHVs in health prevention and disease management, health seeking behavior change, first aid, reproductive and maternal health, gender awareness, HIV/AIDS, infectious and vector borne diseases, and child health.

Voluntarism is cited as a major strength of the program, encouraging local ownership and behavior change for sustainable social transformation. It is also at a crossroads in regards to women's empowerment as well, with some tough decisions in the imminent future (RHDP, 2007).

The FCHVs program, whose secondary motive was the development of women as leaders in their communities, now faces the difficult question of how much longer it will be able to rely on the gender stereotype of free female labor from women restricted to the household, to address 'women's issues' of maternal and child health.

The present research is carried out to explore some of these issues and questions regarding FCHVs, and to better understand the changing dynamics of the program at this critical junction. This research is aimed at assessing the stated role of FCHVs on primary health care and their knowledge in infectious and communicable diseases in seven VDCs in the southern part of Parbat district. Towards this determination the following three questions guided the research, and guide the presentation of findings:

1. What are the roles, responsibilities and scope of FCHVs?
2. What are community perceptions regarding FCHV services?
3. What are the strengths and weaknesses of current government practices and policy on the FCHV Program?

1.3 Objectives

General Objective

The general objective of the present study is to find out the contribution of FCHVs for the primary health care and to evaluate their knowledge on infectious and communicable diseases; and their role for the prevention of such diseases in the study area.

Specific Objectives

- To analyze FCHVs' personal characteristics (socio-economic status) in the study area.
- To find out FCHVs support and contribution on primary health care programs of the Ministry of Health and Population, Nepal.
- To find out FCHVs perception and knowledge on infectious and communicable diseases; and their role for the prevention of such diseases in the study area.
- To evaluate the impact of FCHVs for changing health status of the people in the study area.

1.4 Rationale of the Study

The present study of FCHV with regard to impact evaluation in the study area will be significant in the following ways:

- Study of FCHV has become an essential part to strengthen the basic health delivery service in rural areas of the country.
- Well accepted and committed FCHVs are back bone of the basic health service system in community level. The study will explore the necessity of FCHVs' role in community health service.
- The study of FCHV will have positive and accelerating impact in basic health delivery service in the study area. This study will be useful and good assistance for the planners and the organizations implementing similar programs in the country.
- The study will be helpful to create awareness about the prevention and control of infectious diseases and any others especially in the study area.

The study aims to analyze various variables related to FCHV which is vital to enhance the interest and commitment, regularity in social /community work and the capability at micro level.

II
LITERATURE REVIEW

Generally, the related literature to the topic to be studied was reviewed. As the topic of the study requires the literature on the context of concept, evolution of community participation in government's health plan and policy in health sector, and FCHVs as a grassroots level health structure have been discussed thoroughly in the available literature.

2.1 Community Participation in Health Development

The literatures on community participation in health management are fairly good. In general, the existing related literature has been reviewed. While literature analyzing, few case studies report have dealt specially with the relationship of community participation to Mother and Child Health , Family Planning activities and the available diseases. The reports have also tended to explore the role of members of the community in a whole range of health activities.

Health services are most effective if they are compatible with the expectation and need of the people, free to communicate with the personnel providing the service and if they understand the system easily (Dhungel, 1992).

Pizurki et al. (1987) observed that the factor which either constrain or is in favor of the involvement of women in community health activities were treated at length in WHO book, women as provider of health care. He concluded that if the opportunities provided to a woman for communicating with other women during the normal domestic tasks-water collecting, shopping etc; ensure that much valuable information is passed on. Communication and mutual support within this informal "network" often supplements the work of formal health service providers.

Bichmann et al. (1989) in his study in Nepal, titled "towards the measurement of community participation", describes that the initial stages in the development of a methodology for assessing community participation in health scheme, and suggests community participation is a social process in which specific groups with shared

needs living in a define geographical area actively pursue identification of their needs and take decisions and establish mechanism to meet them.

Ravindran (1995) in Oxfam Discussion Paper-5 describes primary health care approach and maintains that the conscious participation of people in the care of their own health is fundamental to the achievement of good health.

Lankester (1992) describes community health care as health for the people by the people. It co-operate with different resourceful personalities to yield complete integration. He further explains that the community based health care opposes PPNN, Pill for ever Problem, a Needle for every Need. Instead, it emphasizes that communal well being is largely brought about through healthy living patterns and enlightened attitude. Community based health care is not a second rate health service for the poor, as long as it is correctly set up and adequately supervised

According to Oakley (1989), the advantages of the community organizations for health care are as follows.

- A community participation approach is a cost effective way of extending a health care system to the geographical and social periphery of a country although it is far from cost free;
- Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures;
- Community that invest labor, time money and materials in health promoting activities are more committed to the use and maintenance of the things they produce such as water supplies;
- Health Education is most effective as part and parcel of village activities;
- Community health workers, if they are well chosen, have the people's confidence. They may know the most effective techniques for achieving commitment from their neighbors and at the very least are not likely to exploit them. They come under string social pressure to help the community carry out it health promoting activities.

According to Bracht (1990), community health promotion approach has a number of advantages which are as follow.

- The burden of chronic or environmentally induced disease cuts across most sectors of the community;

- Community approaches are better integrated into total community, since interventions are built into existing community structures;
- Community approach better ensures longevity of change because the social context of behavior prescribes certain activities and local ownership generates continual responsibility;
- Community approaches are generally more comprehensive and ensure better allocation and co-ordination of scarce health resources;
- Community approach reflects shared responsibility for health and move away from individual strategies only or victim blaming. Community approach actually augments individual capacity for change.

In line with this principle, the PHC approach therefore calls for a move from hospital-based care alone towards the prevention of ill health, and making health services available at the community level, and emphasizing "self-help" what people can do for them. Several micro studies have brought the complex system of the different communities to light.

2.2 Review of Health Plan and Policies of Nepal

WHO defined the health in a broad term for its member countries is "Health is a state of complete physical, mental and social well being and nor merely the absence of disease or infirmity". Nepal has incorporated this definition of health and Alma-Ata declaration on PHC in first long-term health plan (1975-1990) and fifth five-year plan (1975-1980). If health care in Nepal is to be improved, one must start with the assumption that the villagers faith in their own healing techniques – be they herbal or ritual is not going to be shaken by the occasional visits of medical teams or even by the building of the hospitals.

Nepal had only 50 Doctors, 34 Hospitals, 625 Beds, 24 Dispensaries and 63 Ayurvedic dispensaries during the pre-plan (1951-56). Low life expectancy (28 years) and high IMR (255/1000) was the indicator of the poor health situation within 8.47 million populations. The systematic plan was first started in 1956 known as First five-year plan 1956-61. Malaria Eradication program and Health Assistant and Nursing training program were begun in this period.

The 2nd five year plan (1962-65) focused on TB and Leprosy control program with continues development of the other health service. In the 3rd five year plan (1965-70), the Surveillance of Leprosy (1965) Small Pox Eradication Project (1967) and FPMCH project (1968) were established. The 4th plan (1970-75) continued these entire projects and started pilot projects in Bara and Kaski (1971).

There was a major shift during the 5th plan period (1975-80).Adaptation of Alma-Ata declaration (1978) on "Health for all by 2000"; the 1st Long-term Health Plan (1975-90) prepared for 15 years, the number of medical doctors increased by 457, Panchayat based workers and Village Health Workers were produced 2000 and 1000 respectively during this period. The 6th five-year plan (1985-90) focused more on health infrastructure development.

At the end of the 7th plan the number of health institutions were increased at different level i.e. 745 Health Posts, 26 Health Centers, 44 District Hospitals, 9 zonal Hospitals and 23 other Hospitals. After the restoration of democracy MoH introduced the New National Health Policy – 1991 and the again reorganogram in health sector.

With respect of National Health Policy -1991 the 8th plan (1992-97) brought a new dimension in the health sector of Nepal. Establishment of Primary Health Care Center (PHCC) in each constituency, Health Post (HP) or Sub-health Post (SHP) in each VDC and FCHVs, TBAs, Outreach Clinics and EPI Clinics at community level are the basic health infrastructures identified by the authority to make access to the rural people. At the end of the 8th plan period 137 PHCC, 745 HPs, 3185 SHPs, 46,584 FCHVs, 12,641 TBAs, 13,700 PHC. Outreach Clinic (PHC/ORC) and the same number of EPI outreach were established throughout the nation.

The 9th five-year plan had its greater priority in health sector. The plan expected to achieve an improvement in health status through equitable access to quality health care for all people. To achieve the goal and objective the main policies and strategies of 9th five-year plan were:

- Strengthening District Health System (SDHS).
- Separation of public health section and hospital through organizational management
- Health for All by the year 2000 (HFA 2000) and beyond through accessible essential health services (EHS) through participation at the rural level.

- Decentralized plan to obtain participation and manage health services at local level.

10th five year plan had aimed to reduce the poverty in sustainable way with development of healthy human power and mobilization. The plan had the objectives to improve the quality of health service and increase the access too of poor and disadvantages of rural and remote people and widely expansion of reproductive wealth and family planning services with two major concerns to maternal health service in rural areas.

The First Long-term Health Plan (FLTHP 1975-90) prepared in Nepal's history in 1975. The main objectives and strategies of the first long term health plan are as follows:

- Integration of vertical health projects.
- Organizational change for effectiveness of health services.
- The self-reliance in medicine production.
- Increase community participation in health services.

The Second Long Term Health Plan (SLTHP 1997-2017) is already in an existence. Based on SLTHP 9th and 10th plan was completed and 11th three year Interim Plan is also effective since 2007. The main objectives of SLTHP are to improve health status of vulnerable group (women, children, rural, poor, and underprivileged), extend essential and cost effective health service to the district, and provide appropriate health personnel for quality health care, and increase efficiency and effectiveness of health care system.

It developed the appropriate roles for the public, NGO and private sectors in provision and financing of health services and finally to improve inter and intra sectored co-ordination and provide the necessary condition and support for effective decentralization with full community participation.

In 1991 the MoH announced National Health Policy – 1991 with the principal aim of upgrading the health standards of the majority of rural area by extending basic primary health service up to the village level and provide opportunity to obtain the benefits of modern medical facilities by making service accessible.

Table: Targets of 11th Health Plan and Second Long-term Health Plan

S. No.	Health Indicators	Status of 2006	End of 11th Plan	End of SLTHP (1997-2017)
1.	Infant Mortality Rate (per 1000 live birth)	48	44	25.0
2.	Under Five Mortality Rate (per 000)	61	55	55.0
3.	Total Fertility Rate (TFR)	3.1	3.0	2.5
4.	Average Life Expectancy (LE in Year)	61.9	N/A	73.5
5.	Maternal Mortality Rate (per 100000)	281	250	25.0
6.	Low Birth Weight (LBW %)	N/A	N/A	12.0
7.	Crude Death Rate (CDR)	N/A	N/A	6.0
8.	Crude Birth Rate (CBR)	N/A	N/A	26.0
9.	Delivery by TMP (%)	19	35	95.0
10.	Access to Essential Health Services (EHS)	78.83	90	90.0
11.	Availability of Essential drugs in Health Institution (%)	93.3	95	N/A
12.	Current user of Contraceptive (%)	44.2	53	N/A
13.	Use of Condom (14-35 years) (%)	77	85	N/A
14.	Neonatal Mortality Rate(Per 1000 live birth)	33	31	N/A
15.	Knowledge of Women (15-49) on ways to avoid AIDS (%)	65	75	N/A

Source: MoH Plan and 11th Interim Plan

The current Three Year plan has been introduced as a bridge between the Tenth and Eleventh five-year plans as the country is now heading towards building a new Nepal through a democratic process. It is also to maximize effort in achieving the MDGs. Apart from continuing the momentum of the Tenth Plan; the salient features of this plan are to initiate new programmes not included in the EHCS package and to address the existing weakness in overall manpower of the health system. The right to health will be the main strategic direction as per the interim Constitution, provision of free services to 22 low HDI districts and people below the

poverty line. It will also take up measures to improve health services management and improve the partnership with the private sector, NGOs and other professional organizations. New initiatives include prevention and control of dengue, avian influenza, and introduction of new vaccine-measles, mumps and rubella vaccine (MMR) and health of the elderly.

2.3 FCHV: Policy and Strategy in Nepal

Since the implementation of the FCHV/P in 1988, the context in which FCHVs have been involved in community health improvement has witnessed some significant change in policy, strategy and programs. The new strategy, 2003 has ensured important provisions regarding FCHV/P. The relevant major provisions with this study are mentioned here as follows:

Goal

The National FCHV Program, focused on family planning, maternal/neonatal and child health, including the semi-annual Vitamin A supplementation program, will contribute to Nepal's goal of reducing the total fertility rate and the under 5 mortality and maternal mortality rates

Objectives

- To develop in every ward with at least one FCHV, knowledgeable, trained and well-supported health resource person through capacity building, distance education and supportive monitoring activities, this will reinforce each FCHV's ability to fulfill her role as health educator, referral agent, community mobilizer and community-based service provider.
- To provide FCHVs with necessary skills and support to empower rural women with basic health knowledge and skills in order to increase utilization of available primary health care (PHC) services and participation in community health development.

- To increase community awareness about the importance of the joint roles and responsibilities of FCHVs and MGs through advocacy and health communication activities; and
- To strengthen community level ownership, management and long-term sustainability of the FCHV/P, in conjunction with the LGSA, through the establishment of local funds by local VDC and District Development Committee (DDC) authorities, and through active support and commitment from all levels of implementation, including health facilities (HFs), health facility management committees (HFMCs) and District Health Offices/District Public Health Offices (DHO/DPHOs).

Core Activities of FCHVs

FCHVs are understood to play a supportive role in linking the community with available
PHC services and will continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level.
FCHVs will continue to promote the utilization of available health services and the adoption of preventive health practices among community members.
FCHVs act voluntarily as health educators and promoters, community mobilizers, referral agents and community-based service providers in each of the health areas they are trained.

According to *National FCHV Program Revised Strategy* FCHVs will continue to be encouraged and supported to promote the utilization of available health services and the adoption of preventive health practices in the following core activities.

Family Planning

- Educate couples about the importance of FP and birth spacing

- Provide FP community-based counseling including information on alternative methods, side effects, advantages, disadvantages, where to go for services
- Inform potential clients about VSC static and mobile sites and refer those who desire services
- Refer clients interested in other contraceptive methods to the appropriate health facilities
- Refer complications and infertility concerns to health facilities
- Distribute condoms
- Resupply pill acceptors

Maternal/Neonatal Health

General Antenatal Care

- Educate the community on benefits of delayed first sex, marriage and childbearing, and the importance of safe sex
- Promote balanced nutrition and tetanus toxoid (TT) immunizations for adolescent girls (aged 10-19)
- Educate and motivate women about antenatal care, conveying the following messages:
    - Attend at least 4 antenatal checkups and receive 2 TT immunizations
    - Eat a healthy and varied diet
    - Take iron/folate supplements
    - Get treatment of night blind pregnant women with low does of vitamin A capsule after 1st trimester
    - Reduce workload and get more rest
    - Identify pregnancy-related danger signs
    - Take appropriate action upon observing danger signs
- Refer high risk clients to health facilities

Delivery Care, Postnatal Care and Newborn Care

- Educate and motivate women about safe delivery care, conveying the following messages:
    - Plan for a safe and clean home delivery with skilled attendance
    - Identify delivery-related complications
    - Take appropriate action upon observing complications

- Refer women to health facilities and skilled birth attendants for home delivery
- Educate and motivate women about postnatal care conveying the following messages:
    - Take Vitamin A supplement within 6 weeks postpartum
    - Continue iron/folate supplementation for 6 weeks postpartum
    - Attend 3 postnatal visits
    - Eat a healthy and varied diet
    - Reduce workload and get more rest
    - Plan to use FP methods for birth spacing
    - Identify postpartum danger signs
    - Take appropriate action upon observing danger signs
- Refer women exhibiting danger signs to health facilities
- Promote normal newborn care and educate women about the following messages:
    - Immediate wiping and drying
    - Wrapping and keeping warm
    - Immediate breast feeding including colostrums
    - Delay bathing for at least 24 hours
    - Apply nothing on stump
    - Identify newborn danger signs
    - Take appropriate action upon observing danger signs
- Educate mothers about the importance of preventing harmful newborn practices
- Refer infants with danger signs to health facilities

Child Health

Diarrhea

- Educate mothers how to prevent diarrhea through improved hygiene and sanitation
- Promote three rules on home-based care and treatment of diarrheal dehydration
- Teach mothers about Oral Rehydration Solution (ORS) preparation
- Educate mothers about the signs of dehydration and action to take upon observing signs
- Refer severe cases of diarrheal dehydration to health facilities

- Distribute ORS packets

Acute respiratory infection (ARI), Nutrition, Immunization

- Promote home-based care and treatment of cold, cough andpneumonia
- Educate mothers about ARI danger signs and action to take upon observing danger signs
- Refer severe cases to appropriate health facilities
- Teach mothers about the importance of exclusive breastfeeding for first six months (and no prelacteal feeding) and continued breastfeeding for at least two years
- Promote timely, proper introduction and types of locally available weaning foods after child reaches five months of age
- Promote use of iodized salt
- Identify malnourished children and refer to health facilities
- Distribute semi-annual Vitamin A supplements for all children from six months to five years of age and deworming medication for children from 2 to 5 years of age
- Educate women about what conditions should be treated with high-dose Vitamin A:
    - Measles
    - Persistent diarrhea
    - Night blindness
    - Severe malnutrition
    - Post partum (within 6 weeks of delivery)
    - Refer night blind children and pregnant women, and other cases requiring high-dose Vitamin A treatment to health facilities
- Inform mothers about the importance of routine immunization (BCG, DPT, Measles, Polio, TT) and the dates and locations of immunization clinics
- Identify children and women who need immunizations and encourage their attendance at immunization clinics

Infectious Diseases

STIs and HIV/AIDS, Tuberculosis, Leprosy, Malaria, Kala -azar and Japanese Encephalitis

- Provide information and education on STIs and HIV/AIDS

- Refer suspected STI cases to health facilities for diagnosis and treatment
- Provide information and education on the infectious diseases affecting their locality
- Educate community about transmission, prevention and available treatment
- Refer suspected cases to health facilities

Other Activities

- Provide limited first aid services and refer severe cases to health facilities
- Maintain completed ward register report and submit to supervisor on monthly basis (reports will be collected during monthly supervision visits)
- (Re)activate mother's group, serve as MG secretary and actively participate in regular monthly meetings

Add-on Activities

Whereas core activities are those in which FCHVs in all 75 districts are participating, FCHV "add-on" activities are those undertaken in one or more VDCs, districts or regions, but have not yet been introduced on a national scale. Some FCHV activities, which began as add-on activities -- such as semi-annual vitamin A supplementation -- are now core activities. Add-on activities are fully consistent with FCHV/P goals and objectives and are supported by governmental programs, EDPs or I/NGOs. These partner organizations provide support to FCHVs in capacity building, monitoring and supervision, commodities resupply, community support and mobilization and other necessary FCHV/P activities.

This section describes the FCHV add-on activities that are ongoing and being implemented through support from partner organizations, as well as new categories of add-on activities proposed for FCHV involvement, where sufficient partner support is provided and ensured.

Maternal/Neonatal Health

General Antenatal Care, Birth Planning/ Delivery Care and Postnatal Care

- Refer cases of night blind women to health facilities
- Distribute iron/folate tablets to pregnant and lactating women
- Implement birth preparedness package (BPP) and activities
- Promote planning and preparation for delivery including funds, food, transport

- Counsel on birth spacing and FP methods availability

Child Health

Diarrhe and Community-Based Pneumonia Treatment

- Distribute blue plastic cups
- Identify pneumonia cases
- Treat pneumonia cases in children between 2 months and 5 years of age
- Refer children <2 months with high respiratory rate or other ARI danger signs to health facilities
- Refer all severe pneumonia cases in children under 5 years to health facilities

Immunization

- Mobilize community during polio eradication campaign activities (including National Immunization Days (NID), Sub- NIDs, Mop Up and/or Responsive Mop-up rounds)
- Assist health staff health staff and community members to promote Maternal Neonatal Tetanus Elimination campaign and Hepatitis B immunizations
- Assist health staff and community members in controlling measles outbreak

General Adolescent Reproductive Health

- Provide information and education about prolapsed uterus, menstruation and abortion
- Provide information and education on adolescent reproductive health through MGs (including topics of puberty, physical and emotional changes, conception and methods of contraception)

Infectious Diseases:

Tuberculosis, Malaria, Kala –azar and Japanese Encephalitis Rational Use of Drugs

- Support staff of local health facility with Directly Observed Therapy Short Course (DOTS) activities
- Motivate clients to comply with treatment
- Refer suspected cases to health facility
- Promote the use of insecticide-treated bed nets

- Support health staff with slide collection and presumptive treatment in selected areas
- Refer suspected infectious disease cases to health facilities for diagnosis and treatment
- Educate community about:
- Harmful effects of unnecessary medication
- Treatment compliance
- Appropriate dose, timing and duration.

FCHV Selection and Replacement

The entire membership of the MG members will nominate and select their FCHV based on the following criteria:

- Willing and able to volunteer at least one 10-year term of service
- Local resident of ward
- Between 20 and 44 years old, upon start of service
- Family support of her involvement in the FCHV/P
- Priority will be given to under represented and disadvantaged families (ethnic minorities and dalit)
- Preference will be given to those already involved in social and health activities, including trained and traditional birth attendants
- Preference will be given to women who are literate and have completed primary education; however, illiterate women may also be selected and will be given priority for participation in literacy activities

Capacity Building Activities to FCHV

Basic Training

Basic training will be conducted for all newly recruited FCHVs. The duration of basic training will be increased to 18 days total and will be divided into two 9-day modules to be conducted at 2-month intervals. Basic training materials have been integrated with the revised strategy and the clarification and expansion of FCHVs' expected roles.

The FCHV Section/FHD, in conjunction with DHO/DPHOs, will plan basic training sites within one district, several districts or one region. Recipients of DTOT

for FCHVs will conduct basic training for a minimum of 15 new FCHVs per session, every three years or as needed. Convenient residential training sites will be identified in central areas based on FCHVs' location and travel distance.

Upon completion of basic training, all FCHVs will be provided with the following supplies:

- Training certificate
- Reference manual, a set of BCC materials and a shoulder bag
- Ward register record book and other recording and reporting forms
- Photo identification card
- FCHV signboard
- Essential commodities, which include the following items and quantities:
- **Commodity Quantity**

  - Condoms 100 pieces
  - Pills 5-10 cycles
  - ORS 10 packets
  - Vitamin A capsules per current policy in each district
  - Iron/folate tablets per current policy in each district
  - Cetamol 100 tablets
  - Iodine 100 ml bottle
  - Gentian Violet 5 grams
  - Cotton 1 roll
  - Bandages 10 pieces
  - Scissors 1 piece
  - Other supplies Depending upon availability

To ensure that the prior commodities are regularly replenished for FCHVs, the following activities will be implemented:

- HFMC is responsible to ensure commodities are regularly replenished from the

DHO/DPHO to the HF and will coordinate with the Community Drug Program per current policy in each district.

- Distribute commodities to FCHVs at trimesterly review meetings and to their homes on monthly basis (during VHW supervision visits).
- HF staff will make commodities available to FCHVs on demand with provision of FCHV treatment and distribution records.

The basic set of FCHV/P materials (such as bag, signboard, BCC materials and manual), will be replaced as needed at the time of refresher training.

Refresher Training

At the HP/Ilaka level, five-day refresher training will be conducted for all FCHVs every five years. The refresher training will be conducted PHCC/HP/SHP-ICs who have participated in refresher DTOT, and will be planned according to established training methodologies and content as per the revised curriculum

Revised Training Materials

Three processes have been integrated to contribute to strengthened and expanded FCHV training materials content: the FCHV/P strategy review, FCHV training materials revision, and design document of the FCHV radio DE program. Each has been an ongoing consultative process during 2002-03 with key stakeholders and partners.

To enable FCHVs to fulfill their core roles and responsibilities, additional training support in several areas will be needed. During the revision of FCHV training materials, new and expanded modules covering these topic areas were incorporated into the basic and refresher training curricula and linked to lesson plans developed for the distance education radio program. These new topic areas included:

- Increased interpersonal communication, social mobilization techniques, community-based counseling, group facilitation and MG meeting conduction skills to develop ability and confidence to communicate effectively
- Family planning (with specific focus on informed choice, options, advantages, disadvantages, side effects and where methods are available)
- Maternal and neonatal health (with specific focus on antenatal care, delivery care, postpartum care, newborn care and, danger signs during pregnancy, delivery, postnatal and neonatal periods)

- Child health (with specific focus on home-based care and indications for referral of diarrheal dehydration and ARI and conditions requiring treatment with vitamin A high-dose)
- Infectious diseases (with specific focus on prevention of STIs/HIV and treatment of STIs)
- Adolescent reproductive health (with specific focus on of puberty, physical and emotional changes, conception and contraception needs) (MoH, 2003).

In addition to the FCHV strategy, the Three Year Plan (2008-2011) of the Ministry of Health, which sets the overall direction of the country's health sector also include the following under the objective of providing equal opportunity for health development to all with special emphasis to socially disadvantaged, poor, women and disabled people per the provision of "Basic Health as Human Right" in the Interim Constitution of Nepal in 2007.

- FCHV programme will be strengthened through the establishment of revolving fund of Rs. 50,000 at each VDC level. This fund will be to support and empower these women.
- FCHVs that are above 40 years old and not working will be replaced from indigenous and disadvantaged communities.
- Links and mechanism will be established through FCHV to make funds available for enabling women to avail emergency obstetric service through FCHVs with the "saving and cooperative programme".

It is argued in this study that community participation in health program has brought a significant improvement in the health status of the people. Similarly periodical plan of government and FCHV plan and strategy have really encouraged the people to be more aware, and play vital role to prevent various diseases and live healthy life with cooperation of their own local members (FCHVS). The present study thus contributed to find out the implementation aspect of FCHV strategy, and roles played by FCHV in family planning, maternal care, and their perception and knowledge in infectious and communicable diseases and prevention of such diseases in one of the remote areas of Nepal.

III
RESEARCH METHODS

3.1 Study Area

The study area which includes 7 VDCs- Hosrangdi, Sarangkhola, Huwas, Beulibas, Urampokhara, Tribeni and Bhorle is situated in mid hill district- Parbat of western Nepal. The area comprises diverse land topography such as up-hills, down hills and rivers valley. But folded mountain having a steep gradient in south-west and North-east is the most common feature of the villager.

Study area experiences temperate climate with a monsoon rainfall pattern i.e. summer is hot and wet and winter is cold and dry. However, there is a little variation in climate, the down hill (besi) experiences warm temperate whereas uphill with cool temperate. Some parts of the area are covered with a rich variety of both deciduous and coniferous vegetation. The study area is drained by stream and river. But the distribution of water resources and drinking water supply is uneven .Some villages have been suffering from water deficiency. The scarcity of drinking water is one of the serious problems faced by the people especially in dry season.

Both nuclear as well as joint families are equally found in the study area. Subsistence pattern of farming and pursuing of traditional life are the main factors, which play the significant role for existing joint families in study area.

Gender, caste, religion and ethnicity based social stratification is more prominent than that of class and occupational division. Most of the people were found with the belief of Hinduism and it was followed by Buddhism. So, majority people in the study area follow Hindu rite of passage and also play their respective role in different religious ceremonies.

Majority of the people in study area depend upon agriculture for a livelihood. Varieties of crops such as rice, maize, millet, potato and fruits are cultivated; however rice cultivation is rare in uphill/upland due to cold climate, steep topography and lack of irrigation. Besides agriculture and animal husbandry people of study area were also found to have involved in various income earning activities such as wage laboring, job in outside of the country or foreign employment, trade and business in local market centers, security force, government job, etc.

The study area is not linked with highway but recently the earthen rural road networks are being constructed. An earthen track has been in operation which links Walling at Siddharth highway and Painyu-Hatiya, the local market centre in Huwas VDC. So the people have to carry an ill-people into nearest hospitals either in Pokhara or Palpa by the help of porter up to Painyo-Haitya and sometimes up to Walling.

Each VDCs have the facility of either health post or sub-healthpost. Similarly people were found to have the advantages of national level vaccination and immunization programs. However local people have no easy access to health clinics in their local areas except dispensaries run by health assistants or ANMs in the local market centers in the study area.

In the study area, private or boarding school were recently established in the surrounding areas of local market. Most of the school students were found to have enrolled in public or community school. Every VDC has been facilitating with at least one high school. Two VDCs of the study area namely- Huwas and Tribeni have established higher secondary level with Humanities, Management and Education faculties. Education status of the people especially of disadvantaged, poor and dalit was found quite dissatisfactory compared to other people.

3.2 Population Distribution

Population distribution is uneven in the study area. Population density in down hill and local market areas is generally higher than the other parts. Population density of two VDCs Urampokhara and Beulibas is compratively more than other VDCs of the study area. Population of the study area is composed of various caste and ethnic groups such as Brahmin, Chhetri, Magar, Gurung, Dalit and Newar etc.

Map 1: The location of study area and Parbat district in Nepal.

3.3 Rationale of the Selection of the Study Area

Seven VDCs - Hosrangdi, Sarangkhola, Huwas, Beulibas, Uram, Bhorle and Tribeni of Parbat district in Dhaulagiri zone are selected as the study area in order to study FCHVs and their role in health services in community level.

- The area is one of the remote areas of Nepal where people have no enough access to basic health services.
- Due to absence of hospitals and clinics FCHVs' roles are considered remarkable in the areas.
- Previously, study/research by any one in such activities in the study area was not found. So this is the first endeavor for the study of this phenomenon.

3.4 Nature of Data

It is indispensable for the researcher to collect primary data for this study because only an in-depth analysis for the FCHVs role in community health would accomplish its objectives. The chief sources of primary data are the FCHVs, health officials and patients which were collected by direct structured and unstructured interview, observation, key informants, etc. during the field work period- April 2009 to March 2010. Secondary data have been obtained from earlier published books, reports, journals, articles, government policy, etc. FCHVs, health posts, health workers and patients of the research areas provided both qualitative and quantitative data required for the study.

3.5 Sampling Procedure

All FCHVs (63) of seven VDCs - Hosrangdi, Sarangkhola, Huwas, Beulibas, Uram, Bhorle and Tribeni of Parbat district were selected as samples for the research. The samples size constitutes about 13% of all of Parbat district. Similarly, people suffering from T.B. and Leprosy were also selected as samples on the basis of purposive sampling from the study area. Beside these samples other informants such as health workers, doctors of surrounding clinics, health and population teachers, health in-charge etc have been purposively selected as key informants. During the field work primacy has been given to the more experienced and learned FCHVs who could provide adequate and reliable information to achieve the objectives of the research.

3.6 Research Design

Descriptive and exploratory research designs have been used for the present study. Exploratory research is more helpful to the study of various work or roles carried out by FCHVs in community health. Similarly this is also useful in studying the changing health status of the study area. Descriptive research design is also employed to describe the activities of FCHV and their characteristics.

3.7 Technique of the Data Collection

Both qualitative and quantitative data have been collected by the following techniques:

3.7.1 Interview

Structured and constructed interview method is applied to the study as it allows greater flexibility in the form of interview. Open-ended, however some questions were close ended; interviews were conducted with the FCHVs, patients and other important informants who provided effective and reliable information.

Data on the characteristics of FCHVs, FCHVs' activities, FCHVs' challenges, patient's views, people's views on FCHV and changing health status of the people have been gathered through interviews.

3.7.2 Observation

Observation is probably one of the most effective techniques of data collection used over the decades in the field of both natural and social sciences.

Observation as a systematic and deliberate study through the eye of spontaneous occurrences at the time they occur (Young, 1960). Young argued that the purpose of observation is to perceive the nature and extent of significant interrelated elements within complex social phenomena, cultural pattern or human conduct. In this present study researcher used direct observation technique to find out activities of FCHVs and their influence in health status of the villagers, level of awareness, illness of the people(especially those who were suffering from TB), FCHVs' involvement in family planning programs, maternal health and child care, the condition of health post and sub-health posts, outreach clinics, etc.

3.7.3 Case Study

A case study involves in-depth study of a single example of whatever it is wished to investigate. The case study method is of organizing data in terms of chosen unit. This method was used in this study to obtain the data of specific life cycle of FCHVs and the patients of the study area in order to show their details.

3.7.4 Key Informant Interview

Key informant interviews were conducted during the field work in order to comprehend changing health status, performance of FCHVs, government's support and so on. Health post in-charge, assistants, clinic in-charge and other important persons from the village were interviewed for the reliable and in depth information on the objects.

Data Analysis and Presentation

Data analysis is the most critical constituent of any research work. Data do not speak themselves unless the researcher categories or classifies, manipulates and deposits them in certain orders so as to make them easily comprehensible.
Both descriptive and statistical methods of data analysis are used because of the qualitative nature of the study. Information on the physical setting, FCHVs activities, patients' condition, health trends and scenario, etc. are analyzed by classifying them in different categories. Similarly, data on demographic features, educational status, age structure, distribution of medicines, etc. are analyzed both statistically and descriptively. Analysis of data is also involved statistical distribution, construction of diagram and calculating simple measures like percentage.

3.9 Limitation of the Study

The researcher being a student without much practical knowledge, experience, skills and methodology or research, the finding are liable to be weak. This small scale study confines itself to the few VDCs - Hosrangdi, Sarangkhola, Huwas, Beulibas, Uram, Bhorle and Tribeni of Parbat district therefore finding of the study may not be generalized or the generalization based on the study needs more care if they are to be applied to other context.

This research has been carried out for the partial fulfillment of the requirement for the Degree of Master of Science and Technology in Zoology. Therefore, intensive research could not be possible because of the lack of resource with in short span of time.

3.10 Encounter and Experiences

In any social research the researcher should usually create rapport quickly in the field, without which fulfillment of objectives of the study will be difficult. It is only through the initiation and effort of the researcher that the native people- FCHVs, patients, health workers, etc. become familiar with the stranger (the researcher).

It was difficult to obtain information from the FCHVs, ill people, pregnant women and other on the first few days until a good rapport was established with them. At first, respondents were reluctant to give information suspecting the researcher of being associated with politics, development agent, health officer, etc. So that it was essential to prove with the concern people that the researcher was a free student from Tribhuwan University.

After sometime a good rapport was established with the informants of the research area and it helped the researcher to obtain information of various aspects of local people. The cooperation rendered by the health workers and officials, local leader and school teacher also helped the researcher to collect more information from the study area.

IV

RESULTS

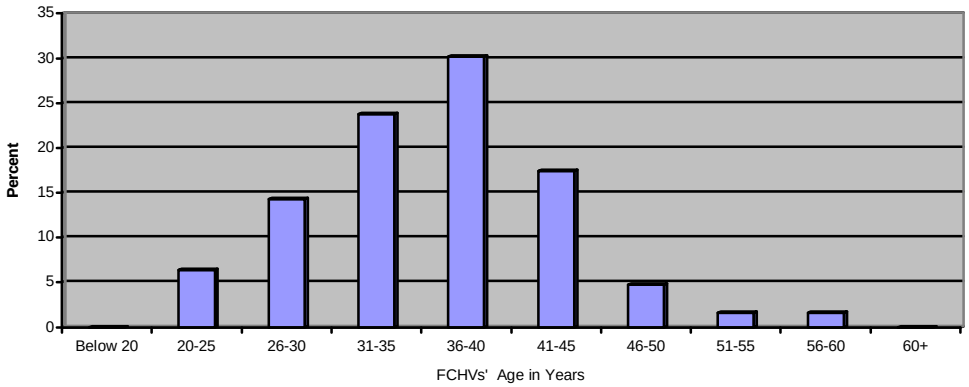
This chapter basically includes the major findings of the research. The findings of the study are closely associated with the specific objectives of the research. The results of the study is classified into four headings, viz. 1) FCHVs personal characteristics, 2) role of FCHVs on family planning, maternal care and child health, 3) infectious and communicable diseases: FCHVs knowledge and role for remedy and 4) FCHVs and changing health status.

4.1 FCHVs- Personal characteristics

4.1.1 Age of FCHVs

Among the total surveyed (63) FCHVs of seven VDCs, the maximum number which is 19, are under the aged between 36 to 40 and it is followed by the aged between 31 to 35, which is 15. Similarly, the percentage of FCHVs aged between 31 to 40 is more than half of the total which is 53.96%, it is followed by aged between 41 to 50, which constitutes 22.22%. The percentage of the FCHVs of age above 51 is very less which makes up only 3.18 % (Diagram 4.1).

Diagram 4.1: Age Structure of FCHVs



(Source: Field Survey 2010)

In conclusion it can be seen that involvement of FCHVs of aged between 21 and 45 is significantly higher than the aged between 46 and above in the study area.

4.1.2 Educational Status of FCHVs

Education or literacy has never been a job requirement for FCHVs but national policy encourages the selection of educated FCHVs. Anecdotally, illiterate FCHVs sometimes require more time to learn new tasks. On the other hand, illiterate FCHVs, particularly those from disadvantaged groups may have much better access to the poor and so it may be well worth the extra effort to train them (USAID and New ERA 2007).

Table 4.1 Educational Status of FCHVs

Level	No. of FCHVs	Percentage
Non-formal (Adult Literacy)	5	7.94
Primary	11	17.46
Lower Secondary	18	28.57
Secondary	28	44.44
Higher Secondary	1	1.59
Total	63	100

(Source: Field Survey 2010)

In the study area, about eight percent FCHVs have not attended school or have no formal education. However, they are literate through adult education classes. Only one (out of 63) or 1.59% FCHV has passed the higher secondary- intermediate in Arts; the highest percentage (44.44%) of FCHVs have attended secondary (grade nine and ten) level and a few of them have also passed SLC (Table 4.1).

Table 4.2: Educational Status of FCHVs by Caste/Ethnicity

Caste	Non-formal	Primary	Lower Secondary	Secondary	PCL
Brahmin/Chhetri	5	9	9	17	1
Ethnic Group	0	1	7	12	0
Dalit	0	1	2	0	0
Total	5	11	18	28	1

As expected, the younger FCHVs are much more likely to be literate than older FCHVs. But there is no gap or difference in the educational status of higher caste, ethnic groups and dalit (Table 4.2).

4.1.3 FCHVs: Distribution by Caste and Ethnic Groups

In the study area, 5 major caste and ethnic groups- Brahmin, Chhetri (including Thakuri and Bharati), Magar, Gurung, Dalit(Bishawkarma and Sunar) and Newar were found. There is no involvement especially from the disadvantaged group or dalit such as Damai and Sarki whose population was also observed remarkable in the study area. Population structure, desire, experience, skill, literacy and socio-cultural background may be the some vital factors that make unequal participation of the female of different caste and ethnic groups in community health. In the study area Newari people were found only in limited area of one VDC- Huwas. So its representation is only one. In some villages such as Sarang khola and Huwas more than 95% FCHVs were found from only Brahmin and Chhetri. The overall distribution is shown in the table 4.3.

Table 4.3: FCHVs by Caste and Ethnic Groups

Caste and Ethnic Groups	No. of FCHVs	Percentage
Brahmin/Chhetri	40	63.49
Magar	12	19.05
Gurung	7	11.11
Dalit	3	4.76
Newar	1	1.59
Total	63	100

(Source: Field Survey 2010)

4.1.4 FCHVs Support

During field work, FCHVs were asked what their main sources of health information were. Their replies were mostly common but not only a single. The most common sources of information mentioned were local public health facilities or health post or sub-health post (90%) and FCHV meetings and training (80%). They replied it jointly because meeting and training were held at their local health post. The FCHVs' supervision was mentioned less often, 35 percent and other health providers- other staff from the local health facility at about 40%.

The mass media, especially radio is considered as an important source of health information however, only 48% FCHVs were found affected by this. Television and newspaper are much less common sources of information (less than 5%) because the area has no access to electricity, TV network and market. Few number of FCHV of study area (8%) mentioned NGOs such as ENPRED- which have been active in working with FCHVs (Diagram 4.2).

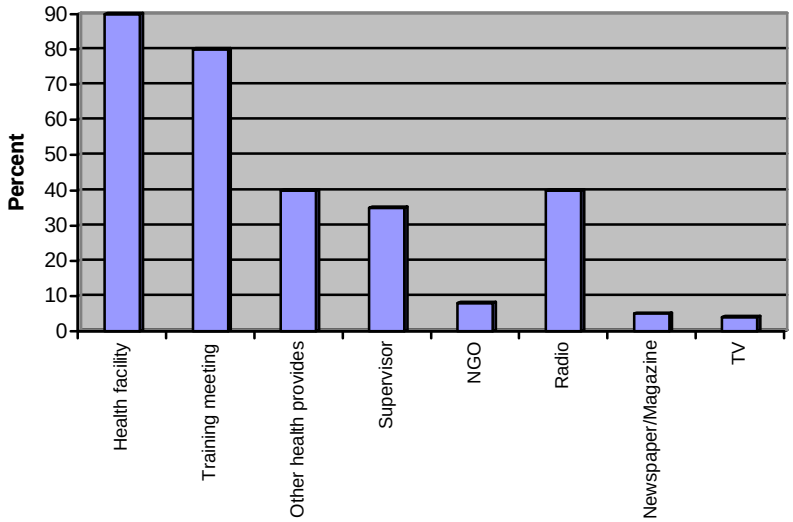


Diagram 4.2: Main sources of Health information for FCHVs

External supervisor, meeting at the health facility, reporting and training are the important measures for contact with people and receive support by FCHVs. In the study area, about 60% FCHVs reported the contact and discussion of their work with supervisor – district or national project staff. All FCHVs should attend meeting with health facilities at least every six months as part of the annual cycle of review meetings for FCHVs of which there are two to three per year. In the study area all the FCHVs replied that they have attended meeting and received an allowance for the training. Similarly about 85 per cent of FCHVs said they have made a monthly basis report of their activities and submitted to health facility.

4.1.5 FCHVs: Primary Occupation and Attitude towards Voluntary Work

Since the study area is an agro-economy village, most of the people were found to have involved in primary economic activities rather than secondary and tertiary economic activities. So, the primary occupation of females including FCHVs was farming, livestock, household work or forest-based economic activities. Only a few FCHVs (3 out of the total) have been involved in temporarily school teaching and (4 out of the total) in a petty self-business.

Those women who could allocate their busy time for community work or who could have a good family support and have interest to serve the community were obvious to join in community health volunteers. Since it is voluntary service or work without any benefit and a basic salary, they show the commitment for the help but not benefit, so that most of the volunteers attitude were found positive, that is they were satisfied with their community work., Only few of them , about 25% volunteers replied that the service as only pain but no gain. These volunteers neither have the good performance and skill nor do they have a strong determination and trust towards the voluntary services.

During field work, FCHVs were asked how long they work in a week. The work load is not constant throughout the month. They have to be more busy in the period of national level vaccination and immunization program and if there are more service seeking people and pregnant women and as well as in the reporting and training session. The average (mean) number of house per week is about 4.5. Besides their household busy schedule, more than 65% FCHVs were highly enthusiastic and willing to take on new tasks in the future.

4.2 Role of FCHVs in Family Planning, Maternal Care and Child Health

4.2.1 Role of FCHVs in Family Planning

In the study area, FCHVs contribution for supplying condoms was found more than they have supplied pills. It shows that male are conscious than the female. On the other hand women using dipopovera felt easier than having pills.

The supply of pills in 3 VDCs- Sarangkhola, Vhorle and Beulibas is nil and it varies in other VDCs too, so that supply of pills doesn't seem enough (Table- 4.4). Inadequate supply and lack of motivation to promote this method are the main factors preventing a larger role for FCHVs to distribute the pills in the study area.

Table 4.4: Distribution of pills and condoms by FCHVs through Health facilities (HP/SHP)

VDCs	Pills distribution(cycles)	Condom distribution/person
Hosrangdi	15	51
Sarangkhola	0	5
Bhorle	0	19
Huwas	47	242
Tribeni	48	131
Beulibas	0	20
Uram	5	98
Total	115	566

(Source: Field Survey Reports 2010)

4.2.2 Role of FCHVs Maternal Care

Counseling given during pregnancy, distributing Iron pregnant women, delivery and newborn care, and post-partum visits and supply of vitamin A, are the important roles and activities that is carried out by FCHVs.

Most FCHVs provide the advice related to antenatal care, tetanus immunization and iron tablets, eating nutritious foods and activities during pregnancy. FCHVs were found highly concerned about pregnant women of their catchment population. Their advice on the use of skilled birth attendants, saving money for an emergency and making transportation plans to the pregnant and her family members were also highly marked in the study area.

Table 4.5: Advice given during Pregnancy

Advice given by FCHVs about	Percentage
Eat nutritious food	90
Go far antenatal care	98
Take iron tablets	80
Get immunization	65
Advice on activities in pregnancy	60
Use a skilled birth attendant	50
Warning on danger signs	30

(Source: Field work 2010)

FCHVs of the research areas were asked whether they know the name of danger signs during pregnancy that require medical attention. Though FCHV training emphasizes five signs (mentioned in the table 4.6) the cent percent FCHVs could not tell all the signs. FCHVs reported that they were not clearly told about such sign. In the research area out of total, 95% FCHV has got knowledge on vaginal bleeding, 70% blurred vision or swelling of face, 65% on headache, 56% on fainting and 48% on abdominal pain (Table 4.6).

Table 4.6: FCHV knowledge of Danger sign in pregnancy

Sign	% of FCHVs
Vaginal bleeding	95
Blurred vision or Swelling of face	70
Severe headache	65
Fainting or Seizures	56
Severe lower abdominal pain	48

(Source: Field work 2010)

Next major contribution of FCHV regarding maternal care is distributing iron to pregnant women. The total distribution of iron in the past one year by FCHV in the study area is shown in Table 4.7.

Table 4.7: Distribution of Iron to pregnant women (in 2066 B. S.)

VDCs	Iron distribution to pregnant women
Hosrangdi	74
Sarangkhola	112
Bhorle	138
Huwas	327
Beulibas	38
Uram	47

(Source: Field work 2010)

The table shows not only the distribution of iron tablets but also the number of pregnant women in the past one year of study area.

FCHVs of the study area were also asked whether they present care for women at the time of delivery in their respective catchments population. Care for women at the time of delivery is not part of the FCHV job description but it turns out that FCHVs are often present of deliveries. Sixty five percent FCHVs of study area reported that they were present at a delivery in the recent year. Some FCHVs (about

25%) report that they also work as a Traditional Birth Attendant (TBA). These FCHV-TBAs presumably do assist at the birth.

During the field study the researcher also concerned to find out FCHVs knowledge on essential new born care such as cord care, drying, wrapping, bathing and breast feeding. Knowledge that a new or boiled blade should be used for the cord is nearly cent percent. For care of the cord stump, only 70 percent of FCHVs said that nothing should be put on the stump. Twenty percent recommended putting oil on the stump, eight percent an unspecified powder and two percent a variety of things like ash, turmeric powder, etc.

Newborn should be dried and wrapped immediately after delivery, although it is common practice to delay these actions until after the placenta is delivered. FCHVs were asked about the timing of both events. In both cases about 60 percent of FCHVs replied “Immediately” (53-57 percent) or “Before placenta is delivered” (4-5 percent). Nearly all the remainder replied “Within an hour”.

Ninety percent of FCHVs supported early breast feeding, either immediately after birth or within the first hour. Eight percent replied “After the newborn’s birth “. And the remaining FCHVs could not reply any clear ideas.

On bathing, 62 percent of FCHVs recommended delaying bathing for 24 hours after birth, which is the recommendation of essential newborn care program so as to prevent hypothermia. Twenty five percent mentioned that the newborn should be bathed within an hour and 13 percent within 2-24 hours after birth. It is interesting to note that the biggest discrepancies are found for early breastfeeding, which has long been a message in FCHV training and delayed bathing, which is a relatively new message.

Over time early breastfeeding practices in Nepal have improved (breastfeeding on the first day increased from 65 percent in 2001 to 85 percent in 2006) but they are still far from optimal (MoH, 2006).

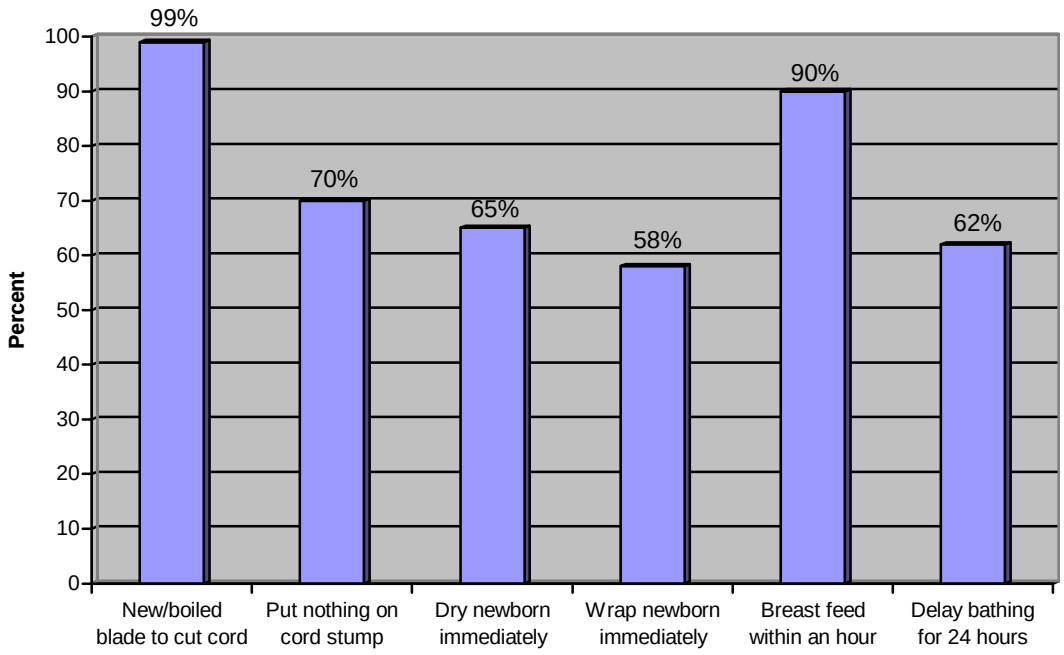


Diagram 4.3: FCHV Knowledge of essential newborn care

It is apparent that special training can change FCHV attitudes. They said that after taking special newborn care program they have become more confident with better knowledge for newborn care.

4.2.3 Post – Partum Visits and Vitamin A

Ninety percent of FCHVs report that they make post-partum visits to women, so this is clearly seen as a routine activity in the FCHV program. When asked how long after birth their most recent post-partum visit had been, 42 percent of FCHVs reported that it was within the first day and 55 percent mentioned within one to three day after birth. These replies support the idea that FCHVs may be a good way to reach women and newborn shortly after birth and provide interventions.

Eighty six percent of FCHVs of the study area reported that they provide vitamin A capsules to post partum women. It shows that almost women who gave birth in rural area received vitamin A from an FCHV.

4.2.4 Role of FCHVs Child Health

In the study area the researcher observed and asked the roles and activities carried out by the FCHVs regarding child health care such as pneumonia treatment, diarrhea care, de-worming, etc.

a) Pneumonia treatment

In order to carry out community pneumonia management, FCHVs are often divided into two groups, treatment FCHVs and referral FCHVs. Both receive the same two phases of training on diagnosis of pneumonia using a timer, recognition of danger signs, advice on home treatment in the absence of serious disease and filling out of referral forms if the child has severe disease. Treatment FCHVs also receive 'cotrim' with which to treat uncomplicated pneumonia.

All trained FCHVs record the number of children they see with acute respiratory illness (cough, with or without fever or rapid breathing). Treatment FCHVs treat children between the ages of 2 months and 5 years who have simple pneumonia (based on respiratory rate) and all FCHVs refer children with symptoms of severe disease.

Both treatment and referral FCHVs refer children who they cannot manage themselves. In the care of treatment FCHVs those children have complications in addition to simple pneumonia, while in the case of referral FCHVs children with simple pneumonia are mixed in, and may be referred either to health facilities or to a treatment FCHV.

b) Diarrhoea Care

During the field study, about seventy percent FCHV were found with ORS. Few out of the remaining (30%) reported that it was not needed because there was no demand, whereas other said that it was due to 'No Supply/Stock Out'. FCHV having

with ‘Blue Plastic Cup’ were found very less in number (only 11 out of 63) in the study area. FCHVs said that they had no any problems for the measurement.

Zinc therapy for children with diarrhea was introduced in Parbat district in 2006 and later rapidly throughout Nepal. Nearly all FCHVs interviewed in the study area had received training in zinc treatment and had their zinc therapy card. All of them knew the correct dose by age and 95 percent knew it should be taken for 10 days. Nearly all had a stock of zinc available (and because of the special program nearly all also had ORS). When asked what the purpose of zinc therapy was 92 percent spontaneously mentioned helping to cure an episode of diarrhea. Fifty-five percent noted that it helped prevent future episodes and 12 percent said it works like vitamin A to strengthen the child.

Since zinc is only meant for children less than five, and is more expensive than ORS, it is important that the common practice of giving ORS to older individuals does not also occur with zinc. So far the data from study area are reassuring in terms of FCHV knowledge and practice related to zinc therapy in diarrhea.

c) Vitamin A and De-worming Mass Distribution Program

Nearly all FCHVs (99 percent) reported that they participate in the twice-annual distribution of vitamin A capsules to children age 6 months to five years. The vitamin A capsules are distributed before each cycle, so vitamin A capsules that FCHVs carry on a daily basis are for the maternal care program rather than for children.

About 90 percent FCHVs provided vitamin A during maternal care. Vitamin A capsules are provided before each cycle to the children under five years.

Only 70 percent of FCHVs have the nutrition flip chart that is supposed to be used to help provide health education during the distribution session. Since FCHVs may use other materials for health education during distribution, this is not a critical loss.

In the study area, when asked if there is a routine immunization session that covers their ward, 99 percent of FCHVs said yes. These sessions include both those

carried out in outreach settings around the VDC and those at the health facility. In the study area, there are 3 to 4 outreach clinics in all VDCS under their respective HP/SHP. The Maternal Child Health Worker (MCHW) or Village Health Worker (VHW), who are also considered as the assistants of FCHVs, collect the children under 5 years in outreach clinics for routine immunizations and Polio immunization.

In the study area the role of FCHVs for both Routine Immunizations and Polio National Immunization Days was found really effective. They have actively been supported the programs for a great success.

4.3 Infectious and Communicable Diseases: FCHVs Knowledge and Role for Remedy

Infectious diseases (tuberculosis, sexually transmitted infections [STI], HIV/AIDS, Leprosy, malaria, Kala-azar, Japanese encephalitis) is one of the core topics that the FCHV program has aspired to promote preventive health practices at the local level, as per GoN priority health activities.

Tuberclusosis is commonly found than other diseases like Filriasis, Malaria, Kala-azar, etc. in the study area. Since the study area is extended from warm to cool temperate climatic region, the diseases basically acute in tropical region were not found in the study area. The cases regarding Leprosy, Malaria, Filriasis and so on recorded neither in health posts nor by other health worker including FCHVs. The researcher observed only two suspected cases regarding Leprosy but it was not confirmed i.e. whether it was normal allergy/itching or Leprosy. There might have HIV/AIDS affected people but it was very difficult to discover. The FCHVs of the study area were asked about HIV suspected patients but they reported no idea about it but they were found to be involved in providing information regarding HIV/AIDS in their catchment area.

The researcher put more concern about the Tuberculosis during the field study when she could not find any crystal cut information regarding other diseases. To find out the status of it she consulted with health officials, FCHVs and patients. The current status of the Tuberculosis is portrayed in table 4.8.

Table 4.8 Status of TB in the study area.

VDCs	Suspected patients	New sputum positive patients	Treatment completed patients among new sputum positive cases	Under Treatment (EP)
Hosrangdi	8	1	1	2
Sarangkhola	3	0	0	3
Bhorle	2	0	0	0
Huwas	5	0	0	4
Tribeni	38	4	1	8
Beulibas	10	2	0	6
Uram	12	4	0	1

(Source: Field work 2010)

The table shows number of patients of different stages. Among the seven VDCs, Tribeni has got the highest number of suspected patients which is 38. It is followed by Uram and Beulibas where the suspected patients are 12 and 10 respectively. In other VDCs the number are less such as 8 in Hosrangdi, 5 in Huwas and 3 in Sarangkhola and 2 in Bhorle.

The coughs of suspected patients are checked in Mardikhola pathology centre which is situated in Huwas VDC. According to the data in the given table all the suspected patients may not have positive sputum. The positive sputum patients are very less compared to suspected patients. It is nil in three VDCs, namely Sarangkhola, Bhorle, and Huwas. Among the positive sputum patients 4 are in each Tribeni and Uram, 2 in Beulibas and 1 is in Hosrangdi.

The table also shows treatment completed patients among new sputum positive cases of the study area in 2009 (2065/2067 B.S.). According to the available information treatment completed cases in Hosrangdi and Tribeni are one in each which is 1 out of 1 and 1 out of 4 respectively. Health officials have also provided treatment to extra pulmonary TB patients. As per the available information in health

post, number of EP (extra pulmonary) TB under treatment patients is highest in Tribeni VDC, which is 8. The number is 6, 4, 3, 2 and 1 in Beulibas, Huwas, Sarangkhola, Hosrangdi and Uram respectively. In Bhorle VDC it is nil.

4.3.1 FCHVs Knowledge and Role

The FCHVs of the study area are occasionally provided a short training about TB in which the time and duration of the training is not fixed. Sometimes workshops and orientation programs are also organized in health centers where the FCHVs receive and share some extra knowledge. The training is not enough even for general ideas. So, about cent-percent FCHVs could not reply the name of the bacteria (*Mycobacterium tuberculosis*) that cause TB, types of TB and a detail treatment process. But the FCHVs are taught about the symptoms of TB. About 90% FCHVs reported about the symptoms of TB.

Some of the senior and experienced FCHVs reported that in the beginning they used to have some fear while they had to deal with infectious patients like lepers and TB. The community also had some negative perceptions about them. Nowadays they take it as common and they do not feel as a curse imposed by divine powers – God, rather they are ready to provide whatever they can to such patients.

FCHVs role seem to be nominal regarding infectious disease like TB, Leprosy, etc. However, their popularity and significance is ever increasing in the community. In the case of TB, the FCHVs could only conduct inquiry about the regular coughing and recommend the suspected to meet health officials. In the study area, 65% FCHVs reported that they provide information and education on the infectious diseases affecting their locality and refer suspected infectious disease cases to health facilities for diagnosis and treatment whereas the remaining (35%) reported that they have just little idea about such diseases and have not involved in any preventive activities.

4.4 FCHVs and Changing Health Status through Community Perception

4.4.1 FCHVs as Health Promoters

FCHVs are perceived by communities as strong promoters of community health care services. Being permanent residents, FCHVs are informed about local health needs and are providing an invaluable service to their communities, especially in preventive health care services through outreach at the household and local group level. Rather than requiring community members to access health facilities, FCHVs visit households to asses the health situation of individuals. They are generally available around the clock to address emergencies, and provide referral when and where necessary.

Case study 1

Madhu Maya Thapa (Magar) is an original inhabitant and a Female Community Health Volunteer of ward no-4 Hosrangdi VDC. She is 35 years old. Her husband works in Gulf country- UAE. She has one son and one daughter; they study grade ten and grade seven respectively in community school. Her primary occupation and source of livelihood is farming along with cattle rearing.

She has served the community nearly for 14 years occupying the position of a FCHV

Since the early period of her life, she had the inner feeling to become a FCHV. In the early period, when she was selected by the community as a FCHV she had many difficulties to face to administer her work. In this context she says, 'My desire to become a FCHV was fulfilled but the society then was not conducive to work. Household chores had to be completed; child had to be reared by oneself, no support but maltreatment from the home. My family members tried their best to oblige me to quit the job saying that it neither earns money nor gives food, but the condition gradually favored me and still today I am continuing serving the people.'

At present she lives in nuclear family. She says, 'I am totally free, I can make all the decisions on family my own, and there is no any external interference. But there is still a major problem-financial condition which always set me back and due to which I can't forget my

domestic works and responsibility towards my children rather to serve community as a primary task.'

Ram Prasad Kafle, the senior Health Post Incharge says,' She is one of the active FCHV. She is continuously giving services like consultation on pregnancy, distribution of Vitamin A, giving polio drops and delivering health messages to the community. Community people are pleased with her service' xyz , the chairperson of the Mothers' Group Ward No 4 of that same village says ' Our Mothers' Group have recently been formed however, the FCHV has been visiting every houses giving Vitamin A, Anti-helminth drugs and Polio drops, thus no children are left behind to take such medicine.

She has not gained any material benefit from the government side, however, she has received full support and love from the community; she is self-satisfied for the reason people coming to her for consultation.

Farming and rearing animal never let her freely involve in community, however, she tries her best to serve her catchments population as a FCHV. In the beginning she lacked confidence, basic skilled and experience to work with community regarding various health related problems and issues. She used to get nervousness in interpersonal communication, counseling and in the process of the treatment moreover, she had a great hesitation/doubt about the people's perception and attitude towards her involvement in family planning, maternal care and infectious diseases like HIV/AIDS, TB, leprosy, etc.

But now, these problems are no more with her. She thinks that health problems will be minimized in the future. "Perhaps my life would have been imperfect if I have not served the community as being a FCHV," she further says," All the Female Community Health Volunteers should realize the saying 'Service is Religion' and devote towards serving the community."

4.4.2 FCHVs as Empowered Women

Many female respondents claimed that their FCHV was the only health worker available to them during times of need, an indirect criticism of health institution absenteeism and dominance by male staff. When questioned as to the reasons for interaction with, and household visits from, FCHVs, the majority of respondents reported reasons associated with family planning, maternal and child health, and mother's group activities. FCHVs report visiting anywhere from 10 and 40 households each month. Social grouping of households visited varies according to the dominant population of the community, and the level of commitment, or activeness, of the individual FCHV. An 'active' FCHV is described by most community members as one who makes regular household visits. While active FCHVs are admired by their communities for health promotion, inactive FCHVs have a detrimental impact on health seeking behavior. Active FCHVs are credited, for example, with making motherhood safer by encouraging prenatal care and ANC check-ups. All 15 out of 25mothers interviewed who sought ANC said they did so, on the advice of their FCHV. The reasons for the variation between mothers seeking only one ANC visit, and those seeking four, are numerous and range from a lack of information, to feelings of fear or shame. Moreover, the long distances between communities and health facilities, health worker absenteeism at health facilities, and lack of female health workers (as opposed to male) were also cited as factors for not seeking follow up with subsequent ANC visits.

Case study 2

I knew the reason for my child's death only after I became an FCHV. My name is Sita Maya Nepali. Now I am 52 years old. I live in Urampokhara, Ward number 5, of Parbat District. Now I have been working as a FCHV. Before that I was limited to my household as a normal house wife, like most other women of my community.

I have many experiences as an FCHV, some of them mesmerizing and some of them melancholic. Let me share one of them. I lost my husband when I was quite young, at the age of 23. The sole responsibility to look after my children fell on me. Misfortune did not come alone, and my agony deepened with my younger son died just four years after my husband. He died because of diarrhoea. There was not any health facility near us at that time, and medicine was not available. He asked for water many times while he was sick, but, according to tradition, I did not give him any. In the end I took him to the local Dhami, but it

was too late. My son passed away in front of the Dhami. Instead of sympathizing, my family blamed me as "alachhini" (wretched). I was alone in my suffering.

Like elsewhere, the FCHV program was launched in our VDC in 1989. My neighbors selected me as a FCHV. We were provided with basic training. The training not only taught me lessons but also unveiled the reason for my child's death.

He had died because of dehydration. Had I given him water, he would probably not have died. These days when I treat the children who suffer from diarrhea in my locality, I remember my child, still begging for water! I have been doing my best as per my knowledge to save the children of my village from the destiny that my child faced. I inform my 'sisters' in the community about health and sanitation, so that they will not suffer like I suffered, from the loss of a small child

Those mothers lacking awareness, confidence, or familiarity with the roles and responsibilities of FCHVs, and who subsequently do not seek their services, are not benefiting from the FCHV program. Sadly, these women are often the ones most in need of FCHV advice and services, often due to poverty or their status and disadvantaged. According to the findings of this research, FCHVs remain the second favored first point of contact by community members, responding to 36% of emergencies following health facilities directly (38%). This clearly demonstrates how invaluable as local level resources FCHVs have become, particularly during emergencies.

Case study 3

Gomata Devi Neupane, 45 years old is an inhabitant of Hosragdi VDC, Parbat district. She is a housewife. Her husband works as a security personnel in New Delhi, India. She has got four daughters. The senior daughter is already married and the others are studying in different levels.

After her second child, she has been suffering from uterus problem. She has also been suffering from ulcer and migrant. Now medicine has become a routine based integral part of her life. Uterus problem appeared actually after her second miscarriage.

She says, "I couldn't share my problems to any one because of so called patriarchy and socio-cultural norms and traditions. Till few years back no female could share their problems regarding maternity, menstruation, pregnancy, etc. in the family and society rather we were supposed to keep it secret which become a great owe to me; and I further claim that it is all because of patrilineal system. On the other hand there was neither health post nor FCHVS to share my pains in that time. So, I went New Delhi for my health checks up with

my husband but it was quite late. She further says I still visit hospitals and clinics in Katmandu and other cities; and I often share my problems to FCHV too."

Gomata believes that FCHVs have become a powerful and effective force to bring improvement in the health status of the ordinary people in the community. Nowadays girls and women share their feeling and problems with FCHVs without any hesitations. According to her, FCHVs are like a social leader because they organize health campaigns, sanitation and women empowerment activities in the local areas. They further take initiation in community development activities along with mother group and other institutions.

IV
DISCUSSION

By Policy, FCHVs are expected to be mature women who are married and have children of their own. This is to make sure that they are respected in the community and that they are less likely to move away (USAID and New ERA 2007:7). In the study area, majority of FCHVs were found between the ages of 30 to 40 years. There are no FCHVs below age of 20 and above aged 60.

Literacy or education is really an important component which is closely associated with any one's performance in their respective fields. During the field work FCHVs were asked about their literacy and level of formal education. In the survey no one replied as they were illiterate. There are five FCHVs, who are literate by non-formal or adult education and rest of the others have attended formal school which ranges from primary to higher secondary (Table 4.1/ 4.2).

By the field study, the researcher came to know that there is no any exterior or higher authorities' intervention for the recruitment of FCHVs; rather they are recruited locally as per participating approach. But some dissatisfaction of locals was seen; they argued that FCHVs are frequently recruited from local advantages families.

According to FCHV revised policy, 2003 basic training for new FCHV is 18 days, including two nine day session two months apart. The policy also instituted a five-year cycle of five day 'refresher' trainings to help maintain the skills of FCHV and replace key suppliers. In the study area; FCHVs were asked about training and the materials they have got. The FCHVs training and the materials mentioned more than 90 percent of the total FCHVs. The materials included a multi-topic flipchart for giving health education, a ward register for recording her basic activities and a FCHV signboard to be placed in her house as an advertisement of her status. But the newer FCHVs with minimum experiences(less than 2 years) who have not received basic training are much less likely to have these items. Almost FCHVs reported having received an allowance within the past six months, which is reassuring in terms of

showing that nearly all FCHVs receive training from the health system on a regular basis, that is, one to two day review meetings three time per year that are a routine part of the program, longer annual review meeting in the NFHP program, orientation training prior to polio distribution and a wide variety of trainings supported by other projects.

According to policy, FCHVs are expected to be selected by a mother's group that is made up of all mothers in the community and she is expected to be a member of the mother's group executive committee, which is to meet monthly to discuss health issues and support the FCHV in her work. So FCHVs were asked whether they meet with a mother's group. FCHVs were also asked whether mother's group executive committee, which is to meet monthly to discuss health issues and support the FCHV in her work. So FCHVs were asked whether they meet with a mother's group or not. About 88 percent of FCHVs report working with a mother's group. FCHVs were also asked whether mother's groups provide support for their work as a FCHV. Overall 55 percent of FCHVs reported that they received assistance from the group for their work.

Many FCHVs reported no idea about the other supports such as Radio health programs and financial supports like Cash Incentives, In-kind Incentives and FCHV Endowment Funds, which are quite common in some VDCs and districts (NSFCHV Report 2006:23).

Patriarchal and patrilineal forms of family which are the most common type in both ancient and modern civilization are also the prevalent type among the households or the people of the study area. The main reasons behind the prevalence of this type of family are the pattern of economic relations themselves, in which the male of the family plays the dominant role.

The NFHP has had a tremendous influence on the percentage of FCHVs having supplies of these method; with 82 percent of FCHVs in NFHP- supported districts having supplies of pills and 83 percent having supplies condom, compared to only 31 percent and 28 percent of FCHVs having pills and condoms, respectively, in non-NFHP supported districts (MoH, 2006). According to data from NDHS 2006

FCHVs provide about one-third of all pills that are distributed in the public sector in Nepal.

FCHVs roles for family planning may be really incredible in the village areas where the literacy is very low, people are untrained, and even more they feel shy and hesitation; and they have no easy access to health officials and contraceptives.

From the starting of FCHV program, FCHVs have been expected to promote family planning. Their role of distribution of pills and condom was found very common rather to injectables and sterilization method, which are considered popular method, in the study area.

The FCHVs were asked to whom they distribute condoms and how many. The study reports they distribute newly married women, and the women having child but not to their husband directly. The locals do not feel easy and comfortable to ask such contraceptives. The amounts they supply depend on availability and the demand. So the supply and use of the contraceptives is not uniform in all parts/ VDCs of the study area. In addition to distribution of pills and condom, FCHVs referred women for contraceptive injectable and voluntary sterilization. Injectables and sterilization have been found more effective means of family planning in the study area, however, FCHV could only refer it, they could not operate these services their own. FCHVs were also asked whether they could have an idea about the impact and side effect of the various contraceptive supplied in study area. Many of FCHVs (about 60%) reported no knowledge and idea, and about 40% reported having some ideas but no crystal cut. The researchers have found miscellaneous opinion from the users-the women. Few users found to be dissatisfied with injectables, and few replied that they were happy and entertained with that, though it was not immediate need, because they gained the weight.

During the field study, majority of the FCHVs reported that, very few pregnant portray openly their condition and problems to FCHVs but many tried to hide the problems. Few of them do not even reveal that they are being pregnant. But the FCHVs and mothers group have tried their best efforts to find out pregnant ladies and give appropriate advice.

Intensification of Maternal and Neonatal Micronutrient Program (IMNMP) of Ministry of health and population has included additional training for FCHVs for systematic distribution of iron to pregnant women. FCHVs of research area were asked whether they had iron tablets at the time of survey and how many pregnant women they had provided iron in the past one year. FCHVs of study area responded positively i.e. they have kept iron tablet as they required and supply systematically to pregnant women.

The FCHVs of the study areas have claimed that they have left none of the pregnant of their catchments population. The most influential factor for unequal distribution, as the table (4.7) portrays, is the uneven population distribution. Perhaps being able to offer iron/foliate tablets provides an incentive for FCHVs to be more active in contacting pregnant women which in turn motivates the women to go for antenatal care.

The Ministry of Health & Population supports the CB-IMCI- Community-Based Integrated Management of Childhood Illness program as a method to improve the management of children with common illnesses. At the community level this involves training FCHVs, as well as Village Health Workers and Maternal Child Health Workers, who provide out reach from health facilities, in the diagnosis and management of simple pneumonia and in the identification and referral of children with more severe disease. Diarrhea is also part of CB-IMCI, but is already party of the national FCHV program and is reviewed separately. More complete IMCI training is provided to higher level workers at health facilities. This program has expanded steadily from the first districts in 1996(when it was called the CBAC- Community Based Acute Respiratory Infection (ARI) and Diarrhea controls program) to almost half the districts in Nepal in 2006.

FCHVs learn to provide ORS to children with diarrhea are part of their basic training and are expected to carry free ORS packets in their kits. Theses are to be re-stocked from the local health facility, which also provide free ORS. IN the mid-1990s due to concern that parents could not accurately measure one liter of water, an inexpensive standard “Blue Plastic Cup” for measuring water to make ORS was

introduced. It was provided to FCHVs in a number of districts, but was not widely distributed to families (USAID and New ERA, 2006).

There are seven commodities associated with community pneumonia treatment. The most essential are pediatric 'cotrim' to treat pneumonia and a special timer that allows the FCHV to count the child's respirations without having to look at a watch at the same time. A treatment book is used to record children treated for pneumonia & a referral book for children with serious illness who are referred. Finally there are three job aid cards; one for classification of children, one for home treatment of minor illnesses and one with the 'cotrim' dose schedule. All materials combine pictures and text so they can be used by illiterate FCHVs.

FCHVs' National policy/strategies have not clearly stated about the roles and activities of FCHVs towards the infectious and fatal diseases like T.B., HIV/AIDS, Leprosy, Filariasis, etc. compared to family planning, maternity and child health, however the researcher equally concerned with the perception, knowledge and role of FCHVs regarding such diseases in the study area. During the field study FCHVs were asked their knowledge and understanding on some infections diseases like Tuberculosis, HIV/AIDS, and Leprosy and so on. But emphasize was given to TB, since the other diseases were not commonly found

The FCHVs of the study are reported that as health volunteers, they worked as bridge between the community (patients) and health officials. FCHVs explore the reality of the patients and their feeling so they convey right message about the patients to health officials. FCHV have no access to medical facilities, that is, medicines, that to be distributed to the TB patients in their catchment area. But they aware the people, suggest the suspects to consult with health officials and inquiry about the symptoms such as regular cough, fever etc.

During the field study the researcher asked TB patients, and health officials about FCHVs roles and contribution to TB patients. Majority of the female patients reported that nowadays they have become much aware and they regularly get consult with their closest supporter with the FCHVs whereas only for male patients share their problems indirectly to FCHV. They go directly either to local health officials or

hospitals, while it becomes more serious. They do not want to disclose all realities in their community and with the FCHVs. The patients reported that FCHVs neither check up nor provide medicines however their counseling and information regarding health services and facilities in the community level are really remarkable. So the patients nowadays are well informed about the distribution of medicines, health camps and other important health events.

The health officials of the study area reported that the FCHVs have simplified their tasks. FCHVs are the bridge between the community and health officials who help to circulate information regarding health facilities outreach clinic and other occasional camps run by Government, NGOs/INGOs and other private sectors. FCHVs role seem to be nominal regarding infectious disease like TB, Leprosy etc. however their popularity and significance is ever increasing in the community for primary health care and safe motherhood.

Ram Prasad Kafle a senior AHW of Hosrangdi Health Post which is established also as a TB cure centre of six sub-health posts – Sarangkhola, Bhorle, Huwas, Beulibas, Tribeni and Taklak – said that the centre has been providing training and leadership program to the FCHVs on primary health care and infectious disease like TB. He believes the program is fruitful but not enough for effective diagnosis and prevention of such diseases. The FCHV could only conduct inquiry about the regular coughing and recommend the suspected to meet health officials said by another AHW of Urampokhara – Jiblal Tiwari.

The effectiveness of FCHVs in this area is not only affected by the programs run by health post and other but their family background , level of literacy and education, past experiences and encouragements are also important factors. So that all FCHVs of the study area were not observed or found playing equal role at awareness and prevention of infectious disease like TB in the research area.

Since the inception of the program, FCHVs have served as frontline local health resource persons who provide community –based health education and services in rural areas with special focus on maternal and child health and family planning issues. FCHVs' role in contributing to a variety of key public health programs,

including family planning, maternal care, child health, vitamin A supplementation/ de-worming and immunization coverage have been conceived really remarkable to improve the health status of rural people like in the study area.

FCHVs are the foundation of Nepal's community-based primary health care system and are the key referral link between the health services and communities. Additionally FCHVs have made significant contributions to women's leadership and empowerment at the Village Development Committee (VDC) level, and several active FCHVs are as VDC members. Majority of health problems in Nepal, particularly in the rural communities, are related to the health of women and children coupled with a lack of human resources.

The role of the FCHVs has been outlined as below;

- To act as voluntary health educators and promoters, community mobilizers, referral agents and community-based service providers in areas of health as per the trainings received.
- To promote the utilization of available health services and the adoption of preventive health practices among community members.
- To play a supportive role in linking the community with available PHC services and to continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level.

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FCHVs play a supportive role in linking the community with available PHC services and will continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level. In all 75 districts in Nepal, it is recognized that FCHVs act voluntarily as health educators and promoters, community mobilizers, referral agents and community-based service providers in each of the health areas for which have been trained

It also reflects the fact that FCHVs are available around the clock to community members. Fathers of children under five replied that they had faith in their FCHVs and contacted them during emergencies because of their availability, and knowledge. Mothers with children under five additionally regarded FCHVs as supporters, morally and practically. They replied that FCHVs provide both medicine and advice free of

cost, referring cases beyond their ability to nearby health facilities. Mothers who tended to be shy were much more comfortable contacting an FCHV during an emergency, as she is generally a 'known' personality and easily obtainable, removing some of the fear of the unknown from emergency situations already accompanied by high stress.

Despite the fact that most people interviewed of the study area expressed strong faith in the abilities of their FCHVs, many still contact traditional healers, health facilities, and private medical sector pharmacies when they have serious health problems. Reasons included 'habit', a strong tradition of using Dhami Jhakri among women, and the fact that FCHVs don't carry medicines and are not trained to prescribe or diagnose complicated conditions. Many cited their first concern during an emergency is availability of medicine, and with knowledge that FCHVs only provide basic medicines, they seek services elsewhere. Some respondents said that, as FCHVs refer emergencies to health facilities anyway, they would rather go there directly. Others (mainly fathers) questioned the quality of services provided by FCHV, a good question when considering how many FCHVs remain untrained, unequipped, and generally uninformed about their duties. In cases of FCHV past neglect, community members overwhelmingly take cases directly to health facilities. All of these responses demonstrate the need to further build the capacity and skills of FCHVs, to improve both their perceptions within the communities, and their ability to provide quality health promotion services.

In addition to recognition as champions of health promotion at the grassroots level, many FCHVs are perceived as social leaders in their communities. Health promotion activities and facilitation of mother's groups provide FCHVs with the skills and confidence to mobilize communities, and to lead. Simultaneously, because of their exposure, many women and mothers rely on FCHVs for advice on topics ranging far from health. Their tasks as social leaders include:

- Teaching informing, and problem solving with communities on topics related to health
- Initiating discussions on social issues such as alcoholism, gambling, and social inclusion

- Running mother's groups including monitoring performance
- Promoting women's empowerment by bringing them from the private to the public domain
- Accountability towards community members and in particular mother's group members
- Leading campaigns for health seeking behavior change
- Supervising local development and micro health project construction
- Running saving and credit programs, ensuring proper investment
- Celebrating health 'days' (HIV/AIDS, Condom, etc.) to generate social awareness

As the FCHV program has matured, so have its' volunteers. Through respect earned by community members, and relationships fostered with local NGOs and development organizations, FCHVs are quickly outgrowing their stereotypical roles as mothers and daughters, restricted to the home (and willing to work for free). Many FCHVs were found to be involved in local organizations and NGOs, settlement of petty cases of their localities, and working to reduce social deformities like alcoholism.

FCHVs support is also recognized in development projects and construction. Working together with mother's group members, there are many examples where water resources have been cleaned, roads and irrigation canals constructed, bridges built, drinking water sources developed, and toilets provided to households. FCHVs social performance has no limitation. They link their duties in health with overall social awareness and development. In few VDCs of the study area FCHVs conducted a cleaning campaign and collected money to support a disadvantaged woman during pregnancy on the occasion of their reformation. This study found that most FCHVs, despite complaints about the lack of support they receive within the program, are highly encouraged to be social leaders within their communities. In some cases, however, the lack of proper knowledge and guidance by their supervisors is hindering their capacity to facilitate change.

VI

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

Through their voluntary services, Female Community Health Volunteers (FCHVs) contribute extensively to the health and well being of their communities, in particular to the women and children in rural areas of Nepal. FCHVs are present in all wards of study area. Their median age is 36 years and 100% of them literate; 55% of FCHVs have been working for more than 10 years. On average, the FCHVs were found to work for 5.1 work hours per week and 76% of them willing to increase the amount of time they spend working as FCHV in the future.

In summary the major functions carried out by FCHVs in the study area encompass the following:

- Providing information on family planning and distributing contraceptives
- Encouraging vasectomies among those who desire no more children
- Counseling pregnant mothers on nutrition and iron supplementation
- Encouraging mothers to seek ANC and PNC visits at local health facilities
- Conveying information on immunizations
- Assisting national campaigns (vitamin A, polio)
- Educating communities about nutrition, hygiene and sanitation, and communicable diseases including diarrhea
- Encouraging communities to keep their water sources clean
- Counseling mothers who suffer from uterine prolapsed
- Facilitating mother's group meeting as a secretary, including providing health education, and running saving and credit programs.
- Keep concern on infectious and communicable diseases and their preventive measures.

- Provide information and education on the infectious diseases affecting their locality and refer suspected infectious disease cases to health facilities for diagnosis and treatment.

It can be concluded that, although not lacking in shortcomings, the FCHV program continues to provide notable support in community primary health care. The health sector has grown dependent on FCHVs over the last two decades. Most FCHVs show unwavering dedication to their duties, despite long years without pay or proper recognition.

Health related institutions and projects in community level, social organizations and local people have acknowledged the efforts undertaken by FCHVs in health care promotion, and will continue to provide support. This study hopes that empowerment and encouragement of FCHVs will continue to bring sustainable change in their performance and consequently produce huge improvements in the health status of the people particularly of women and children in remote communities.

6.2 Recommendation

FCHVs are able to support a variety of public health programs. They are the main provider for vitamin A and de-worming for children. They are an important contributor to family planning, maternal care, immunizations, care for sick children and other programs. Although FCHV program function well in Nepal, it must be noted that the output level of FCHV activity depends on the degree of support of the community and the functioning of the health system (WHO, 2008). FCHVs will be able to achieve their goals only when other health workers sanctioned to the peripheral level facilities perform their assigned tasks.

The following areas have been identified as major issues which need to be improved to have a fully functioning FCHV programmes. The program has to be well designed to help achieve high coverage especially to include the poor and disadvantaged groups.

- There is a substantial backlog of new FCHVs who have not received basic training. So there is a vital need to ensure that all FCHVs receive appropriate

and necessary trainings. Trainings and guidelines should be based on local needs and disease situations, and should be regularly updated to include new and innovative topics like BPP, to further enhance FCHV outreach activities.

- FCHV performance is closely related to the availability of supplies and the support and motivation provided to them. Absence of these would result in low level of performance. First aid and reference materials should be supplied regularly. Adult literacy components should also be explored for illiterate FCHVs.
- According to the latest Nepal Demography Health Survey, inadequate medicinal supplies prevented FCHVs from treating one fifth of the children who came for diarrhoea treatment. So, regular supply of medicines upto every FCHV must be ensured.
- Evidence indicates that FCHVs need additional training on issues relating pregnancies, delivery and child health care to promote community-based maternal and newborn care; and similarly infectious and communicable diseases like TB, leprosy, HIV/AIDS, etc.
- The main source of health information for FCHVs is from their training and their local health facility. Other medium of providing information should be explored to keep them regularly updated.
- It was clear on all levels that, with increasing expectations of FCHVs, changing gender relations and women's empowerment in Nepal, the issue of incentives is increasingly becoming important to FCHVs. 25% of FCHVs report having an endowment fund in their VDC, but only 20% has been used yet to support their activities.
- FCHVs expressed that having a uniform was an important factor enhancing their motivation and increasing their respect within their communities. Provision of items like uniforms, umbrellas, bags, slippers, flashlights and radios currently varies by geographical areas. The researcher suggest that uniforms should be mass distributed to all FCHVs, and other incentives should be performance based, may be on the number of cases referred to the health facility, or the number of family planning distributed. Additionally, in lieu of the controversy of voluntary female labor, the FCHV program should explore further beneficiary packages outside of salary; for example free health care,

health insurance, training to become an ANM, and cash awards for services done.

- The finding reveals that the participation of the female from scheduled caste in FCHV program is poor in proportion with their population in study area. On the other hand, FCHVs of higher caste do not quite enjoy serving the lower caste groups. So, the concerned authorities and civil society should discourage social inequality and discrimination, and empower the female of scheduled caste to participate in FCHV program.
- Considering that the selection criteria was rarely adhered to in the study area, and most stakeholders were unaware of what the criteria specified, it is clear that the criteria for FCHVs should be made much more specific, clear, and transparent. Updating the criteria, and promoting it widely, is an urgent need, for realization of the principles of the criteria in the characteristics of the FCHVs will take many years. As the FCHV program is the only grassroots level program directly concerned with improving maternal and child health, it must be strongly linked to the policy in order to meet program objectives.

VII

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Annex 1- Photographs

An FCHV counseling pregnant woman

An FCHV receiving necessary health supplies/ commodities from health official at Health Post

An FCHV talking with TB patients

An FCHV involving in Polio Immunization, Vitamin A and De- worming program

FCHVs, health officials and the researcher at Hosrangdi Health Post

The researcher taking interview with Senior Health Incharge and Health Assistant in Hoshrangdi Health Post

Annex 2

Questionnaire

The example of format for structured interviews is made below to ask with the volunteers, patients and other key informants of Hoshrangdi-VDC, Parbat district.

1. Head of the Household Name:
   Age: Sex: M/F

2. Number of Family members

3. Family type
   a) Joint Family
   b) Nuclear Family

S. No.	Name	Age	Related to Head	Education	Occupation	Remark
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

A. **Questionnaire to Volunteers**

1. How long you have been involved in this FCHV Program?
2. How did you join in FCHV?
3. Did your family members create any obstacle during the initiation or participating in FCHV? [Yes/No]
4. What are various activities of FCHV?
5. Are there any organizations or agencies to support the activities run by FCHV?
6. Are the supports or helps enough to run the program?
7. What are the various trainings and knowledge you have got since your involvement in FCHV?
8. Which diseases are given more emphasized by your activities?
9. What is yours (FCHVs) contributions towards the awareness and eradication of infectious and communicable diseases among common people?
10. Have you got any trainings or orientation regarding infectious and communicable diseases like TB, leprosy, HIV /AIDS, etc.?
11. Do you aware the people above HIV /AIDS?
12. How do you aware the women towards STDs (Sexually transmitted diseases) and diseases related with vaginal discharges?
13. Are their any people affected by infectious and communicable diseases? If yes, how do you treat them?
14. Do you provide any treatments and medicine to the patient?
15. Where do you refer the patients for the further check up or diagnosis of diseases?
16. In what ways, you promote the family planning activities?
17. Do you visit and provide care to the women at the time of delivery?
18. What is your ideas/knowledge about new born care such as cord care, drying wrapping, bathing and breast feeding?
19. Do you visit the women for post partum care?
20. In what sense, the FCHVs activities are advantageous for common people?
21. What are the main sources of health information to FCHV?
22. Do you regularly run the activities and follow the patient?

23. What is the various community supports to FCHVs?
24. What is the perception or attitude of the participants about FCHV?

(Activities related with pregnant women and children)

25. How do you support pregnant women?(Before and after birth of child)
    b) Advisory support ----------
    c) Medicinal support ----------
    d) Vaccines and Immunization ----------

26. Do you know about CB- IMCI (Community – Based Integrated Management of Childhood Illness)? ----(Yes/No)
27. What are the different activities towards child care in CB-IMCI?
28. Do you cooperate in Vitamin A and De-worming Mass Distribution Programs?
29. Is there a routine immunization session that covers your ward?(Yes or No)
30. What are your contributions towards routine immunizations and Polio National Immunization days?

B Questionnaire to Beneficiaries (Patients)

(About community health and hygiene)

1. Do you know about community health and hygiene? (Yes or No)
2. Do you think that community health and hygiene is necessary in village community?(Yes or No)
3. Do you maintain health and hygiene?(Yes or No)
4. Is cleanliness necessary for health?
5. What are mostly occurring common infectious diseases in your community?

(About FCHV)

6. To which disease are you suffering from?
7. How long are you suffered?
8. What are the symptoms of the disease?

9. Have you checked up?
10. Where did you get check up? (Baidya/Doctor/Health Post/Others)
11. Do you know about infectious diseases? (Yes/No)
12. Do you know about STDs (HIV/AIDS)?
13. Do you know about FCHVs?(Yes/No)
14. How do they treat or co operate you?
15. Are you satisfied with the help providing by FCHVs?
16. What are the supports or helps providing by FCHVs to the patient?
17. Have you got any medicines or advice from FCHVs?
18. Do you find any improvement in your health by using the medicines?
19. Do you regularly visit FCHV?(Yes/No)