



Impact Evaluation of Approaches to Strengthen Health Facility Operation and Management Committees in Nepal:

SUMMARY OF THE BASELINE REPORT

June 2015



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Cover photograph, by Jessica Fehringer, MEASURE Evaluation, shows a village in Syangia district of Nepal that was included in this survey.

Impact Evaluation of Approaches to Strengthen Health Facility Operation and Management Committees in Nepal:

Summary of the Baseline Report

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Introduction

The Gender, Policy, and Measurement (GPM) Program is implemented by the Health Policy Project (HPP) and MEASURE Evaluation with support from the U.S. Agency for International Development (USAID). GPM has partnered with Suaahara, a community-focused program in Nepal dedicated to improving the health of pregnant and lactating women and children less than two years of age. Suaahara works closely with the government of Nepal (GON) to strengthen policies and programs that aim to improve health and nutritional status and with health facilities to improve health counseling and care services and connect families to reproductive health; maternal, newborn, and child health (MNCH); and family planning (FP) services.

Together, Suaahara and GPM are integrating gender and social inclusion (GESI) and community participation components into existing GON guidelines, processes, and training for Health Facility Operation and Management Committees (HFOMCs). This effort, the Strengthening HFOMCs through a Community Engagement Approach project (herein called Strengthening HFOMCs), is a capacity-strengthening intervention for HFOMCs to ensure that issues related to GESI are addressed as part of the delivery of quality government health services in MNCH as well as FP services in Nepal. The Strengthening HFOMCs project includes two capacity-strengthening approaches:

- GESI HFOMC training (Approach A); and
- GESI HFOMC training plus community engagement (Approach B).

In 2014, MEASURE Evaluation developed a mixed-methods research design and led baseline data collection for an impact evaluation of the Strengthening HFOMCs project in Nepal. The aim of the impact evaluation is to understand the added value of including GESI and community engagement intervention components on household- and community-level health outcomes, as well as on the utilization of healthcare services by women and children under two years old in Nepal. Using quantitative baseline and endline data from household, individual, and community surveys, as well as a variety of qualitative methods, the evaluation at endline will compare the effectiveness of Approach A (GESI HFOMC training) with the effectiveness of Approach B (GESI HFOMC training plus community engagement), which are being implemented in Syangja and Baglung, respectively. A third study arm (in Parbat) will serve as the control, in which no intervention activities will be implemented.

Nepali data collection partners, the Institute for Social and Environmental Research–Nepal (ISER-N) and Research Inputs and Development Action (RIDA), carried out baseline quantitative and qualitative data collection, respectively, from July 2014 to October 2014. This brief summarizes key findings from that baseline research and describes the overall design of the evaluation. Endline data collection and subsequent analyses, using both baseline and endline data to determine the impact of the intervention approaches, will be carried out in mid-2016.

Background

Nepal's geographic, religious, and ethnic/caste diversity, along with the limited role of women and girls as decision makers, poses significant barriers to achieving equitable health outcomes. To address these disparities, the GON has prioritized incorporating GESI into the country's health policies, programs, and plans. Recent GON GESI strategy seeks to make HFOMCs inclusive and equitable, to make local bodies responsible for participatory planning based on the needs and demands of target groups, and to create trust between healthcare providers and communities.

Despite significant progress made toward this goal, a number of challenges remain. For example, although HFOMC guidelines mandate otherwise, some HFOMCs are not truly inclusive, are comprised of primarily men and community leaders, or do not fully empower disadvantaged members to voice their opinions. The Suaahara project aims to address these critical gaps in the scale-up of HFOMCs.

Suaahara is a five-year, USAID-funded project that uses a community-focused approach dedicated to improving the health and nutritional status of pregnant and lactating women and children less than two years of age in 41 Nepal districts. To increase women's and disadvantaged groups' (DAGs') use of health services, Suaahara works through the Strengthening HFOMCs project to increase the capacity of HFOMCs to address GESI for quality health services and to use HFOMCs to reach the poor. The project's objectives are to:

- make HFOMCs inclusive and ensure that women and representatives from disadvantaged groups are empowered to meaningfully participate in committee meetings and the decision-making processes;
- strengthen the capacity of HFOMCs to lead inclusive and collaborative quality improvement processes for community health services and programs; and
- create momentum for women and DAGs to voice their health concerns and preferences to address local health issues.

In Strengthening HFOMCs, Suaahara integrates GESI and community participation components into the existing GON guidelines, processes, and training for HFOMCs.

Impact Evaluation Design

At endline, the evaluation will examine the intended and unintended MNCH/FP and health service impacts of integrating GESI into capacity building with HFOMCs in Baglung and Syangja. Syangja will receive the Approach A intervention, Baglung will receive the Approach B intervention, and Parbat will serve as the control district.

The primary questions that the evaluation will seek to answer at endline are the following:

1. What is the impact of integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs, versus the impact of standard capacity-

strengthening activities with HFOMCs on:

- use of maternal and child nutrition and health services by DAGs; and
- health service quality for DAGs?

2. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact than standard capacity-strengthening activities on:

- use of maternal and child nutrition and health services for DAGs; and
- health service quality for DAGs?

The mixed-method evaluation design employs three components:

1. A quasi-experimental design using the “difference-in-difference” (DID) technique with longitudinal (at the community level) baseline and endline household (HH) and women’s surveys. We will also conduct community surveys in all sampled wards with groups of community leaders.
2. Baseline and endline qualitative research component:
 - a. At both time points:
 - i. Patient exit interviews with MNCH/FP clients
 - ii. Waiting room observations at health facilities
 - iii. Observations and/or review of meeting minutes of HFOMC meetings
 - iv. In-depth interviews (IDIs) with female and DAG HFOMC members
 - v. Key informant interviews (KIIs) with health facility staff and with district-level stakeholders
 - vi. Focus group discussions (FGDs) with mothers and fathers of children under two years of age
 - b. At endline only:
 - i. KIIs with community leaders and program staff and FGDs with HFOMC members.
3. Use of intervention and health facility monitoring data, including intervention data on implementation costs

Methods and Baseline Sample Sizes

Quantitative

We calculated baseline quantitative survey sample sizes using the percent of women reporting health facility (HF) delivery for their most recent live birth, as per the 2011 Nepal Demographic Health Survey (DHS), an expected minimum change after the interventions, and the desired power to detect this change. We selected the sample using a stratified, three-stage cluster design.

ISER-N conducted the community, household, and women’s surveys. Research staff completed HH interviews with 3,775 households and women’s interviews with 3,845 mothers having a child younger than 2 years of age. They also conducted the community survey in all 325 selected wards with small groups of 2,196 community leaders. The community survey included modules on basic community characteristics, health service availability, and recent positive and negative

economic shocks. Key HH survey modules included demographics and household composition. The women’s survey modules covered child health; infant and child feeding practices; pregnancy, facility births, and post-natal care; family planning; and HFOMC and other health activity exposure and opinions, among other topics.

ISER-N cleaned the quantitative data and conducted analysis of the baseline data using a statistical analysis program. ISER-N researchers created appropriate variables and generated results on means and proportions separately for intervention and comparison areas and by social status. For key variables, ISER-N conducted either Pearson chi-square test or Analysis of Variance (ANOVA) statistical test to detect any statistically significant differences between intervention and control groups. No multivariate analyses were conducted.

Qualitative

We purposively selected four village district committees (VDCs) per district (total of 12 VDCs) from the list of VDCs selected in the quantitative component and one health facility per VDC in which to conduct the qualitative research. VDCs and health facilities were selected to cover a mix of health facility types, locations, and DAG mapping results.

RIDA carried out the baseline qualitative data analysis. RIDA staff reviewed transcripts, notes, and other data collection materials and identified emerging themes by tool and by section, as applicable. RIDA then conducted a thematic analysis.

Table 1. Qualitative Methods, Sample Sizes, and Key Topics

Qualitative Method	Number of Respondents or Observations	Domains Covered
HFOMC meeting observations/minutes review	10	<ul style="list-style-type: none"> Information on HFOMC functioning, capacity, and GESI integration
In-depth interviews with HFOMC members	21	<ul style="list-style-type: none"> Experience as an HFOMC member Understanding of the role of HFOMCs and how they relate to communities and health facilities Comfort participating in HFOMC meetings/activities Engagement with district level staff
Health facility observations	12	<ul style="list-style-type: none"> Service quality by noting patient wait time (particularly if varies by caste/ethnic group/etc.), noise level (and related privacy of provider-client discussions), staff interactions with clients, and availability of free essential medicines and basic essential equipment
Key informant interviews (KIIs) with health facility (HF) staff	12	<ul style="list-style-type: none"> Experience interacting with and/or serving as a HFOMC member Understanding of the role and accountability of HFOMCs and how they relate to communities and health facilities Understanding GESI integration into health services Experiences interacting with communities regarding health service concerns and related themes

(Table continues next page)

Qualitative Method	Number of Respondents or Observations	Domains Covered
KIIs with district level stakeholders	6	<ul style="list-style-type: none"> • Interactions/engagement with and attitudes towards HFOMCs • Knowledge and understanding of the HFOMC’s role and functions • Perceptions on inclusion of community priorities in health services and impacts on health care utilization • Perceived quality and responsiveness of health care at the selected health centers
Exit interviews with MNCH clients	133	<ul style="list-style-type: none"> • Topics covered in the client visit • Privacy • Provider attitude • Satisfaction with care • Length of wait and consult
Community focus group discussions (FGDs) with 105 mothers and 80 fathers of children under age 2	12	<ul style="list-style-type: none"> • Community’s knowledge and understanding of the HFOMC’s role and functions • Attitudes towards health planning and HFOMCs • Exposure to the work of community based organizations on improving community participation in planning and decision-making for health services • Perceptions on inclusion of community priorities in health services and impacts on health care utilization • Perceived quality and responsiveness of health care at the selected health centers

Summary of Key Results

HFOMC Exposure and Opinions

A small proportion of mothers – 5% to 11% by district – reported that they had heard of HFOMCs, with more non-DAG mothers than DAG mothers reporting this. Among the 309 mothers who had heard of HFOMCs, few had knowledge of the HFOMC roles and responsibilities, names of members, or how one takes concerns to HFOMCs. Only one in five of these 309 reported that they had ever attended an HFOMC meeting and, similarly, one in five reported that they had taken a concern to a meeting. Examples of concerns brought to meetings included health facility staff management, and managing availability of medicines and equipment.

Mothers familiar with HFOMCs had low confidence in HFOMCs’ abilities to perform their role and address the concerns and needs of the community, women, and DAGs. Of mothers who had heard of HFOMCs, 21% to 35% by district reported that HFOMCs have complete capacity to perform their roles. About one-third of the mothers in Baglung and Parbat, and 21% of mothers in Syangja, reported that HFOMCs fully knew about specific concerns of women regarding health services. Similarly, only one in five mothers familiar with HFOMCs reported that the committees adequately addressed women’s specific concerns about health services. Approximately a quarter of these women reported that HFOMCs fully knew about DAGs’ specific health service concerns. Likewise, 26% of the HFOMC-aware mothers in Baglung, 19% in Parbat, and 15% in Syangja reported that HFOMCs adequately addressed the specific health service concerns of DAGs. Most of the remaining mothers reported that the committees “somewhat” adequately knew and addressed specific concerns of women and marginalized persons.

Qualitative data revealed that wherever they are functional, HFOMCs have been useful to acquire and mobilize local level resources (especially through VDC). HFOMCs are considered mostly inactive, however without regular meetings and performing well below their potential. Mothers and fathers were often unaware of the HFOMC and its activities. Among participants who were familiar with the HFOMCs, there was perceived political bias of the HFOMCs and how they were formed; this bias was reported to affect their relationship with the community. It was noted that the HFOMCs were enthusiastic about upgrading the physical facility. They were less interested in strengthening the available HF and staff to deliver quality service. HFOMC members had a general sense of GESI as referring to participation of disadvantaged groups and equal treatment, but they did not have specific knowledge or understanding of special provisions or facilities needed to achieve this. Lastly, there were no platforms for the HFOMC and community members to discuss health issues. Despite having female and DAG members represented in the HFOMC, the HFOMCs were not able to represent the health needs of the female and DAG community in the absence of mechanisms to communicate between the community and HFOMCs.

Distance as a Barrier to Health Service Access

Traveling long distances on foot to health facilities was a service barrier that was experienced disparately across groups and districts. The time to reach the most visited government health service on foot varied by mothers’ social status; for example, in Baglung, DAG mothers reported an average of 76 minutes travel time, as compared to 45 minutes for non-DAG mothers (figure 1). Looking at travel time by district, on average, Baglung mothers reported longer travel time on foot than mothers in Parbat and Syangja. Moreover, during FGDs, mothers noted long travel time as a deterrent to seeking healthcare.

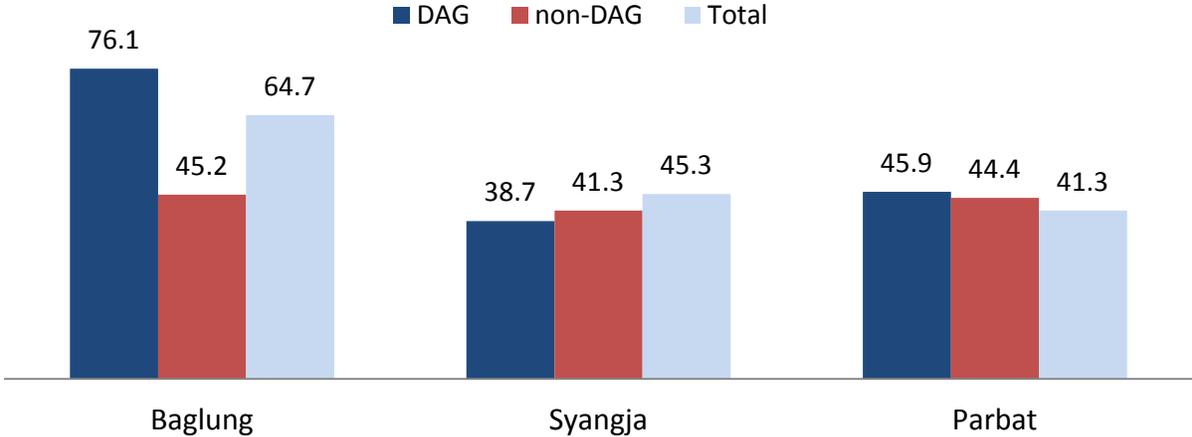


Figure 1. Mean travel time (minutes) to nearest HF on foot by district and social status.*

* Statistical tests showed that the difference in travel time between districts was statistically significant with a p value <0.001 and the differences between DAGs and non-DAGs were statistically significant in Baglung (p value<0.001) and Parbat (p value=0.01)

Health Service Quality and Satisfaction (General)

The quantitative and qualitative data painted similar stories of health service quality and satisfaction. The vast majority of respondents to the women's survey rated facilities in the top three of five levels across all areas of service satisfaction (waiting time; service hour convenience; and availability of health professionals, staff, and medicines). Parbat received the highest district ratings across all areas of service satisfaction. For those women who did report concerns, the most frequently noted were lack of medicine or supplies, poor availability of staff, long wait time for services, inconvenient facility hours, and lack of certain health services. For example, 10% to 11% of women in all three districts reported concern with lack of medicine or supplies and 8% to 10% reported poor availability of health workers. There was some variation by district, with Syangja reporting higher levels of concern compared to others on most topics.

Review of the qualitative data showed that district stakeholders, HF staff, and mothers and fathers in the community had some concerns about poor service quality, citing poor infrastructure, inadequate availability of staff, limited opening hours, low availability of medicine and equipment, and poor training as contributors. Client exit interviews and FGDs showed concern with long wait times, some clients being charged for free services and medicines, and mothers and fathers questioning the effectiveness of medicines (e.g., past expiry date). Most mothers, however, were satisfied with the quality of health services and appreciated the home-based support of FCHVs and health workers.

Awareness of Health Service Availability

Awareness of availability of FP, routine health checkups, and child health services varied by mothers' social status and by district. Thirty-nine percent of mothers in Baglung, 18% in Parbat, and 22% in Syangja reported that FP services were available at their HF. Child health services were reported as available by 16% of mothers in Baglung, 46% in Parbat, and 13% in Syangja. In general, more non-DAG mothers reported the availability of these services than DAG mothers. Post-natal care was the least frequently reported available service.

Child Illness and Care Seeking Practices

Reports of childhood illness differed by social status. A higher proportion of DAG mothers reported that their child had diarrhea in the last two weeks as compared to non-DAG mothers; in Parbat, for example, 13% of non-DAG mothers versus 8% of DAG mothers reported diarrhea in the prior two weeks. Among mothers who reported their child had diarrhea, 71% to 75% reported that they sought advice or treatment. A slightly higher percentage of DAG mothers reported that they sought advice or treatment compared to non-DAG mothers.

About one-third of mothers reported their children had a fever in the last two weeks. Among these mothers, most reported that they sought treatment or advice, but a lower proportion of DAG mothers reported that they sought advice or treatment compared to non-DAG mothers (figure 2).

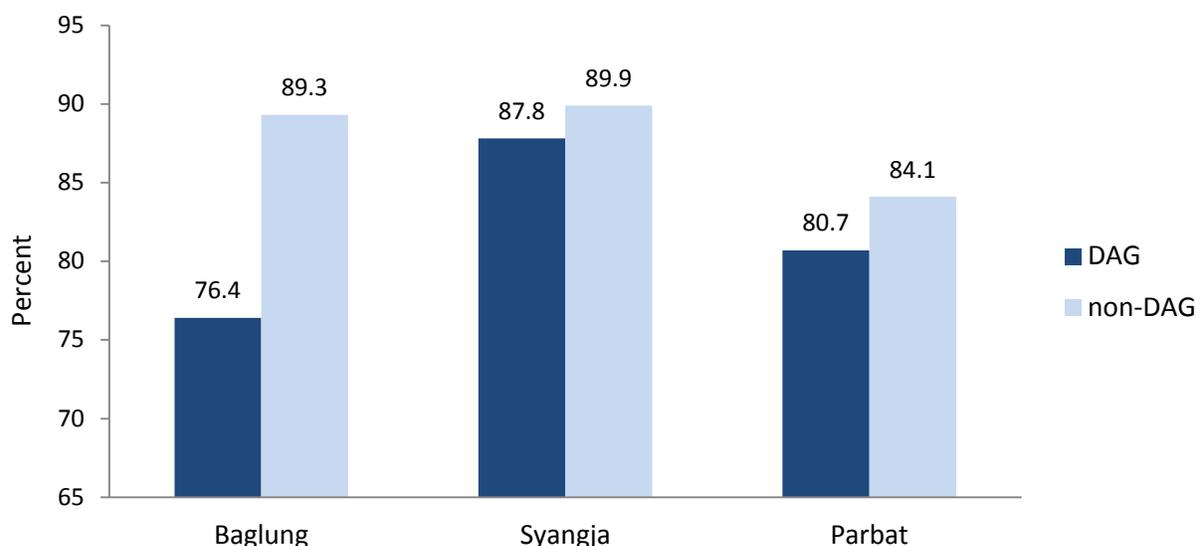


Figure 2. Child fever treatment seeking patterns, by district and social status.*

* Statistical tests showed that the intervention and control groups were significantly different (p value <0.01) and that DAGs and non-DAGs were significantly different in Baglung (p value <0.01)

Among mothers who reported that their child had a common cold accompanied by rapid or difficult breathing in the last two weeks, about 73% reported that they sought advice or treatment. A higher proportion of mothers who sought advice or treatment for their child's diarrhea, fever, or common cold contacted private clinics as compared to government health services.

Child Weight and Height Measurement/Well-Child Visits and Breastfeeding Practices

Most mothers reported their child's weight was ever measured, but this varied by social status with more non-DAG mothers than DAG mothers reporting that their child's weight had ever been measured; it also varied by district — 90% in Baglung, 97% in Parbat, and 94% in Syangja.

A higher proportion of non-DAG mothers relative to DAG mothers also reported that health professionals at their last visit talked about the growth of the child; for example, 23% of non-DAG mothers as compared to 15% of DAG mothers in Syangja. About a third of mothers reported a well-child visit within the past six months. Children's full vaccination coverage was 92% to 98%.

Over 78% of mothers reported that they exclusively breastfed until their child was six months old. Exclusive breastfeeding was 89% of higher for infants under one month of age.

Antenatal Care

Report of at least one visit for antenatal care (ANC) was nearly universal, but there were many differences in ANC services and satisfaction by social status. Seventy percent to 84% of mothers

reported attending four or more ANC visits. This proportion was higher for non-DAG mothers; for example, 83% of non-DAG mothers in Baglung received four or more ANC services compared with 63% of DAG mothers (table 2).

The mothers' report of which type of ANC provider they saw also varied by their social status. More non-DAG mothers reported receipt of ANC care by a skilled health professional (SHF) than DAG mothers. Lastly, while women generally went to government sites for ANC, the source of ANC varied by mothers' social status; for example, 27% of DAG mothers as compared to 44% of non-DAG mothers from Baglung reported ANC from a government hospital.

Table 2. Antenatal Care Practices by Percentage

	Baglung			Parbat			Syangja		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
Mothers receiving antenatal care	90.1	97.6*	92.9*	95.4	98.8*	97.3*	93.0	97.0*	94.7*
Not receiving antenatal care	9.9	2.4	7.1	4.6	1.2	2.7	7.0	3.0	5.3
Number of visits									
None	9.9	2.4	7.1	4.6	1.2	2.7	7.0	3.0	5.3
1 visit	4.6	1.2	3.4	2.9	0.8	1.8	3.8	1.3	2.7
2 visits	7.8	3.0	6.0	4.6	1.8	3.0	4.9	1.7	3.5
3 visits	15.2	10.6	13.5	11.5	6.0	8.5	14.3	11.0	12.9
4 visits or more	62.5	82.9	70.1	76.4	90.2	84.0	70.0	83.1	75.5

* Chi-square statistical test showed the three groups were different by District (p value < 0.001) and also different by social status within each district (p value < 0.001).

ANC Satisfaction

Nearly all mothers who received ANC services reported being very satisfied or somewhat satisfied with services across all satisfaction domains. The two exceptions that received lower ratings were for staff listening to their concerns and the visit helping to prepare them for the birth. Mothers' satisfaction with antenatal services varied by social status for all domains in Baglung and Parbat — a lower proportion of DAG mothers reported the highest satisfaction level on all domains as compared to non-DAG mothers.

Childbirth Services

There were differences by district and by social status for childbirth services. Nearly 70% of mothers in Parbat and Syangja reported HF births compared with only 44% in Baglung. A higher proportion of non-DAG mothers in all three districts gave birth at a HF as compared to DAG mothers; this difference was most pronounced in Baglung (figure 3).

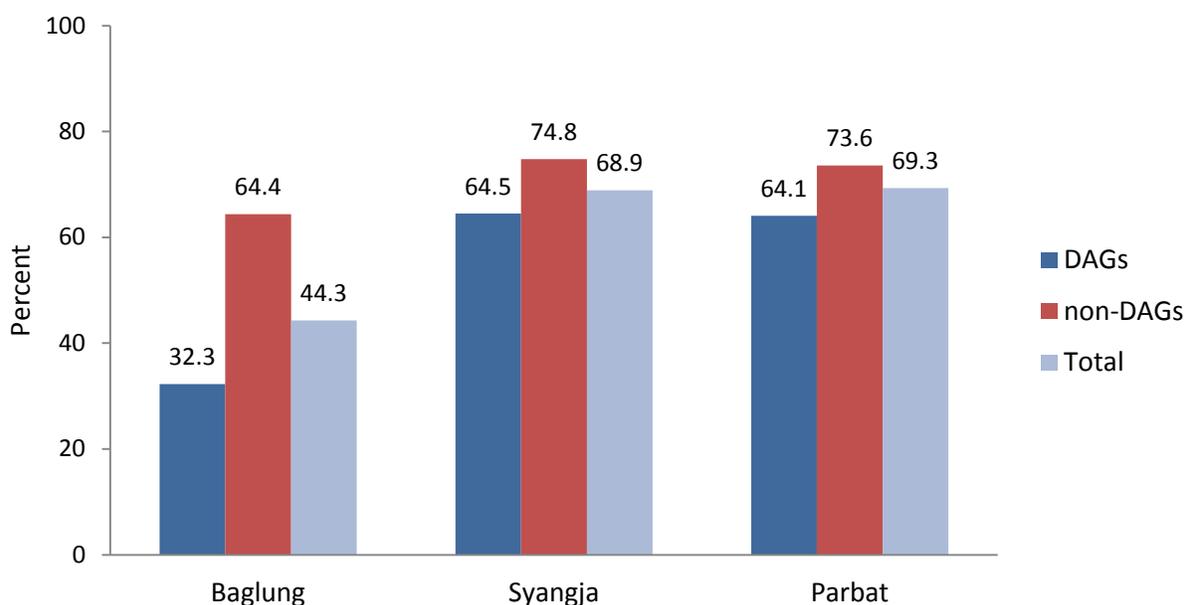


Figure 3. Women reporting birth at a health facility, by district and social status.*

* Statistical tests showed that the groups were significantly different by district (p value <0.001) and within all districts by social status (Baglung and Parbat p values <0.001 ; Syangja p value $=0.001$)

Only 31% of mothers in Baglung as compared to 69% of mothers in both Parbat and Syangja reported that they were assisted by a skilled health professional (SHP) during childbirth. More non-DAG mothers reported receiving assistance from SHPs than DAG mothers.

Satisfaction with Childbirth Services

Almost all mothers reported that they were either very satisfied or somewhat satisfied with the services they received during child birth. Parbat mothers reported slightly higher satisfaction.

Post-Natal Care for Mother

Post-natal care (PNC) was high for HF births and low for non-HF births. There were also disparities in receipt of PNC by social status. Among mothers who delivered at a HF, 84% in Baglung, 91% in Parbat, and 87% in Syangja reported that their health was checked by a health care provider at the hospital. More non-DAG mothers in Baglung and Syangja reported that their health was checked as compared to DAG mothers (figure 4).

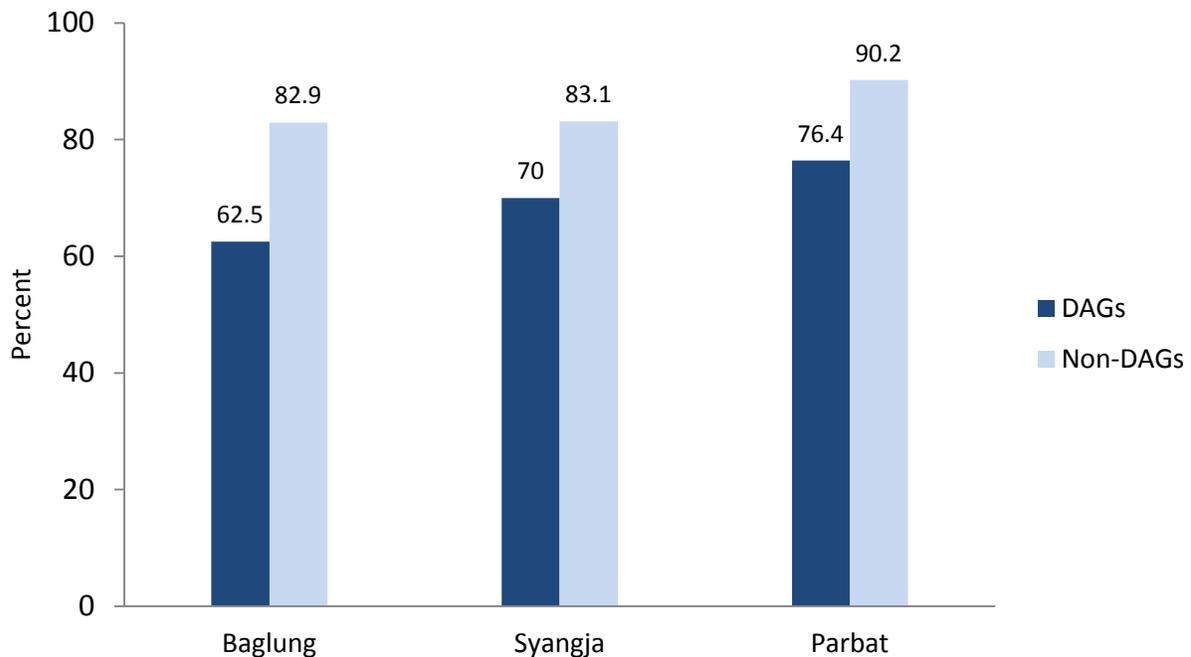


Figure 4. Among mothers reporting health facility birth, percentage whose health was checked by provider before leaving facility, by district and social status.*

* Statistical tests showed that the groups were significantly different by district (p value<0.001) and within Syangja (p value<0.05) and Baglung (p value=0.01) by social status.

Among mothers who did not give birth at a HF, only about one-tenth reported that their health was checked by a health care provider; of these women who had their health checked, most reported that they were checked after more than six days — 80% in Baglung, 64% in Parbat, and 76% in Syangja. Except in Baglung, a higher proportion of non-DAG mothers as compared to DAG mothers reported that their health was checked after six days.

Satisfaction with PNC for Mother

Nearly all mothers reported that they were either very satisfied or somewhat satisfied with the services they received after child delivery. Satisfaction was slightly lower with regard to staff listening to concerns. Also, similar to several other service areas, Parbat mothers reported greater satisfaction with the PNC they received across all domains (staff attentiveness, friendliness, respectfulness, knowledge, and listening).

PNC for Children

Among those who gave birth at a HF, 78% to 88% reported that the health of their child was checked before leaving the facility. Again, a higher proportion of non-DAG mothers reported that their child's health was checked (figure 5).

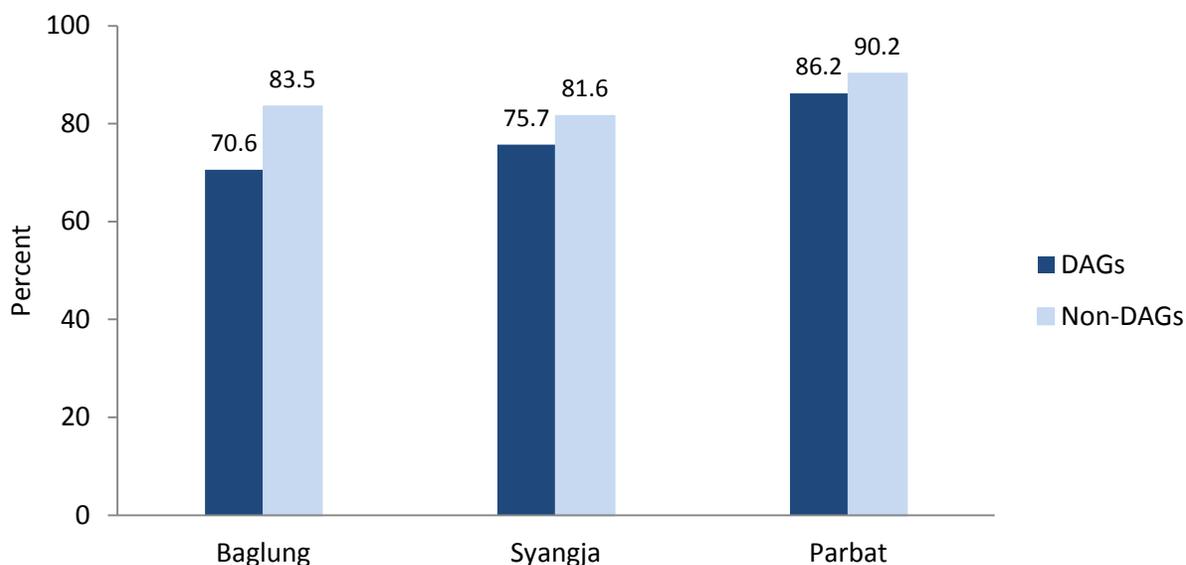


Figure 5. Among mothers reporting health facility birth, percentage who reported their child’s health was checked by provider before leaving facility, by district and social status.*

* Statistical tests showed that the groups were significantly different by district (p value<0.001) and by social status in Baglung (p value=0.001) and Syangja (p value<0.05).

Among mothers who did not give birth at a HF, only 26% in Baglung reported their child’s health was checked compared to 37% each in Parbat and Syangja.

Satisfaction with PNC for Children

Nearly all mothers reported that they were either very satisfied or somewhat satisfied with the service they received for their child after delivery. Parbat mothers reported greater satisfaction with their child’s post-natal care across all domains (staff attentiveness, friendliness, respectfulness, knowledge, listening, and helpfulness in taking care of their child) than mothers in Baglung and Syangja. Although satisfaction was generally high overall, fewer women reported the highest response level for staff listening to mothers’ concerns, as compared to most other satisfaction questions. In all districts, DAG mothers were more likely than non-DAG mothers to report that staff listen only a little.

FP Knowledge, Use, and Counseling

Knowledge of any modern method of FP was almost universal and uniform. Of nine* total modern methods, an average of six methods was known to mothers. A higher proportion of non-DAG mothers compared to DAG mothers reported that they knew about each of the nine modern methods (figure 6).

* The nine modern methods were: female sterilization, male sterilization, intrauterine device (IUD), injectables, implants, pills, male condom, female condom, and emergency contraception.

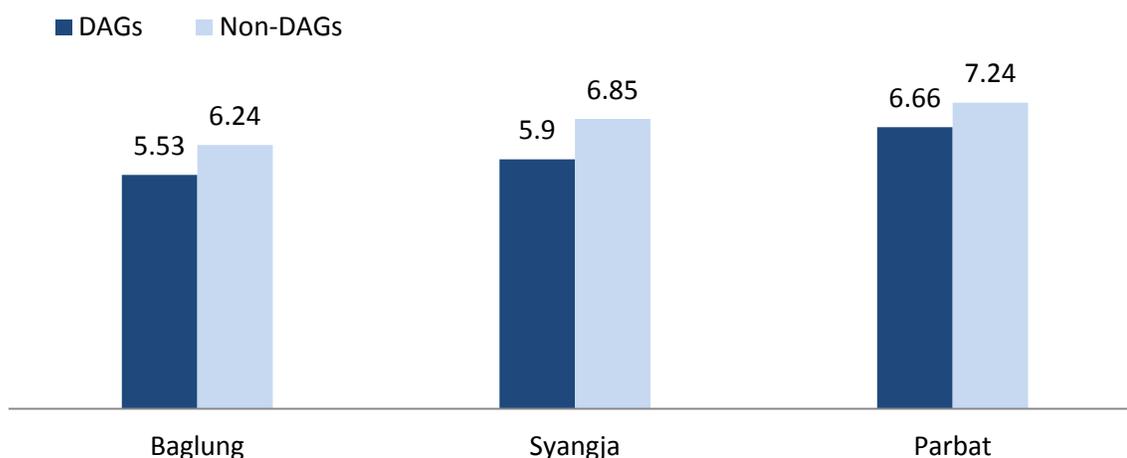


Figure 6. Mean number of modern FP methods known, by district and DAG status.*

* Statistical tests showed a significant difference between districts (p value<0.001) as well as between DAGs and non-DAGs within all districts (p value<0.001).

For knowledge of specific modern methods, there was variation by district. For example, 81% mothers in Parbat knew about IUDs compared to 57% in Baglung and 59% in Syangja.

Of mothers who were not pregnant, 14% in Baglung, 19% in Parbat, and 11% in Syangja reported that they were using a modern or non-modern method of family planning. In Syangja and Parbat, as compared to non-DAGs in the same district, more DAG mothers reported they were currently using FP. Almost all family planning users were using modern methods in all three districts, with injectables most commonly reported (5% to 9%). The pill and condoms were the next most commonly reported methods. In client exit interviews, respondents noted that while they typically preferred injections to oral and other forms of contraceptives, health workers mostly suggested they instead use condoms and other forms of FP with fewer side effects.

Nearly one-fourth of mothers reported that they were counseled on healthy timing and spacing of pregnancy (HTSP), and there were differences in report by district and social status (figure 7). A higher proportion of mothers in Parbat (31%) reported that they were counseled as compared to those in Baglung (19%) and Syangja (18%). In addition, a higher proportion of non-DAG mothers in all districts reported being counseled on HTSP as compared to DAG mothers.

Satisfaction with HTSP Counseling

Most mothers who received counseling reported that they were either very satisfied or somewhat satisfied with the counseling service. More DAG mothers than non-DAG mothers reported that they were very satisfied with the counseling they received. Parbat mothers reported the greatest satisfaction with their most recent HTSP consultations.

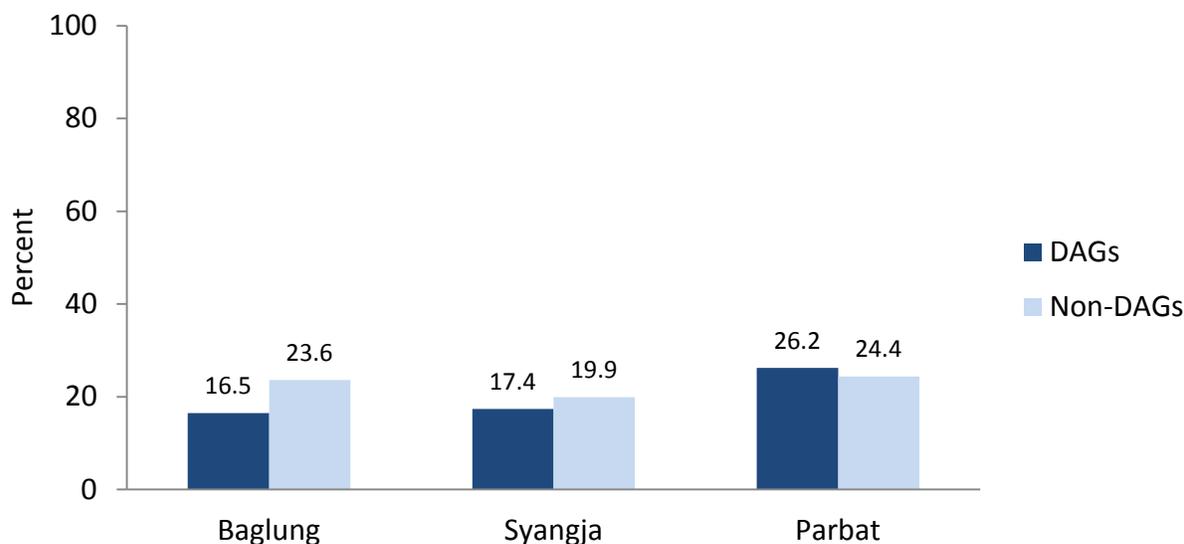


Figure 7. Women’s report of having ever been counseled on healthy timing and spacing of pregnancy, by district and social status.*

* Statistical tests showed a significant difference between Districts (p value <0.001) as well as between DAGs and non-DAGs in Baglung and Syangja (p value <0.001 for both).

Parbat Relations with Syangja and Baglung

To help assess the potential for spillover from intervention to control areas, several questions on relations with Baglung and Syangja were asked only of Parbat quantitative study participants. Sixty-one percent of Parbat mothers reported that they had family members or friends in Baglung or Syangja. In addition, 32% reported that they visited health institutions in those districts for health services.

Conclusions

These baseline data are useful to help us understand the comparability of the three study districts at baseline and to assess the potential for spillover effects from intervention to control areas. The responses from Parbat participants on relations with Baglung and Syangja indicate spillover could be a concern since many have family or friends in those districts and roughly one-third go to these districts for health services. Other data suggest that the intervention and control districts are not comparable on a number of key MNCH/FP outcomes, including child illness treatment-seeking behavior, birth-related service use, and FP knowledge. These differences will need to be taken into account during the evaluation endline analysis to accurately estimate the impact of the intervention approaches on MNCH/FP and other outcomes of interest.

The disparities between DAG mothers and non-DAG mothers were significant across many critical MNCH/FP outcomes. DAG mothers generally had lower awareness of available health services and used pregnancy and birth-related health services at lower rates than non-DAG mothers. Similarly, for FP outcomes, DAG mothers reported knowing fewer modern methods of FP and less commonly reported having received counseling on HTSP. These inequities

underscore the importance of GESI integration and capacity building interventions to improving MNCH/FP in these districts.

The interventions could also be useful to improve perceived health service quality, as participants in both study components expressed related concerns. Twenty to forty percent of surveyed women reported concerns with health service quality; the most frequently reported were lack of medicine or supplies, poor availability of staff, long wait time, and lack of certain health services. Qualitative participants expressed concerns, including poor service quality, inadequate availability of staff, limited opening hours, low availability of medicine and equipment, and questionable effectiveness of medicines.

Finally, the data on HFOMCs suggest that, while HFOMCs have proven useful in mobilizing resources and upgrades to facilities, HFOMCs are not living up to their potential. Awareness of HFOMCs was low among mothers in the quantitative survey as well as among community participants in the qualitative components. Among study participants who were familiar with HFOMCs, knowledge of their role and responsibilities was generally scant. Qualitative data specifically showed that HFOMCs were seen as mostly inactive, politically biased, without regular meetings, focused on physical facility improvements rather than service quality, and unconnected to the community and its needs. Considering these results, the Suaahara interventions could have great impact on HFOMC utility and effectiveness.

Table 3. Summary of Key Indicators by Percentage

	Baglung (%)			Parbat (%)			Syangja (%)		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
<i>ANC and Childbirth</i>									
Mothers receiving ante-natal care	90.1	97.6*	92.9*	95.4	98.8*	97.3*	93.0	97.0*	94.7*
ANC 4 visits or more	62.5	82.9	70.1	76.4	90.2	84.0	70.0	83.1	75.5
Mothers receiving care during birth from skilled health providers	23.5	43.7	31.0	64.2	72.7	68.8	64.5	74.8	68.8
Births in health facility	32.3	64.4*	44.3*	64.1	73.6*	69.3*	64.5	74.8*	68.9*
<i>PNC — Mother</i>									
Among home births: Healthcare provider checked on mother's health (anytime) after delivery	8.0	12.2	9.6	9.0	10.3	9.7	10.2	9.3	9.8
Among home births: Healthcare provider checked mother's health within 48 hours	0.4	0.9	0.7	1.5	1.7	1.6	1.9	1.1	1.5

(Table continues next page)

	Baglung (%)			Parbat (%)			Syangja (%)		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
Among HF births: <i>Healthcare provider checked on mother's health after delivery before leaving facility</i>	80.3	86.9*	83.8*	91.3	90.6	90.9*	84.6	90.7*	87.4*
PNC — Child									
Among home births: <i>Healthcare provider checked on child's health after birth (anytime)</i>	25.9	27.0	26.3*	36.0	37.6	36.9*	36.7	37.4	37.0*
Among HF births: <i>Healthcare provider checked on child's health, before leaving facility</i>	70.6	83.5*	77.6*	86.2	90.2	88.5*	75.7	81.6*	78.4*
Child Health									
Diarrhea in last two weeks	15.6	14.2	15.0	13.3	8.3	10.5	14.0	7.4	11.2
Among those reporting diarrhea in the last two weeks: <i>Sought diarrhea advice/treatment</i>	71.6	69.4	70.9	77.8	72.1	75.4	75.0	68.6	73.2
Fever in last two weeks	31.0	27.6	29.7	31.4	29.9	30.6	34.9	29.4	32.6
Among those reporting fever in the last two weeks: <i>Sought fever advice/treatment</i>	76.4	89.3*	80.8*	80.7	84.1	82.5*	87.8	89.9	88.6*
Had cold plus also had rapid or difficult breathing in last two weeks	16.8	14.0	15.8	12.1	11.1	11.6	14.8	9.7	12.7
Among those reporting cold plus also had rapid or difficult breathing in the last two weeks: <i>Sought cold advice/treatment</i>	73.8	71.8	73.1	81.1	74.4	77.6	74.2	76.1	74.8
Weight ever measured	88.5	93.7*	90.4*	95.6	97.8*	96.8*	92.8	94.7	93.6*
Weight measured in last six months	53.1	46.2	50.5	42.1	36.2	38.9	43.0	36.8	40.4
Health professional talked about growth	12.4	17.7	14.4	26.5	40.2	34.0	15.2	22.6	18.3

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	Baglung (%)			Parbat (%)			Syangja (%)		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
Exclusively breastfed age 0 to 5.9 months [†]	86.9	82.1	85.2	87.3	80.6	83.8	76.7	80.8	78.3
Proportion of children 6-23.9 months of age who receive foods from 4 or more food groups	60.1	64.7	61.9	65.9	78.3	72.7	64.1	74.5	68.6
Currently breast feeding: ^{†,‡} Proportion of children 6 to 23.9 months of age who receive a minimum acceptable diet (apart from breast milk)	46.3	43.2	45.1	48.3	56.5	52.6	48.3	57.8	52.3
FP and HTSP Counseling									
FP use, modern methods	13.7	13.4	13.6*	22.4	15.8*	19.8*	11.7	8.3*	10.3*
Mean number of methods known	5.53	6.24*	5.8*	6.66	7.24*	7.0*	5.90	6.85*	6.3*
HTSP – ever counseled, yes	16.5	23.6*	19.1*	26.2	34.4	30.7*	17.4	19.9*	18.4*
Ever Heard of HFOMCs									
Yes	2.6	9.3*	5.0*	6.4	15.2*	11.2*	5.2	11.6*	7.9*
Ever submitted a concern to HFOMCs (among those who had heard of HFOMCs)	22.7	10.6	14.5	17.9	17.0	17.2	5.9	14.5	11.2

* Statistics tests showed differences by district and/or social status.

† Breastfeeding status was determined with the question, "Are you still breastfeeding?" with yes/no possible responses.

‡ MAD was not calculated for non-breastfeeding children (n=65), as data on numbers of milk feedings was unavailable.

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