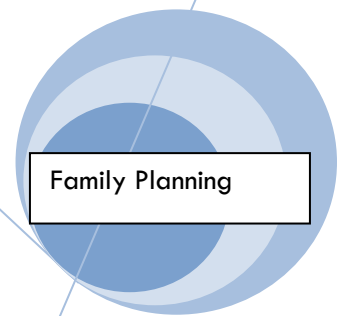


# Study on Effectiveness of Integration of Family Planning into Agriculture and Economic Empowerment Program for Access and Coverage

Submitted to  
Adventist Development and Relief  
Agency (ADRA), Lalitpur, Nepal



Report on research entitled

**“Study on Effectiveness of Integration of Family Planning into Agriculture and Economic Empowerment Program for Access and Coverage”**

“carried out from 2014-2016 by Birat Nepal Medical Trust (BNMT) with the financial support of Adventist Development and Relief Agency (ADRA), Lalitpur, Nepal.

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## Executive summary

The Government of Nepal's (GoN) Nepal Health Sector Programme II (NHSP II) 2010-2015 indicates that FP is a high priority and has set the objective to gradually reduce the population growth rate; satisfy demand for high quality services; and reduce unmet need. Therefore Family Planning (FP) is a priority program of the Government of Nepal.

Integrated reproductive health and family planning (RH/FP) programming is a cost-effective, client centered way to increase client access to information and services. When health and non-health agencies include RH/FP services and/or information in their programs, the resulting increase in the number of service delivery points leads to fewer missed opportunities, greater continuity of care, increased RH/FP access, and the sense on the part of clients that services are responsive to and respectful of their needs. Integrated reproductive health and family planning (RH/FP) programming is a cost-effective, client centered way to increase client access to information and services. When health and non-health agencies include RH/FP services and/or information in their programs, the resulting increase in the number of service delivery points leads to fewer missed opportunities, greater continuity of care, increased RH/FP access, and the sense on the part of clients that services are responsive to and respectful of their needs. Integrating Family Planning and Immunization for High Impact has already been practiced in many parts of the world including the recently MoHP testing for introducing FP in immunization programme in Nepal. This study is unique in its own kind as it looks at the effectiveness integration of family planning into agriculture and economic empowerment program for access and coverage. This is a pilot initiative towards future scalability and sustainability.

Adventist Development and Relief Agency Nepal is implementing the "Technical Integration Coverage and Access (TICA) project in fifteen VDC of three districts: Rupandehi, Palpa and Kapilvastu in western development region of Nepal. This project will integrate needed FP services into the current Develop Local Economy to Eradicate Poverty (DEEP) Project. Through the TICA project, ADRA will increase the access to and demand for family planning services. As planned, this study was conducted in two phases: before implementation of TICA project in DEEP project areas (baseline) and after implementation of TICA in DEEP project areas (endline). This report presents the comparative findings of endline study with respect to baseline study.

Both baseline and endline study was conducted on five Village Development Committees (VDCs) in each of the three districts where DEEP is implemented: Rupandehi, Palpa and Kapilvastu in western development region of Nepal. The study design was interventional (first phase as pre intervention and second phase as post intervention). Baseline was quantitative descriptive, whereas endline study was quantitative descriptive and qualitative focus group discussion. All women from the selected group were included in the

study. Data was collected by interview, using semi-structured interview guideline. Data was entered into Epidata and descriptive statistics were performed by using SPSS.

A total of 493 and 525 women were included in baseline and endline study respectively. There were 16 different Women Groups in baseline and 20 different Women Groups in endline. In both baseline and endline, majority of the respondents were Hindu and had ethnicity either Disadvantaged Janjatis or Upper caste groups. Similarly, in both baseline and endline, majority of the respondents had Informal education. Most of the respondents, in both baseline and endline, lived in either nuclear or joint family. In both baseline and endline, agriculture was the main occupation of majority of the respondents; however, there was a dramatic increase in proportion of female involved in agriculture in endline, compared to baseline. There were no difference in socio-demographic characteristics between baseline and endline participants in terms of religion and family type. However, baseline participants significantly differed from endline participants with respect to age, ethnicity, educational status, main occupation/profession and sufficiency of annual income.

The effectiveness of TICA was measured in terms of change in knowledge and practice for FP use during the intervention, changes in decision making choice by couples for FP methods and utilization and change in negotiation skills of women on FP methods use after the integration process. Overall, there has been an augmentation in knowledge of family planning among study participants. Compared to baseline participants greater proportion of endline participants had correct understand about family planning. A substantial increment in knowledge of women in endline was achieved in terms of knowledge on at least four types of contraceptives and knowledge on emergency contraceptives (EC).

Similarly, a satisfactory success in practice of family planning was achieved in endline. A significant increment in endline over the baseline was seen in terms of proportion of couples ever using any family planning methods. Compared to baseline, the use of short term contraceptives has decreased in endline, whereas the use of permanent method of contraception, especially male sterilization/ Vasectomy has increased.

Comparative study of baseline and endline, it appeared that female preferred long acting contraceptives over short acting in endline. This was demonstrated by decreased proportion of women using pills/ oral tablets and depo/Sangini and increased proportion of women using intra uterine device (IUD); however the proportion of women using implant has declined. In both baseline and endline, majority of the respondents had obtained the family planning devices from government health institution and greater proportion of respondents paid for the family planning devices in endline compared to baseline.

Compared to baseline, in endline, husbands were more willing to use the FP method. Similarly, compared to baseline the preference among couple for husband using the FP methods has increased in endline These

facts, in conjunction with increased proportion of vasectomy in endline, further proves that males more willing to utilize a FP method. There has also been improvement in negotiation skills of women for FP and child spacing. The proportion of the women, in endline, discussing about FP with their husband has slightly increased than baseline, but the increment was not significant statistically. However, the proportion of the woman discussing about birth spacing with their husband slightly increased in endline.

Overall, in both base line and endline, majority of the women were satisfied with various aspects of health facility as well as health workers. However in endline, compared to baseline, a greater proportion of women expressed that the behavior of health workers was not polite and respectful. Similarly, greater proportion of women in endline compared to baseline expressed that health workers forced them to accept the family planning methods.

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## Acronyms

ADRA	Adventist Development and Relief Agency
BNMT	Birat Nepal Medical Trust
CPR	Contraceptive Prevalence Rate
DEEP	Develop Local Economy to Eradicate Poverty
EC	Emergency Contraceptives
FP	Family Planning
GoN	Government of Nepal's
HMIS	Health Management Information Systems
MDG	Millennium Development Goal
MoHP	Ministry of Health and Population
NHSP	Nepal Health Sector support Programme
RH	Reproductive Health
STI	sexually transmitted diseases
TICA	Technical Integration Coverage and Access
VDCs	Village Development Committees

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# Chapter 1 INTRODUCTION

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## 1.1 Background

The Government of Nepal's (GoN) Nepal Health Sector Programme II (NHSP II) 2010-2015 indicates that FP is a high priority and has set the objective to gradually reduce the population growth rate; satisfy demand for high quality services; and reduce unmet need. Government of Nepal has achieved significant progress on health sector despite the long conflicts and others. However there has been a notable decline in the contraceptive prevalence rate for modern FP method in the country between 2006 and 2011 as 44% and 43% respectively. Some of the districts in Nepal, CPR are even lower than 30.0%; still long way to reach MDG Goal of 67% by 2015. This figure is creating concerns among various stakeholders working in family planning program. Therefore Family Planning (FP) is a priority program of the Government of Nepal.

Integrated reproductive health and family planning (RH/FP) programming is a cost-effective, client centered way to increase client access to information and services. When health and non-health agencies include RH/FP services and/or information in their programs, the resulting increase in the number of service delivery points leads to fewer missed opportunities, greater continuity of care, increased RH/FP access, and the sense on the part of clients that services are responsive to and respectful of their needs. Integration is a powerful way to reach women, men, and youth who may not otherwise seek RH/FP care, but whose RH/FP needs may be especially great. Integrating FP into non health-sector development projects such as private institutions, cooperatives and recently MoHP testing introducing FP in immunization programme could be an effective way to facilitate access to FP and other health services and information for women and communities. Evidence confirms that family planning contributes to broad development goals of poverty reduction, enhanced education, environmental sustainability, and gender equality. But, improving access to contraception has largely remained an effort contained within the health sector. Therefore, more evidence is needed on whether and how such efforts can work, and what types of models might be replicated and scaled up. Integrating Family Planning and Immunization for High Impact has already been practiced in many parts of the world (1-16). This study is unique in its own kind as it looks at the effectiveness integration of family planning into agriculture and economic empowerment program for access and coverage. This is a pilot initiative towards future scalability and sustainability.

Adventist Development and Relief Agency (ADRA) Nepal is implementing the "Technical Integration Coverage and Access (TICA) project funded by USAID/APC through ADRA International. It is implemented by ADRA Nepal in fifteen VDC of three districts: Rupandehi, Palpa and Kapilvastu in western development region of Nepal. The project is integrated into ADRA's DEEP project in the districts. Technical Integration

for Coverage and Access (TICA) project will integrate needed FP services into the current Develop Local Economy to Eradicate Poverty (DEEP) Project. The DEEP project aims to improve the economic status of families in the targeted districts. Hence, the project presents an appropriate opportunity for integrating FP activities. TICA is designed to leverage the community access points and resources of DEEP to address family planning needs and challenges in the targeted areas. The proposed FP activities will concentrate on five Village Development Committees (VDCs) in each of the three districts where DEEP is implemented. Through the TICA project, ADRA will increase the access to and demand for family planning services. ADRA will focus on increasing FP knowledge and demand for services, both of which will be accomplished through behavior change; raising FP awareness of community group members, and trainings; and on increasing service provision by conducting FP camps at community project sites and increasing the capacity of facilities through training and basic equipment.

With this research, ADRA aims to collect more systematic evidences to support the integration results. This study was planned in two phases: before implementation of TICA project in DEEP project areas (baseline) and after implementation of TICA in DEEP project areas (endline). This report presents the comparative findings of endline study with respect to baseline study.

## **1.2 Objective of the Study**

### **1.2.1 General objective**

In overall, the General objective of the research is to:

- Assess the effectiveness of FP interventions when paired with agriculture and economic empowerment interventions; and to assess the impact of economic empowerment programs when paired with family planning.

### **1.2.2 Specific objectives**

- I. To assess the benefits from FP integration into DEEP projects
- II. To assess change in knowledge and practice for FP use after the integration process
- III. To assess decision making choice by couples for FP methods and utilization
- IV. To compare negotiation skills of women on FP methods use
- V. To study relationship between increased FP use and increased income

## **1.3 Research Questions**

- I. Is there any change in FP use before and after integration?
- II. Do we see an increase in the use of modern FP methods of DEEP beneficiaries after the integration of TICA (stratified by commodity)?

- III. Does there exist any differences in knowledge and utilization practice in DEEP beneficiaries before and after intervention?
- IV. Are women planning to space children at a greater rate given the tangible benefits from economic empowerment?
- V. Are males more willing to utilize a FP method or have their wives use a method because they see the economic benefits of DEEP?
- VI. Do women choose different methods due to increased incomes? Do they go from short acting to long acting or permanent for instance?
- VII. Are women negotiating for FP and child spacing after learning about FP via TICA? Is there any change in the negotiation skills before and after TICA implementation?

## **1.4 Survey Organization and Management**

A survey executive committee was formed to accomplish the study. The details of the core team are provided in [Annex 1](#).

# Chapter 2 METHODOLOGY

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## 2.1 Study Area

The study was conducted on five Village Development Committees (VDCs) in each of the three districts where DEEP is implemented. First is the *Palpa District* which is a mid-hill district of western Nepal with a total population of 261,180 (male: 115,840; female: 145,340). The contraceptive prevalence rate (CPR) of this district is 35.3% which is slightly higher than the average regional CPR of 31%. Second is the *Rupandehi District* which is a Terai district of western Nepal with a population of 880,196 (male: 432,193; female: 448,003). The CPR of this district is 31.6%. Third is the *Kapilvastu District* which is a Terai district with a total population of 571,936 (male: 285,599; female: 286,337). The CPR of this district is 33.4%.<sup>1</sup>

## 2.2 Study design

The study design was interventional (first phase as pre intervention and second phase as post intervention). The baseline study was already accomplished in 2014/15 and endline study was carried out in 2015/16. This report presents the comparative findings of both pre and post intervention. Both the pre and post intervention was quantitative descriptive.

## 2.3 Study population

The study populations were married women of reproductive age group belonging to DEEP beneficiaries.

## 2.4 Sample size

The size of the sample was calculated as 25% of total DEEP beneficiaries from women's groups i.e. 25% from 1800 (N) = 450 (n). Group classification was also 25% from total 60 groups = 15 groups. However, the actual sample size in baseline and endline was 493 and 525 respectively ([Figure 1](#)). Similarly, there were 16 and 21 women groups in baseline and endline respectively.

## 2.5 Sampling frame

Sampling frame was married women of reproductive age belonging to DEEP beneficiary.

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<sup>1</sup>DOHSR, 2010/11

## 2.6 Unit of analysis

Unit of analysis was individual.

## 2.7 Sampling technique

Total targeted Women Groups were 60 within the project area. In a baseline 16 Women Groups were selected randomly to meet the required sample size. We adopted census method to select the women. In endline we again randomly selected 20 Women Groups among the targeted WGs to meet the required sample size i. e. 525; again by using census method to select the women. We did not follow the same women groups in endline to minimize the bias. All 60 women groups were included in TICA Intervention. So we randomly selected 20 women groups among the 60 Women Groups.

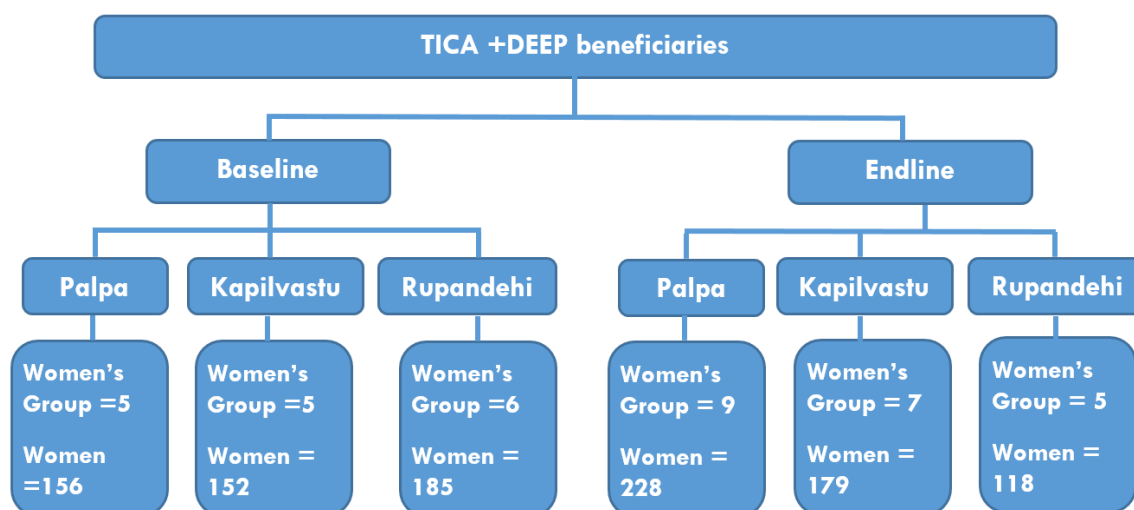


Figure 1 Sampling and sample size

## 2.8 Data Collection and Mobilization of the Field Staffs

Data was collected by Interview, using semi-structured interview guideline and by focus group discussion. Six FGD were organized in three districts: Palpa, Rupandehi and Kapilvastu. Three women, two men and one adolescent group were formed for the FGD to discuss on the benefits and challenges faced during the implementation of FP activities. The same data collection tool for quantitative study was used for baseline and endline and is provided in Annex 3. Baseline data was collected before the intervention whereas endline data was collected after the intervention. Prior to data collection, orientation was given to enumerators and supervisor based on the guideline developed by research team. A total of 16 field enumerators, 11 Supervisor and 2 Project Officer were employed in the field for data collection in baseline. Similarly, there were 14 field enumerators and 4 Supervisor in endline. In endline, data collection



was done on 18 - 30 November 2015. In both study, baseline and endline, data coding and data entry was done by the AHEAD-Nepal, Maharajgunj, Kathmandu and clean dataset were submitted to ADRA, Nepal.

## 2.9 Data Analysis and Presentation

Data processing was done in three phases namely data entry program development, data entry and data cleaning. The following process was carried out for overall data management:

**Development of coding system:** A scientific coding system was developed using alphabets and numbers.

**Selection of software, data masking and data entry:** Data was entered into Epidata. The Checks feature of the software was employed for data validation as per the need/requirement of the data. During the data entry process, strict data quality control procedures, codes and checks were undertaken. Through the Checks feature of the software limits, restrictions and jumps was used to define what data can or should be entered in a cell. This prevented the data entry personnel from entering invalid data. Also, random re-checking of data entered with the field data was carried out. Additionally, data were also checked in excel using filter options. Any outliers were cross validated with the original questionnaire.

**Data analysis:** The data entered in Epidata was exported to SPSS format and was checked for all the inconsistencies. The SPSS Descriptive was used for data analysis as per requirements. For multiple response data where the respondents can choose or provide more than one response, multiple response analysis was done. The multiple responses was organized in multiple dichotomy (i.e. 1=yes and 0= no). The multiple responses were defined for all questions where multiple responses were expected. Then the crosstab option was used to obtain frequencies or percentages according to number of respondents/responses. (The syntax used is: Analyze - multiple response - define variable sets. Create the sets. Then going back to the command: Analyze -multiple response - frequencies or crosstabs). The analyzed data was presented into tabular and graphical forms while drafting the report. For all continuous variables, Shapiro-Wilk test for normality used to check distribution of the data and when the test was significant ( $p$  value  $< 0.05$ ) and suggested non-normal distribution of variable, we used non-parametric test.

## 2.10 Focus group discussion

Qualitative data collection technique included focus group discussions (FGDs). Six FGD were organized in three districts: Palpa, Rupandehi and Kapilvastu. Three women, two men and one adolescent group were formed for the FGD to discuss on the benefits and challenges faced during the implementation of FP

activities in order to explore understanding and experiences of these beneficiaries groups. Thematic analysis was employed to identify the key themes and sub-themes that arose during the FGDs.

## **2.11 Limitation of the Survey**

Although an interventional design, this study is limited to interventional groups only and fails to take into account control group. Another limitation of the study is that the baseline or pre-test data collection and the programme implementation occurred nearly the same time.

## Chapter3 STUDY FINDINGS FOR WOMEN'S GROUP

Data was collected from a total of 525 women; from 20 different Women Groups. This study included 179 Women from 7 Women Groups in Kapilvastu; 228 Women from 9 Women Groups in Palpa and 118 Women from 4 Women Groups in Rupandehi. [Table 1](#) below shows the distribution of women in various women groups in the respective districts in the endline study.

**Table 1 Distribution of Respondents in endline study**

District	Women Group	Number	Percent
Kapilvastu	Mankamana Mother's Group	19	3.62
	Janaki Women Group	25	4.76
	Mayadevi Women Group	28	5.33
	Milijuli Women Group	28	5.33
	Janjagaran Women Group	26	4.95
	Shiva Sagar Women Group	28	5.33
	Janchetana Women Group	25	4.76
Palpa	Fulbari Women Group	24	4.57
	Shanti Women Group	31	5.90
	Ekata Women Group	24	4.57
	Shrijanshil Women Group	22	4.19
	Laligurans Women Group	21	4.00
	Kalika Women Group	26	4.95
	Ujjwal Women Group	25	4.76
	Adarsha Women Group	29	5.52
	Saraswati Women Group	26	4.95
Rupandehi	Deep Jyoti Women Group	30	5.71
	Deurali Women Group	25	4.76
	Poornima Women Group	30	5.71
	Chetana Women Group	11	2.10
	Fulbari Women Group	22	4.19
<b>Total</b>		<b>525</b>	<b>100.00</b>

## 3.1 Socio-demographic distributions of the respondents

### 3.1.1 Age

The median age of the respondents was 30 years (Interquartile Range = 10). When the analysis was done district wise, the median age of the respondents in Kapilvastu, Palpa and Rupandehi was 34 years (Interquartile Range = 13), 33 years (Interquartile Range = 12) and 33 years (Interquartile Range = 12) respectively.

### 3.1.2 Ethnic Distribution

HMIS classification for ethnicity was referred to categorize the respondents into various ethnic groups. The ethnic background of majority (58.5%) of the woman was Disadvantaged Janjatis followed by Upper caste groups (27.6%). The endline findings are similar to baseline ethnic characteristics of respondents. Table 2 shows the ethnic distribution of the respondents in baseline and endline.

Table 2 Ethnic Distribution

Ethnicity	Baseline n (%)	Endline n (%)
Dalit	86(17.48)	60(11.4)
Disadvantaged Janjatis	260(52.85)	307(58.5)
Disadvantaged non-dalit Terai caste	2(0.41)	5(1)
Relatively advantaged Janjatis	2(0.41)	5(1)
Upper caste groups	142(28.86)	145(27.6)
Religious Minorities	-	3(0.6)
Total	492(100)	525(100)
P value = 0.026		

### 3.1.3 Religion Distribution

Majority of the respondents, in both baseline and endline, were Hindu, followed by Buddhist (1%). Figure 2 shows the religious distribution of the respondents in baseline and endline.

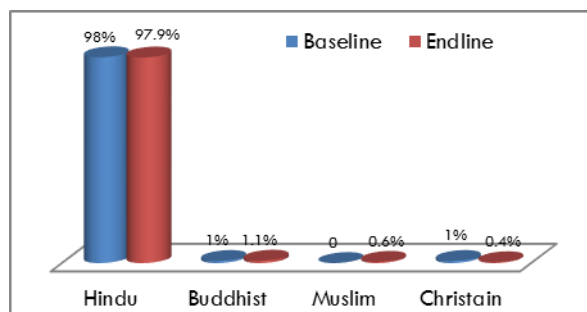


Figure 2 Religion Distribution

### 3.1.4 Educational status

In the endline, most (44.8 %) of the respondents had only informal education. One fifth of the respondents had completed primary education and only 17 % of the respondents had completed secondary education. The percentage of respondent with under graduation and graduation was insignificant. These findings are quite similar to the baseline educational status of the respondents, where almost half of the baseline women had informal education; followed by completed primary education by 32.7 % of the respondents. Table 3 gives a comparative description of the educational status of the respondents in baseline and endline.

Table 3 Educational status of the Respondents

	Baseline n (%)	Endline n (%)
Illiterate	29(5.9)	4(0.8)
Informal education	246(49.9)	235(44.8)
Completed primary education	161(32.7)	115(21.9)
Completed secondary education	42(8.5)	89(17)
Completed higher secondary education	14(2.8)	78(14.9)
Completed bachelor level	1(0.2)	3(0.6)
Completed master level and	-	1(0.2)
Total	493(100)	525(100)
P value <0.001		

### 3.1.5 Main Occupation/Profession

Although, agriculture was the main occupation of the respondents in both baseline and endline; the proportion has been dramatically increased from 41% in baseline to 93.3% in endline. Another significant change has been observed in the proportion of foreign employment, which had been significantly reduced from 25.6% in baseline to 0.8% in endline. Table 4 shows the details of main occupation/profession of respondents in baseline and endline. Of the socio-demographic characteristics, where most of them have

remained comparatively constant in baseline and endline; main occupation/profession of respondents has shown the most fluctuation. Compared to baseline, the proportion change in occupation in endline with respect to ethnicity is given in [Table 5](#) .

**Table 4 Main Occupation/Profession of Respondents**

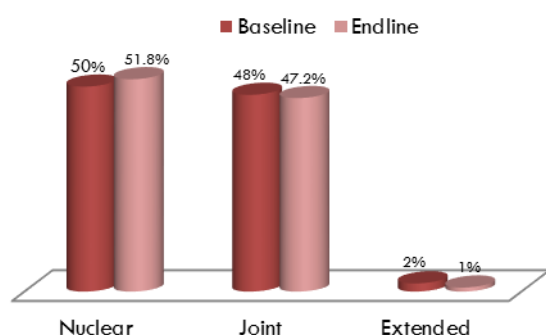
Main Occupation/Profession	Baseline n (%)	Endline n (%)
'Professional/technical/managerial	46(9.3)	8(1.5)
Business	23(4.7)	9(1.7)
Labor (skilled and unskilled)	68(13.8)	13(2.5)
Agriculture	202(41)	485(93.3)
Household worker	5(1)	1(0.2)
Foreign employment	126(25.6)	4(0.8)
Pensions	13(2.6)	-
Others	10(2)	-
Total	493(100)	525(100)
P value <0.001		

**Table 5 Proportion change in occupation with respect to ethnicity**

Cast/Surname	'Professional /technical/ managerial	Business	Labor (skilled and unskilled)	Agriculture	Household worker	Foreign employment
Dalit	-3.6	-1.9	-6.6	52.9	-2.3	-31.4
Disadvantaged Janajatis	-10.3	-2.2	-15.7	49.9	-0.1	-17.8
Disadvantaged non-dalit Terai caste	0	0	-50	100	0	-50
Relatively advantaged Janajatis	-50	0	0	50	0	0
Upper caste groups	-4.9	-4.2	-4.2	52.8	-1.4	-33.1
Religious Minorities	0	0	0	100	0	0

### 3.1.6 Family Type

The family types of most of the respondents have been fairly comparable in baseline and endline. In endline, family types of most of the respondents were either nuclear (51.8%) or joint (47.2%); whereas, insignificant proportion (1%) of the respondents had extended type of family; the findings being similar to baseline. [Figure 3](#) shows the family type of respondents in baseline and endline.



**Figure 3 Family Type of Respondents**

### 3.1.7 Sufficiency of Annual Income

Differences in response with regards to sufficiency of annual income have been observed in endline with respect to baseline. In baseline, more than half (53%) of the respondents had some savings after meeting all the annual expenditures. This proportion has dropped down to 26.3% in the endline. Similarly, a quarter of the respondents in baseline earned annual income that was sufficient to meet their annual expenditures. This figure has been raised to 50% in the endline. [Table 6](#) shows the sufficiency of annual income in baseline and endline.

**Table 6 Sufficiency of Annual Income**

Income Sufficient for	Baseline n (%)	Endline n (%)
3 month	34(7)	32(6.1)
6 months	39(8)	44(8.4)
9 month	34(7)	46(8.8)
1 year	123(25.2)	262(50.3)
Some saving	259(53)	137(26.3)
Total	489(100)	521(100)
P value <0.001		

## 3.2 Knowledge on Family planning

The analysis of knowledge on family planning revealed that almost all (99.6%) respondents had heard about family planning. Similarly, 67.8% of the woman had correct understanding about family planning. More than half (62.1%) of the respondents correctly defined family planning as a method to avoid unwanted pregnancy. Few of the woman also incorrectly defined family planning as Methods to prevent sexually transmitted diseases (5.7 %) and method to protect from serious illnesses (5.1%). These findings are similar to the baseline findings. [Table 7](#) gives a description of respondent's knowledge on family planning in baseline and endline.

**Table 7 Knowledge on Family planning**

Heard about Family planning	Baseline n (%)	Endline n (%)
No	1(0.2)	2(0.4)
Yes	490(99.8)	521(99.6)
<b>Total</b>	<b>491(100)</b>	<b>523(100)</b>
<b>P value = 0.737</b>		
<b>Women who correctly Understand about Family Planning</b>		
No	189(38.6)	169(32.2)
Yes	301(61.4)	356(67.8)
<b>Total</b>	<b>490(100)</b>	<b>525(100)</b>
<b>P value = 0.039</b>		
<b>Women understanding on Family Planning</b>		
No response	142(29)	17(3.2)
Method to avoid unwanted pregnancy	281(57.3)	326(62.1)
Methods to prevent STI	20(4.1)	30(5.7)
Method to protect from serious illnesses	16(3.3)	27(5.1)
Others	31(6.3)	125(23.8)
<b>Total</b>	<b>490(100)</b>	<b>525(100)</b>

### 3.2.1 Source of information on family planning

The source of information on family planning was investigated in terms of first hand source and additional source. Further analysis was done to reveal the proportion of women who knew about at least 2 sources for obtaining additional information on family planning. In baseline, most of the respondents identified friends/neighbors (21.3%), school/ teacher (19.9%), FCHV (18.6%), women's literacy group (18.0%) and health institution/ health workers (12.5%) as the source for obtaining first information on family



planning. A slight difference in proportion was observed in endline where women's literacy group (24.7%), FCHV (20.4%), school/ teacher (18.1%) and friends/neighbors (17.1%) were respondent's choice of source of first information on family planning in descending order. Similarly, family, husband, media (TV radio/ newspaper/pamphlet) and pharmacy were also identified as the source for obtaining first information on family planning but their proportion was comparatively insubstantial [Table 8](#). Similar to the baseline findings, in endline as well health institution/ health workers (49.5%) and FCHV (33.7%) were identified as the major sources for obtaining additional information on family planning [Table 8](#). In endline, substantial proportion (94%) of the woman lacked the knowledge on at least 2 sources for obtaining additional information on family planning. Only 6% of the women knew about at least 2 sources for obtaining additional information on family planning. However, there has been slight increase in proportion of women who knew about at least 2 sources for obtaining additional information on family planning in endline (6%), compared to baseline proportion of 3%. [Figure 4](#) shows the comparative proportion of women who know at least 2 sources for additional information in endline with respect to baseline.

**Table 8 Source of information on family planning**

Source of first information on family planning	Baseline n (%)	Endline n (%)
Friends/neighbors	104(21.3)	89(17.1)
School/ Teacher	97(19.9)	94(18.1)
FCHV	91(18.6)	106(20.4)
Women's literacy group	88(18)	128(24.7)
Health Institution/ health worker	61(12.5)	43(8.3)
Family	24(4.9)	20(3.9)
Husband	17(3.5)	14(2.7)
Media (TV Radio/ Newspaper/Pamphlets)	5(1)	2(0.4)
Pharmacy	1(0.2)	22(4.2)
Cooperatives	-	1(0.2)
<b>Total</b>	<b>488(100)</b>	<b>519(100)</b>
<b>Source of additional information *</b>		
Health Institution/ health workers	206(42.2)	254(49.5)
FCHV	176(36.1)	173(33.7)
Women's literacy group	47(9.6)	30(5.8)
Friends/Neighbors	44(9)	33(6.4)
Husband	22(4.5)	24(4.7)
School/ teacher	5(1)	6(1.2)
Family	3(0.6)	6(1.2)

Pharmacy	3(0.6)	18(3.5)
Cooperatives	2(0.4)	7(1.4)
* Denotes multiple response		

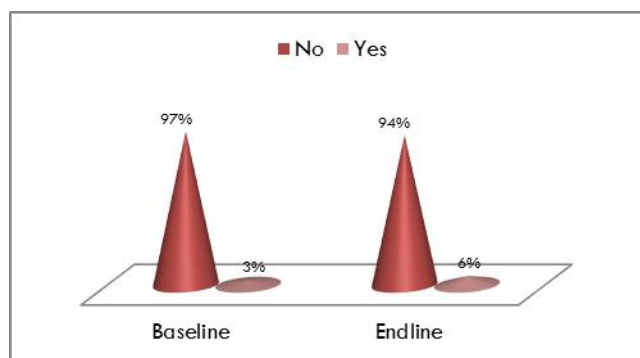


Figure 4 Women who know at least 2 sources for additional information

### 3.2.2 Knowledge on contraceptives

The analysis of knowledge on different types of contraceptives revealed that majority of the respondents had heard about short acting methods of contraception namely; pills/ oral tablets (91%), condom (90%) and depo/sangini (96%). In context to long acting method of contraception, more than half of the respondents had heard about implant (64.7%) and intra uterine device (58.3%). Similarly, regarding permanent method of contraception, 38.2% and 66.2% of the respondents had heard about male sterilization/vasectomy and female sterilization /minilap respectively. Comparing these findings with baseline, the proportion of respondents who have heard about these contraceptives has increased for each of the contraceptives types (Table 9). Among the women who had heard about the various types of contraceptives, a further analysis was done to assess the proportion of women who had heard about at least four types of contraceptives. The analysis revealed that majority of the respondents (81%) had heard about at least four types of contraceptives, which shows an increment over the baseline proportion of 60% (Figure 5). Compared to baseline proportion of 23%; there has been a substantial increase in proportion of women who knew about emergency contraceptives (EC) in endline (80.8%). Figure 6

Table 9 Heard about different types of contraceptives

Types of contraceptives*	Baseline n (%)	Endline n (%)
Pills/ oral tablets	395(80.9)	474(91)
Condom	418(85.7)	469(90)
Sangini	446(91.4)	500(96)
Intra Uterine Device	233(47.7)	304(58.3)
Implant	242(49.6)	337(64.7)
Vasectomy	165(33.8)	199(38.2)
Minilap	215(44.1)	345(66.2)

\* Denotes multiple response

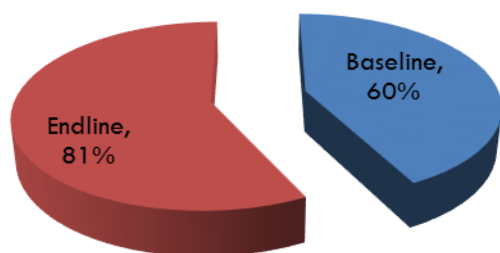


Figure 5 Women who heard at least four types of contraceptives

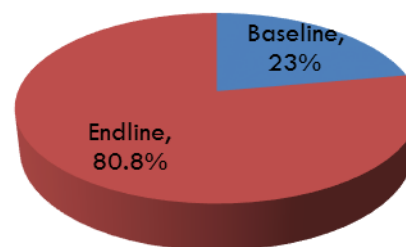


Figure 6 Women who know about Emergency Contraceptives

### 3.2.3 Knowledge on Source for obtaining contraceptive devices

The knowledge of the woman on source for obtaining contraceptive devices was explored. The analysis revealed that majority (72.3 %) of the woman identified government health institution followed by FCHV (10.7%) as the source for obtaining contraceptive devices. Similarly, private health institution (5.8%), pharmacy (8.1%), non-governmental health institution (1.7%) and cooperatives (1.4%) were also identified as the source for obtaining contraceptive devices but by fewer proportions of the respondents. Comparing these findings with the baseline, although the findings are to some extent similar, the proportion has increased in endline for government health institution (Table 10).

Table 10 Women who knew where to get contraceptive devices

Source for obtaining contraceptive devices	Baseline n (%)	Endline n (%)
Government health institution	303(68.2)	373(72.3)
Female community health volunteer	70(15.8)	55(10.7)
Private health institution	35(7.9)	30(5.8)
Pharmacy	28(6.3)	42(8.1)
Non-Governmental health institution	6(1.4)	9(1.7)
Cooperatives	2(0.5)	7(1.4)
Total	444(100)	516(100)

### 3.3 Practice of Family planning

#### 3.3.1 Use of Family planning devices

The practice of family planning was assessed in terms of ever use and current use. A further inquiry was made to assess the types of contraceptive ever used and currently used. The findings revealed that 81.1 % of the respondents (couple) had ever used any family planning methods, which is an increment over the baseline proportion of 73% use (Figure 7).

Short term contraceptives were the most commonly ever used contraceptives. Sangini/depo/injectable was the most frequently used contraceptives among the respondents in past, followed by oral contraceptives/pills (31.7%). The ever use of long acting contraceptives were low i.e. implant was used by only 5.2% of the cases; whereas only 4.7% of the cases used intra uterine devices (IUDs)/ Copper T. With respect to permanent method of contraception, female sterilization/ minilap were a popular choice among respondents and were ever used by 16.7% of the woman; whereas the use of male sterilization/ vasectomy was comparatively low i.e. 7.4%. The findings are comparatively similar to the baseline findings (Table 11). In context to current use of any family planning method, half (50%) of the respondents (couples) were currently using any family planning method (Figure 8); the proportion being slightly less than the baseline proportion of 52%. Likewise the findings for ever use of contraceptives; short term contraceptives were the most commonly used current contraceptives too. Sangini/depo/injectable was the most frequently used current contraceptives among the respondents. Sangini, pills/ oral tablets and condom were currently used by 21.6%, 12.8% and 8.4% of the respondents respectively. The current use of long acting contraceptives were low i.e. implant was used by only 8 % of the cases; whereas only 4.8 % of the cases used Intra Uterine Devices (IUDs)/ Copper T. With respect to permanent method of contraception, female sterilization/ minilap were a popular choice among respondents and were used by 26 % of the woman; whereas the use of male sterilization/ vasectomy was 18.4 % (Table 13). Compared

to the baseline, there has been a decline in the proportion of current short term contraceptives users; whereas, a substantial increase in proportion of current users of permanent contraceptives, especially vasectomy was observed. The median duration of using current family planning methods was 60 months (Interquartile Range = 96).

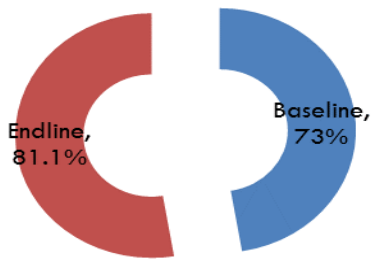


Figure 7 Couple ever used any Family planning

Table 11 Types of Contraceptives Ever Used

Types of Contraceptives	Baseline n (%)	Endline n (%)
Pills/ oral tablets	94(28.1)	129(31.7)
Condom	52(15.5)	67(16.5)
Sangini	130(38.8)	161(39.6)
Intra Uterine Device	14(4.2)	19(4.7)
Implant	28(8.4)	21(5.2)
Vasectomy	17(5.1)	30(7.4)
Minilap	56(16.7)	68(16.7)
Total	391(116.7)	495(121.6)

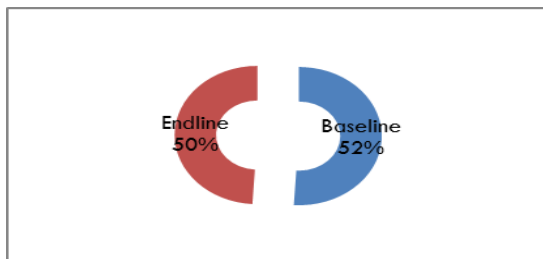


Figure 8 Spouse currently using any Family planning method

Table 12 Current use of FP stratified by age

Age group	Baseline n (%)		Endline n (%)	
	FP Non-user	FP User	FP Non-user	FP User
15-19	13(6)	6(2.5)	8(3.2)	1(0.4)
20-24	51(23.6)	35(14.8)	31(12.4)	24(9.6)
25-29	45(20.8)	61(25.8)	42(16.9)	43(17.1)
30-34	34(15.7)	39(16.5)	57(22.9)	60(23.9)
35-39	34(15.7)	35(14.8)	51(20.5)	51(20.3)
40-44	22(10.2)	41(17.4)	34(13.7)	43(17.1)
45-50	17(7.9)	19(8.1)	26(10.4)	29(11.6)
Total	216(100)	236(100)	249(100)	251(100)

Table 13 Types of family planning methods currently being used by spouse

Types of family planning methods	Baseline n (%)	Endline n (%)
Pills/ Oral Tablets	43(18.1)	32(12.8)
Condom	24(10.1)	21(8.4)
Depo/ Sangini	61(25.6)	54(21.6)
Intra Uterine Device (IUD)	7(2.9)	12(4.8)
Implant	29(12.2)	20(8)
Vasectomy	19(8)	46(18.4)
Minilap	55(23.1)	65(26)
Total	238(100)	250(100)

### 3.3.2 Source and cost for obtaining Family planning devices:

Among the current users of FP, further investigation was done to assess the source for obtaining FP devices as well the cost incurred in obtaining the devices. Majority (81.8%) of the respondents had obtained the family planning devices from government health institution (Table 14). Private health institute, non-government institutions, pharmacy, cooperatives and mobile camps were also identified as the sources for obtaining FP devices, but by comparatively fewer respondents; the findings being similar to baseline (Table 14). Majority of the respondents (80%) did not pay for the FP devices they have used (Figure 9). Comparatively a slightly higher proportion of respondent's i.e. 89% of the respondents had reported that they did not pay for the FP devices in baseline study. Of the 20% of the respondents who paid for FP devices; the median amount paid by them was NRs. 50 (Interquartile Range = 55).

Table 14 Sources for currently used Family planning devices

Sources	Baseline n (%)	Endline n (%)
Government health institution	201(85.9)	198(81.8)
Private health institute	16(6.8)	11(4.5)
Non-government institutions	5(2.1)	7(2.9)
Pharmacy	5(2.1)	17(7)
Cooperatives	1(0.4)	2(0.8)
Mobile camps	6(2.6)	7(2.9)
Total	234(100)	242(100)

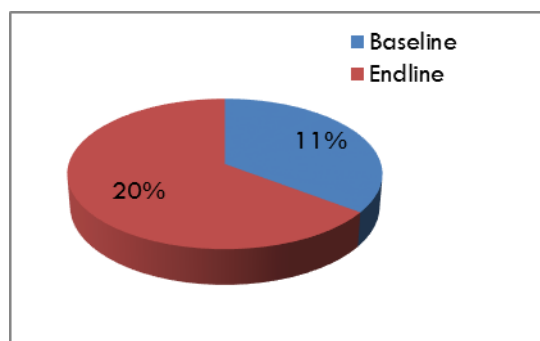


Figure 9 Pay for the family planning devices

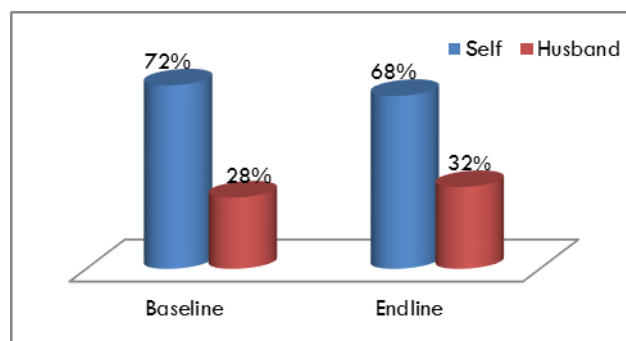


Figure 10 Decision made to use the current family planning method

### 3.3.3 Motivation and decision making for FP use

It was overwhelming to see that between the couple, majority (68%) of the woman made self-decision to use the current family planning method (Figure 10); although this proportion has been declined from a baseline proportion where 72% of the woman made self-decision to use the current family planning method. Among the current users of FP, the main source of motivation was husband (68.4%) and FCHV (14.4%); findings being consistent to baseline results. Family, neighbor, health worker, friend and local resource person were also identified as source of motivation, by comparatively lesser proportion. (Table 15)

Table 15 Source of motivation for current use of FP

Person who motivated to use the current Family planning method	Baseline n (%)	Endline n (%)
Husband	119(56.9)	143(68.4)
Family	12(5.7)	21(10)
Friend	4(1.9)	1(0.5)

<b>Neighbor</b>	<b>10(4.8)</b>	<b>1(0.5)</b>
<b>Health worker</b>	<b>8(3.8)</b>	<b>9(4.3)</b>
<b>FCHV</b>	<b>54(25.8)</b>	<b>30(14.4)</b>
<b>Local resource person</b>	<b>2(1)</b>	<b>4(1.9)</b>
<b>Total</b>	<b>209(100)</b>	<b>209(100)</b>

### 3.3.4 Reasons for not using family planning devices

The reasons for not using family planning devices were explored among the respondents who did not use any types of family planning devices at the time of this study. The main reason identified for not using FP devices currently was husband not living together (88.8%). In smaller proportion of woman, lack of availability of devices, lack of awareness, shyness to use the device and lack of availability at the proximity were identified as the reasons for not using family planning devices. Similar findings were observed in baseline study too (Table 16).

**Table 16 Reason for not using any family planning methods**

<b>Reasons</b>	<b>Baseline n (%)</b>	<b>Endline n (%)</b>
<b>Husband not living together</b>	<b>122(90.4)</b>	<b>151(88.8)</b>
<b>Device not available</b>	<b>6(4.4)</b>	<b>5(2.9)</b>
<b>Lack of awareness</b>	<b>3(2.2)</b>	<b>5(2.9)</b>
<b>Due to shyness</b>	<b>3(2.2)</b>	<b>1(0.6)</b>
<b>Too far</b>	<b>1(0.7)</b>	<b>8(4.7)</b>
<b>Total</b>	<b>135(100)</b>	<b>170(100)</b>

### 3.3.5 Willingness and preference to use family planning devices

The willingness and preference among the couple for using family planning devices in future were explored among the respondents who did not use any types of family planning devices at the time of this study. In majority of the cases (54.9%), the woman was herself willing to use the FP method; whereas, in approximately 18.7% of the respondents, both were willing to use; findings being consistent with baseline study. The willingness among husband to use the FP method was comparatively low i.e. only 15.5%; however this figure has substantially increased compared to baseline. Similar to baseline, it was also surprising to see that among about 11 % of the respondents both husband and wife were neither using any FP method currently nor they are unwilling to use it in future. Table 17



An inquiry into the preference among couple to use the family planning method revealed that in majority of the cases (82%), the couple preferred wife to use the FP methods (Figure 11). However, compared to baseline the preference of husband to use the FP methods has increased in endline (Figure 11). The discussion among couples about family planning was overwhelming as 87% of the respondents discussed about FP with their husband; the proportion being slightly increased than baseline (Figure 12).

Table 17 Willingness to use the family planning methods

	Baseline n (%)	Endline n (%)
Me	186(57.1)	223(54.9)
Both	78(23.9)	76(18.7)
No one	45(13.8)	44(10.8)
Husband	17(5.2)	63(15.5)
Total	326(100)	406(100)
P value <0.001		

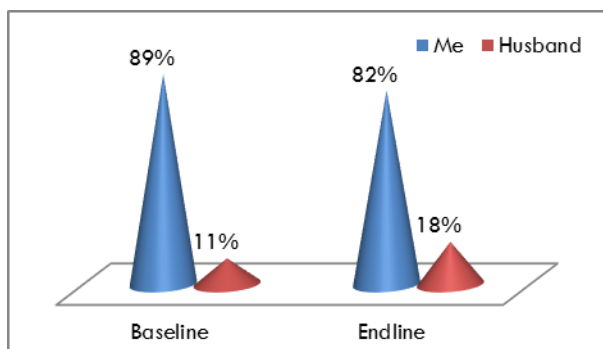


Figure 11 Preference among couple to use the Family planning method

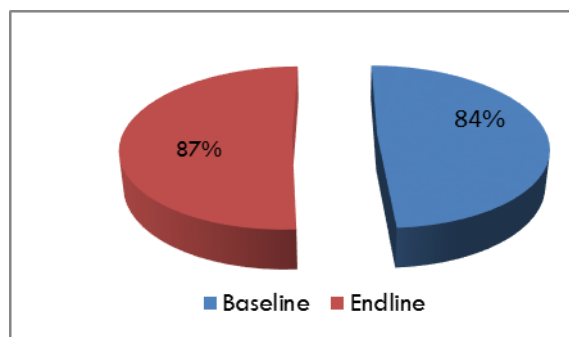


Figure 12 Discussion about family planning with husband

### 3.3.6 Knowledge and practice of birth spacing

The median (IQR) optimal gap between two births as expressed by women in baseline and endline was 60 (24) months and 60 (15) months respectively ( $p=0.42$ ). Majority (77%) of the woman discuss about birth spacing with their husband; the proportion being slightly increased than baseline (Figure 13). Almost all (98%) of the woman opined that family planning method helps in increasing quality of life (Figure 14).

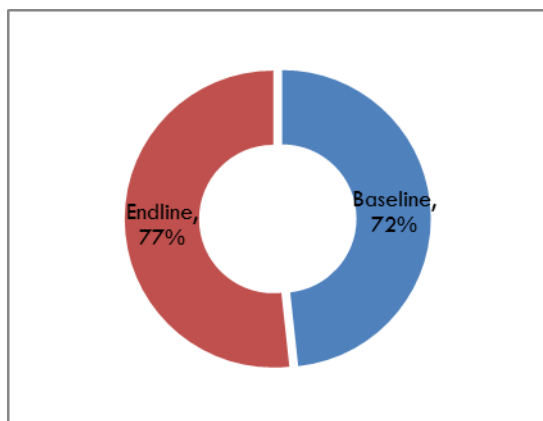


Figure 13 Discussion with husband about birth spacing

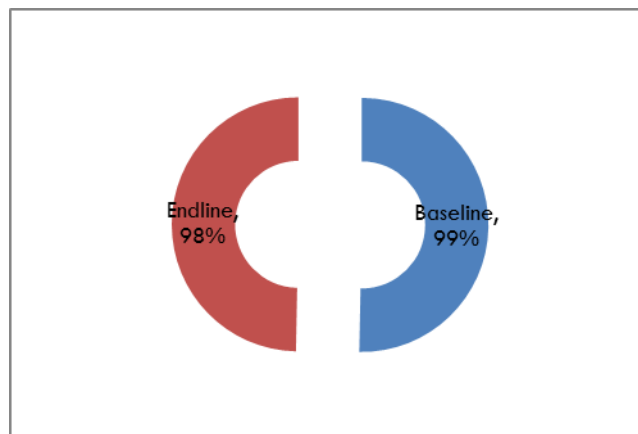


Figure 14 Family planning method helps in increasing quality of life

### 3.3.7 Satisfaction towards health facility and health workers

Overall, majority of the woman seems to be satisfied with various aspects of health facility as well as health workers. Majority (76.7%) of woman opined that the waiting time at the health institution to obtain services was not long. Similarly, almost all of the women were satisfied with cleanliness of the institute (98.8%) and with the privacy during examinations/ checkup (94.8%). The behavior of the health worker towards the client appear satisfactory as almost all (91.4%) of the woman expressed that the behavior of health workers was polite and respectful. Similarly in majority (88.1%) of the cases, woman perceived that health workers did not forced to accept any family planning methods. Almost all (98.8%) of the women expressed their satisfaction with the time provided by the health workers. Overall, 98.8% of the woman expressed satisfaction with the overall behavior of the health workers. The responses to satisfaction towards health facility and health workers were similar in baseline and endline (Table 18).

Table 18 Satisfaction towards health facility and health workers

		Baseline n (%)	Endline n (%)	P value
Waiting time perceived too long (n=325)	No	248(76.3)	323(76.7)	0.481
	Yes	318(98.8)	416(98.8)	0.600
Satisfaction with the cleanliness of the institute (n=322)	Yes	299(92.6)	399(94.8)	0.139
	Yes	318(98.8)	414(98.8)	0.603
Satisfaction with the privacy during examinations/ checkup (n=323)	Yes	312(96.6)	385(91.4)	0.003
	Yes	312(96.6)	385(91.4)	0.003

<b>Health workers forced to accept any family planning methods (n=323)</b>	<b>No</b>	<b>252(78)</b>	<b>371(88.1)</b>	<b>&lt;0.001</b>
<b>Satisfaction with the overall behavior of the health workers (n=322)</b>	<b>Yes</b>	<b>316(98.1)</b>	<b>415(98.8)</b>	<b>0.325</b>

### 3.4 Findings of Focus Group Discussion

Six FGD were organized in three districts: Palpa, Rupandehi and Kapilvastu. Three women, two men and one adolescent group were formed for the FGD to discuss on the benefits and challenges faced during the implementation of FP activities.

#### 3.4.1 Qualitative Findings of Women’s Group

Three women’s group, one in each of the three districts was involved in a focus group discussion. The women’s groups involved in FGD included: Namuna women’s group, Dhuvan-5, Palpa, Chetanshil women’s group, Poraha-4, Rupandehi and Janachetana women’s group, valward-6, Kapilvastu. Following six main themes emerged from the women’s group:

##### 3.4.1.1 Knowledge and Relation between TICA Project and DEEP Project

DEEP project improved economic status by establishing cottage industry, improved skill and created employment opportunity, whereas TICA project improved awareness on family planning methods. Therefore, DEEP was involved in economic activities, skill development, and income generation whereas TICA helped in family planning (FP) services.

##### 3.4.1.2 Activities/Intervention of TICA Project

The focus group identified that TICA project helped in capacity building by training health workers on FP services and orienting different male and female groups on market management. Different activities of TICA project as identified by women’s group FGD includes: discussion about family planning, income generation activities, conduction of FP camps and awareness raising activities on FP services.

##### 3.4.1.3 Benefits/ Outcomes of TICA project

Several benefits of TICA project was identified by the Women’s group FGD. The participants of the project were more open and able to talk with others and they had developed strong organizational structure, increased participation in meetings. They also benefited by gaining respect and support from the family members, individual and community. They felt that the project changed the perception and attitude

of family and community on use of FP services. The women were able to raise voice against anti social activities: alcoholism and gambling. They were also able to perform collaborative social service. TICA project also helped to increase the support and motivation of family for the women to involve in social work. TICA increased the purchasing capacity of the women through income generating activities (household goods, medicine, food, stationary etc. for children) which built positive attitude and respect from the family members. As the income generating activities were increased, the economic burden of family was reduced and it helped to change the community attitude. TICA also increased knowledge and experiences sharing on pregnancy, health check up, breastfeeding and menstruation to adult and young women. An increased knowledge on family planning methods: pills, condom, sangini, Intra Uterine Device, implant, vasectomy and minilap, adolescent sexual and reproductive health was another benefit of TICA project.

#### **3.4.1.4 Poverty eradication and agriculture activities and improvement of the economic status**

TICA project helped to increase economical status through animal husbandry (goat, buffaloes, and cows), bee keeping, fish keeping, milk production, and other skillful training. As for example -Green vegetables cultivation, mushroom production and fresh home regulation by Namuna women Group, Dhuvan-5, Palpa and investment of 60 thousands in community based agriculture program and irrigation by Chetanshil women Group, Poraha-4, Rupandehi. It also helped to increase saving capacity and practices in saving and credits facilities, increased family income and purchasing capacity. TICA also helped to improve the economic status by developing entrepreneurship, improving collective bargaining capacity and enabling to take decision independently. As a representative sample of the participants' responses, one woman best captured the theme of improved economic status in her comments:

*“Before joining the DEEP project, it was quite hard to manage education, household activities but TICA project empower to save money for co-operative and easy to manage household activities”.*

#### **3.4.1.5 Availability of contraceptive services which change knowledge in use of FP services**

Women's group FGD has acknowledged that TICA project increased knowledge on family planning methods such as oral pills, condom, sangini, Intra Uterine Device, implant, vasectomy and minilap and ANC, PNC visit. It also ensured easy accessed to family planning services from health worker, health Post, Marie Stopes, village area's clinic, NGO and INGO sectors. Many activities about FP have been done in collaboration with Health worker, Health Post and Medical Sectors.

#### **3.4.1.6 Suggestion for TICA Project**

The women's group FGD suggested that participants needed non-formal education, training and awareness program. Similarly, they identified that further skill development activities are required for participants. They also revealed the need for more economic support in addition to the need of education materials which helps to discuss FP services. They emphasized on providing education to the co-operative members specially women. The need to increase self-reliance and self confidence on oneself and among friends and the need to further aware about sanitation and health related activities were also disclosed.

#### **3.4.2 Qualitative Findings of Male Group**

Two FGD were organized in Kapilvastu and Palpa districts. The men's groups involved in FGD included: Hathousa-6, Kapilvastu, and Male Group Sathyabati-4, Palpa. Following six main themes emerged from the male's group:

##### **3.4.2.1 Knowledge and Relation between TICA Project and DEEP Project**

All of the group members knew about Family planning. According to the male groups, DEEP project conducted FP program, sanitation program, market management, and awareness program and skill development. It discussed about Gender Based Violence. They also acknowledged that the project improved their economic status and helped to educate their children. DEEP Project and TICA promoted FP services and reduced number of child in community.

##### **3.4.2.2 Activities/Intervention of TICA Project**

The male's focus group identified that TICA project helped in capacity building by training health workers on FP services and orienting different male and female groups on market management. Different activities of TICA project as identified by male's group FGD includes: promotion of economic empowerment, income generating activities, conduction of FP camps and awareness raising activities on FP services.

##### **3.4.2.3 Benefits/ Outcomes of TICA project**

Several benefits of TICA project was identified by the male's group FGD. The participants of the project were able to do social service collaboratively and improved family support and increased involvement in the social work. The project also improved employment and increased involvement of male and female in group discussion on FP, GBV, child marriage and sanitation. The project ensured direct participation of men group in market management and information centre management.

#### **3.4.2.4 Poverty eradication and agriculture activities and Improvement of the economic status**

TICA project helped to increase economical status through animal husbandry (goat, buffaloes, and cows), bee keeping, fish keeping, milk production, and other skillful training. It also helped to increase saving capacity and practices in saving and credits facilities; improved income generating skills; increased family income and purchasing capacity. TICA also helped to improve the economic status by developing entrepreneurship, improving collective bargaining capacity and enabling to take decision independently.

#### **3.4.2.5 Availability of contraceptive services which change knowledge in use of FP services**

Men's group FGD has acknowledged that TICA project increased knowledge on family planning methods such as oral pills, condom, sangini, Intra Uterine Device, implant, vasectomy and minilap. It also ensured easy accessed to family planning services from health worker, health Post, Marie Stopes, village area's clinic, NGO and INGO sectors. The project also helped to increased activities on FP in collaboration with Health worker, Health Post and Medical Sectors

#### **3.4.2.6 Suggestion for TICA Project**

The males group suggested that TICA Project should provide educational materials for the program and additional fund is needed for program. They also suggested including training on agriculture and business.

### **3.4.3 Qualitative Findings of Adolescent Group**

One FGD was organized in Palpa districts from Sathi Shichya Group, Baldenghadi-2, Palpa. Following four main themes emerged from the adolescent group:

#### **3.4.3.1 Activities/Intervention of TICA Project**

The major activities of TICA project for adolescent was conduction of Sathi Shichya program for boys and girls and the discussion on Sathi Shichya program in health centre and youth friendly centre. Different learning methods such as games were also introduced.

#### **3.4.3.2 Benefits/ Outcomes of TICA project**

Increased awareness on adolescent health, FP methods like pills, condom, sangini, Intra Uterine Device, Implant, vasectomy and minilap, gender equality, youth friendly program and education on reproductive

health were the main benefits of TICA project as identified by the adolescent group FGD. Additionally, shared learning and experiences to their younger brother, sister, relatives and friends about gender equality and life skill training were other benefits of the project.

#### **3.4.3.3 3.4.3.3 Effects on Society**

According to the Adolescents groups, TICA increased awareness on FP, GBV and child marriage. It also increased knowledge on unsafe sex, reproductive health and FP and helped to reduced child marriage in the community.

#### **3.4.3.4 3.4.3.4 Suggestion for TICA project**

Adolescents suggested that FP services should be provided in periphery level health facilities. They also identified the need for regular availability of newspaper on reproductive health matters and the need to provide educational materials to needy individual.

### **3.5 Effectiveness of TICA**

There were no difference in socio-demographic characteristics between baseline and endline participants in terms of religion ( $p=0.230$ ) and family type ( $p=0.217$ ). However, baseline participants significantly differed from endline participants with respect to age (Mann-Whitney U,  $p<0.001$ ), ethnicity (Table 2), educational status (Table 3), main occupation/profession (Table 4) and sufficiency of annual income (Table 6).

Overall, there has been an augmentation in knowledge of family planning among study participants. Although, almost all of the participants had heard about family planning in both baseline and endline (Table 7); however, greater proportion of endline participants had correct understand about family planning, compared to baseline participants and the difference was statistically significant ( $p=0.039$ ). Majority of the respondents did know about at least 2 sources for additional information of family planning in both baseline and endline (Figure 4). Although, the proportion of women who knew about at least 2 sources for additional information of family planning was slightly higher in baseline, the finding was statistically insignificant ( $p=0.138$ ). There has been a substantial increment in proportion of women who had heard about at least four types of contraceptives in endline, compared to baseline (Figure 5), and the finding was statistically significant ( $p<0.001$ ). Additionally, compared to baseline; there has been a substantial increase in proportion of women who knew about emergency contraceptives (EC) in endline (Figure 5), the finding being statistically significant ( $p<0.001$ ).

A satisfactory success in practice of family planning has been achieved in endline. There has been a statistically significant increment in endline over the baseline (Figure 7), in terms of proportion of couples ever using any family planning methods ( $p=0.001$ ). Compared to the baseline, although there has been a slight decline in the proportion of current users of any of the family planning methods (Figure 8), but the decline was not significant statistically ( $p=0.624$ ). A greater proportion of respondents paid for the family planning devices in endline compared to baseline (Figure 9), the difference being statistically significant ( $p=0.008$ ).

In endline, the willingness among husband to use the FP method was comparatively low i.e. only 15.5%; however this figure has substantially increased compared to baseline (Table 17) and the difference is statistically significant ( $p<0.001$ ). Consistent to baseline, in endline too in majority of the cases (82%); the couple preferred wife to use the FP methods. However, compared to baseline the preference of husband to use the FP methods has increased in endline (Figure 11) and the finding was statistically significant ( $p=0.013$ ). In both baseline and endline, majority of the respondents discussed about FP with their husband; the proportion being slightly increased than baseline (Figure 12), but the increment was not significant statistically ( $p=0.105$ ).

Majority of the woman, both in baseline and endline, discuss about birth spacing with their husband; the proportion being slightly increased in endline (Figure 13) and the increment was statistically significant ( $p=0.048$ ). There was no statistically significant difference in women between baseline and endline (Figure 14) in terms of their opinion that family planning method helps in increasing quality of life ( $p=0.109$ ).

There was statistically no difference among respondents on their satisfaction with various aspects of health facility as well as health workers; except for polite and respectful behavior of health workers and forcefulness of health workers forced to accept any family planning methods (Table 18). Although the behavior of the health worker towards the client appear satisfactory as almost all of the woman, in baseline and endline expressed that the behavior of health workers was polite and respectful but compared to baseline lower proportion of women felt that the behavior of health workers was polite and respectful and the finding was significant statistically ( $p=0.003$ ). Similarly, greater proportion of women in endline compared to baseline expressed that health workers forced them to accept the family planning methods and this finding was also statistically significant ( $p<0.001$ ).



# Chapter4 CONCLUSIONS AND RECOMMENDATIONS

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## 4.1 Conclusions

Data was collected from a total of 525 and 493 women; from 20 and 16 different Women Groups in baseline and endline respectively. In both baseline and endline, majority of the respondents were Hindu and had ethnicity either Disadvantaged Janajatis or Upper caste groups. Similarly, in both baseline and endline, majority of the respondents had Informal education. Most of the respondents, in both baseline and endline, lived in either nuclear or joint family. In both baseline and endline, agriculture was the main occupation of majority of the respondents; however, there was a dramatic increase in proportion of female involved in agriculture in endline, compared to baseline. There were no difference in socio-demographic characteristics between baseline and endline participants in terms of religion and family type. However, baseline participants significantly differed from endline participants with respect to ethnicity, educational status, main occupation/profession and sufficiency of annual income.

The effectiveness of TICA was measured in terms of change in knowledge and practice for FP use during the intervention, changes in decision making choice by couples for FP methods and utilization and change in negotiation skills of women on FP methods use after the integration process. Overall, there has been an augmentation in knowledge of family planning among study participants. Compared to baseline participants greater proportion of endline participants had correct understand about family planning. A substantial increment in knowledge of women in endline was achieved in terms of knowledge on at least four types of contraceptives and knowledge on emergency contraceptives (EC).

Similarly, a satisfactory success in practice of family planning was achieved in endline. A significant increment in endline over the baseline was seen in terms of proportion of couples ever using any family planning methods. Compared to baseline, the use of short term contraceptives has decreased in endline, whereas the use of permanent method of contraception, especially male sterilization/ Vasectomy has increased.

Comparative study of baseline and endline, it appeared that female preferred long acting contraceptives over short acting in endline. This was demonstrated by decreased proportion of women using pills/ oral tablets and depo/ Sangini and increased proportion of women using intra uterine device (IUD); however the proportion of women using implant has declined. In both baseline and endline, majority of the respondents had obtained the family planning devices from government health institution and greater proportion of respondents paid for the family planning devices in endline compared to baseline.

Compared to baseline, in endline, husbands were more willing to use the FP method. Similarly, compared to baseline the preference among couple for husband using the FP methods has increased in endline. These facts, in conjunction with increased proportion of vasectomy in endline, further proves that males more willing to utilize a FP method. There has also been improvement in negotiation skills of women for FP and child spacing. The proportion of the women, in endline, discussing about FP with their husband has slightly increased than baseline, but the increment was not significant statistically. However, the proportion of the woman discussing about birth spacing with their husband slightly increased in endline.

Overall, in both base line and endline, majority of the women were satisfied with various aspects of health facility as well as health workers. However in endline, compared to baseline, a greater proportion of women expressed that the behavior of health workers was not polite and respectful. Similarly, greater proportion of women in endline compared to baseline expressed that health workers forced them to accept the family planning methods.

## **4.2 Recommendations/lessons learned**

Although the proportion increased in endline, it was discouraging to see that the willingness among husband to use the FP method was still low (15.5%). Thus, male should also be encouraged to participate in family planning issues. Male involvement in FP should be the area of action and research in future. It was also surprising to see that 13.8 % and 10.8% of the couple in baseline and endline respectively, were neither using any FP method currently nor they are unwilling to use it in future. Specifically, these couples should be counseled on FP. In-depth study among these couples can be conducted to identify the barriers to FP utilization.

It has been noted that FCHV, mother groups, school/teacher, friends/neighbors, and women's literacy groups are the good source of information on family planning. Therefore, such groups need to be mobilized effectively. The success of TICA in terms of increasing knowledge of FP, increasing the practice of long term and permanent method of contraception and promoting male willingness, participation in FP, suggests that integration of FP into agriculture and empowerment programme, immunization and non-health sector may increase the contraceptive prevalence rate (CPR).

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## Annex 1 Core team for the project

S.N	Resource Person	Affiliation
1.	Prof. Naveen Shrestha	Principal Investigator (PI) , BNMT Nepal
2.	Mr. Suman Chandra Gurung	Deputy Principal Investigator, BNMT Nepal
3.	Ms. Saruna Ghimire	Senior Research Associate, BNMT Nepal

## Annex 2 Terms of Reference for the evaluation team

<b>TERMS OF REFERENCE (ToR)</b> <b>For</b> <b>RESEARCH</b> <b>ON</b> <b>TECHNICAL INTEGRATION COVERAGE AND ACCESS</b>
<p><b>A. Introduction:</b></p> <p>Adventist Development and Relief Agency (ADRA) Nepal is implementing the “ Technical Integration Coverage and Access (TICA) project funded by USAID/APC through ADRA International and implemented by ADRA Nepal in fifteen VDC of three districts: Rupandehi, Palpa and Rupandehi, in western development region of Nepal. The project is integrated into ADRA’s DEEP project in the districts. The total budget of this action is 249,999 for 24 months.</p> <p>ADRA Nepal has planned to conduct research study of the project through an independent external individual consultant researcher. The duration of this survey will be approximately 90 days working days including visits to the project districts, The study is planned to conduct in two phases: before implementation of TICA project in DEEP project areas and after implementation of TICA in DEEP project areas.</p> <p><b>B. Background of the project</b></p> <p>Family Planning (FP) is a priority program of the Government of Nepal. The Government of Nepal’s (GoN) Health Sector Program Implementation Plan 2010-2015 indicates that FP is a high priority and has set the objective to gradually reduce the population growth rate; satisfy demand for high quality services; and reduce unmet need. There has been a notable decline in the contraceptive prevalence rate for modern FP method in the country between 2006 and 2011 as 44% and 43% respectively. Still very far to reach MDG Goal of 67% by 2015.<sup>2</sup>This figure is creating concerns among various stakeholders working in family planning program.</p> <p>Integrating FP into non health-sector development projects can be an effective way to facilitate access to FP and other health services and information for women and communities. ADRA realizes the importance of</p>

<sup>2</sup>Nepal Demographic Health Survey 2006 and 2011.

investing in social and economic development as well as FP/RH. With this purpose ADRA is implementing Technical Integration for Coverage and Access (TICA) project which is a USAID funded project under partnership with Advancing Partners and Communities (APC) through ADRA International. The project duration is for two years starting from February 2014 till January 2016. Total budget includes as US\$ 249,999.

Technical Integration for Coverage and Access (TICA) project will integrate needed FP services into the current Develop Local Economy to Eradicate Poverty (DEEP) Project. The DEEP project aims to improve the economic status of families in the targeted districts. Hence, the project presents an appropriate opportunity for integrating FP activities. TICA is designed to leverage the community access points and resources of DEEP to address family planning needs and challenges in the targeted areas.

The proposed FP activities will concentrate on five Village Development Committees (VDCs) in each of the three districts where DEEP is implemented. First is the *Palpa District* which is a mid-hill district of western Nepal with a total population of 261,180 (male: 115,840; female: 145,340). The contraceptive prevalence rate (CPR) of this district is 35.3% which is slightly higher than the average regional CPR of 31%. Second is the *Rupandehi District* which is a terai district of western Nepal with a population of 880,196 (male: 432,193; female: 448,003). The CPR of this district is 31.6%. Third is the *Kapilvastu District* which is a terai district with a total population of 571,936 (male: 285,599; female: 286,337). The CPR of this district is 33.4%.<sup>3</sup>

Through the TICA project, ADRA will increase the access to and demand for family planning services. ADRA will focus on increasing FP knowledge and demand for services, both of which will be accomplished through behavior change; raising FP awareness of community group members, and trainings; and on increasing service provision by conducting FP camps at community project sites and increasing the capacity of facilities through training and basic equipment.

*Expected Results 1 (ER 1): Increased knowledge and interest of family planning in communities*

To achieve this expected result, two activities will be carried out: 1) Individual and group counseling and education provided to target beneficiaries and (2) Increase in family planning (FP) trainings and awareness campaigns.

*Expected Results 2 (ER2): Improved access to family planning services*

To achieve this expected result (ER2), two activities will be carried out: (1) Increased provision of FP commodities at the community level and (2) Increased FP trainings to service providers at the community level.

*Expected Results 3 (ER3): Improved Quality of Family Planning Services and Education*

To achieve this expected result (ER3), two activities will be carried out: (1) Assess client satisfaction on available FP services and (2) Increase monitoring visits from D/PHO for quality control.

### **C. Background of why this is needed**

The integration of FP and agriculture is an area that has garnered tremendous attention from donors, particularly USAID, over the last few years. The interest for USAID has gained traction, due to the DFAP programs and focus on the 1,000 day “window of opportunity”. Family planning is an essential component of the 1,000 days; as preventing unwanted pregnancies and increasing the birth to delivery intervals lead to improved health and nutrition and reduced maternal and child mortality.

This research is also critical, as TICA focuses on adolescents. The post-2015 Millennium Development Goals (MDGs) will include recommendations for civil society organizations and donors to focus greater efforts on reaching youth and adolescents. Researching effective mechanisms of reaching adolescents with FP interventions and delaying pregnancies will place ADRA above the curve in identifying creative ways to meet the need of this unique population.

Integrating FP into non health-sector development projects can be an effective way to facilitate access to FP and other health services and information for women and communities. Evidence confirms that family planning contributes to broad development goals of poverty reduction, enhanced education, environmental sustainability, and gender equality. But, improving access to contraception has largely remained an effort

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<sup>3</sup> DOHSR, 2010/11

contained within the health sector. Therefore, more evidence is needed on whether and how such efforts can work, and what types of models might be replicated and scaled up. This is a pilot initiative towards future scalability and sustainability.

With this research we aim to collect more systematic evidences to support the integration results.

*Research findings will be used in the following ways:*

- Publications to broaden global awareness about ADRA's work
- Presentations to various stakeholders including donors and peer agencies
- To leverage future proposals that call for the integration of agriculture, health and nutrition, such as DFAPs
- Gather best practices
- Identify a potential niche or "hedgehog" for ADRA
- Distribution to the ADRA network
- Generate evidence to scale related interventions

#### **D. Objective**

##### General

- To assess the effectiveness of FP interventions when paired with agriculture and economic empowerment interventions; and to assess the impact of economic empowerment programs when paired with family planning.

##### Specific

1. To understand the benefits from FP integration into development projects
- 3: To assess change in knowledge and practice for FP use after the integration process
- 4: To assess decision making choice by couples for FP methods and utilization
- 5: To compare negotiation skills of women on FP methods use
- 6: To study relationship between increased FP use and increased income

#### ***Research questions to be answered***

- 1) Do we see an increase in the use of modern FP methods of DEEP beneficiaries after the integration of TICA (stratified by commodity)?
- 2) Are there any changes in FP use before and after integration?
- 3) Does there exist any differences in knowledge and utilization practice in DEEP beneficiaries before and after intervention?
- 4) Are women planning to space children at a greater rate given the tangible benefits from economic empowerment?
- 5) Are males more willing to utilize a FP method or have their wives use a method because they see the economic benefits of DEEP?
- 6) Do women choose different methods due to increased incomes? Do they go from short acting to long acting or permanent?
- 7) Are women negotiating for FP and child spacing after learning about FP via TICA? Is there any change in the negotiation skills before and after TICA implementation?

#### ***Variables under the Study***

##### Independent variables

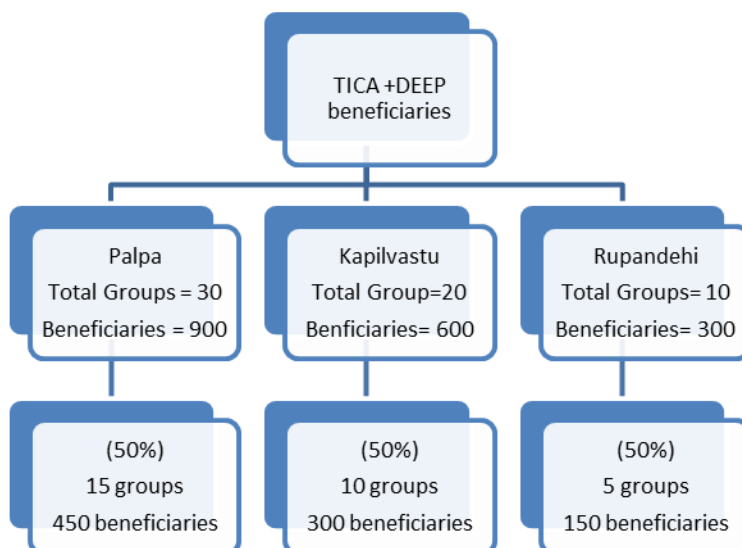
- Individual Income
- Source of Income
- Couple Decision making
- Entrepreneurship
- Education
- Couple Negotiation
- Knowledge on FP methods

**Dependent variables**

- Family Planning method utilization

**Methodologies:**

- The study design will be interventional (first phase as pre intervention and second phase as post intervention)
- The study type will be mixed type including both quantitative and qualitative
- The study method will be descriptive /comparative analytical
- The study populations are married women of reproductive age group belonging to DEEP beneficiaries
- The size of the sample will be 50% of total DEEP beneficiaries from women’s groups i.e. 50% from 1800 (N) = 900 (n). Group classification will also be 50% from total 60 groups = 30 groups
- Sampling frame is married women of reproductive age belonging to DEEP beneficiary. Unit of analysis is individual
- Sampling technique will be non-probability type with Simple Random Cluster Sampling



**Figure 15: Sampling and sample size**

**Instruments**

Research questions	Instrument
1) Is there any change in FP use before and after integration?	<ul style="list-style-type: none"> <li>• Individual and FGD interviews</li> <li>• Quantitative and qualitative questionnaires</li> </ul>
2) Do we see an increase in the use of modern FP methods of DEEP beneficiaries after the integration of TICA (stratified by commodity)?	<ul style="list-style-type: none"> <li>• Individual and FGD interviews</li> <li>• Quantitative and qualitative questionnaires</li> </ul>
3) Does there exist any differences in knowledge and utilization practice in DEEP beneficiaries before and after intervention?	<ul style="list-style-type: none"> <li>• Individual and FGD interviews</li> <li>• Quantitative and qualitative questionnaires</li> </ul>
4) Are women planning to space children at a greater rate given the tangible benefits from economic empowerment?	<ul style="list-style-type: none"> <li>• Individual and FGD interviews</li> <li>• Quantitative and qualitative questionnaires</li> </ul>

5) Are males more willing to utilize a FP method or have their wives use a method because they see the economic benefits of DEEP?	FGD with males	
6) Do women choose different methods due to increased incomes? Do they go from short acting to long acting or permanent for instance?	<ul style="list-style-type: none"> <li>• Individual and FGD interviews</li> <li>• Quantitative and qualitative questionnaires</li> </ul>	
7) Are women negotiating for FP and child spacing after learning about FP via TICA? Is there any change in the negotiation skills before and after TICA implementation?	FGD Women	

### E. Expertise Required

The research consultant/ team should consist of two members and will be led by a Principal Researcher with Advanced Public health degree /MBBS with MPH/ Master Degree with demography, experienced in similar research activities, specifically experienced in Family Planning, familiar to government family planning service system and experienced in integrative approaches on health and economic developments livelihood and economic development. The co- researcher with Master in any discipline, experienced in research of similar researches, should have knowledge on government family planning service delivery and livelihood/entrepreneur development system.

### F. Process/Activities;/Schedule

The proposed research will be carried out in two phases i) first phase pre intervention and ii) second phase post intervention

**Phase 1: Pre intervention of TICA project as baseline research:** As the research intended to study the family planning status of in the sampled area, the study will focus on gathering family planning related information to use as baseline information on different variables and will be completed by September. Based on the preset TICA interventional activities and the recommendations from the first phase study, the activities will be implemented in sampled areas immediate after the first phase study. Since the study is aimed to see the impact of an integrated approach (DEEP and TICA), the second phase of the study is planned in the later quarter of the project (September to December 2015).

- ✓ Conduct baseline information collection by September 2014 (*Note: The baseline information collected had already been started by ADRA Team and required expert's inputs for further questions to be added if any*)
- ✓ Analysis on baseline information collection by first week of November 2014
- ✓ Prepare a baseline report by second week of November 2014.

### Phase 2: Post Intervention of TICA project :

Immediately after first phase of study completed, the TICA proposed interventional activities and the recommendations from the first phase will be carried out after necessary revision and the actions as follows:

- ✓ Revise and finalize tools based on the research questions and as per project requirement by September 2015
- ✓ Orientation to enumerators by October 2015
- ✓ Field level Data Collection by October 2015
- ✓ Analysis on information collected by November 2015
- ✓ Prepare final research report by November 2015



Phase 3:

- ✓ Dissemination of Research Findings
- ✓ Submit for publication

**G. Deliverables**

The project ADRA team will undertake to produce the following deliverables:

**i) First phase: pre intervention period:**

1. Inception report after preliminary meeting with ADRA team
2. Final research tools after reviewing the pre designed tools from ADRA
3. Filed visit plan
4. Draft report of first phase pre intervention period report as baseline report

**ii) Second phase: post intervention period**

1. Final revised tools as required for second phase post intervention research.
2. Field visit plan
3. Submits draft reports and collect the feedback from project team
4. Submits report to ADRA Nepal in documented and electronic version
5. Disseminate research findings in the relevant forum

**G. Reporting:**

The research consultant will prepare a research report that describes the research process .

The research consultant should review the preset baseline tools, analyse the information collected by ADRA team, prepare baseline report with recommendations for interventional approaches.

Comparative findings from first phase and second phase research. Based on the findings, the consultant /team is required to make a brief presentation based on the draft report to ADRA and the staff from research team/the consultant before finalizing the report. The final report should incorporate the feedback and comments provided in this debriefing meeting. This report will set the bench mark for the project for the project period based on the set indicators.

The final report should include the following sections:

1. Executive summary
2. Table of Contents
3. Background
4. Objectives of the Survey
5. Research methodology
6. Findings: including all relevant issues stated in the Specific Objectives
7. Recommendations/lessons learned
8. Appendices:
  - a) Terms of Reference for the evaluation team
  - b) Research tools
  - c) List of places visited
  - d) List of documents reviewed
  - e) List of people interviewed etc.

**Study on Effectiveness of Integration of Family Planning into Agriculture and Economic Empowerment Program for Access and Coverage**

Form #

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Computer Entry #

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Women Group #

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Beneficiary #

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Namaskar!

My Name is ..... I am from ADRA Nepal. We are here to do a survey on adolescence sexual and reproductive health and family planning. This survey will help us to improve our program all over Nepal. Your information is very important and valuable which will only be used to achieve our survey objectives. Your participation is voluntary. You are free not to provide any answers or can quit the interview at anytime.

Your information will be confidential. This interview will last for about 25 minutes.

Do you have any questions for us? Do you wish to take part in this survey?

Thank you.

Willing to participate:


Start the interview:

Not willing to participate:

Do not start the interview:

Place of Interview: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

Name of Interviewer:

Name of Interviewee:

Interview started time: \_\_\_\_\_

Interview ended time: \_\_\_\_\_

**Section A: Socio-demographic Information**

1	Cast/Surname	
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2	Religion			
	Hindu	<input type="text" value="1"/>	Buddhist	<input type="text" value="2"/>
	Muslim	<input type="text" value="3"/>	Christian	<input type="text" value="4"/>

3	How many years you completed on your last Birthday	Age
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4	What is your highest education level?	
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5	What are your main occupation /profession?	
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6	Type of Family?			
	Nuclear	<input type="text" value="1"/>	Joint	<input type="text" value="3"/>
	Extended	<input type="text" value="2"/>		

7	How long your family can eat form your annual income?			
	3 month	<input type="text" value="1"/>	6 months	<input type="text" value="2"/>
	9 month	<input type="text" value="3"/>	1 year	<input type="text" value="4"/>

	We have some saving	5	
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8 Do you have any domestic animals/pets?

a. Yes                      b. No (if no go to question no. 9)

If yes, then what are those animals? Please specify the number.

**Types of Animals Numbers (Current)**

Buffaloes	Local.....	Hibride.....
Cows	Local.....	Hibride.....
Pigs	Local.....	Hibride.....
Sheeps/Goats	Local.....	Hibride.....
Chicken/Ducks	Local.....	Hibride.....
Others (specify)	Local.....	Hibride.....

9 What are the main sources of family income and expenditure?

Sources of Income

Sources of income	Average income (Rs)
Agriculture	
Livestock's	
Business	
Cottage Industry	
Skilled job	
Daily Wages	
Government Services	

Self Employed	
Remittances	
Pension	
Others(Specify)	

Areas of Expenditure

Areas of Expenditure	Average Annual Expenses
Education	
Health services utilisation	
Festivals	
Households	
Purchasing of Food	
Agriculture	
Animals	
Others(Specify)	

10	<p>Is anyone in your family working overseas?</p> <p>yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2</p> <p>If yes,</p>
10.1	<p>How many?</p> <p>_____</p>
10.2	<p>In Which Country?</p> <p>_____</p> <p>_____</p>

11	<p>Excluding you, is there anyone from your family associated with this cooperative?</p> <p>Yes <input data-bbox="599 342 696 420" type="text" value="1"/> no <input data-bbox="1073 342 1130 420" type="text" value="2"/></p> <p>11.1 If yes, then who?</p> <p>Husband <input data-bbox="599 567 696 644" type="text" value="1"/> Son <input data-bbox="1073 567 1130 644" type="text" value="2"/></p> <p>Daughter <input data-bbox="599 718 696 795" type="text" value="3"/> Daughter in law <input data-bbox="1073 718 1130 795" type="text" value="4"/></p> <p>Others <input data-bbox="599 869 696 947" type="text" value="5"/></p>
12	<p>What is your marital Status?</p> <p>Married <input data-bbox="735 1098 803 1176" type="text" value="1"/> Never married <input data-bbox="1154 1098 1211 1176" type="text" value="2"/></p> <p>Divorced/separated/widow <input data-bbox="735 1249 803 1327" type="text" value="3"/></p>
<p>(Question no 13 and 14 for only married couple)</p>	
13	<p>What was your age when you got married? _____ age</p>
15	<p>Do you have any children?</p>

Yes		<input type="checkbox"/>	No	<input type="checkbox"/>	
If yes					
In the womb	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Age _____
Youngest/ Last Born	Son	<input type="checkbox"/>	Daughter	<input type="checkbox"/>	Age _____
Fourth Born	Son	<input type="checkbox"/>	Daughter	<input type="checkbox"/>	Age _____
Third Born	Son	<input type="checkbox"/>	Daughter	<input type="checkbox"/>	Age _____
Second Born	Son	<input type="checkbox"/>	Daughter	<input type="checkbox"/>	Age _____
Eldest/ First Born	Son	<input type="checkbox"/>	Daughter	<input type="checkbox"/>	Age _____

Section B: Knowledge on Family Planning

15.	Have you heard about Family planning?
Yes	<input type="checkbox"/> No <input type="checkbox"/>

16.	<p>What do you understand by Family planning?</p> <p>Method to avoid unwanted pregnancy <input style="width: 40px; height: 30px;" type="text"/> 1 Methods to prevent sexually transmitted infections <input style="width: 40px; height: 30px;" type="text"/> 2</p> <p>Method to protect from serious illness <input style="width: 40px; height: 30px;" type="text"/> 3 Others _____</p>
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17	<p>Where did you get your first information on family planning?</p> <p>Husband <input style="width: 40px; height: 30px;" type="text"/> 1 Family <input style="width: 40px; height: 30px;" type="text"/> 2 Friends/neighbors <input style="width: 40px; height: 30px;" type="text"/> 3 Women's literacy group <input style="width: 40px; height: 30px;" type="text"/> 4</p> <p>School/Teacher <input style="width: 40px; height: 30px;" type="text"/> 5 Pharmacy <input style="width: 40px; height: 30px;" type="text"/> 6 Health workers <input style="width: 40px; height: 30px;" type="text"/> 7 Institution/ FCHV <input style="width: 40px; height: 30px;" type="text"/> 8</p> <p>Cooperatives <input style="width: 40px; height: 30px;" type="text"/> 9 Media (TV Radio/ Newspaper/Pamphlet/Poster) <input style="width: 40px; height: 30px;" type="text"/> 10</p>
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18.	<p>If you need additional information on family planning, where and whom do you consult?</p>
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Husband	<input type="text" value="1"/>	Family	<input type="text" value="2"/>	Friends/Neighbors	<input type="text" value="3"/>
School/ teacher	<input type="text" value="4"/>	Pharmacy	<input type="text" value="5"/>	Health Institution/ workers	<input type="text" value="7"/>
Cooperatives	<input type="text" value="7"/>	FCHV	<input type="text" value="8"/>	Women's group	<input type="text" value="9"/>

19. What are the different methods/devices you heard of family planning?

Pills/ oral tablets	<input type="text" value="1"/>	Condom	<input type="text" value="2"/>
Sangini	<input type="text" value="3"/>	Intra Uterine Device	<input type="text" value="4"/>
Implant	<input type="text" value="5"/>	Vasectomy	<input type="text" value="6"/>
Minilap	<input type="text" value="7"/>		

20 Do you know about Emergency contraceptive pills?

Yes	<input type="text" value="1"/>	No	<input type="text" value="0"/>
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21	Where do you get your contraceptive devices?  Government health institution <input type="checkbox"/> 1 Private health institution <input type="checkbox"/> 2  Non Governmental health institutions <input type="checkbox"/> 3 Pharmacy <input type="checkbox"/> 4  Cooperatives <input type="checkbox"/> 5 Female community health volunteers (FCHV) <input type="checkbox"/> 6
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Section C: Practice of Family Planning

22	Have you (Couple) ever used any Family planning methods?  Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0
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23	If yes, which device/ method you have used?
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Pills/ Oral Tablets	<input type="text" value="1"/>	Condom	<input type="text" value="2"/>
Sangini	<input type="text" value="3"/>	Intra Uterine Device (IUD)	<input type="text" value="4"/>
Implant	<input type="text" value="5"/>	Vasectomy	<input type="text" value="5"/>
Minilap	<input type="text" value="7"/>		

24	Are you (Husband and Wife) using any Family planning method currently?		
Yes	<input type="text" value="1"/>	No	<input type="text" value="0"/>

(If the answer is "Yes", then go to question number 25 to 32, if the answer is "No" then go to the question number 33 to 35 )

25	Which method of family planning is currently being used?		
Pills/ Oral tablets	<input type="text" value="1"/>	Condom	<input type="text" value="2"/>
Sangini	<input type="text" value="3"/>	IUD	<input type="text" value="4"/>
Implant	<input type="text" value="5"/>	Vasectomy	<input type="text" value="6"/>

	Mini lap <input data-bbox="578 268 634 342" type="text" value="7"/>																
26	How long have you been using the current family planning methods ? _____ Months																
27	<p>Where do you get your family planning devices?</p> <table data-bbox="289 871 1169 1297"> <tr> <td data-bbox="289 871 682 951">Government health institution</td> <td data-bbox="682 871 743 951"><input data-bbox="686 871 738 951" type="text" value="1"/></td> <td data-bbox="743 871 1104 951">Private health institute</td> <td data-bbox="1104 871 1169 951"><input data-bbox="1109 871 1161 951" type="text" value="2"/></td> </tr> <tr> <td data-bbox="289 1018 682 1098">Non government institutions</td> <td data-bbox="682 1018 743 1098"><input data-bbox="686 1018 738 1098" type="text" value="3"/></td> <td data-bbox="743 1018 1104 1098">Pharmacy</td> <td data-bbox="1104 1018 1169 1098"><input data-bbox="1109 1018 1161 1098" type="text" value="4"/></td> </tr> <tr> <td data-bbox="289 1165 682 1297">Cooperatives</td> <td data-bbox="682 1165 743 1297"><input data-bbox="686 1165 738 1297" type="text" value="5"/></td> <td data-bbox="743 1165 1104 1297">camps</td> <td data-bbox="1104 1165 1169 1297"><input data-bbox="1109 1165 1161 1297" type="text" value="6"/></td> </tr> <tr> <td></td> <td></td> <td data-bbox="938 1165 1104 1207">Mobile</td> <td></td> </tr> </table>	Government health institution	<input data-bbox="686 871 738 951" type="text" value="1"/>	Private health institute	<input data-bbox="1109 871 1161 951" type="text" value="2"/>	Non government institutions	<input data-bbox="686 1018 738 1098" type="text" value="3"/>	Pharmacy	<input data-bbox="1109 1018 1161 1098" type="text" value="4"/>	Cooperatives	<input data-bbox="686 1165 738 1297" type="text" value="5"/>	camps	<input data-bbox="1109 1165 1161 1297" type="text" value="6"/>			Mobile	
Government health institution	<input data-bbox="686 871 738 951" type="text" value="1"/>	Private health institute	<input data-bbox="1109 871 1161 951" type="text" value="2"/>														
Non government institutions	<input data-bbox="686 1018 738 1098" type="text" value="3"/>	Pharmacy	<input data-bbox="1109 1018 1161 1098" type="text" value="4"/>														
Cooperatives	<input data-bbox="686 1165 738 1297" type="text" value="5"/>	camps	<input data-bbox="1109 1165 1161 1297" type="text" value="6"/>														
		Mobile															
28	<p>Who influence/motivate you to use the current Family planning method?</p> <table data-bbox="289 1522 1169 1885"> <tr> <td data-bbox="289 1522 576 1602">Husband</td> <td data-bbox="576 1522 743 1602"><input data-bbox="581 1522 633 1602" type="text" value="1"/></td> <td data-bbox="743 1522 1104 1602">Family</td> <td data-bbox="1104 1522 1169 1602"><input data-bbox="1109 1522 1161 1602" type="text" value="2"/></td> </tr> <tr> <td data-bbox="289 1669 576 1749">Friend</td> <td data-bbox="576 1669 743 1749"><input data-bbox="581 1669 633 1749" type="text" value="3"/></td> <td data-bbox="743 1669 1104 1749">Neighbor</td> <td data-bbox="1104 1669 1169 1749"><input data-bbox="1109 1669 1161 1749" type="text" value="4"/></td> </tr> <tr> <td data-bbox="289 1816 576 1885">Health worker</td> <td data-bbox="576 1816 743 1885"><input data-bbox="581 1816 633 1885" type="text" value="5"/></td> <td data-bbox="743 1816 1104 1885">FCHV</td> <td data-bbox="1104 1816 1169 1885"><input data-bbox="1109 1816 1161 1885" type="text" value="6"/></td> </tr> </table>	Husband	<input data-bbox="581 1522 633 1602" type="text" value="1"/>	Family	<input data-bbox="1109 1522 1161 1602" type="text" value="2"/>	Friend	<input data-bbox="581 1669 633 1749" type="text" value="3"/>	Neighbor	<input data-bbox="1109 1669 1161 1749" type="text" value="4"/>	Health worker	<input data-bbox="581 1816 633 1885" type="text" value="5"/>	FCHV	<input data-bbox="1109 1816 1161 1885" type="text" value="6"/>				
Husband	<input data-bbox="581 1522 633 1602" type="text" value="1"/>	Family	<input data-bbox="1109 1522 1161 1602" type="text" value="2"/>														
Friend	<input data-bbox="581 1669 633 1749" type="text" value="3"/>	Neighbor	<input data-bbox="1109 1669 1161 1749" type="text" value="4"/>														
Health worker	<input data-bbox="581 1816 633 1885" type="text" value="5"/>	FCHV	<input data-bbox="1109 1816 1161 1885" type="text" value="6"/>														

	Local person resource <input type="text" value="7"/>
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29	Who decide to use the current family planning method?
	Self <input type="text" value="1"/> Husband <input type="text" value="2"/>

30	How far is your nearest health facility to get the family planning methods and what is the mode of transportation?
	By _____ Minute Bicycle/ Riksa _____ Minute
	foot
	Bike _____ Minute Bus/Car/Jeep _____ Minute
	Tanga/Bell Gada/ _____ Minute
	Gada

31	Do you pay for the family planning devices?
	Yes <input type="text" value="1"/> No <input type="text" value="2"/>

32	If yes, then how much you have to pay for the devices?? _____ Rs.
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33	What is the reason for not using any family planning methods?
	Device not available <input type="text" value="1"/> Lack of awareness <input type="text" value="2"/>

	Too far	<input type="text" value="3"/>	Due to shyness	<input type="text" value="4"/>
	Husband not living together/ working abroad	<input type="text" value="5"/>		

34	Who (you or your husband) is more willing to use the family planning methods?			
	Me	<input type="text" value="1"/>	Husband	<input type="text" value="2"/>
	Both	<input type="text" value="3"/>	No one	<input type="text" value="4"/>

35	Who do your husband prefers to use the Family planning method (between you and your husband)?			
	Me	<input type="text" value="1"/>	husband	<input type="text" value="2"/>

36	Have you discussed about family planning with your husband?			
	Yes	<input type="text" value="1"/>	No	<input type="text" value="0"/>

37=	Do you think family planning method helps in increasing the quality of life?			
	Yes	<input type="text" value="1"/>	No	<input type="text" value="0"/>

38=	Were all your pregnancy planned? (Do not ask this question if the answer of the section A, questions number 14 is "NO" )			
	Children	Yes	No	

	In the womb	<input type="checkbox"/>	<input type="checkbox"/>
	Youngest/ First Born	<input type="checkbox"/>	<input type="checkbox"/>
	Fourth Born	<input type="checkbox"/>	<input type="checkbox"/>
	Third Born	<input type="checkbox"/>	<input type="checkbox"/>
	Second Born	<input type="checkbox"/>	<input type="checkbox"/>
	Eldest/ First Born	<input type="checkbox"/>	<input type="checkbox"/>

39 What is the optimal gap between two births? \_\_\_\_\_ Months

40 Have you discussed with your husband about the birth spacing?

Yes  No

Section D: Satisfaction on Family Planning Services

41	Do you need to wait too long to get services from this institute?f	Yes <input type="checkbox"/>	No <input type="checkbox"/>
42	Are you satisfied with the cleanliness of this institute?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

43	Are you satisfied with the privacy during examinations/ checkup?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
44	Are you satisfied with the time provided by the health workers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
45	Did the health workers have polite and respectfull behaviour?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
46	Did the health workers forced you to accept any family planning methods/ services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
47	Are you satisfied with the overall behaviour of the health workers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

At last

- 1) Inform the interviewee about the completion of the questioner
- 2) Thank the interviewee for her time and information.

**ADRA Nepal, TICA Project - November, 2015**

**Focus Group Discussion Guideline**

**INFORMED CONSENT**

*Namaste!*

My name is \_\_\_\_\_. I am here on behalf of the Family Planning (TICA) project to collect a baseline information and to learn more your knowledge, attitude and practices on Reproductive health. The information you provide is very important and valuable to us and will be used for the intended purpose. The information will be kept anonymous and will not be used as an assessment relating to your career. You may decide to choose whether or not to take part in this study and may also decide to withdraw from it at any time.

This discussion will take about 30 to 45 minutes to complete. I hope that you will participate and help us accomplish this study by providing required information. You can stop the interview any time after we have started the process if you wish to do so.

At this time, do you want to ask me anything about the study?

Yes

Do you want to participate in this study?



Yes

No

All information about you will remain strictly confidential.

Thank you!

For the participants:

I understand that my participation in this study is completely voluntary and that my signature below indicates that I give my informed and voluntary consent to participate in the study.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Upon consent of the discussion participants, please proceed discussion

**FGD Guidelines 1: Women Group**

1. Have you heard about TICA project?
2. What are the relation between TICA project and DEEP project?
3. Do you also carry out activities related to TICA?
4. What are major benefits from TICA?
5. Have you participated in TICA project?
6. What type of activities involved in TICA project?
7. Have your participants in Poverty eradication And Agriculture activities along with Family Planning Program?
8. How do you think you can improve the economic status from DEEP project?
9. What are the Changes in FP knowledge and use?
10. Where do you get your contraceptive services?
11. What funds are used when you are planning activities through your group?
12. How can you suggest in TICA project?
13. Anything you would like to add?

**FGD Guidelines 2: Men Group**

1) Have you heard about TICA project?
2) What are the relation between TICA project and DEEP project?

3) Do you also carry out activities related to TICA?
4) What are major benefits from TICA?
5) Have you participated in TICA project?
6) What type of activities involved in TICA project?
7) Have your participants in Poverty eradication And Agriculture activities along with Family Planning Program?
8) Have you had any role in choice of FP methods?
9) How do you think you can improve the economic status from DEEP project??
10) What are the Changes in FP knowledge and use?
11) How can you suggest in TICA project?
12) Anything you would like to add?

**FGD Guidelines 3: Adolescence Group**

1. Have you heard about TICA project?
2. Do you also carry out activities related to TICA?
3. What are major benefits from TICA?
4. Have you participated in TICA project?
5. What type of activities involved in TICA project?
6. Have your participants in Poverty eradication And Agriculture activities along with Family Planning Program?
7. What are the role preference and decisive role in choice of FP methods?
8. How do you think you can improve the economic status from DEEP project?
9. How can you suggest in TICA project?
10. Anything you would like to add?

Thank you.