How Does the FCHV Contribution to MoH Programs Now Compare to the Past?

Save the Children

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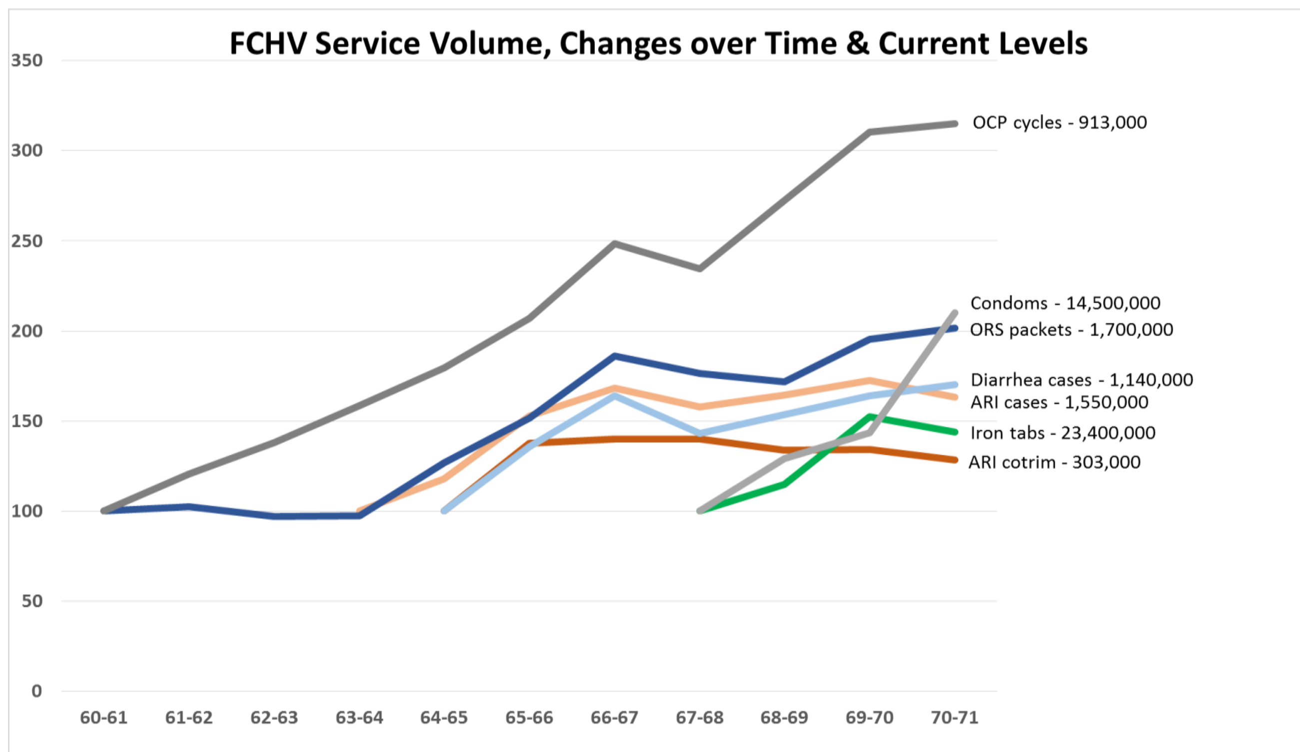
One often hears that although Female Community Health Volunteers (FCHVs) have made important contributions in the past, there is less need for them now—at least in service delivery roles they've been playing. If they're to be retained at all, we hear, perhaps they could confine their attention to demand creation and referral. But what does HMIS data tell us about the evolution of their contribution to key MNCH/FP/nutrition programs—particularly their service delivery roles (i.e., beyond demand creation and referral)? Department of Health Services Annual Reports track several key indicators to characterize the FCHV contribution. Over the years, for some of these interventions there have been changes in how they're reported, but the Annual Reports nevertheless give us a useful picture of the evolution of the FCHV direct contribution to these programs. This graph uses an index of 100 to indicate the baseline value, the first year data are available in the form currently used, and therefore shows proportionate increase over the following period.

Family Planning

Distribution of oral contraceptive pills (the second most popular temporary method in Nepal after injectables) has long been part of the FCHV role. At the beginning of the 10-year period captured in the figure above, FCHVs were responsible for distributing 290,000 cycles of OCPs, accounting for 29% of the total distributed through the public sector. This contribution has steadily increased, with FCHVs now distributing over 900,000 cycles, accounting for half of the public sector contribution. They have played a similarly important role in condom distribution. Over the earlier years of this period, this was tracked differently—in terms of the number of beneficiaries to whom they had provided condoms. Over that earlier period the number of beneficiaries reached was typically around 1.3 million per year. Since 2067/68—when DoHS started to track the number of condoms distributed—this number has more than doubled and stands now at 14,500,000 per year.



Management of Childhood Illness

The FCHV role in ARI and diarrhea case-management dates back to the early 1990s, but this was only fully scaled up nationwide by around 2008. Throughout this period, the private sector has been the main source of care. From HMIS data, for diarrhea we see an increase of approximately 70% in the number of cases treated by FCHVs over the past six years (during which CBIMCI was delivered nationwide). This has been associated with a doubling in the number of ORS packets distributed by FCHVs—approximately half of all those distributed in the public sector. The FCHV role in ORS distribution is more important in the terai—where they account for 70% of all public sector distribution (vs. 28% in Hill districts and 22% in Mountain districts).

We see a somewhat similar picture for acute respiratory infection (ARI), with an increase of about 60% over the last six years in cases seen by FCHVs and a 30% increase in

cases treated with cotrim, which in 2070/71 accounted for 45% of all ARI/pneumonia cases treated with antibiotics in the public sector. This proportion does not vary across ecologic zones.

Nutrition

FCHV at Sankhusawa counselling pregnant women
Photo: Suaahara Program/Save the children

Nepal's world-renowned vitamin A supplementation program has—since it was fully scaled up almost 15 years ago—consistently achieved greater than 90% coverage for children aged 6 months to 5 years. Distribution has relied primarily on FCHVs. Current coverage continues at over 90%, as confirmed by the MICS 2014 survey.

Beginning under the Iron Intensification Initiative, which was started almost 15 years ago, FCHVs have been tasked with monthly resupply of iron-folate supplements to pregnant women. This has made an important contribution to Nepal having achieved and maintained the highest antenatal iron-folate coverage among low-income countries. From HMIS data, we see an increase of approximately 45% in the number of iron tablets distributed by FCHVs, over the past three years, now amounting to 28,400,000 per year.

Conclusion

According to the indicators used in the Department of Health Services Annual Reports, there has certainly been no decline in the contribution of FCHVs to MNCH/FP/nutrition service delivery. On the contrary, there is a consistent pattern across these indicators of increasing performance. Indeed they continue to play a vital role in these particular areas of service. If an FCHV role in these areas were to be discontinued, this would mean important reductions in service to the population, particularly affecting the disadvantaged and those having poorer geographic access to facility-based or private sector services.

Table: FCHV Contribution as % of all GoN Primary Healthcare

Vitamin A supplement distribution	>95%
Oral contraceptive pills	~50%
Condoms	>50%
ORS for diarrhea	50% (70% in the terai)
Antibiotics for ARI	45%

This document is prepared by Save the Children's Saving Newborn Lives program.