Executive Summary: Knowledge, Attitudes, and Practices Surveys

Introduction

The Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project in Nepal focuses on building the technical capacity and institutional and financial sustainability of the Nepal CRS Company (CRS), a Nepalese social marketing organization and key USAID partner. Key to this mandate is strengthening CRS's ability to generate and use data for decision-making. CRS leads the USAID-funded Ghar Ghar Maa Swasthya (GGMS), or Healthy Homes project, in 49 hill and mountain districts of Nepal. The GGMS project aims to increase access to family planning and child health products through product marketing and distribution. From 2017-2020, CRS focused on increasing the cost-efficiency of its social marketing activities with the ultimate goal of transitioning away from donor funding by the end of the GGMS project. See Box 1 for CRS activities promoting sustainability. Recognizing the tradeoffs between sustainability and ensuring product access, SHOPS Plus and CRS aimed to carefully balance the two objectives.

Box 1: CRS Sustainability Activities

Since 2017, CRS has implemented several measures to improve their financial sustainability as they prepare to graduate from USAID funding. Specifically, they have focused on improving operational efficiencies and increasing cost recovery while remaining a leading provider of family planning and child health products. Examples include:

- Implementing incremental price increases on key health products based on regular price reviews;
- Developing and following a product procurement plan based on evidence-based forecasting of product needs and sales;
- Rationalizing product distribution, including delivering directly to distributors, consolidating the number of distributors used to maximize efficiencies, and tailoring distribution strategies to specific geographic areas;
- Limiting new outlet openings to areas of greatest need based on identified market gaps; and
- Focusing promotion efforts on products that have market competition and tailoring materials and messaging to the population segments most likely to use the product.

The GGMS project also includes a more intensive community-based social and behavior change program called the Remote Area Initiative (RAI), which is implemented in rural parts of four hill districts. CRS intentionally selected these remote districts because of their extremely limited access to health information and services. CRS redesigned the RAI program in 2018 with support from SHOPS Plus. Since that time, the redesigned program has focused on family planning access and choice, diarrhea prevention and treatment, use of antenatal care (ANC) services and facility delivery, and uterine prolapse (UP) prevention and treatment.

In 2017-18 and 2019-2020, SHOPS Plus conducted two knowledge, attitudes, and practices (KAP) surveys in collaboration with CRS to 1) inform the redesigned RAI curriculum, 2) evaluate the RAI program's effectiveness, and 3) understand if product access and use changed in GGMS areas in light of sustainability promotion activities.

Methods

SHOPS Plus subcontracted with New Era to conduct baseline and endline household surveys, representative of the GGMS and RAI districts. We selected 118 clusters using a probability proportional to size methodology. New Era conducted a comprehensive household listing in each cluster, and randomly selected households for sampling. The same clusters were sampled in both the baseline and endline surveys. The baseline sample included currently and never married women age 15-49 who are normal residents of the sampled household. The endline survey, conducted two years after the baseline, sampled households with women age 17-49 to include a cohort of respondents who were similar in age to those interviewed at baseline. See Table 1 for baseline and endline sample sizes.

After completing the baseline survey in 2018, SHOPS Plus analyzed results in collaboration with CRS to inform the RAI curriculum. Additional details on baseline findings and how CRS used them are available in a SHOPS Plus brief and report. At endline, we examined descriptive differences between 1) GGMS baseline and endline and 2) RAI baseline and endline, considering differences with $p<0.05$ to be statistically significant. Descriptive differences in the results section show many improvements between baseline and endline surveys. It is important to note that these differences cannot be directly attributed to the GGMS or RAI programs, as it is possible that other external factors may have influenced increases in health knowledge, attitudes, and practices.

Table 1. Number of Women Interviewed in KAP GGMS and RAI Baseline and Endline Surveys

Survey	GGMS	RAI
Baseline	1,337	1,956
Endline	1,593	1,916

Results

RAI Exposure. In the two years that CRS implemented the redesigned RAI program, one-third of respondents in RAI districts reported participating in RAI program activities. Among those who reported exposure, 29 percent participated in one activity, 29 percent participated in two activities, and 42 percent participated in three or more activities. RAI activities covered distinct health topics, and individuals could participate in the topics that interested them. Family planning was the topic of choice for 83 percent of women who participated in a RAI activity. The second most commonly attended health topic was uterine prolapse (78 percent), followed by health and hygiene (66 percent). Safe motherhood was the least common session attended by exposed respondents (35 percent).

Family Planning. The modern contraceptive prevalence rate (mCPR) increased significantly among married women in GGMS areas only (from 40 to 45 percent) due to an increase in implant use, a product that is not promoted by CRS. Knowledge of emergency contraception (EC) increased significantly in GGMS (from 23 to 28 percent) and RAI areas (from 30 to 36

percent). Knowledge of EC is even higher among respondents in RAI districts who participated in at least three RAI activities (51 percent). The study results did not find a significant increase in use of EC in either GGMS or RAI areas. Finally, among GGMS pill and injectable users, the share of the public sector-supplied government brand increased significantly, resulting in a corresponding decrease in use of CRS brands (Pills: CRS brand share decreased from 59 to 46 percent in GGMS areas; Injectables: CRS's Sangini brand share decreased from 26 to 16 percent in GGMS areas).

Key attitudes related to contraception improved significantly from baseline to endline. For example, perceived availability of short-acting methods increased and perceived shopkeeper stigma when purchasing a contraceptive method decreased. In addition, at endline, fewer women reported that their partners and in-laws were opposed to modern contraception use. Several barriers to family planning uptake remain among all women, including concern that pills and injectables will result in bodily harm and low social support from partners to use contraception.

ANC and Facility Delivery. Among women who gave birth in the last three years, receipt of four or more ANC visits increased in both GGMS (65 to 74 percent) and RAI areas (71 to 78 percent). Among respondents who participated in at least three RAI activities, receipt of 4+ ANC visits was even higher (94 percent). Facility delivery among women who gave birth in the prior three years increased in GGMS (59 to 72 percent) and RAI areas (68 to 74 percent), though this increase is only significant in GGMS areas.

Childhood Diarrhea. Use of both oral rehydration salts (ORS) and zinc among children who had diarrhea in the three months preceding the survey did not significantly change (GGMS: 25 to 19 percent; RAI: 18 to 20 percent). Knowledge of zinc increased significantly among respondents in RAI districts with at least three program exposures (87 percent compared to 66 percent of RAI respondents with no program exposure). Several attitudes related to zinc improved in GGMS and RAI areas, but these changes are only significant in GGMS areas. Such attitudes include perceived availability, affordability, and harmfulness of zinc.

Handwashing and Water Treatment. The RAI curriculum emphasized the importance of handwashing during six key times related to food preparation and consumption and bathroom use. Knowledge of these six handwashing times increased in both GGMS and RAI areas. On average, respondents knew 3.3 times at baseline and 3.6 times at endline. Knowledge of handwashing prior to cooking increased most substantially, from 43 to 55 percent in RAI areas.

Box 2: Additional Rigorous Analyses

We conducted two additional rigorous analyses called a difference in difference (DID) and a treatment on the treated (TOT) analysis to determine if the increases in the RAI indicators were caused by the intervention. We used the GGMS districts as a control group since these districts did not receive the intensive social and behavior change communication RAI curriculum. We found that the RAI intervention did not have a statistically significant impact on six primary outcomes.[1] Therefore, we cannot directly attribute changes to the RAI program, as other factors may have also influenced increases.

[1] The six primary outcomes are:

1. Modern contraceptive prevalence rate for condoms, pills, and injectables
2. Use of ORS and zinc for diarrhea treatment in the last three months
3. Receipt of 4+ ANC visits among women who gave birth in the last three years
4. Knowledge of six important times to wash hands
5. Knowledge of chlorine as a water treatment method
6. Health facility delivery among women who gave birth in the last three years

In addition, there were increases in use of a fixed handwashing station (83 to 98 percent) and presence of both soap (66 to 80 percent) and water (32 to 93 percent) in the handwashing station in RAI areas. Use of a water treatment method increased in RAI areas (62 to 67 percent), primarily due to an increase in boiling followed by water filter use. Use of a water treatment method was even higher among respondents in RAI districts who participated in at least three activities (78 percent). While knowledge of chlorine increased from 6 to 8 percent in RAI areas, this change is not significant, and chlorine knowledge remains low.

Uterine Prolapse. The percentage of respondents from RAI districts who heard information about preventing UP increased significantly from baseline to endline (42 to 59 percent). This percentage is even higher among respondents who participated in at least three activities (93 percent). The practice of preventing UP (e.g., pelvic floor exercises and avoiding heavy lifting) increased significantly among respondents exposed to at least three RAI activities (14 percent compared to 6 percent among RAI respondents with no program exposure), yet prevention remains low. Finally, seeking care for UP did not increase (approximately 75 percent at baseline and endline) among respondents with UP.

Implications for RAI Program

After two years of implementation, the RAI program reached one-third of women of reproductive age with the social and behavior change curriculum. Many knowledge and attitude indicators increased, which are more feasible to change within a relatively short two-year time frame as compared to health practices. Moving forward, CRS should review the RAI program's design, including coverage and intensity, to identify strategies to reach more women with the program.

Across health topics, the KAP survey found that participation in multiple RAI activities was associated with improved health knowledge and practices. For example, RAI respondents who participated in at least two activities were more likely to use modern contraception and have knowledge of zinc. Respondents who participated in at least three RAI activities were more likely to have knowledge of EC, receive four ANC visits, treat their water, and take steps to prevent UP. While we cannot confirm that increased RAI exposure caused these associations, it is worth considering the hypothesis that program intensity, and designing for depth rather than breadth, is critical for success.

Several key family planning attitudes changed in RAI areas, breaking down barriers to family planning uptake that SHOPS Plus identified at baseline. For example, perceived availability of injectables increased, providing more women with the opportunity to access contraception. The perception that shopkeepers treat women badly when buying contraception decreased. This social stigma can be a powerful barrier to contraceptive use. CRS tackled this challenge in the RAI curriculum by encouraging women to feel confident when they enter a shop and by conducting provider detailing to sensitize shop keepers to women's right to purchase contraception. Finally, the KAP survey found a decrease in disapproval of modern contraception use among in-laws. These types of sociocultural norms can be extremely difficult to alter, so these data points demonstrate important successes for the CRS RAI program.

Implications for GGMS Program

Since 2017, CRS has focused on achieving financial sustainability while maintaining product access and use. The KAP study largely found that access and use were maintained, and in some cases, even improved. For example, perceived access to short-acting methods and mCPR increased in the GGMS districts. In addition, perceived availability and affordability of

zinc for childhood diarrhea increased in GGMS areas. These findings suggest that CRS has adequately balanced its goals of preparing to graduate from donor funding and avoiding negative impacts to the market.

In addition to access and use, particular hard-to-alter social norms improved in GGMS areas in the absence of specific CRS activities to address such norms outside of the RAI districts. For example, perceived shopkeeper stigma when purchasing contraception, opposition to modern contraception among partners and in-laws, and the perception that zinc for childhood diarrhea is harmful decreased. These changes suggest that other market actors may be fostering positive attitudes, further enhancing the readiness of the Nepal family planning market to transition away from donor funding.

Despite an increase in mCPR, the study found decline in CRS's brand share for pills and injectables. This could be due to price increases among these brands that CRS enacted to promote cost recovery. These decreases pose a risk to CRS's sustainability and SHOPS Plus plans to investigate this further through a qualitative exploration.

Finally, despite the broad factors that suggest the sustainability of CRS, and of the Nepal family planning market in general, there are particular knowledge and attitude barriers that persist. For example, women continue to believe that hormonal contraceptive methods will result in health problems. In addition, support from male partners to use and learn about contraception—such as the belief that your partner would use a condom if asked—remains low. These must be addressed to improve health seeking behaviors and health outcomes.

Conclusion

The KAP results demonstrate key improvements in health knowledge and attitudes, including hard-to-change cultural norms related to contraceptive use. Several critical health practices also increased, such as routine ANC visits, use of safe water treatment, and use of modern contraception in GGMS areas. After two years of implementation, the newly designed, evidence-based RAI curriculum is reaching 1 in 3 women in target districts. Women in RAI districts demonstrated increased health knowledge and positive attitudes, and women who participated in multiple RAI activities showed positive changes in their health practices. CRS should explore strategies to expand RAI program coverage and intensity moving forward. Results from the GGMS districts highlight CRS's successful transition towards sustainability while maintaining product access and use, indicating that the social marketing organization is well positioned to operate independently of donor support without sacrificing public health goals.