PROGRESS INC.

Email: contact@progressinccompany.com

Web: www.progressinccompany.com

EXTERNAL EVALUATION OF CARE'S SYSTEM-LEVEL IMPACT IN NEPAL THROUGH THE SELF-APPLIED TECHNIQUE FOR QUALITY HEALTH TOOL

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Contents

SECTION 1: INTRODUCTION

Nepal's health scenario, particularly concerning child and maternal health, reflects both progress and ongoing challenges amidst its diverse geographical and socio-economic contexts. Over recent decades, concerted efforts from government initiatives, NGOs, and international collaborations have significantly improved health outcomes, yet disparities persist across regions and populations. Maternal health in Nepal has seen notable advancements. Initiatives such as the Safe Motherhood Program have contributed to reducing maternal mortality rates, although challenges remain in remote and marginalized communities where access to healthcare services is limited. Skilled birth attendance has increased, yet only about 60% of births are assisted by trained professionals, underscoring the need for continued investment in healthcare infrastructure and training.

Child health indicators in Nepal show progress, with declines in under-five mortality rates attributed to improved access to immunization, nutrition programs, and healthcare services. However, malnutrition remains a critical issue affecting child development, particularly in rural and disadvantaged areas. Programs targeting early childhood development and nutrition have been pivotal, yet more comprehensive strategies are needed to address persistent challenges. Geographical and socio-economic disparities influence health outcomes significantly. Remote mountainous regions face logistical hurdles in accessing healthcare, compounded by seasonal challenges like monsoon rains and landslides. Cultural beliefs and practices also impact health-seeking behaviors, affecting maternal, newborn and child health practices and outcomes.

Poor and marginalized women often encounter obstacles in accessing healthcare information and services in Nepal. In response to this equity gap, CARE Nepal introduced a social mapping tool named Self-Applied Technique for Quality Health (SATH) within Health Mothers' Groups (HMGs) . The objective of this approach is to enhance women's access to health services and information, empowering them to take informed actions based on their learnings. Since 2008, CARE Nepal has implemented SATH in over 3,100 HMGs across 42 districts out of 77, through various projects. To assess the effectiveness of SATH, evaluation reports, case studies, relevant articles, and policy documents were reviewed and analyzed. It was found that SATH significantly contributes to strengthening the community health system by fostering women's involvement in health matters and operationalizing HMGs. Moreover, the tool aids in generating demand for, and utilization of, healthcare services by empowering women and supporting advocacy efforts.[1] (Dangol,2023)

As a result of these positive outcomes, the Government of Nepal adopted SATH as a successful approach under the Equity, Access, and Utilization Program in 2021. This initiative aims to improve access to, and utilization of, child health and nutrition services among marginalized communities, and it has since been expanded nationwide.

1.1 HOW SATH TOOL CAME IN THE PICTURE

The Female Community Health Volunteer (FCHV) program plays a crucial role in Nepal's overall health system, reaching both remote and urban areas. While the effectiveness of FCHVs is well-established in remote areas, their effectiveness in urban areas remains a topic of inquiry. The FCHV program is the foundation of Health Mothers' Groups (HMGs). The studies however indicate that the potential of HMGs remain underutilized in terms of participation of reproductive aged women.[2]. Before the establishment of HMGs, some districts, including Bara and Parsa, had pregnant women's groups supported by CARE through the REFLECT project under the Advocacy for Healthy Life (AHL) initiative.

The Self Applied Technique for Quality Health (SATH) tool has been a pivotal part of the FCHV program's success, evidenced through project level evaluations implemented by CARE and its partners. Launched in Kailali and Doti districts initially in 2008, it was later replicated in 42 districts by Suaahara II. Based on the success of SATH tool implementation at the grassroots level, the tool was integrated in Equity and Access Program of Child Health Division in 2021 which provided scope for the tool to be implemented across 753 local levels in Nepal. However, since 2023, the federal government has discontinued funding for the program,

[1] https://www.km4djournal.org/index.php/km4dj/article/view/530/678
[2] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-13859-6

leaving it up to local levels to finance HMGs and FCHVs to implement SATH. Unfortunately, the status of how many local governments have allocated funds for programs using the SATH tool remains unknown. Although a draft HMG revitalization document has been finalized, its implementation status remains unknown.

The records indicate active presence of over 52,000 FCHVs working at the community level, who are responsible to lead and run the Health Mother Groups.[3] Provided that 15-20 women are involved in each of these groups, nearly one million mothers are associated with this community-level health structure, which serves to bridge the gap between health facilities and the community. Moreover, the revised National Health Policy of 2075 (2018) also emphasizes the importance of FCHVs and HMGs.

The SATH tool's sustainability is bolstered by the fact that the manual itself is owned and replicated by the government. The FCHV Strategy-2075 also mentions the SATH tool, describing how to operate HMGs. Additionally, the FCHV training manual, which includes a 10-day training program, incorporates components of the SATH tool, particularly during the first session, which focuses on mapping exercises[4]. Furthermore, the tool is dynamic and can be used for mapping all health indicators, not just those related to maternity and child care. It can also be utilized as a broader Participatory Rural Appraisal (PRA) tool to map social issues, including child marriage, school dropouts, etc., in collaboration with relevant groups and stakeholders.

1.2 OBJECTIVES

This evaluation will establish CARE's contribution to systems-level change, identify systems-level change outcomes, and estimate the number of people whose lives are improved as a result of those systems-level changes.

The evaluation shall be centered around the following objectives:

- Identify the specific system or systems that were impacted by CARE's advocacy or influencing efforts, whether it's at the local, regional, or national level, and whether it involves multiple interconnected systems.
- Understand the process through which the systems-level change occurred, including the obstacles that had to be addressed and the specific advocacy or influencing tactics employed to achieve the change. This may include policy advocacy, coalition building, community mobilization, or other strategies.
- Assess CARE's specific contribution to the systems-level changes, including the role CARE played in supporting partners who contributed to the change and the advocacy approaches used. This may include direct advocacy efforts by CARE, capacity building of partners, or facilitating multi-stakeholder collaborations.
- Identify the outcomes of the systems-level changes, both from the perspective of CARE and other relevant actors within the system. It seeks to understand the impact of the change on various stakeholders and whether the desired outcomes were achieved.
- Determine the specific locations or areas where the changes occurred, both within the system and among the target population. It aims to understand the geographical scope of the change and whether it was localized or widespread.
- Quantify the impact of CARE's contributions to the systems-level changes, including the number of people whose lives have been positively affected as a result of the change. This may include direct beneficiaries as well as indirect beneficiaries impacted by the scaled intervention.
- Assess the extent to which the model scaled and how many people's lives are better through the scaled intervention compared to CARE alone. It aims to understand the broader impact of the scaled intervention beyond CARE's direct contributions.

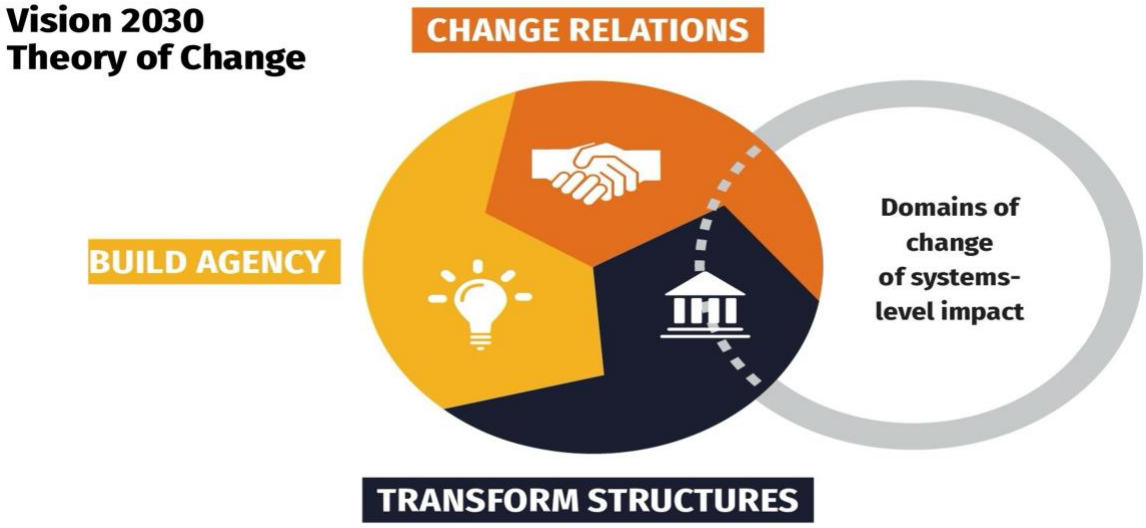
[3] https://doi.org/10.1093/cdn/nzac039

[4]FCHV Training Manual 2022; Available at http://nssd.dohs.gov.np/usermanuals/FCHV%20Hand%20Book.pdf

SECTION 2: LITERATURE ANALYSIS

2.1 CONCEPTUALIZING SYSTEM-LEVEL IMPACT

Systems-level impact in CARE's programming refers to the significant, sustainable changes in people's lives resulting from alterations in the underlying structures and mechanisms that govern societal operations. CARE's Vision 2030 Theory of Change (ToC) emphasizes three levels of change necessary to combat poverty and gender inequality: agency, relations, and structures. Systems-level change directly supports this framework by aiming to transform relational and structural dynamics, **leading to more sustainable and widespread impacts (CARE, 2022).**



Domains of change of systems level impact

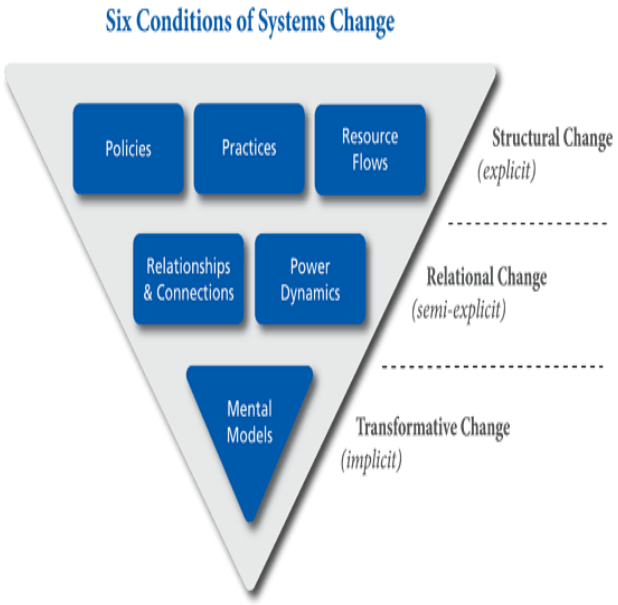
Pathways to Achieving Systems-Level Impact

CARE's approach to systems-level change incorporates multiple pathways to scale, ensuring comprehensive and enduring impacts across various sectors and regions. These pathways include:

1. **Advocacy**: Influencing policies, programs, and budgets of governments and other power holders to create an enabling environment for systemic change.
2. **Social and Gender Norms Change**: Promoting positive shifts in societal norms and behaviors, particularly regarding gender relations.
3. **Support for Social Movements**: Empowering social movements to take collective action for social and political change.
4. **Systems Strengthening and Social Accountability**: Enhancing the quality, availability, and responsiveness of services provided by governments and institutions.
5. **Inclusive Market-Based Approaches**: Promoting economic and environmental sustainability through market-driven solutions.
6. **Scaling Proven Models**: Expanding successful models through partnerships with governments, private sectors, and civil society organizations (CARE, 2022).

Theoretical Perspectives on Systems Change

The concept of systems change has been explored extensively across various fields, including education, health, and engineering. Deborah Chang (2019) articulates systems change as the process of shifting conditions that perpetuate societal problems. She identifies six critical conditions necessary for effective systems change: policies, practices, resource flows, relationships, power dynamics, and mental models. Structural changes encompass policies, practices, and resource flows, while relational changes involve relationships and power dynamics. Transformative changes address mental models and ideologies (Chang, 2019).



Dr. Ben Taylor (2016) emphasizes that systemic change involves altering functions or structures within a system to benefit the target group sustainably. He introduces the Adopt, Adapt, Expand, Respond (AAER) framework as a heuristic for achieving systemic change. This framework outlines stages of introducing innovations, institutionalizing behavior changes, expanding impact, and ensuring adaptive responses within supporting functions and rules (Taylor, 2016).

SECTION 3: METHODOLOGY

3.1 RESEARCH METHODS

The evaluation employed both qualitative and quantitative approaches to collect required information for the study. Qualitative approaches consisted of document review, key informant interviews (KIIs), and focus group discussions (FGDs), whereas participatory ranking exercises (PRE) were used as quantitative method.

3.2 DATA COLLECTION TOOLS

Document Review: The purpose of document review was to examine Advocacy and Influencing Impact Reporting (AIIR) Tools and relevant reports to construct a logical framework and Theory of Change for investigating system-level changes and project impact along systems-level pathways. This comprehensive review process laid foundation for our subsequent analysis, ensuring a thorough understanding of the project's achievements and contributions to systems-level change.

Key informant Interviews (KIIs): KIIs were conducted with relevant central and local level stakeholders in sample districts with the view of gathering information about their perceptions of CARE Nepal's contributions to institutionalize SATH, performance and impact of the program, and factors contributing to the success of the program including strengths and weaknesses. In total, 18 KIIs were conducted at different levels of government, of which 6 were from the central level, 5 each from Kailali and Salyan districts, and 4 each from Doti and Rupendehi districts. For interview purposes, different set of discussion guidelines were prepared to guide the interviews.

Focus Group Discussions (FGDs): The purpose of FGDs was to solicit information about the personal experiences of the Female Community Health Volunteers (FCHVs), members of Health Mother Groups (HMGs), and broader community members. In total 14 FGDs were conducted. Of which, 8 FGDs were

conducted with the HMGs, 7 with the FCHVs, and 4 with the community members. A set of discussion guideline was prepared to guide the discussions.

Participatory Ranking Exercises (PRE): The purpose of PRE was to solicit information about perceptions of HMGs and the outcomes of the SATH Tool. Information was collected via group exercises with the selected HMGs who have practiced the SATH Tool using on-site scoring sheets using Likert Scale method. Provided by CARE Nepal[5], the research instruments included a series of statements related to project outcomes and impact.

Quantitative Survey: The purpose of the quantitative survey is to solicit perceptions of HMG members regarding the usefulness of the SATH Tool. The survey utilized a research tool provided by CARE Nepal[6]. In total, the survey interviewed 287 HMG members, of which 128 were from Kailali district, 101 from Rupendehi, 32 from Salyan, and 26 from Doti district.

SECTION 4: FINDINGS

In previous years, the government's focus on the health sector leaned heavily towards infrastructure rather than improving services and facilities. In response, CARE Nepal launched an advocacy campaign to address systemic issues where health was treated as a subordinate sector of development. Between 2007 and 2009, CARE Nepal engaged in policy dialogues with the government to operationalize Health Mothers Groups (HMGs) within the system. Following successful piloting in five districts of the Far-West (Doti, Kailali, Kanchanpur, Dadeldhura, and Achham), which demonstrated positive outcomes in Outcome Monitoring, a rights-based approach was adopted.

The SATH tool was introduced, focusing particularly on enhancing maternal, neonatal, and child health care during the critical 1000 golden days[7]. This tool primarily involved HMGs and FCHVs. Its core objective was to foster accountability within government health systems, improve access, and strengthen existing health facilities. Initially piloted in Doti and Kailali, the SATH tool expanded across nine districts in the Far Western region beginning in 2016 (recently in Sudurpaschim Province) alongside the Suaahara program, ultimately reaching 3100 HMGs in 42 districts[8].

4.1 SYSTEM LEVEL CHANGES

4.1.1 SYSTEM LEVEL CHANGE: POLICY CHANGE

The continuous advocacy efforts by CARE Nepal, including generation of evidence around effectiveness of the SATH (Self-Applied Technique for Quality Health) tool, it was integrated into the **Equity, Access, and Utility Guideline (Community Mobilization guideline) 2076 B.S. (2021)** under the Ministry of Health and Population. The Government adopted the SATH tool in its Equity, Access, and Utilization Program in 2021 through the advocacy efforts of CARE Nepal and its partners. This milestone marked a significant achievement in localizing the SATH tool within Nepal's health policy framework. CARE Nepal's rigorous policy advocacy played a pivotal role in this integration, highlighting its commitment to advancing maternal, newborn and child health initiatives.

[5] CARE Nepal ensured the information from the data collection tools were sufficient for capturing CARE's internal impact indicators

[6] CARE Nepal ensured the information from the data collection tools were sufficient for capturing CARE's internal impact indicators

[7] In Nepali, "Sunaula Hazar Din" means, "Golden 1000 Days" – which is a critical window of opportunity between conception and the age of two years that, with good health and nutrition, can mitigate the risks of malnutrition that hamper a child's long-term physical and cognitive development.

[8]https://suaahara.hki.org.np/resources/docs/KM/5.%20The%20SATH%20Approach-%20A%20Cornerstone%20in%20Increasing%20Demand%20for%20Health%20and%20Nutrition%20Services%20among%20Marginalized%20Communities.pdf

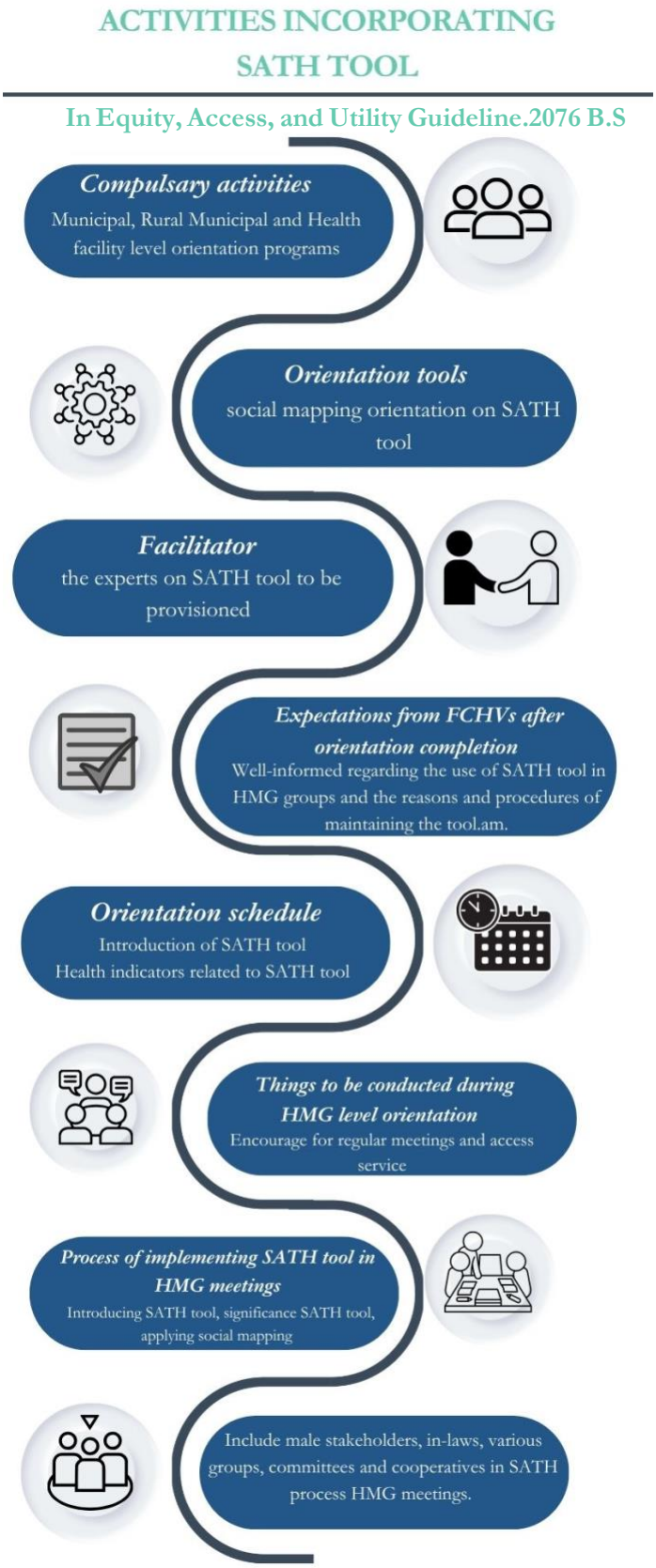
The inclusion of the SATH tool in government policy documents underscores its recognized effectiveness and relevance in community mobilization for healthcare. As a key component of the Equity, Access, and Utility Guideline, the SATH tool is now positioned as a strategic approach to enhance community engagement and improve health service utilization across all 753 local levels in Nepal. This policy alignment not only validates the tool's impact but also paves the way for its systematic implementation and scaling within the country's healthcare system.

This development not only strengthens the government's commitment to maternal, newborn and child health but also enhances the sustainability and scalability of SATH initiatives nationwide. It signifies a collaborative effort between CARE Nepal and governmental stakeholders to institutionalize effective community-based health interventions, thereby ensuring equitable access to quality healthcare services for all Nepali citizens, particularly in remote and marginalized communities. The major provisions that have been made under the guidelines are as follows:

POLICY ADOPTION AND INTEGRATION

SATH tool has been adopted into national health policies like the Equity, Access, and Utility Guideline. The government of Nepal has incorporated SATH tool under its **Equity and Access Program** as **Community Mobilization Guideline 2076** (in the initiative of Family Welfare Division, Ministry of Health and Population). During one of the KIIs, it was mentioned that this integration has led to improvements in health outcomes, including increased utilization of maternal, newborn and child health services and higher vaccination coverage in communities engaged through SATH-led HMGs. Government adoption has also facilitated substantial investments in training, infrastructure, and outreach, strengthening local health systems and expanding access to healthcare in remote areas. This collaborative effort underscores the effectiveness of CARE's approach in achieving sustainable health service improvements nationwide. Also, it has been incorporated in the training module developed for FCHVs. Additionally, Provincial Health Policies of different provinces including IMNCI (Integrated Management of Newborn and Childhood Illness) guidelines have directly or indirectly integrated the SATH tool in their plans and provisions which has proven to be a significant accomplishment of CARE. In one of the central levels KIIs, the respondent focused on how the SATH tool got incorporated in policy at multiple levels.

The training package for FCHVs' was first time revised by the government and incorporated into its strategy in 2076 B.S. This integration occurred at the policy level, aligning with the federal restructuring, where the initiative was implemented. Initially, mapping was introduced at the health facility level and connected to district-level operations. Subsequently, it extended to local-level health facilities and eventually culminated in actual mapping within HMGs.



This process signifies a comprehensive integration of FCHVs' training into governmental strategies, starting from policy formulation and extending through hierarchical levels of health facility management, ultimately empowering local-level initiatives like HMGs through structured mapping efforts. One government official highlighted how the SATH tool has facilitated changing health systems in Nepal.

Cumulative effects are seen as results of SATH tool in the overall health system. New Born Intensive Care Unit (NICU), Special Newborn Care Unit (SNCU), Antenatal Care (ANC), Post-Natal Care (PNC) services can be taken as the indirect outcomes of SATH tool. Despite the neonatal mortality rate is still the same.

CARE's role was to provide a functional tool to government for the government to then adopt SATH across almost 4,000 municipal levels, including rural municipalities. It was also possible to track the impact and changes of 52,000 HMGs around the nation. One of the Central level respondents highlighted how the government replicated the SATH tool in all tiers of government and its working modalities.

"We aligned our activities with HMGs and local government through various projects. These efforts were supported by successful models and a convincing approach, including the integration and highlighting of the FCHVs model package. Our agendas were synchronized with the SATH tool, guided by CARE, across all 753 locations in Nepal. Each municipality allocated a budget ranging from 60,000 to 100,000 rupees for these tasks. The orientation process was intensive in some areas, particularly in the 45 districts where capacity building at the local level was observed to be necessary. The SATH tool was successfully incorporated into welfare divisions and child health facilities at the organizational and programmatic levels."

LOCALIZATION OF SATH TOOL:

The SATH tool was localized through a systematic approach tailored to local contexts and needs. Initially piloted in specific districts like Doti and Kailali, it underwent rigorous adaptation and customization based on local feedback and data. CARE Nepal collaborated closely with community stakeholders, including HMGs and FCHVs, to ensure the relevance and effectiveness of the tool. Training sessions and capacity-building initiatives were conducted to equip local participants with the skills needed to implement and sustain the SATH tool's strategies. This localization process ensured that the SATH tool effectively addressed local health challenges and aligned with community norms and practices, enhancing its impact and sustainability.

"Advocacy of SATH tool remained to be like a high-hanging fruit, which took a long time to receive."

One former CARE staff member noted that the SATH tool had to go through a lot of advocacy insistence to be approved by the Central level government. After persistent advocacy efforts, the SATH tool was successfully localized, significantly empowering HMGs and FCHVs. This localization has boosted the initiative's impact on service seeking behaviors and strengthened linkages with health facilities. As a result, even marginalized and impoverished communities have shown increased interest in accessing available health resources and services, particularly those related to safe motherhood. The initiative's success underscores the transformative potential of community-driven health initiatives in improving healthcare access and outcomes in underserved populations.

4.1.2 SYSTEM LEVEL CHANGE: STRENGTHENED HEALTH SYSTEM

The SATH tool has significantly benefited communities by enhancing health awareness and access to essential services through HMGs and FCHVs. It has empowered communities by involving them in health decision-making and promoted better health outcomes through monitoring and preventive practices. By building the capacity of local volunteers, SATH has facilitated effective advocacy and fostered community ownership of health initiatives. Its integration into local governance has strengthened health systems, ensuring sustainable improvements in community health across various demographic groups.

The HMG meetings have evolved into a platform where community health needs are identified and advocated for, prompting effective delivery of health services tailored to local requirements. Previously, health services were primarily confined to health posts and hospitals, with limited outreach to communities. However, following the implementation of the SATH tool in HMG meetings, there has been a notable expansion in service delivery directly to underserved populations. Initiatives such as door-to-door visits, monthly growth monitoring, counseling for new mothers and pregnant women, and infant immunization have been initiated by local health providers as a result of the SATH tool's advocacy and community-driven demand.

Figure 1: Weight monitoring among children using the Mid-Upper Arm Circumference (MUAC) measuring tape to help identify malnutrition at Salyan.

4.1.3 SYSTEM LEVEL CHANGE: SOCIAL NORMS TRANSFORMATION

Health-related social norms transformation

The ongoing disparity in service utilization and unequal involvement of women in health decision-making are recognized as pivotal factors affecting maternal, newborn and child health outcomes in Nepal.

The interventions of the SATH tool intersected with other synergistic social norms, fostering mindset changes facilitated by CARE. While technical indicators were prioritized, the Suaahara II project, as a significant initiative, prominently featured Gender Equality and Social Inclusion (GESI) as a primary component linked with HMGs. Addressing caste-based discrimination and implementing safeguarding policies posed challenges, yet grassroots-level meetings were focused and well-received by the community. These efforts proved supportive, leading to observable changes as marginalized community members, particularly women and mothers, found improved access to healthcare services. Interface meetings were actively attended by group members. During the FGD with community members in the Kanchan Rural Municipality, one of the respondents stated that due to the black color tika put on the mapping chart, women in fear of humiliation have started to visit public health post for ANC visits. The label of Black tika is used for households whose rate of utilization are nil or lower than other households in the community.[9]

[9] In Nepalese culture, "Black Tika" symbolizes negative omens or bad luck, often used in rituals to ward off evil influences. Unlike the auspicious red tika, the black mark is associated with addressing misfortune or protecting against adverse events.

The chart is quite big and its normal in villages to be more concerned about other's issues than one's own, so the black tika in the chart is a big thing for us. The FCHVs make everyone understand the impact and in turn motivate them to follow the health protocols.'

In other assessed districts as well, there has been a noticeable increase in women attending ANC visits due to the motivation of avoiding red markings on their homes on the map. Furthermore, women's awareness levels have significantly improved with the implementation of the SATH tool in the community. During a FGD with FCHVs in Kothaimai, one FCHV mentioned that pregnant women's awareness about visiting public health posts for ANC services has greatly increased.

Before, the women used to hide their pregnancy until they were 3-4 months pregnant, and that also when and if one of us asked them, however, today after the SATH exercise, they have started telling us themselves. They are less shy about matters related to pregnancy and have started to understand that their shyness might cost them their own and their child's life.

Gender and Caste related social norms transformation

Community participation in regular HMG meetings facilitated by the SATH tool has created essential platforms for orienting and sensitizing both women and men on the significance of the "1000 golden days" and safe motherhood practices. This initiative has yielded valuable insights into enhancing equitable and high-quality health service systems, ensuring universal access. One former CARE staff noted…

SATH tool is a best practice for community involvement, equity, access etc.

The empowerment of women through the SATH tool is evident in the increased decision-making power regarding their health and family planning issues (See tables in Annex). Women are now actively seeking their health-related rights independently, marking a significant shift towards self-advocacy and autonomy in healthcare matters.

By fostering dialogue and awareness within HMG meetings, the SATH tool has not only strengthened community engagement but also promoted a supportive environment where women are encouraged to assert their health needs and preferences confidently. This empowerment contributes to sustainable improvements in maternal, newborn and child health outcomes, demonstrating the transformative impact of community-led initiatives like SATH. One participant in the FGD of HMGs in Rupandehi emphasized...

Once we had tried conducting awareness campaign as well during the 21st of the month, while we have monthly checkup sessions and it was very effective, it would be great to be able to conduct more of such sessions with the knowledgeable people.

During a PRE, with women from Rupandehi, the women shared how they have started to feel empowered regarding their health-related decision making after they introduced SATH tool in their HMG meetings.

Now the women take their decisions on their own regarding the healthcare services they require. They have built good knowledge regarding ANC, PNC visits, care of infants, immunization, vaccination etc.

During a FGD in Kothaimai, one FCHV highlighted that the women participating in HMG meetings have become more assertive and knowledgeable about their health rights and needs. They are actively engaged in discussions about maternal, newborn and child health, accessing information previously inaccessible to them. This empowerment has translated into women taking more proactive roles in healthcare decision-making within

their families and communities, ultimately leading to improved health outcomes. The SATH tool's role in fostering this empowerment underscores its effectiveness in promoting gender equity and community engagement in health initiatives.

Women are comparatively more empowered than before; they even have citizenship nowadays. They can speak in front of their father-in-law, which in itself is a very big change. However, the cases of domestic violence in itself are the major issue in our area.

Specifically targeting marginalized communities, there has been a notable increase in attendance at HMG meetings. Individuals from these communities are now actively engaging and demonstrating a heightened concern for available health services. Both survey and interview resuls show that community members have gained empowerment in making informed decisions about choosing healthcare facilities, adopting healthier behaviors and practices, and embracing family planning initiatives. This shift signifies a significant advancement in community participation and empowerment, facilitated by the SATH tool.

Mothers engaged with SATH participated in trainings, promoting inclusion of socially excluded individuals.

The SATH tool has promoted equity and access by actively engaging mothers in training and ensuring the inclusion of socially excluded individuals. It has focused on bridging gaps in access to healthcare services, particularly for marginalized communities, through targeted initiatives like HMGs and FCHVs. By emphasizing community participation and empowerment, the SATH tool has contributed to reducing disparities in healthcare access and promoting equity in health outcomes across different demographic groups. Additionally, its emphasis on regular monitoring and support has helped to ensure sustained engagement and improved accessibility to essential health services, thereby fostering a more inclusive healthcare environment.

There are equitable health services for everyone in the community. There is one system of life insurance for women where they have to pay Rs. 100, and then are eligible for free checkups and medicines during pregnancy. However, in this ward, there are 11 FCHVs and communities, but SATH is only implemented in 5, we need to change that. Also, one of the major problems we have is the issue of a proper birthing center, as even the nearest health center has lack of medical staff.

(As per one of the FGDs with FCHVs in Rupandehi)

Overcoming challenges like caste-based discrimination and safeguarding policies, grassroots-level meetings were targeted and well-received by communities. This approach supported observable changes, particularly enhancing health service access for marginalized populations, including women and mothers.

(As per one of the Central levels KIIs)

In the Terai region, particularly among Muslim communities, there has been a profound transformation in social norms related to healthcare access. The implementation of the SATH tool has played a pivotal role in promoting regular HMG meetings, acting as a catalyst for increased participation from marginalized communities. This initiative has not only encouraged dialogue but has also fostered a supportive environment where individuals feel empowered to advocate for their health rights and preferences. The SATH tool's impact is evident in the positive changes observed among Muslim communities, highlighting its effectiveness in bridging healthcare disparities and promoting inclusive healthcare practices.

Family Planning-related social norms transformation

Embracing Support: A Husband's Role in the Health Mother Group

In Rupandehi, Mr. X defied cultural norms by steadfastly attending Health Mother Group (HMG) meetings alongside his pregnant wife, who was learning Nepali. As a member of an orthodox Muslim family, X's presence was a testament to his unwavering support and commitment to his wife's well-being. Despite initial challenges, he saw his role not just as a translator but as an active participant, offering valuable insights and suggestions to enhance the group's initiatives.

X quickly became a source of inspiration within the community, challenging traditional gender roles and encouraging other husbands to engage more actively in supporting their wives during pregnancy. His involvement bridged cultural divides and fostered a sense of inclusivity within the group, where he was respected for his dedication and contributions.

As the pregnancy progressed, X's bond with the HMG deepened. He continued to attend meetings eagerly, advocating for programs that promoted maternal, newborn and child health. His journey exemplified the transformative impact of individual commitment and community engagement, demonstrating that true progress in healthcare comes from breaking down barriers together.

X's story remains a powerful reminder that supportive partnerships and inclusive participation are key to nurturing healthy families and communities.

Previously, family planning norms in the assessed districts showed minimal engagement, with FCHVs reporting little to no inquiries about contraceptive pills. However, following the implementation of the SATH tool, there has been a notable transformation in family planning practices. Now, even male members are actively seeking out FCHVs for contraceptive pills, indicating a shift towards greater awareness and acceptance of family planning methods within the community. This change underscores the positive impact of the SATH tool in reshaping societal norms and promoting inclusive healthcare access. In a FGD taken at Kothaimai, the FCHVs highlighted the social norms related transformations observed in the community.

The women do ask for their deserved rights related to their and their child's health, but when it comes to the family planning tools, they are still shy to talk about it. It is mostly men who come to ask for the pills and condoms. Due to this, even the population is being controlled as people are open to these family planning tools. When their wife is pregnant, even the men come either to the meetings or come to meet us personally to learn about the basics they need to know as a husband and future father.

Compared to the past, husbands are becoming more educated and aware and are comfortable with sending their wives to the meetings along with learning about pregnancy so that mother and children remain healthy. Looking at it from the viewpoint of a very conservative Muslim community, this can be considered as an achievement—women being able to come out of their houses and raise their views and opinions.

Additionally, the involvement of supportive male members during pregnancy and lactation phases has increased. This participation not only promotes gender equity in healthcare decision-making but also strengthens family support systems critical for maternal and child well-being. During one of the PREs, discussions were made in the changes in health behavior, which included...

Previously, in Madheshi community we didn't even want to vaccinate both the mother and the infant. We believed that it would kill both the mother and the infant baby. Due to the high home delivery rates before, women died from excessive blood flow and other emergencies, but now the good practices have been initiated through SATH tool. Everyone

is quite informed about the nitty-gritties of the safe motherhood practices. Now the same women who were previously scared, have become change agents in our community.

Figure 2 : FGD with HMG at Kothaimai, Rupandehi

4.1.4 SYSTEM LEVEL CHANGE: SOCIAL ACCOUNTABILITY

The SATH tool has filled the gaps that existed between health care facility service providers and the service seekers. Advocacy at various administrative levels, from local tiers to self-application and management, showed increased accountability. Users of health facilities were notably accountable on the supply side, while the demand side demonstrated significant effectiveness. As the tool enhanced the responsibilities of FCHVs, they solicited required information from lactating mothers and pregnant women and linked it up with the available public health services. SATH contributed to enhancing and scaling-up the availability and quality of services.

As per one of the FGDs with community members in Rupandehi, the changes in the behavior of health professionals have also indicated the heightened level of social accountability amidst health professionals.

More than the health post, their concern lies in the behavior of the health officials who are rude and scold them for trivial matters. Despite the distance, when went alone, leaving the sick members at home, they are not even given access to the basic medicines.

Not only did the attitudes and perspectives of health care workers became more sensible and accountable towards the health care needs and requirements of the right holders, the tool also subsidized the regular meetings of the HMGs. Community participation has increased which has also improved social accountability as per one of the former CARE staff.

Interface has been created through SATH tool amidst health care service providers and receivers; as the service receivers have gradually started to seek answers. Dialogues have been initiated in the communities for further enhancement of available resources and delivery of health services. SATH tool has proven itself as a community-led initiation that has contributed in the larger goals of reaching to unreached, strengthening of Universal health coverage and promising 2030 SDG agenda of Leave no one Behind.

4.1.5 SYSTEM LEVEL CHANGE: HEALTH CARE SYSTEM ACCOUNTABILITY

The SATH tool significantly bolstered accountability within Nepal's healthcare system on both supply and demand sides (dual accountability). Health facilities, empowered by community feedback and engagement facilitated through tools like SATH, became more responsive to local health needs. They adapted their services and practices to better meet community expectations, thereby enhancing service quality.

Simultaneously, community members actively participated in advocating for improved health services. Through platforms like HMGs, they voiced concerns, provided feedback, and played a pivotal role in decision-making processes concerning health provision. This dual accountability mechanism ensured that health services were not only accessible but also tailored to the needs and preferences of the communities they served. In an FGD taken with HMGs in Rupandehi, the need for an awareness campaign was raised by the members.

> ***Once we had tried conducting awareness campaign as well during the 21st of the month, while we have monthly checkup sessions and it was very effective, it would be great to be able to conduct more of such sessions with the knowledgeable people.***

The synergy between enhanced supply-side responsiveness and empowered demand-side advocacy fostered a more effective and equitable healthcare system in Nepal. It contributed to better health outcomes by aligning service delivery with community expectations and needs, ultimately promoting high-quality, accessible healthcare across the country.

4.1.6 SYSTEM LEVEL IMPACT QUANTIFICATION (ESTIMATES)

The integration of the SATH tool into equity and access guidelines and FCHV training protocol has provided opportunities to contribute to positive maternal health and nutrition outcomes across Nepal. There are more than 52 thousand FCHVs[10] in Nepal and each FCHV leads and facilitates HMG in their catchment area. However, not all HMGs across Nepal are currently functional. NDHS (2022) revealed that out of close to 15,000 women interviewed, only 29.1%[8] women of reproductive agre reported that there was HMG in their ward. Furthermore, among those women who reported presence of HMG in their ward, only 17.3%[11] women were actively participating in the HMG. As the evidence around SATH's contribution to functionalize HMG has been established, using these nationally representative proportions, the estimated total women who were participating in HMG in the past six months across Nepal was **432,304**. This number indicates contribution from SATH beyond the project's scope[12] as SATH's contribution to HMGs.

The table below illustrates further details of the quantification of system-level impact numbers.

Indicators/Items	Values	Source
Percentage who report having a Health Mothers' Group in their ward (P1)	0.291	NDHS 2022
Total sample	14,845	NDHS 2022
Number of FCHVs (A)	54,000	GoN

[10] Ministry of Health and Population, 2014 (https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/fchv_2014_national_survey_report_a4_final_508_0.pdf)

[11] NDHS, 2022 (https://www.dhsprogram.com/pubs/pdf/SR275/SR275.pdf)

[12] Internally, this impact will be reported under CARE indicator 17 (# of new, amended or better implemented policies, legislation, multilateral agreements, programs, and/or budgets responsive to the rights, needs and demands of people of all genders)

Indicators/Items	Values	Source
Average number of members (B)	29.6	Manandhar et al., 2022 (https://doi.org/10.1093/cdn/nzac039)
Total members in HMG (A*B)	1,598,400	
Total WRA (All Nepal)	8,587,167	HMIS, DoHS (2022)
Proportion of WRA actively participating in HMG in past 6 months (among those who reported HMG in their ward) (P2)	0.173	NDHS 2022
Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	0.626	NDHS 2022
Total WRA reporting HMG in their ward (All Nepal) [Total WRA*P1]	2,498,866	Extrapolation from NDHS and all Nepal data
Total WRA actively participating in HMG in past 6 months [Total WRA reporting HMG*P2]	**432,304**	

4.2 OUTCOMES

After implementing CARE's SATH tool, notable health outcomes have been achieved, including increased rates of institutional deliveries and improved access to primary healthcare services[13]. Government involvement in health initiatives has been enhanced, leading to better resource utilization and strengthened community mobilization efforts for sustainable health improvements.

At the local level, noticeable changes have been observed in behaviors, increased service utilization, shifts in social norms, and enhancements in government programs. While these changes cannot solely be attributed to CARE's advocacy efforts or the SATH tool, they are partially reflected in the practices observed during HMG meetings and FCHV trainings. Most of the credit can be given to CARE for this significant change in the health system, as even the government officials claimed that they have replicated SATH tool into their plans and programs, on the basis of CARE's SATH tools. The SATH tool has contributed to these realizations, yet it is important to acknowledge that it operates within the broader framework of government programs.

4.2.1 HEALTH SYSTEM AND MATERNAL, NEWBORN AND CHILD HEALTH (MNCH)

CARE's interventions primarily targeted the health system, focusing on maternal, newborn and child health (MNCH). The goal was to improve health outcomes for mothers and children through better service delivery, increased utilization of health services and community participation. By integrating the SATH tool, CARE aimed to enhance the quality and accessibility of health services, particularly in underserved and marginalized communities. Maternal, newborn and child health outcomes have significantly improved following the implementation of the SATH tool, as evidenced by reductions in maternal and child mortality and morbidity rates, as well as improved access to healthcare services. In one of the FGDs with HMGs, they highlighted the SATH interventions on MNCH.

[13] Suaahara II Household Survey, 2022. Available at https://pdf.usaid.gov/pdf_docs/PA00ZWFZ.pdf

Decrease in the maternal mortality rate owing to the cases of excess blood flow during deliveries. Awareness regarding the importance of iron tablets, calcium tablets, regular checkup and vaccinations. Opportunity for exposure and empowerment in the pretext of HMG meetings

In one of the KIIs with representative from the Family Welfare Division (FWD), the improvement in MNCH was also emphasized...

Despite the impacts of SATH tool are cumulative, SATH has resulted in the number of ANC and PNC visits, under 5 mortality rate has decreased, still far way to go for neonatal mortality rate.

Most of the FGDs and KIIs generated conclusions regarding the contribution of SATH tool adoption in improved MNCH as:

According to a KII with Dalit Ward member:

In the past, there was a high rate of infant mortality and low knowledge of how to take proper care of a mother or children. The SATH model although has been adopted at the federal level programs, is yet to be adopted at the municipality and community levels. Due to the limitation in budget, it has only been used as a piloting in 5 of the communities.

On the basis of one of the FGDs with HMGs:

There are no cases of maternal and infant mortality in our community. Most people are educated nowadays and thus, take their health very seriously. The finance is the issue for some but women get a total of Rs. 3300 during childbirth and even get incentives such as chicks, seeds, salt, soaps, protein powder, nail cutter and many more as per the provision. There has been many changes like the increasing institutional delivery, low rate of infant mortality and less children getting sick. In our society, there are monthly meetings but since there is no tangible development seen through this process, there is no support from the male members. Moreover, parenthood is seen as a women's job so men don't really take initiatives for accessing and utilizing the health services in the community.

In Doti, a decrease in neonatal deaths suggests improved healthcare practices and higher utilization of health facilities for neonatal care.

Before, the women used to hide their pregnancy until they were 3-4 months pregnant, and that also when and if one of us asked them, however, today after the SATH exercise, they have started telling us themselves. They are less shy about matters related to pregnancy and have started to understand that their shyness might cost them their own and their child's life.

The utilization of the SATH tool in HMG meetings has brought about significant and diverse behavioral changes among participants. One of the notable changes is the increase in adherence to government protocols for Antenatal Care (ANC) and Postnatal Care (PNC) visits. This has led to improved maternal health monitoring and early detection of potential complications, thereby enhancing maternal, newborn and child health outcomes.

Changes in nutrition-related behaviors and practices have also been observed, with greater awareness and adherence to dietary guidelines aimed at improving maternal and child nutrition. Furthermore, there has been an improvement in immunization coverage, ensuring that children receive timely vaccinations to prevent

diseases and promote overall health. In another FGD with HMG members in Rupandehi, the women discussed upon the increment in vaccination and immunization behaviors.

Awareness regarding the importance of iron tablets, calcium tablets, regular checkup and vaccinations.

A participatory exercise was conducted with the HMG members to assess the positive outcomes from the SATH intervention. In regards to the positive impact experienced by the HMG members , in all three categories of district, age and caste/ethnicity, improvement in childcare and hygiene (most of the HMGs and FCHVs conducted sessions on childcare and hygiene, such as the initiation of weight monitoring and MUAC measurement for childcare, as well as enhanced access to resources that promote hygiene throughout pregnancy and during early motherhood for hygiene, including soap, dignity kits, cloths, nail cutters and nutritious food items) was the most reported change brought about by SATH tool, with respondents from Doti district (84.6) with the highest percentage observed, followed by Kailali (83.3). The same data disaggregated by age revealed that on average, the higher age groups identified a higher proportion of positive changes in the community compared to the lower age groups. All respondents over the age of 50 (100%) identified positive changes in the improvement of childcare and hygiene, followed by 71.1% of respondents aged 35-49. Caste/ Ethnicity-disaggregated data revealed that all Muslim respondents (100%) identified improvement in childcare and hygiene as a positive change in the community, with 80.6% Brahmin/Chhetri agreeing to the same.

Positive changes were the most reported impact of SATH on Community Health Practices across all districts, age groups and caste/ ethnicity, with 87.1 being the common count in all three categories, with respondents from Rupandehi (100%) all agreeing to positive changes. In age wise desegregation, all age groups agreed to experiencing positive changes in the community with 91.4% aged 25-35, followed by the 15-18 age group (87.5%). Ethnicity-disaggregated data revealed that all Muslim respondents and all those from other ethnic groups (100%) felt that SATH had a positive change on community health practices. 99.7% of respondents from the Janajati ethnic group felt the same, followed by 88.9% of Dalit respondents, and 56.1% of Brahmin/Chhetri.

When queried about the extent to which the SATH tool enhances awareness of maternal and child health care services, promotes the utilization of these services, and impacts their use within the community, the majority of responses leaned positively on the scale of very good. District level data indicated that across all three dimensions of healthcare services- awareness, service utilization, and community impact; scores of 46.3%, 46.7% and 49.5% respectively were rated as very good. Similarly, the number for the age wise and caste/ethnicity categories also reveals the same number for all three aspects of healthcare services with 46.3% on enhancing awareness, 47.7% promoting the utilization of healthcare services and 49.5% on utilization of maternal and child healthcare services in the community after SATH tool implementation.

4.2.2 IMPROVED INSTITUTIONAL CHILD DELIVERIES

There has been a notable increase in the number of institutional child deliveries in all four districts due to the implementation of SATH tool in the HMG meetings. This change reduces risks associated with home births, ensuring safer delivery conditions for mothers and infants. The decrease in maternal mortality rates in the intervened districts can be attributed to the management of cases involving excessive blood flow during institutional deliveries. Moreover, there has been a notable rise in the number of births occurring in healthcare facilities despite the low financial resources and suitable infrastructural supports like ambulances. One of the FCHVs from Kothaimai, Rupandehi stated that there still exist infrastructural and economic barriers for institutional deliveries.

Sometimes it takes a long time for the ambulance to reach us and there have been cases where the child was delivered on the way. For some people, this can be affordable, but for some, it might cause them to lose their jewelry and property someday.

4.2.3

One of the women lived in a community that didn't practice any tools like SATH. She was unaware about the ANC check-ups, Iron, Calcium tablets etc. because of which she miscarried her baby. Later she went to her parent's house and started attending HMG meetings. She became aware about ANC visits, nutrition, medicinal supplements etc. She has recently given birth to a beautiful baby girl.

MPROVED HEALTH BEHAVIOR CHANGE

The interventions led to positive health behavior changes, such as increased awareness and practice of institutional deliveries and regular health check-ups, although societal changes were harder to measure without continued external intervention. Awareness regarding the importance of iron tablets, calcium tablets, folic acids, regular check-ups and vaccination has been realized in almost all districts assessed. During a FGD in Semrana, one of the participants shared about the change in their health behaviors and urged for further services.

Once we had tried conducting awareness campaign as well during the 21st of the month, while we have monthly checkup sessions and it was very effective, it would be great to be able to conduct more of such sessions with the knowledgeable people.

4.2.4 EXPANSION IN HEALTH CARE SERVICES

In case of Kanchan rural municipality, Government entities have enhanced access to healthcare services through financial incentives, including Rs. 1000 for nutritious food, Rs. 800 for eight regular check-ups, and Rs. 1000 for transportation costs associated with these visits. Additionally, they provide seasonal benefits, paid ambulance services for emergencies at no cost to pregnant women, designated vaccination days, and complimentary measurements and weight checks for children. Pregnant women also receive free video x-rays under these initiatives, further expanding access to healthcare services.

4.2.5 IMPROVED CAPACITY OF HEALTH WORKERS

After the long-term advocacy efforts of CARE and localization of the SATH tool, the proficiency of health attendants has enhanced, which played a crucial role in promoting increased and safe institutional deliveries. Through training and skill development initiatives from both CARE and the local governments, health attendants have been equipped with the knowledge and capabilities necessary to manage childbirth effectively within healthcare facilities. This has resulted in improved maternal and neonatal health outcomes, as skilled attendants can provide timely and appropriate care during labor and delivery. Their expertise ensures that complications are identified and managed promptly, reducing the risks associated with childbirth. Overall, the competency of health attendants underscores the importance of continuous training and professional development in enhancing the quality and safety of maternal healthcare services.

However, gaps still exist in the deployment of skilled human resources in the health posts. Most of the health post in-charges shared that they are lagging behind due to the unavailability of skilled health personnels. During a FGD taken with FCHVs in Salyan, Kapurkot.

All of us got the training, which was initiated by SUAAHARA, but the use of tika in itself was very confusing. There were a variety of colors, shapes and sizes of tika due to which it got a little complicated and overwhelming.

The need for refresher courses for FCHVs was identified and addressed to ensure ongoing effective service delivery. In the FGD with the FCHVs in Rupandehi, one of the FCHVs stated that their own knowledge needs to be refreshed time and again, so that they can share it with the community members.

It has been almost two years, there has been no trainings for the FCHVs. We do conduct the regular monthly meetings, but if there is no new knowledge among us or no refreshment trainings for us, it will become monotonous at some point. FAIRMED provided consistent support, offering training on conducting exercises and updating us on new government regulations and benefits for women and children. Additionally, the government supplied mats and registers to encourage regular meeting conduct. However, there remains a clear need for ongoing training to enhance our capabilities further."

Not only the FCHVs, the HMGs too showed the gap in capacity building and training required for them. In one of the FGDs in Rupandehi with HMG, the members highlighted their need for further trainings.

There should be more trainings for us- if there are new people then we can get new knowledge as same people can only provide us with limited information. There should be counselling services for women during the pregnancy and lactating stages as they are confused during that time."

Empowering FCHVs Through Technology: The Need for Training

In Kapurkot, Salyan, Female Community Health Volunteers (FCHVs) discussed a groundbreaking initiative by the local government: the SMS/MMS system for managing information about pregnant and lactating mothers. This system automatically registers pregnant women during their first ANC visit at the health post, sending real-time health updates to the FCHVs via SMS.

Despite its advanced and systematic approach, FCHVs expressed challenges with the initiative. While provided with mobile phones and SIM cards, insufficient top-up limits hinder their ability to input necessary information effectively. They emphasized the critical need for refresher training to fully utilize the technology and ensure accurate reporting.

The FCHVs underscored that proper training would not only enhance their efficiency but also empower them to provide timely and comprehensive support to pregnant women in their communities. They highlighted the importance of ongoing support to navigate technological challenges and maximize the benefits of this innovative health management system.

PARTICIPATORY RANKING EXERCISE

Using a spider web exercise, the data show the impact of the SATH tool on a group level. In terms of increased awareness of maternal and child healthcare, impact of the SATH tool on maternal and child healthcare utilization, and assessment of child and maternal healthcare service utilization post-implementation, Kailali ranks the highest with mean score of 4, 4.3 and 3.8 respectively signifying a satisfied result. Rupandehi with mean score 4.3 in both improvement in community health standards over time and increased involvement of women in healthcare decision-making has the highest level indicating a very positive attitude among the group members. In addition, Kailali has the higher mean score of 4 in cases like the confidence level to access to child and maternal healthcare services, the accessibility of health services for children and women in the community, the effectiveness of HMGs in promoting child and maternal healthcare, assessing the empowerment levels of local HMGs member and 3.8 in assessing the performance of HMGs members. On the contrary, the response from Doti district lies between 2.5 to 3.5 indicating a bad

to neutral response on the impact made by SATH tool. Whereas in Rupandehi and Salyan, reported average score between 3 and 4, revealing a positive response to the impact of the SATH program.

Table 1: Mean Score from Participatory Ranking Exercise

	Doti	Kailali	Rupandehi	Salyan	Total
	Mean	Mean	Mean	Mean	Mean
Increase in awareness of maternal and child health services	3.0	4.0	3.5	3.0	3.5
Impact of SATH tool on maternal and child healthcare utilization	2.7	4.3	3.9	3.3	3.7
Assessment of child and maternal healthcare service utilization post-implementation	2.8	3.8	3.7	2.8	3.5
Improvement in Community Health Standards over time	3.7	4.0	4.3	2.8	3.9
Increased involvement of women in healthcare Decision-making	3.3	3.9	4.3	3.3	3.9
Access to child and maternal healthcare services: Confidence level	2.8	4.0	3.8	4.0	3.7
Accessibility of health services for children and women in the community	3.0	4.0	3.7	3.3	3.6
Effectiveness of HMGs in promoting child and maternal healthcare	3.3	4.0	3.8	3.3	3.7
Assessing the empowerment levels of local HMGs member	3.0	4.0	3.5	3.3	3.6
Assessing the performance of HMGs members	2.7	3.8	3.5	3.0	3.4

4.3 PROCESS

Following extensive advocacy efforts, CARE Nepal's SATH tool gained recognition and approval from the Government of Nepal. It was systematically integrated into government documents, plans, policies, and guidelines, including the training module for FCHVs, where nearly one-third of the content was dedicated to improving Maternal, Newborn and Child Health (MNCH) and enhancing safe motherhood practices. This integration underscores the SATH tool's success in enhancing FCHV capacities and facilitating discussions, awareness, and knowledge sharing during HMG meetings at all levels. Topics related to the SATH tool are a central focus during awareness campaigns. During a FGD with HMG members in Rupandehi, participants emphasized the tool's practicality in boosting their understanding and awareness of MNCH and safe motherhood issues.

To support implementation, extensive training and capacity-building initiatives were launched for HMGs and FCHVs, focusing on social mapping and health discussions. The Community Health Score Board (CHSB) ensured proper health facility supply-side projection, while the SATH tool stimulated community demand. Notably, the SATH tool was introduced through meticulous scoping and statistical analysis in selected districts and weaker municipalities and health facilities, evolving into an innovative approach tailored to local contexts. The SATH tool had to go through a lot of hurdles before its approval from the government of Nepal. As per one former CARE staff…

Initially the government of Nepal, kept questioning about the relevance and feasibility of SATH tool in Far Western Region and the massive demand it generated from grass root level regarding the existing health system. Government didn't easily approve the initiative in its initial phase, which compelled CARE to go through a long advocacy process for SATH's approval and make government comprehend it's significance and relevance.

Before and after the implementation of the SATH tool, systemic challenges and barriers needed addressing, particularly in the initial coordination between HMGs and FCHVs. Initially, the necessity and sustainability of the FCHV program faced scrutiny, though some stakeholders supported its continuity. Over time, there was a shift towards activating HMGs through FCHVs, with strong backing from the government and significant male involvement. Health services began with door-to-door delivery, fostering community acceptance and accessibility. This approach created a sense of ease and comfort among community members, leading to increased attachment between communities and health facilities. HMGs expressed pride in their accomplishments as mapping efforts expanded, creating more opportunities and fostering community acceptance simultaneously. As per one of the FGDs with FCHVs in Rupandehi, community members have turned quite affirmative towards the HMG meetings and comprehended well about the usage of the tool.

Figure 3: FCHV at Doti exhibiting the SATH Community Map in Kedar Health Mothers' Group

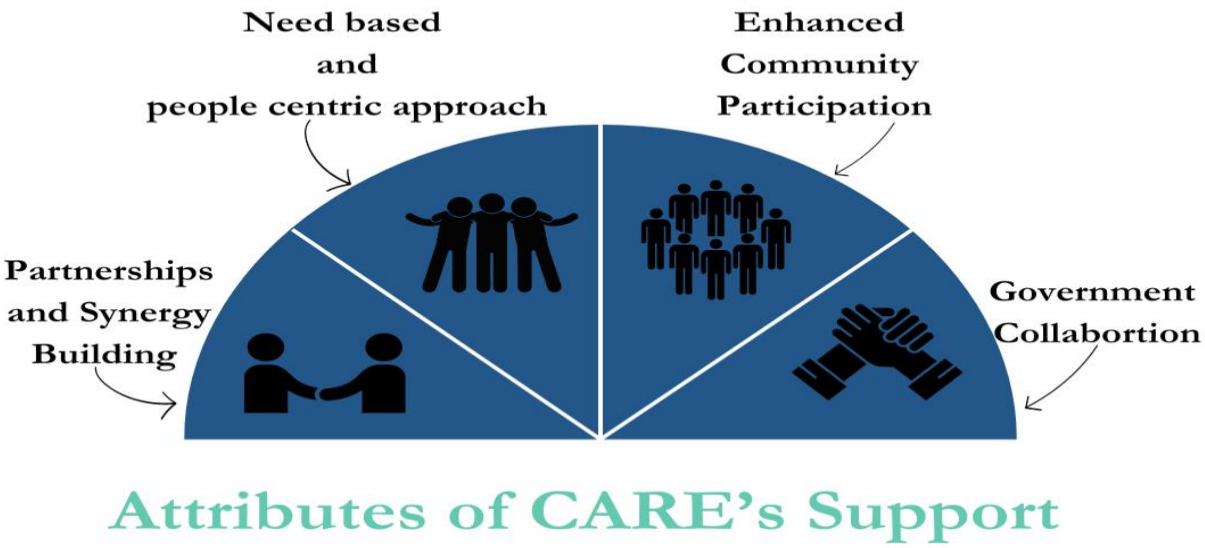
Similarly, the support of the family and community members through actions like giving space in the Madrasa for checkup, providing free lunch services and allowing the female family members to come out of the houses were discussed as the visible impacts in their way of life.

The support provided by the FCHVs were highly appreciated by the HMG in improving MNCH. When asked how effective respondents think Health Mother's groups (HMGs) promote maternal and child healthcare in their community, on average 56.1% of the respondents (district, age and caste/ethnicity) responded as being effective (very good). District desegregated data reveals that 76.6% respondents from Kailali and 47.5% of respondents from Rupandehi had the highest number compared to other two districts. In the same area of efficacy, respondents from age group 15-18 (88.9%) agreed with the effectiveness the HMGs promote maternal and child health care in the community. In the data concerning caste/ethnicity, Janajati is at the midpoint with 60%, while Dalit follows at 56.3%.

On average, 51.9% of the total respondents rated the assessment of empowerment levels among HMGs in the community as very good in data disaggregation of district, age and caste/ethnicity, in which Kailali (63.3%),

respondents from age group 25-35 (53.5%) and Muslim (100%) had the highest percentage agreeing to the members being empowered in the community. Similarly, 47.7% of the respondents on average rated very good on the performance of the members of the HMGs in district, age and caste/ethnicity disaggregated data with Rupandehi (53.5%), respondents from age group 35-49 (54.2%) and Muslims (53.8%) being the highest number in the respective category in rating the HMGs members performances.

4. 4 ATTRIBUTES OF CARE'S SUPPORT



4.4.1 PARTNERSHIPS AND SYNERGY BUILDING

The SATH initiative in Nepal operates through a collaborative approach that emphasizes partnerships and synergy across multiple stakeholders, including government bodies, NGOs like CARE Nepal, local health institutions, and communities. This collaboration ensures alignment with national health policies, leverages government resources, and integrates into existing health systems for sustainability. CARE Nepal and other partners contribute technical expertise and funding to implement innovative health interventions tailored to local contexts. Community engagement and capacity building efforts empower local stakeholders, including FCHVs, fostering ownership and sustainability of health initiatives. By integrating activities with other development sectors and maintaining robust monitoring and evaluation frameworks, SATH aims to maximize impact and achieve lasting improvements in healthcare delivery and community health outcomes throughout Nepal.

Through collaborations with projects such as Fair-Med, OHW, Cradle, Emphasis, AIN, SUHARA consortium, SAMMAN, and others, partnerships between HMGs, FCHVs and the government have successfully facilitated the integration and effective implementation of the SATH program in various plans, policies, and programs. For successful implementation, it emphasizes the importance of the government being proactive and willing to contribute independently. This includes taking initiative, providing support beyond passive acceptance, and

actively engaging in efforts to achieve effective implementation and sustainability of projects or programs. In one of the Central level KIIs it was stated that…

It is only the external organization doing the work at present, the support government is doing is not creating hurdles for them. To ensure the successful implementation, they should be willing to contribute through their own initiative as well.

In a recent FGD with FCHVs in Salyan, the fruitful partnerships forged with CARE Nepal for the successful deployment of the SATH tool were emphasized. These partnerships have been instrumental in ensuring that the SATH tool's benefits are maximized and sustained within community health initiatives.

The various health related programs brought in by the many organizations as well as the health-related initiatives by the government contributed to such changes. SATH did pave the way for the changes to occur, but it would be wrong to consider it as a sole contributor.

CARE Nepal has recognized the importance of enhancing awareness and knowledge levels, yet acknowledges the ongoing need for orientation to health facilities, training of FCHVs, and fostering ownership of the SATH model within health facilities where expertise lies. Additionally, there is a clear focus on gathering feedback and evaluations from stakeholders involved. The initiative highlights the imperative of promoting self-realization and behavioral change across all levels, supported by the establishment of a dedicated focal person to supervise and monitor these activities effectively. This integrated approach by CARE Nepal underlines their commitment to synergizing efforts through the SATH tool for comprehensive community health improvement.

4.4.2 NEED -BASED AND PEOPLE-CENTRIC APPROACH

The SATH tool is designed around the needs and perspectives of the community it serves, making it inherently people-centric. It empowers local communities by providing them with the tools and knowledge to actively participate in improving their own health outcomes. This approach ensures that interventions are tailored to address specific health challenges identified within each community, thereby enhancing their relevance and effectiveness. By focusing on community engagement and participation, the SATH tool fosters a sense of ownership among community members. It encourages them to take proactive steps towards accessing healthcare services and adopting healthier practices. This grassroots involvement not only strengthens local health systems but also promotes sustainability as communities continue to drive and support health initiatives over the long term. Also, focusing on the health related practical and strategic needs of marginalized populations, the SATH tool applied equitable and participatory approaches that fulfilled the distinct community needs and preferences. As per one of the KIIs taken in Doti…

SATH tool encouraged the vulnerable and marginalized people to utilize the health services incorporated in the aforementioned program and projects.

In one of the Central levels KIIs, it was stressed that SATH tool must be participatory and people centric, due to which it has easily scaled-up.

SATH tool is, people to people focused grass-root intervention that takes together demand generation and health delivery supply, side by side.

Furthermore, the SATH tool's emphasis on community needs ensures that interventions are responsive and adaptable to local contexts. It promotes inclusivity by involving diverse stakeholders, including women, marginalized groups, and local health providers, in decision-making processes. This collaborative approach

helps to build trust and cooperation, essential for achieving meaningful and lasting improvements in health outcomes at the grassroots level.

Comparative studies showed tremendous changes in the health services and facilities and the community members extremely enjoyed it a lot.

4.4.3 ENHANCED COMMUNITY PARTICIPATION

Community participation was integral to CARE's strategy, particularly through the implementation of the SATH tool and regular community meetings. These initiatives aimed to cultivate a culture of health advocacy and active participation among local residents. Women and marginalized groups, in particular, were empowered to engage actively in health-related initiatives, thereby fostering inclusivity and enhancing the effectiveness of healthcare interventions. The SATH tool facilitated social mapping and regular HMG meetings, which provided platforms for community members to voice their healthcare needs and concerns. Through these meetings, participants not only received essential health information but also contributed to decision-making processes regarding local health services. This inclusive approach ensured that healthcare initiatives were grounded in community insights and priorities.

Moreover, by empowering women and marginalized groups to play proactive roles in health advocacy, CARE Nepal promoted a more equitable distribution of healthcare resources and services. This empowerment led to increased awareness, improved health-seeking behaviors, and ultimately better health outcomes within these communities. Overall, CARE's emphasis on community participation through the SATH tool and HMG meetings fostered a sense of ownership and responsibility among community members towards their own health. It underscored the importance of inclusive participation in driving sustainable improvements in healthcare delivery and outcomes across Nepal.

During one of the KIIs with former CARE staff, they indicated that SATH majorly contributed to generating behavioral changes in services like:

During the time of Maoist insurgency, violence was rampant in all sectors and health sector couldn't stay aloof of it. Mobility was restricted, evil practices like Chaupadi got rampant and treatments related to HIV AIDS were made unfair. But no one dared to stop the practices of SATH and CHSB as both remained neon, community-based initiatives. Realizations and ownerships were seen in both right holders and duty holders for the continuation of SATH tool, even during emergencies.

4.4.4 GOVERNMENT COLLABORATION

The collaboration with government entities and other like-minded organizations, including the Family Welfare Division and IMNCI, ensured that health interventions were not only implemented but also sustained and scaled at the national level. The government's integration of the SATH tool into its plans, policies, and guidelines exemplifies effective collaboration. Successful partnerships with local government authorities have facilitated the widespread replication of the SATH tool in many regions. According to Mr. Ramsharan Pyakurel, a former staff member of CARE, these initiatives involving the SATH tool have demonstrated substantial success.

Bridging Gaps: Integrating SATH Tool and CHSB Recommendations

In a VDC near Attariya, efforts to enhance program planning and budget allocations saw a transformative collaboration between local stakeholders and innovative health initiatives. The SATH tool, known for its community-driven approach, and the Community Health Score Board recommendations played pivotal roles in shaping discussions during a VDC Council meeting.

Local representatives and health experts gathered to discuss the implementation of these recommendations, aiming to address existing gaps in healthcare services. Through insightful presentations and discussions, the meeting highlighted the importance of integrating community insights and evidence-based strategies into planning processes.

This initiative not only fostered a deeper understanding of local health needs but also paved the way for informed decision-making in allocating resources effectively. The collaborative effort underscored the significance of participatory approaches in achieving sustainable improvements in maternal, newborn and child health outcomes.

As a result, the VDC Council embraced the recommendations, recognizing their potential to bolster healthcare delivery and enhance community well-being. This successful integration of the SATH tool and CHSB recommendations stands as a testament to the power of local collaboration and evidence-based planning in driving positive health outcomes.

4.5 SUSTAINABILITY AND SCALING-UP

CARE Nepal developed the SATH tool as a social mapping tool aimed at enhancing community well-being and improving health system performance. Initially introduced in 2008 in Kailali and Doti districts through the USAID-funded CRADLE Project, SATH targeted marginalized populations to improve maternal and newborn health outcomes. It served as a demand-side intervention, successfully regularizing HMG meetings and enhancing access to maternal, newborn health, and nutrition services. The mid-term evaluation of the CRADLE Project recognized SATH as an effective intervention, contributing to increased participation, empowerment, service access, and equity in health service utilization within community health systems. As per one of the Central level KIIs, the SATH tool has ensured both the integration of SATH in government's programming and scaling up of MNCH initiatives.

We align the activities with the HMGs with government at local level through various projects. Similarly, the impression of the activities was convincing and successful model, FCHVs model package also incorporated and highlighted and the agendas and incorporated SATH tool that helped with the guidance by CARE in all 753 locations.

As per one of the KIIs taken in Doti..

The implementation of SATH resulted in notable changes in individual behaviors among end-users, providers, and local communities. This included regularizing Health Mothers' Group meetings in alignment with approved government guidelines, increasing participation of eligible women and new members in these groups, and disseminating information about available health services through local facilities for women and children.

The inclusion of the SATH tool in government training programs and health strategies ensured its long-term sustainability. Its proven success in various districts underscored its effectiveness, prompting wider adoption and integration into national health policies. Communities are beginning to witness improvements in MNCH and other achievements facilitated by the SATH tool. It is increasingly being incorporated into local-level planning and processes. Continuous reflection, review, and adjustments based on lessons learned are essential

for future planning. Recognized by the government as a community-owned initiative, the SATH tool has achieved enduring success. As per one of the central level KIIs..

SATH tool is already sustainable as it has already gone to all 77 districts of Nepal and being implemented in all 753 local levels.

Encouraged by these outcomes, CARE Nepal expanded the implementation of SATH to over 3,100 HMGs across 44 districts from 2016 onwards. The tool's success prompted the Government of Nepal to incorporate it into the Equity, Access, and Utilization program guidelines, underscoring its role in fostering community ownership and functionalizing HMGs effectively.

Following the successful implementation of SATH at the local level, its adoption at the federal and central levels was catalyzed and initiated with government health service approval. Starting in two districts, it expanded to five districts through the SUHARA program, focusing on both demand and supply sides. CARE concentrated on strengthening family planning services and improving access to health facilities, ensuring continuity across different districts until 2022. The initiative aimed to promote equity in child health access, leading to the selection of SATH-adopted districts during discussions and subsequent program initiation. As per one of the Central level KIIs…

The mapping of municipalities, involving over 52,000 initiatives by CARE and other organizations, commenced at the ward level of HMGs and health facilities. The program identified weak areas based on FCHVs indicators, leading to their inclusion in government training packages and strategic integration. This integration extended to policy levels and was implemented federally, integrating mapping into district-level health facilities and ultimately into HMGs. FAIRMED, One Heart World, and other organizations later adopted the tool, contributing to its enhanced success and broader implementation.

Bhumirajmandu Health Post: Enhancing Maternal, newborn and child health

Bhumirajmandu Health Post in Doti has established itself as a model of comprehensive healthcare delivery. It boasts full immunization coverage for children and robust maternal health initiatives, including a medical abortion program and prevention of mother-to-child transmission efforts. Since 2016, it has maintained a safe motherhood emergency fund and introduced essential amenities like new delivery beds, autoclaves, and electric baby warmers. The health post also provides a maternity waiting house with accommodation and nutritional support, along with regular orientation on safe abortion for FCHVs and blanket distributions for institutional delivery mothers. These initiatives underscore its commitment to community-centered healthcare and improving health outcomes for all residents.

With numerous replications, SATH as a community monitoring tool has enhanced social accountability. Little hesitation is seen in picking up the same name as "SATH tool or *Tika Bidhi"* given by CARE, but wider initiations are taken to incorporate the tool in various planning and programming of the communities for the sake of maternal, newborn and child health care. Initially, accountability for the tool extended beyond health departments to include VDC and district levels, along with other relevant bodies. Social mapping was conducted to plot available health facilities and households, and following the tool's introduction, it was subsequently expanded and scaled up.

Continuity and financial sustainability are primary challenges observed post-implementation, particularly affecting marginalized and vulnerable groups who initially felt more secure. Political and technical challenges for FCHVs have been notable, though an enabling environment is evident at the local level. Meetings' effectiveness in influencing service utilization, budget allocations, provision of attire, mobile recharges, and distribution of resources like mobiles and bicycles in the Terai region have shown disparities in non-governmental sectors. Separate budget allocations and agreements with Nepal Telecom for FCHVs have been implemented, yet a significant gap remains in health promotion through HMGs and FCHVs. Capacitating FCHVs adequately has been lacking in recent phases, despite their evolving roles in response to empowerment and changing health facility service dynamics at the ward level. Financial challenges remain a key motivational factor, with training provided but voluntary efforts dwindling amid evolving demands and contexts. The presence of health facilitators at the ward level highlights persistent gaps in supply-side capabilities and intersections that require attention. In a KII with a former CARE staff member, the existing gaps have been highlighted as…

Figure 4: FGD with FCHVs at Triveni Ward no. 3 and 4, Salyan

> ***There has been various gaps in the system level that could or has directly or indirectly been affecting the maternal, newborn and child health. The genuine and important part was how are meetings run, the effect on the service utilization is being provided or not, and budget allocation, dress was being provided, mobile recharge, distribution of mobile and recharge, cycle in the terai region, were provided to FCHVs and gaps was seen in the non-governmental sectors.***

Community members expressed positive commitments towards the change brought about by the project. It was evident from the participatory exercise conducted with the HMG members. When asked to rate how important the changes brought about by SATH are using a 1-5 scale, 1 being very bad and 5 being excellent, the response were on a positive scale of 43.2% marking very good, 32.4% of total respondents selected 5. On average, a greater proportion of respondents from the Kailali district rated the importance of changes brought about by SATH as either excellent (50.8%) or very good (35.2%), compared to other districts. Conversely, the Salyan district rated the importance of changes on lower scale compared to other districts, with the majority of respondents

(56.3%) selecting neutral, 3.1% of respondents selecting 1 (very bad). The same data disaggregated by age revealed that on average, the higher age groups placed greater importance on the changes brought about by SATH compared to the lower age groups. 90% of total respondents aged 50 and above selected either very good or excellent. The data on caste/ethnicity also demonstrates significant positive impacts (very good, 43.2) attributed to the changes facilitated by SATH tool.

SECTION 5: CHALLENGES

Intensive monitoring was not observed and the need to link country-wide scale up within the health institutions at a local level was not observed. Initiatives were cut off during the COVID-19 pandemic and became static. If

SATH had been implemented continuously, health indicators would have been appraised in alignment with the original plan. CARE and partner organizations are contributing to new programs, integrating and maintaining SATH where it has been adopted. CARE is aligning with the mechanisms and model and local budget is being allocated. Proper quality assurance is needed and government activities need to be targeted towards addressing pressing health issues.

5.1 RESOURCE GAP

Despite efforts to strengthen healthcare services in Nepal, significant challenges persist in the deployment of skilled human resources at health posts. According to health post in-charges, a critical shortage of qualified healthcare personnel continues to hinder the effective delivery of essential medical services. This shortage severely impacts the capacity of health posts, particularly in remote and underserved areas, to provide comprehensive healthcare, including maternal, newborn and child health services, emergency care, and preventive health programs. As a result, communities often experience delays in accessing vital healthcare services, leading to compromised health outcomes, especially during emergencies or periods of high demand. Addressing these gaps requires strategic initiatives to recruit, train, and retain skilled healthcare professionals, as well as increased investment in healthcare infrastructure and workforce development. By prioritizing these efforts, Nepal can improve the availability and quality of healthcare services, ensuring equitable access to healthcare for all its citizens. During one of the KIIs, one of the local representatives highlighted the existing resource gap for the continuation of the SATH tool.

> ***There has been changes in awareness and knowledge level, however, need for the orientation to the health facilities, training to the FCHVs, ownership of the SATH model by the health facilities due to it being their area of expertise and also the feedback and evaluation collection from the involved stakeholders is very visible.***

Local government bodies have been reluctant to separately budget for FCHVs and HMGs as there have been additional issues that need more priority. As the research team got a chance to attend an annual meeting for budget planning, the following resource gap was identified.

> *The discussion about the demand of FCHVs was also considered, regarding the provision of lunch during the HMG meetings, however, was concluded as it would be very expensive to do so for every group and in the long run as there are 83 HMGs in the district.*

In one of the FGDs with FCHVs in Rupandehi, the FCHVs highlighted the resource gaps that have further created challenges and obstacles in following the SATH tool during HMG meetings.

> *The FCHVs emphasized the need for further training, buying tikas and flex prints for SATH tool new knowledge, resources for conducting SATH meetings and convenient access to government health facilities to ensure the meetings remain effective.*

FCHVs face significant challenges related to their participation in HMG meetings and adherence to the SATH tool, as outlined in the government's Equity, Access, and Operation Guideline 2076 B.S. These challenges primarily stem from inadequate access to resources and lack of economic support. FCHVs often struggle with insufficient facilities, materials, and financial sustainability, which not only demotivates them but also hinders their effective engagement in health initiatives at the community level. The discrepancy between policy guidelines and practical implementation exacerbates these issues, highlighting the need for policy reforms to ensure equitable resource allocation, capacity building, and sustainable funding mechanisms for FCHVs. Addressing these challenges is crucial for enhancing the effectiveness and sustainability of community health programs in Nepal.

Advocacy efforts were directed towards securing increased funding from the government to support health interventions. There remains a critical necessity to establish at least one health post or birthing center in every ward and to replicate health facilities. However, a significant challenge arises from conflicting priorities between health experts and local representatives empowered to make budget decisions related to healthcare.

Despite WHO's guideline recommending that countries allocate at least 10% of their total budget to health services, Nepal currently allocates less than 7% to healthcare, according to one of the Central-level KIIs taken with CARE staff. This underinvestment poses challenges in adequately funding healthcare infrastructure, personnel, and essential services, limiting the country's capacity to address widespread health issues effectively. Prioritizing the WHO's target of 10% could potentially lead to substantial improvements in healthcare accessibility, quality, and outcomes nationwide, aligning Nepal's health system more closely with international standards and goals.

The lack of adequate health infrastructure, such as health posts and birthing centers, in each ward underscores the urgent need to improve healthcare accessibility across communities. This initiative not only aims to enhance maternal, newborn and child health services but also to ensure comprehensive healthcare delivery closer to people's homes. Despite this clear need, challenges persist due to differing perspectives between healthcare professionals advocating for improved services and local authorities tasked with allocating budget resources. Balancing these priorities is crucial for effectively addressing healthcare gaps and improving health outcomes at the grassroots level. In a KII with one of the former CARE staff members, he highlighted the role of the planning process in prioritization:

> ***In local level health planning process, health indicators are most of the time compared with other infrastructural development. The actual achievements can be seen in those places where health sector is properly prioritized and the planning and budgeting as well as implementation part are properly aligned.***

According to one of the KIIs,

> ***The genuine and important part was how are meetings run, the effect on the service utilization is being provided or not, and budget allocation, dress was being provided, mobile recharge, distribution of mobile and recharge, cycle in the terai region, were provided to FCHVs and gaps was seen in the non-governmental sectors.***

5.2 FUNCTIONALITY OF HMGS

The SATH tool can be used as long as there is existence of HMGs in a community. Across Nepal, only 3 out of 10 women of WRA reported having a health mothers group in their ward and only about 18% of those women who repoted HMG in their ward actively participated in the meeting in the last six months before the survey. Such grim situation of HMGs across Nepal could be affecting the participation and collective health promotion approaches and uptake of healthy behaviors among community members and it won't be possible for FCHVs to utilize the SATH tool as a participatory process without convening of mothers and WRA of the community. This situation of low presence and functionality of HMGs is posing issues in the consistent use of SATH tool.

5.3 OWNERSHIP ISSUES

The ambiguity surrounding the ownership of the SATH tool within HMGs and among FCHVs reflects a critical need for clarity and defined ownership structures. Despite its widespread adoption by numerous NGOs, INGOs, and government programs, there exists community hesitation to recognize SATH solely as a product of CARE, a significant player in the health sector. They perceive the SATH tool as a joint initiative of GoN and CARE Nepal. This ambiguity poses a substantial challenge to the tool's long-term sustainability and effectiveness. The lack of clear ownership undermines efforts to institutionalize and integrate SATH into community health initiatives fully. Clear ownership is essential not only for accountability and sustainability but

also for ensuring that stakeholders, particularly FCHVs and HMGs, understand their roles in utilizing and maintaining the tool's impact.

In one of the FGDs , the FCHVs highlighted upon their dire need of trainings and their condition caused by the confusing ownership issues amidst government and other stakeholders.

> ***We need re-orientation and refreshment trainings regarding SATH tool. We have turned out to be like orphaned children; it depends solely on us either to follow the SATH tool or not so, proper monitoring and supervision is also required.***

Resolving this ambiguity requires collaborative efforts among stakeholders to establish transparent ownership frameworks, foster community trust, and secure sustainable support for SATH as a crucial component of healthcare delivery in Nepal.

As per a KII,

> ***Even though the FCHVs might call lack of tika as an issue, the main issue here is lack of ownership and proper monitoring mechanism from the side of the government.***

It was unclear if these changes occurred mainly because of SATH or a related intervention by CARE. Participants reported a whole range of health programs as well as reforms in the broader society, which were designed and implemented by several other stakeholders. Further, changes in local economy, developmental activities and the increased access to news and other popular media have occurred through several waves of democratization and most recently with the *federalization* of the state.

However, it is clear that as a new intervention, SATH's full contribution to specific areas like policy advocacy, policy integration at all three tiers of government and incorporation of the SATH tool in the local health system and its implementation establishes SATH tool as an innovative initiative. Whereas, SATH partially contributed to the improved utilization of the health system and MNCH and positive transformations on social norms (health related and other). The overall health system itself is dynamic entity whose effects are difficult to be segregated from the progress made by SATH and other regular programs of the government.

5.4 TRAINING NEEDS

The need for refresher courses for FCHVs was identified and addressed to ensure ongoing effective service delivery. In the FGD with the FCHVs in Kothamai, one of the FCHVs stated that their own knowledge needs to be refreshed time and again, so that they can share it with the community members.

> ***It has been almost two years, there has been no trainings for the FCHVs. We do conduct the regular monthly meetings, but if there is no new knowledge among us or no refreshment trainings for us, it will become monotonous at some point. FAIRMED provided consistent support, offering training on conducting exercises and updating us on new government regulations and benefits for women and children. Additionally, the government supplied mats and registers to encourage regular meeting conduct. However, there remains a clear need for ongoing training to enhance our capabilities further.***

Not only the FCHVs, the HMGs too showed the gap in capacity building and training required for them. In Kothaimai HMG, the members highlighted their need for further trainings.

> *There should be more trainings for us- if there are new people then we can get new knowledge as same people can only provide us with limited information. There should be counselling services for women during the pregnancy and lactating stages as they are confused during that time.*

5.5 MONITORING AND SUPERVISION:

The SATH tool should be approached as a collaborative concept that emphasizes identifying successful past practices and assessing their applicability in current contexts. However, persistent gaps in proper monitoring and follow-up mechanisms have deepened these challenges.

Effective oversight from entities such as the government and CARE Nepal, including comprehensive Monitoring and Evaluation (M&E) processes, is crucial for ensuring the effective operation of HMGs, FCHVs, and the SATH tool. This necessity was underscored in a KII at the central level, highlighting the urgent need for consistent supervision and evaluation to address these gaps and enhance the tool's sustainability and impact.

They should review SATH tool, rethink upon it based upon the experiences learnt, it should be revisited and reanalyzed for formulating new plans and policies in all levels.

SECTION 6: RECOMMENDATIONS AND FUTURE DIRECTIONS

As per the assessments conducted in all four districts, it's crucial to determine who is responsible for ongoing implementation of SATH, including resourcing HMGs, FCHVs, and providing continuous training and monitoring. This approach will help in understanding the synergies and impacts of various efforts, thereby guiding future strategies and ensuring effective utilization of resources towards sustainable health outcomes. The following recommendations were suggested by the participants of the study.

FOR HEALTH AUTHORITIES:

- Foster better coordination among different districts to share best practices, resources, and success stories in relation to maternal and child health outputs.
- Organize regional training workshops to standardize health practices and ensure consistent implementation across districts.
- Develop a regional framework for monitoring and evaluating health interventions to identify gaps and areas for improvement.

FOR POLICY IMPLEMENTATION:

- Advocate for increased budget allocation for health services at the regional level to support sustained health interventions.
- Ensure strict enforcement of health policies and protocols to maintain high standards of care and service delivery.

FOR GOVERNMENT AND STAKEHOLDER COLLABORATION:

- Establish national multi-stakeholder platforms to facilitate collaboration and coordination among government agencies, NGOs, and other stakeholders.
- Develop and implement sustainability plans to ensure that health interventions continue to benefit the population after initial project funding ends.
- Improve the overall health system, including managing inadequate human resources and providing free ambulance services.
- Address confusion regarding supply-side fulfillment and adoption of the SATH tool.
- Increase the number of trained health officials and prioritize supply-side planning and interventions.
- Enhance equitable access to health facilities and integrate systems like SMS and MMS.

- Activate and revitalize HMGs where needed and ensure regular meetings and motivation for FCHVs.
- Develop rural municipalities as demonstration sites for the SATH tool and ensure proper utilization for achieving health outcomes.
- Establish strong reporting mechanisms and local government initiatives for feedback and monitoring.

FOR CARE NEPAL:

- Advocate for the continuation or renewal of SATH implementation at local levels.
- Collaborate to fill gaps in financial support to increase government ownership of the SATH tool for providing refresher trainings and awareness on the SATH tool.
- Modify the SATH tool based on contextual needs and ensure time-relevant interventions.
- Strengthen monitoring and supervision mechanisms across all administrative levels.
- Facilitate proper handover plans to the government and develop exit and sustainability strategies.
- Introduce interventions that involve community participation for escalating the SATH tool.

FOR FCHVS AND HMGS:

- Provide motivation through reward mechanisms and ensure refresher trainings on the SATH tool.
- Resume the SATH tool in areas where it has stopped and ensure community-led ownership and awareness of its benefits.
- Strengthen follow-up and reporting mechanisms to enhance the effectiveness of community health initiatives.

SECTION 6: ANNEX

ANNEX 1: PARTICIPANT LIST

FGD Participation Sheet			
Progress Inc.			
Project: SATH Tool System Level Impact Evaluation- CARE Nepal			
Name of the expert	XXX		
Name of the field researcher	YYY		
District	Kailali, Doti		
Name	**Sex**	**Location**	**Type of FGD**
[name redacted]	M	Tikapur- 7, Kailali	Community member
[name redacted]	M	Tikapur- 7, Kailali	Community member
[name redacted]	M	Tikapur- 7, Kailali	Community member
[name redacted]	F	Tikapur- 7, Kailali	Community member
[name redacted]	F	Tikapur- 7, Kailali	Community member
[name redacted]	F	Tikapur- 7, Kailali	Community member
[name redacted]	F	Tikapur- 7, Kailali	Community member
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Female Community Health Volunteers
[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group

[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
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[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
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[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
[name redacted]	F	Tikapur- 7, Kailali	Health Mothers' Group
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
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[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur Municipality, Kailali	Female Community Health Volunteers
[name redacted]	F	Joshipur- 2, Kailali	Health Mothers' Group
[name redacted]	F	Joshipur- 2, Kailali	Health Mothers' Group
[name redacted]	F	Joshipur- 2, Kailali	Health Mothers' Group
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[name redacted]	F	Joshipur- 2, Kailali	Health Mothers' Group
[name redacted]	F	Boktan Phudsil R.M., Doti	Health Mothers' Group

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[name redacted]	F	Boktan Phudsil R.M., Doti	Female Community Health Volunteers
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member
[name redacted]	M	Boktan Phudsil R.M., Doti	Community member

ANNEX II: QUESTIONNAIRE SETS

KII with Government Officials (Federal and Provincial)

- How and when did the Nepal government decide to adopt the SATH tool for its programs?
- What were the key factors or evidence that influenced the government's decision to integrate the SATH tool into its programs? Can you describe the process through which the government took ownership of the SATH tool?

- What were the main challenges or obstacles faced during the integration of the SATH tool into government programs, and how were they addressed?
- How has the Nepal government demonstrated ownership of the SATH tool since its adoption? Probe about the ownership, planning, and financing of SATH at the sub-national level (province and municipality). What specific actions has the government taken to integrate the SATH tool into its existing programs and systems?
- What measures has the government put in place to ensure the effective implementation and sustainability of the SATH tool across different levels of the health system?
- What impact has the integration of the SATH tool had on government programs and health outcomes since its adoption? Probe about changes in social norms, advocacy impacts, system strengthening, social accountability by comparing before and after SATH implementation.
- How does the government plan to sustain and further scale the use of the SATH tool in the future?
- What role did CARE Nepal play in advocating for the integration of the SATH tool into government programs? How did CARE Nepal collaborate with the government during the adoption and integration process?
- Were there any other development agencies or partners involved in promoting the adoption of the SATH tool, and if so, what was their role?
- How has the SATH model transitioned from the local to federal level in terms of policy integration? In your view, is it successfully transitioned? If not, why?
- Can you describe any specific policies or guidelines that have been developed at the federal level to support the implementation of the SATH model? What role has CARE Nepal played in advocating for policy changes and integration of the SATH model into government programs at the federal level?
- How have stakeholders at the federal, provincial, and local levels collaborated to support the implementation of the SATH model and improve utilization of health services?

KII with Government Officials at Local Level

How has the SATH model been localized at the municipality and community levels following its adoption by the Nepal government's federal-level program? What specific changes or adaptations have been made to the SATH model to suit the needs and context of different municipalities and communities?

- Can you describe the process through which the SATH model has been implemented at the local level beyond CARE Nepal's projects?
- Have there been any challenges or successes in implementing the SATH model at the local level, and if so, what are they?
- What are the changes brought by the implementation of SATH model in the local level? Probe about changes in social norms on seeking healthcare services (esp. maternal and child health care), functionality of HMGs, capacity building of FCHVs and so on.
- Have there been any notable policy changes or initiatives related to maternal and child health services as a result of the SATH model implementation?
- Who supported these changes through the implementation of SATH tool and how?
- What support has been provided by rural municipalities or local government bodies to facilitate the implementation of the SATH model? What role have rural municipalities played in supporting the localization and implementation of the SATH model at the community level?
- How have municipalities collaborated with other stakeholders, including CARE Nepal and community members, to ensure the successful implementation of the SATH model?
- Can you discuss any examples of successful partnerships or initiatives between municipalities and other stakeholders to support the SATH model implementation?

KII with Health Workers at Facility Level

- Can you provide examples of specific impacts or improvements that resulted from the implementation of the SATH model? What methodologies or indicators have been used to measure the impact of the SATH model, and what have been the main findings? Probe about changes in social norms, advocacy impacts, system strengthening by comparing before and after SATH implementation.
- How has CARE Nepal (or any other development agencies or projects such as Suaahara II) contributed to the adoption, and implementation of SATH tool for improving health services and outcomes at the local level?
- How assertive are community members in demanding their rights and entitlements related to health services? Has it changed after the implementation of SATH tool? If yes, how? What are the main barriers to assertiveness among community members, and how can these barriers be addressed through advocacy efforts?
- How has the implementation and localization of the SATH tool impacted the quality of life for community members, particularly in terms of maternal and child health outcomes? Can you discuss the situation before and after the introduction and implementation of SATH tool?
- Have there been any challenges or successes in implementing the SATH model in the community, and if so, what are they?

KII with organizations who have adopted SATH

- How have you integrated the SATH model into your organization's existing maternal and child health programs? What strategies have you employed to scale up the SATH model within your projects?
- How have you adapted the SATH model to fit the specific context of the areas where you operate? Probe for any changes in the SATH model to meet their requirements.
- How has the replication of the SATH model been received by local communities and health workers?
- What factors have facilitated or hindered the adoption of the SATH model in your projects?
- Can you share any success stories or case studies from the areas where you have replicated the SATH model? (specific examples of improved health outcomes or success stories resulting from the SATH model)
- What advocacy strategies have been most effective in promoting the SATH model among policymakers and stakeholders? What policy changes have resulted from your advocacy efforts related to the SATH model?
- How have you engaged community members and other stakeholders in advocacy efforts related to the SATH model?
- How have you collaborated with government agencies and other NGOs/INGOs to advocate for the SATH model? What barriers have you encountered in advocacy, and how have you overcome them?
- In what ways has the SATH model empowered women and other community members to take charge of their health?
- What challenges have you faced in promoting social norms change, and how have you addressed them through the use of SATH tool? Has this been successful? Please provide reasons.
- What overall impact has the SATH model had on maternal and child health outcomes in the areas where you operate? How have health service utilization rates changed since the implementation of the SATH model?
- What monitoring and evaluation frameworks have you used to assess the impact of the SATH model? (If any evaluation/research is available, then please request to provide the report or data, if possible)
- What were the main obstacles/challenges that required to be addressed to achieve these system level changes? Any specific strategies that were employed to address those challenges?
- What were the main intended outcomes from the implementation of SATH tool? Probe about outcomes of system-level changes. Were they all achieved? What were the factors that led to the success? What remains to be achieved? Any unintended consequences that you can mention?

- What lessons have you learned from scaling the SATH model that could be applied to other regions or projects?
- What measures have you put in place to ensure the sustainability of the SATH model in your projects? How do you plan to continue scaling and improving the SATH model in the future?
- What recommendations would you make to other organizations looking to replicate the SATH model?
- Any additional thoughts?

KII with representatives from CARE

- Can you describe the initial development process of the SATH tool and the key objectives behind its creation?
- What are the advocacy wins that you see has happened in terms of SATH tool? Can you please elaborate?
- What systems were impacted or changed due to those advocacy wins of SATH tool? At what level and how the changes occurred: at federal, provincial, and local levels. Probe about changes in health service delivery, accountability of local levels (including FCHVs, health care providers, local leaders), social norms, advocacy, and maternal and child health outcomes that have been observed since the implementation of the SATH tool.
- How has CARE Nepal and its partners contributed to the changes mentioned above?
    - How has CARE advocated for the adoption and integration of the SATH tool at various levels, and what policy changes have resulted from these advocacy efforts?
    - How has CARE engaged communities to change social norms related to maternal and child health, and what specific initiatives have been implemented to promote these changes?
    - In what ways has the SATH tool empowered women and other community members to take charge of their health, and how has CARE used the tool to educate communities?
- What were the main obstacles/challenges that required to be addressed to achieve these system level changes? Any specific strategies that were employed to address those challenges?
- What were the main intended outcomes from the implementation of SATH tool? Probe about outcomes of system-level changes. Were they all achieved? What were the factors that led to the success? What remains to be achieved? Any unintended consequences that you can mention?
- What lessons has CARE learned from scaling the SATH tool that could inform future scaling efforts, and can you share any success stories or case studies?
- What measures has CARE and its partners put in place to ensure the sustainability of the SATH tool, and what are the future plans and recommendations for other organizations looking to replicate the tool?
- Any additional thoughts?

Health Mothers Group:

- Have you heard about the SATH tool before? If yes, could you please share what you know about it and how it is being used in your community?
- How accessible are maternal and child health services in your community? How has the SATH tool encouraged you to utilize maternal and child health services?
- How has the utilization of maternal and child health services changed since the implementation of the SATH tool?
- How has maternal and child health outcomes have changed since the implementation of SATH tool?
- What are the persisting challenges and issues in accessing and utilizing health services in your community? How those challenges could be addressed?

- Have you noticed any changes in your awareness about these services since the implementation of the SATH tool?
- In what ways do HMGs empower women to make informed decisions about their health and the health of their families? How has SATH tool helped to empower women?
- What do you perceive as the main benefits of the SATH tool and HMGs for the community?
- What changes would you like to see in the future regarding maternal and child health services in your community?
- Do you have any suggestions for improving the effectiveness and functionality of HMGs and the SATH tool?

FCHVs:

- Have you heard about the SATH tool before? If yes, could you please share what you know about it and how it is being used in your community?
- Have you noticed any changes or improvements in maternal and child health services since the introduction of the SATH tool? If yes, could you please describe these changes? Have you observed any changes in yourself and among the community members or within the local health system? Probe about changes in social norms, service utilization, service quality, awareness among mothers and so on.
- What contributed to such changes? Discuss role and contribution of SATH tool including process of the change.
- How functional do you consider HMGs to be in carrying out their activities effectively? Have you noticed any changes in the functionality of Health Mothers Groups (HMGs) as a result of implementing the SATH tool?
- How has the SATH tool impacted your work as an FCHV? Please share any specific experiences related to SATH tool.
- What impact has the SATH tool had on the empowerment of women in your community? Could you share specific examples of such changes?
- Are there any challenges in implementing SATH in your community? Please elaborate such challenges and how they can be addressed.
- How assertive are community members in demanding their rights and entitlements related to health services? Has it been influenced by SATH tool?
- Do you think there is equitable access to health services for women and children in your community? Why or why not? How has SATH supported/contributed to ensure equitable access?
- How aware are you about the maternal and child health services available in your community?
- Have you noticed any changes in your awareness about these services since the implementation of the SATH tool?
- Were you and the mother's group supported by any development partners or projects while implementing SATH? If yes, could you please explain the contribution of those entities?
- Do you have any suggestions for improving the effectiveness and functionality of HMGs and the SATH tool?

Community Members (Including Men):

- Have you heard about the SATH tool before? If yes, could you please share what you know about it and how it is being used in your community? Change in situation before and after that?
- How has the SATH tool encouraged you to utilize maternal and child health services?
- What specific activities or initiatives have been implemented by HMGs to improve maternal and child health outcomes?
- How functional do you consider HMGs to be in carrying out their activities effectively?

- Have you noticed any changes or improvements in maternal and child health services since the introduction of the SATH tool? If yes, could you please describe these changes?
- How accessible are maternal and child health services in your community?
- How has the SATH tool encouraged you to utilize maternal and child health services?
- How has the utilization of maternal and child health services changed since the implementation of the SATH tool?
- Do you think there is equitable access to health services for women and children in your community? Why or why not?
- How aware are you about the maternal and child health services available in your community?
- Have you noticed any changes in your awareness about these services since the implementation of the SATH tool?
- How actively are community members, including men, involved in the activities of HMGs?
- In what ways do HMGs empower women to make informed decisions about their health and the health of their families?
- Have you noticed any changes in the level of community engagement since the establishment of HMGs?
- What do you perceive as the main benefits of the SATH tool and HMGs for the community?
- What changes would you like to see in the future regarding maternal and child health services in your community?
- Do you have any suggestions for improving the effectiveness and functionality of HMGs and the SATH tool?

ANNEX III: QUANTITATIVE FINDINGS

69.1% of total respondents (287) identified improvement in childcare and hygiene as a positive change in the community from the SATH program, followed by nutrition and vaccination (39.6%) and decline in infant mortality rate (11.3%). 6.9% of total respondents identified no positive changes in the community. District-disaggregated data revealed that across all four districts, a greater proportion of respondents identified improvement in childcare and hygiene as a positive change in the community compared to decline in infant mortality rate and nutrition and vaccination.

Table 1: District-disaggregated data of positive changes in the community from the SATH program

	Doti	Kailali	Rupandehi	Salyan	Total
Improvement in childcare and hygiene	84.6	83.3	53.5	50	69.1
Decline in infant mortality rate	19.2	1.7	22.8	3.6	11.3
Nutrition and vaccination	38.5	60.8	25.7	0	39.6
No change	11.5	2.5	0	46.4	6.9

The same data disaggregated by age revealed that on average, the higher age groups identified a higher proportion of positive changes in the community compared to the lower age groups. For example, all respondents over the age of 50 (100%) identified positive changes in the improvement of childcare and hygiene, followed by 71.1% of respondents aged 35-49, 70.7% of respondents aged 19-25, 66.9% of respondents aged 25-35, and 44.4% of respondents aged 15-18 who identified the same. All respondents in the 15-18 age group

and in the over 50 age group identified changes in the community from the SATH program, with 0% to no change in the community.

Table 2: Age-disaggregated data of positive changes in the community from the SATH program

	15-18	19-25	25-35	35-49	Over 50	Total
Improvement in childcare and hygiene	44.4	70.7	66.9	71.1	100	69.1
Decline in infant mortality rate	33.3	9.3	10.3	11.1	20	11.3
Nutrition and vaccination	33.3	33.3	44.9	33.3	50	39.6
No change	0	10.7	5.1	8.9	0	6.9

Ethnicity-disaggregated data revealed that all Muslim respondents (100%) identified improvement in childcare and hygiene as a positive change in the community, compared to 80.6% Brahmin/Chhetri, 72.7% Janajati, 53.8% of respondents from other ethnicity groups, and 43.3% Dalit. A greater proportion of Dalit respondents identified the decline in infant mortality, while a greater proportion of Janajati respondents (43.6%) identified nutrition and vaccination as a positive change compared to other ethnicity groups.

Table 3: Ethnicity-disaggregated data of positive changes in the community from the SATH program

	Brahmin/ Chhetri	Janajati	Dalit	Muslim	Others
Improvement in childcare and hygiene	80.6	72.7	43.3	100	53.8
Decline in infant mortality rate	11.3	9.4	16.7	0	15.4
Nutrition and vaccination	25.8	46	36.7	20	43.6
No change	11.3	5.8	13.3	0	0

When asked to rate how important the changes brought about by SATH are using a 1-5 scale, 1 being very bad and 5 being excellent, 32.4% of total respondents selected 5 (excellent), 43.2% selected 4 (very good), 23% selected 3 (neutral), 1% selected 2 (bad), and 0.3% selected 1 (very bad). On average, a greater proportion of respondents from the Kailali district rated the importance of changes brought about by SATH as either excellent (50.8%) or very good (35.2%), compared to other districts. Conversely, the Salyan district rated the importance of changes brought about by SATH lower compared to other districts, with the majority of respondents (56.3%) selecting 3 (neutral), 3.1% of respondents selecting 1 (very bad), and no respondents selecting 5 (excellent).

Table 4: District-disaggregated data regarding the importance of changes brought about by SATH

	Doti	Kailali	Rupandehi	Salyan	Total

Very bad (1)	0	0	0	3.1	0.3
Bad (2)	0	0	0	9.4	1
Neutral (3)	42.3	14.1	18.8	56.3	23
Very good (4)	38.5	35.2	58.4	31.3	43.2
Excellent (5)	19.2	50.8	22.8	0	32.4

The same data disaggregated by age revealed that on average, the higher age groups placed greater importance on the changes brought about by SATH compared to the lower age groups. 90% of total respondents aged 50 and above selected either 4 (very good) or 5 (excellent), whereas 68.5% of total respondents in the 19-25 age group selected the same.

Table 5: Age-disaggregated data regarding the importance of changes brought about by SATH

	15-18	19-25	25-35	35-49	Over 50	Total
Very bad (1)	0	0	0.7	0	0	0.3
Bad (2)	0	1.3	1.4	0	0	1
Neutral (3)	22.2	30.3	20.1	22.9	10	23
Very good (4)	55.6	46.1	41	43.8	40	43.2
Excellent (5)	22.2	22.4	36.8	33.3	50	32.4

Ethnicity disaggregated data reveled that all Muslim respondents (100%) selected either 4 (very good) or 5 (excellent) when asked about the importance of changes brought about by SATH. The majority within each of the other ethnic groups selected the same, with 43.8% of Dalit respondents, 35.9% of Janajati respondents, 26.2% of Brahmin/Chhetri respondents, and 17.9% of other ethnic groups choosing the highest option (excellent).

Table 6: Ethnicity-disaggregated data regarding the importance of changes brought about by SATH

	Brahmin/ Chhetri	Janajati	Dalit	Muslim	Others	Total
Very bad (1)	0	0.7	0	0	0	0.3
Bad (2)	1.5	1.4	0	0	0	1
Neutral (3)	36.9	21.4	9.4	0	20.5	23
Very good (4)	35.4	40.7	46.9	50	61.5	43.2
Excellent (5)	26.2	35.9	43.8	50	17.9	32.4

19.6% of total respondents felt that SATH impacted knowledge about hygiene, childcare, vaccine, and nutrition. 87.1% of total respondents felt that SATH brought about positive change and 4.6% were unsure. No respondents reported negative changes associated with SATH. District-disaggregated data revealed that all respondents in Rupandehi (100%) reported SATH having a positive change on community health practices, closely followed by respondents in Kailali (99.2%) reporting the same. The majority of respondents in Doti (88%) felt that SATH impacted knowledge about hygiene, childcare, vaccine, and nutrition, followed by 25% of respondents in Salyan, 14.3% of respondents in Kailali, and no respondents (0%) in Rupandehi.

Table 7: District-disaggregated data regarding how SATH impacted community health practices

	Doti	Kailali	Rupandehi	Salyan	Total
Knowledge about hygiene, childcare, vaccine, nutrition	88	14.3	0	25	19.6
Positive change	12	99.2	100	71.4	87.1
Negative change	0	0	0	0	0
Unsure	8	0.8	0	28.6	4.6

The same data disaggregated by age revealed that the different age groups generally felt the same regarding how SATH impacted community health practices. 91.4% of respondents aged 25-35 reported SATH having a positive change on community health practices, followed by the 15-18 age group (87.5%), the 19-25 age group (83.9%), the 35-49 age group (81.8%), and the over 50 age group (80%). Only the 15-18 age group had no respondents who felt that SATH impacted knowledge about hygiene, childcare, vaccine, and nutrition.

Table 8: Age-disaggregated data regarding how SATH impacted community health practices

	15-18	19-25	25-35	35-49	Over 50	Total
Knowledge about hygiene, childcare, vaccine, nutrition	0	24.2	19.8	15.9	20	19.6
Positive change	87.5	83.9	91.4	81.8	80	87.1
Negative change	0	0	0	0	0	0
Unsure	12.5	1.6	4.3	6.8	10	4.6

Ethnicity disaggregated data revealed that all Muslim respondents (100%) identified improvement in childcare and hygiene as a positive change in the community, compared to 80.6% Brahmin/Chhetri, 72.7% Janajati, 43.3% Dalit, and 53.8% of respondents from other ethnicity groups. A greater proportion of Dalit respondents identified the decline in infant mortality, while a greater proportion of Janajati respondents identified nutrition and vaccination as a positive change compared to other ethnicity groups.

Ethnicity-disaggregated data revealed that all Muslim respondents and all those from other ethnic groups (100%) felt that SATH had a positive change on community health practices. 99.7% of respondents from the

Janajati ethnic group felt the same, followed by 88.9% of Dalit respondents, and 56.1% of Brahmin/Chhetri respondents. Conversely, a greater proportion of Brahmin/Chhetri respondents felt that SATH impacted knowledge about hygiene, childcare, vaccine, and nutrition, followed by Muslim respondents (20%), Janajati respondents (12.5%), and Dalit respondents (11.1%).

Table 9: Ethnicity-disaggregated data regarding how SATH impacted community health practices

	Brahmin/ Chhetri	Janajati	Dalit	Muslim	Others	Total
Knowledge about hygiene, childcare, vaccine, nutrition	47.4	12.5	11.1	20	0	19.6
Positive change	56.1	97.7	88.9	100	100	87.1
Negative change	0	0	0	0	0	0
Unsure	12.3	2.3	3.7	0	0	4.6

When asked how much the SATH tool increases awareness of maternal and child health services, the disaggregated data by district shows that largest share of respondents from Doti (34.6%), Kailali (52.3%), and Rupandehi (50.5%) reported the extent as very good. Whereas 50% of respondents from Salyan were neutral.

The larger share of respondents from Doti (38.5%), Kailali (48.4%), and Rupandehi (53.5%) reported the extent that the SATH tool has encouraged the use of maternal and child health care servies as very good. 37.5% of respondents from Salyan reported the extent as bad.

Most respondents from Kailali (58.6%) and Rupandehi (55.4%) reported that the rate of utilization of maternal and child health care services in their community after implementation as very good. The larger share of respondents from Doti (65.4%) and Salyan (43.8%) were neutral when asked about the usage of these services.

Table 10: District-disaggregated data regarding SATH tool and child/maternal healthcare services

		Doti	Kailali	Rupandehi	Salyan	Total
How much does the SATH tool increase your awareness of maternal and child health services?	Excellent	3.8	28.9	5.9	0	15.3
	Very Good	34.6	52.3	50.5	18.8	46.3
	Neutral	26.9	17.2	43.6	50	31
	Bad	30.8	1.6	0	31.3	7
	Very Bad	3.8	0	0	0	0.3
To what extent has the SATH tool encouraged the use of maternal and child health care services?	Excellent	3.8	32	11.9	0	18.8
	Very Good	38.5	48.4	53.5	25	46.7
	Neutral	34.6	17.2	34.7	34.4	26.8
	Bad	15.4	2.3	0	37.5	6.6

	Very Bad	7.7	0	0	3.1	1
How would you rate the utilization of maternal and child health care services in your community after implementation?	Excellent	0	5.5	4	0	3.8
	Very Good	3.8	58.6	55.4	31.3	49.5
	Neutral	65.4	32	40.6	43.8	39.4
	Bad	26.9	3.9	0	21.9	6.6
	Very Bad	3.8	0	0	3.1	0.7

A larger share of respondents ages 15-18 (66.7%), ages 19-25 (40.8%), and ages 25-35 (54.9%) said the extent the SATH tool increases their awareness of maternal and child health services was very good. The larger share of respondents ages 35-49 (43.8%) were neutral. An equal share of respondents over 50 years reported the increased awareness as excellent and neutral (40% each).

The larger share across all age groups reported the extent that the SATH tool encouraged them to use maternal and child health care services as very good.

66.7% of respondents ages 15-18, 51.3% of respondents ages 19-25, and 58.3% of respondents ages 35-49 rated the utilization of maternal and child health care services in their community after implementation as very good. An equal share of respondents ages 25-35 (45.1%) and over 50 years (40%) rated the utilization as very good or were neutral.

Table 11: Age-disaggregated data regarding SATH tool and child/maternal healthcare services

		15-18	19-25	25-35	35-49	Over 50	Total
How much does the SATH tool increase your awareness of maternal and child health services?	Excellent	0	10.5	17.4	14.6	40	15.3
	Very Good	66.7	40.8	54.9	33.3	10	46.3
	Neutral	33.3	36.8	22.9	43.8	40	31
	Bad	0	10.5	4.9	8.3	10	7
	Very Bad	0	1.3	0	0	0	0.3
To what extent has the SATH tool encouraged the use of maternal and child health care services?	Excellent	33.3	11.8	22.2	16.7	20	18.8
	Very Good	55.6	44.7	47.2	45.8	50	46.7
	Neutral	11.1	31.6	26.4	25	20	26.8
	Bad	0	9.2	3.5	12.5	10	6.6
	Very Bad	0	2.6	0.7	0	0	1
How would you rate the utilization of	Excellent	22.2	1.3	3.5	4.2	10	3.8
	Very Good	66.7	51.3	45.1	58.3	40	49.5

maternal and child health care services in your community after implementation?	Neutral	11.1	40.8	45.1	25	40	39.4
	Bad	0	5.3	5.6	12.5	10	6.6
	Very Bad	0	1.3	0.7	0	0	0.7

Disaggregated data based on ethnicity revealed that a larger share of respondents who identify as Brahmin/Chhetri (33.8%) and Jananati (51.7%) rated the SATH tool as very good at increasing their awareness of maternal and child health services. A larger share of respondents who identified as Dalit (40.6%) and Muslim (50%) were neutral towards the statement. Most respondents who identified outside of these ethnicities (59%) reported their rating as very good.

When asked to what extent the SATH tool has encouraged the use of maternal and child healthcare services, disaggregated data reveals that across all ethnicity groups, with the exception of Muslims, respondents rate the SATH tool as very good. An equal share of Muslims (33.3%) rated the SATH tool as very good, excellent, or were neutral.

When asked to rate the utilization of maternal and child health care services in their community after implementation, disaggregated data reveals most respondents who identify as Janajati (57.2%), Dalit (43.8%), Muslim (66.7%) or 'other' (51.3%) rate the utilization as very good. Brahmin/Chhetri respondents were neutral towards this statement.

Table 12: Ethnicity- disaggregated data regarding SATH tool and child/maternal healthcare services

		Brahmin/Chhetri	Janajati	Dalit	Muslim	Others	Total
How much does the SATH tool increase your awareness of maternal and child health services?	Excellent	13.8	18.6	15.6	33.3	2.6	15.3
	Very Good	33.8	51.7	37.5	16.7	59	46.3
	Neutral	24.6	29	40.6	50	38.5	31
	Bad	26.2	0.7	6.3	0	0	7
	Very Bad	1.5	0	0	0	0	0.3
To what extent has the SATH tool encouraged the use of maternal and child health care services?	Excellent	15.4	20	31.3	33.3	7.7	18.8
	Very Good	38.5	52.4	34.3	33.3	51.3	46.7
	Neutral	26.2	24.1	21.9	33.3	41	26.8
	Bad	18.5	2.8	9.4	0	0	6.6
	Very Bad	1.5	0.7	3.1	0	0	1
How would you rate the utilization of maternal and	Excellent	1.5	5.5	6.3	0	0	3.8
	Very Good	32.3	57.2	43.8	66.7	51.3	49.5

child health care services in your community after implementation?	Neutral	47.7	33.8	37.5	33.3	48.7	39.4
	Bad	16.9	3.4	9.4	0	0	6.6
	Very Bad	1.5	0	3.1	0	0	0.7

When asked how much respondents agree with the statement that the health standards of the community have improved now compared to the previous years, most respondents from Doti (53.8%), Kailali (70.3%), and Rupandehi (47.5%) reported that they agree. 65.6% of respondents from Salyan were neutral. None of the respondents strongly disagreed with the statement.

When asked whether they agree that women in their community are more involved in decisions-making than ever before, most respondents from Kailali (72.7%) and Rupandehi (40.6%) agreed with the statement, whereas 73.1% of respondents from Doti and 56.3% of respondents from Salyan were neutral.

Respondents were asked to rate their confidence that they can access maternal and child healthcare services when needed. Most respondents from Doti (61.5%) and Salyan (53.1) were neutral towards this statement, whereas 58.6% of respondents from Kailali and 61.4% of respondents from Rupandehi were confident.

61.5% of respondents from Doti and 56.3% of respondents from Salyan reported neutral sentiments when asked what their level of access to health services for women and children in their community is. 41.4% of respondents from Kailali and 59.4% of respondents from Rupandehi reported the access was very good.

Table 13: District-disaggregated data regarding agreement with statements about community healthcare

		Doti	Kailali	Rupandehi	Salyan	Total
How much do you agree with the statement: "The health standards of the community have improved now compared to the previous years"?	Strongly Agree	3.8	18	30.7	0	19.2
	Agree	53.8	70.3	47.5	25	55.7
	Neutral	23.1	10.9	21.8	65.6	22
	Disagree	19.2	0.8	0	9.4	3.1
	Strongly Disagree	0	0	0	0	0
How much do you agree with the statement: Women in my community are more involved in decision-making about the healthcare than ever before"?	Strongly Agree	0	14.1	32.7	0	17.8
	Agree	23.1	72.7	40.6	34.4	52.6
	Neutral	73.1	11.7	26.7	56.3	27.5
	Disagree	3.8	0.8	0	3.1	1
	Strongly Disagree	0	0.8	0	6.3	1
How confident are you that you can access maternal and child healthcare	Very Confident	0	18.8	11.9	0	12.5
	Confident	23.1	58.6	61.4	37.5	30
	Neutral	61.5	20.3	26.7	53.1	30

services when needed?	Uncertain	15.4	2.3	0	9.4	3.5
	Very Uncertain	0	0	0	0	0
What is the level to access to health services for women and children in your community?	Excellent	0	25	11.9	3.1	15.7
	Very Good	19.2	41.4	59.4	25	43.9
	Neutral	61.5	27.3	28.7	56.3	34.1
	Bad	19.2	4.7	0	15.6	5.6
	Very Bad	0	1.6	0	0	0.7

Disaggregated data based on age revealed that most respondents across all age groups agreed with the statement that the health standards of the community have improved now compared to the previous years. No respondent from any age group strongly disagreed with the statement.

Apart from respondents ages 15-18 years, most of those across all age groups agreed with the statement that women in their community are more involved in decision-making about healthcare than ever before. An equal share of respondents in the 15–18-year age group (33.3%) strongly agreed, agreed, or were neutral.

Most respondents across all age groups reported that they are confident that they can access maternal and child healthcare services when needed. No respondent reported feeling very uncertain that they can access these services.

Apart from respondents ages 35-49 years, most respondents across all age groups rated the level of access to health services for women and children in their community as very good. Those ages 35-49 (35.4%) years were neutral.

Table 14: Age-disaggregated data regarding agreement with statements about community healthcare

		15-18	19-25	25-35	35-49	Over 50	Total
How much do you agree with the statement: "The health standards of the community have improved now compared to the previous years"?	Strongly Agree	44.4	14.5	19.4	22.9	10	19.2
	Agree	55.6	53.9	58.3	52.1	50	55.7
	Neutral	0	26.3	20.1	22.9	30	22
	Disagree	0	5.3	2.1	2.1	10	3.1
	Strongly Disagree	0	0	0	0	0	0
How much do you agree with the statement: "Women in my	Strongly Agree	33.3	7.9	22.2	20.8	0	17.8
	Agree	33.3	55.3	51.4	50	80	52.6
	Neutral	33.3	34.2	24.3	29.2	10	27.5

community are more involved in decision-making about the healthcare than ever before"?	Disagree	0	1.3	1.4	0	0	1
	Strongly Disagree	0	1.3	0.7	0	10	1
How confident are you that you can access maternal and child healthcare services when needed?	Very Confident	33.3	6.6	12.5	16.7	20	12.5
	Confident	66.7	44.7	56.9	58.3	50	54
	Neutral	0	40.8	29.2	20.8	30	30
	Uncertain	0	7.9	1.4	4.2	0	3.5
	Very Uncertain	0	0	0	0	0	0
What is the level to access to health services for women and children in your community?	Excellent	22.2	9.2	16	22.9	20	15.7
	Very Good	66.7	47.4	44.4	33.3	40	43.9
	Neutral	11.1	36.8	34	35.4	30	34.1
	Bad	0	5.3	4.9	8.3	10	5.6
	Very Bad	0	1.3	0.7	0	0	0.7

Disaggregated data of ethnic identity revealed that the larger share of respondents across all ethnicities agreed with the statement that the health standards of their communities have improved now compared to previous years. No respondent strongly disagreed with the statement.

With the exception of respondents who identified as Brahmin/Chhetri, disaggregated data shows that most respondents across all ethnicities agreed with the statement women in their communities are more involved in decision-making about healthcare than ever before. Most respondents part of the Brahmin/Chhetri (53.8%) ethnic group were neutral towards this statement. This trend was present when respondents were asked how confident they are that they can access maternal and child healthcare services when needed, as most respondents reported that they are confident. Whereas most respondents who are Brahmin/Chhetri (47.7%) were neutral. No respondent reported that they feel very uncertain that they can access these services.

Most respondents who identify as Janajati (48.3%) and Dalit (46.9%) reported that their level of access to health services for women and children in their community as very good. 66.7% of respondents who identify as Muslim said their level of access to these services was excellent. Whereas 50.8% of Brahmin/Chhetri respondents were neutral.

Table 15: Ethnicity-disaggregated data regarding agreement with statements about community healthcare

	Brahmin/Chhetri	Janajati	Dalit	Muslim	Others

How much do you agree with the statement: "The health standards of the community have improved now compared to the previous years"?	Strongly Agree	10.8	21.4	21.9	16.7	23.1
	Agree	43.1	61.4	62.5	66.7	48.7
	Neutral	33.8	17.2	12.5	16.7	28.2
	Disagree	12.3	0	3.1	0	0
	Strongly Disagree	0	0	0	0	0
How much do you agree with the statement: "Women in my community are more involved in decision-making about the healthcare than ever before"?	Strongly Agree	7.7	16.6	28.1	16.7	33.3
	Agree	33.8	66.2	46.9	66.7	35.9
	Neutral	53.8	15.2	25	16.7	33.3
	Disagree	1.5	1.4	0	0	0
	Strongly Disagree	3.1	0.7	0	0	0
How confident are you that you can access maternal and child healthcare services when needed?	Very Confident	9.2	13.8	12.5	50	7.7
	Confident	36.9	58.6	62.5	33.3	61.5
	Neutral	47.7	24.8	18.8	16.7	30.8
	Uncertain	6.2	2.8	6.3	0	0
	Very Uncertain	0	0	0	0	0
What is the level to access to health services for women and children in your community?	Excellent	10.8	15.2	28.1	66.7	7.7
	Very Good	27.7	48.3	46.9	16.7	33.3
	Neutral	50.8	32.4	12.5	16.7	33.3
	Bad	10.8	3.4	9.4	0	2.6
	Very Bad	0	0.7	3.1	0	0

When asked how effective respondents think Health Mother's groups (HMGs) promote maternal and child healthcare in their community, desegregated data reveals that 76.6% of respondents from Kailali and 47.5% of respondents from Rupandehi report the effectiveness as very good. Most respondents from Salyan (43.8%) were neutral towards this statement, whereas an equal share of respondents from Doti (34.6%) were neutral or rated it as very good. No respondent from these districts reported the effectiveness as very bad.

Most respondents from Kailali (63.3%) and Rupandehi (51.5%) rated the level of empowerment of the HMGs members doing in your community as very good. 61.5% of respondents from Doti and 43.8% of respondents from Salyan were neutral. No respondent rated the level of empowerment as very bad.

Most respondents from Kailali (52.3%), Rupandehi (53.5%), and Salyan (37.5%) rated the performance of the members of HMGs as very good. 65.4% of respondents from Doti were neutral.

Table 16: District-disaggregated data regarding performance of HMGs

		Doti	Kailali	Rupandehi	Salyan	Total
How effective do you think Health Mother's groups (HMGs) promote maternal and child healthcare in your community?	Excellent	3.8	8.6	17.8	12.5	11.8
	Very good	34.6	76.6	47.5	18.8	56.1
	Neutral	34.6	14.1	33.7	43.8	26.1
	Bad	26.9	0.8	1	25	5.9
	Very Bad	0	0	0	0	0
How would you rate the level of empowerment of the HMGs members doing in your community?	Excellent	0	7.8	8.9	3.1	7
	Very good	15.4	63.3	51.5	37.5	51.9
	Neutral	61.5	28.9	37.6	43.8	36.6
	Bad	23.1	0	2	15.6	4.5
	Very Bad	0	0	0	0	0
How would you rate the performance of the members of HMGs?	Excellent	0	2.3	9.9	9.4	5.6
	Very good	11.5	52.3	53.5	37.5	47.4
	Neutral	65.4	36.7	35.6	25	37.6
	Bad	19.2	7	1	28.1	8.4
	Very Bad	3.8	1.6	0	0	1

Disaggregated data reveals that most respondents from each age group rate the effectiveness of HMGs at promoting maternal and child healthcare in their communities as very good. No respondent from the surveyed age groups rated the effectiveness as very bad.

When asked to rate the level of empowerment of HMGs members are doing in their communities, most respondents from each age group report the level of empowerment as very good. No respondent from the surveyed age groups rated the level of empowerment as very bad.

Most respondents ages 15-18 years (44.4%), 25-35 years (47.9%), and 35-49 years (54.2%) rated the performance of the members of HMGs as very good. An equal share of respondents ages 19-25 years (43.4%) and over the age of 50 years (40%) rated the performance as very good or were neutral towards the statement.

Table 17: Age-disaggregated data regarding performance of HMGs

		15-18	19-25	25-35	35-49	Over 50	Total
How effective do you think Health Mother's group (HMGs) promote maternal and child healthcare in your community?	Excellent	11.1	6.6	11.1	22.9	10	11.8
	Very Good	88.9	55.3	57.6	50	40	56.1
	Neutral	0	31.6	25.7	22.9	30	26.1
	Bad	0	6.6	5.6	4.2	20	5.9
	Very Bad	0	0	0	0	0	0
How would you rate the level of empowerment of the HMGs members doing in your community?	Excellent	22.2	2.6	7.6	10.4	0	7
	Very Good	44.4	50	53.5	50	60	51.9
	Neutral	33.3	42.1	34	37.5	30	36.6
	Bad	0	5.3	4.9	2.1	10	4.5
	Very Bad	0	0	0	0	0	0
How would you rate the performance of the members of HMGs?	Excellent	33.3	5.3	4.9	4.2	0	5.6
	Very Good	44.4	43.4	47.9	54.2	40	47.4
	Neutral	22.2	43.4	36.8	33.3	40	37.6
	Bad	0	6.6	9	8.3	20	8.4
	Very Bad	0	1.3	1.4	0	0	1

Disaggregated data based on various ethnic identities reveals that most respondents rated the effectiveness of HMGs promoting maternal and child healthcare in their community as very good. No respondent rated the effectiveness as very bad.

When asked to rate the level of empowerment HMGs are doing in their communities, most Brahmin/Chhetri respondents (43.1%) and most Dalit (40.6%) respondents were neutral towards this statement. 60% of Janajati respondents, 100% of Muslim respondents, and 51.3% of respondents from other ethnic identities rated the level of empowerment as very good. No respondent rated the level of empowerment as very bad.

A larger share of Brahmin/Chhetri (46.2%) and Muslim (83.3%) respondents were reported a neutral response when asked to rate the performance of the members of HMGs. 53.1% of Janajati and Dalit respondents rated the performance as very good, as well as respondents from other ethnic identities.

Table 18: Ethnicity-disaggregated data regarding performance of HMGs

		Brahmin/Chhetri	Janajati	Dalit	Muslim	Others	Total
How effective do you think Health Mother's group (HMGs) promote maternal and child healthcare in your community?	Excellent	6.2	14.5	15.6	16.7	7.7	11.8
	Very Good	50.8	60	56.3	50	51.3	56.1
	Neutral	29.2	22.8	21.9	33.3	35.9	26.1
	Bad	13.8	2.8	6.3	0	5.1	5.9
	Very Bad	0	0	0	0	0	0
How would you rate the level of empowerment of the HMGs members doing in your community?	Excellent	4.6	5.5	25	0	2.6	7
	Very Good	38.5	60	34.4	100	51.3	51.9
	Neutral	43.1	33.1	40.6	0	41	36.6
	Bad	13.8	1.4	0	0	5.1	4.5
	Very Bad	0	0	0	0	0	0
How would you rate the performance of the members of HMGs?	Excellent	4.6	4.8	12.5	0	5.1	5.6
	Very Good	30.8	53.1	53.1	16.7	53.8	47.4
	Neutral	46.2	34.5	28.1	83.3	35.9	37.6
	Bad	18.5	6.2	3.1	0	5.1	8.4
	Very Bad	0	1.4	3.1	0	0	1