IMPACT EVALUATION

Interventions to Strengthen the Health Facility Operations and Management Committees in Nepal

Final Report

Jessica Fehringer, MEASURE Evaluation; **Mary Allegra Paul**, MEASURE Evaluation; **Dirgha Ghimire**, ISER-N; **Jeevan Raj Lohani**, RIDA; **Prem Bandhari**, ISER-N; **Diwakar Basnet**, RIDA; **B. C. Kalpana**, RIDA; and **Kamana Uprety**, RIDA

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ABSTRACT

MEASURE Evaluation conducted a quasi-experimental impact evaluation of the "Strengthening HFOMCS" program in Nepal. There were three treatment groups: 1) Approach A, or basic gender and social inclusion (GESI) integrated capacity building with health facility and operations management committees (HFMOCs); 2) Approach B, or all of Approach A plus community engagement activities (CEA); and 3) control. The evaluation collected data in Syangja, Baglung, and Parbat districts, which corresponded to Approach A, Approach B, and control, respectively. Baseline data collection took place in mid-2014 and end line data collection in late 2016 and early 2017. Methods included focus groups discussions, key informant interviews, health facility observations, health facility client exit interviews, HFOMC meeting observation, and quantitative household surveys. The women's survey sample size was 3,845 at baseline and 3,902 at end line. Results showed a small positive program impact on use of child growth monitoring services and their quality. Impact results for other outcomes were not systematic and may have been due to contamination by other programs. Qualitative results showed that there were also small, but promising, effects on the HFOMCs' functioning, communication and collaboration with the community; and some women and disadvantaged group members of HFOMCs reported increased confidence and participation in HFOMC meetings as well as sharing of health service information with other DAGs and women. Qualitative results did not reveal differences between Approaches A and B. Per cost-effectiveness calculations, Approach B (compared to Approach A) was very cost-effective. Recommendations for future programs and advocacy are discussed.

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Cover photo: Bonnie Gillespie, courtesy of Photoshare

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TABLES

ABBREVIATIONS

AHW	auxiliary health worker
ANC	antenatal care
CB-IMNCI	community-based integrated management of neonatal and child illness
CBO	community-based organization
CEA	community engagement approach
DAG	disadvantaged group
DDC	District Development Committee
DHS	Demographic and Health Survey
DID	difference-in-difference
DOHS	Department of Health Services
DPHO	District Public Health Office
EA	enumeration area
FCHV	female community health volunteer
FGD	focus group discussion
FP	family planning
GDP	gross domestic product
GESI	gender equality and social inclusion
GON	Government of Nepal
GPM	Gender, Policy, and Measurement [Program]
HF	health facility
HFOMC	Health Facility Operation and Management Committee
HH	household
HPP	Health Policy Project
HTSP	healthy spacing and timing of pregnancy
ICER	incremental cost-effectiveness ratio
IDI	in-depth interview
ISER-N	Institute for Social and Environmental Research-Nepal
KII	key informant interview
MAD	minimum acceptable diet
MBBS	Bachelor of Medicine, Bachelor of Surgery
MMF	minimum meal frequency
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
MOHP	Ministry of Health and Population

MSC	most significant change
NGO	nongovernmental organization
NPR	Nepalese rupee
ORS	oral rehydration solution
PHC	primary health care
PNC	postnatal care
RIDA	Research Inputs and Development Action International
TBA	traditional birth attendant
TOT	training of trainers
USAID	United States Agency for International Development
VDC	village development committee

EXECUTIVE SUMMARY

Introduction

Women, girls, and members of disadvantaged groups (DAGs) in Nepal face structural barriers and discrimination that affect their access to education, economic opportunities, healthcare, and ultimately, health outcomes. Recognizing these inequalities, the Government of Nepal (GON) prioritized the incorporation of gender equality and social inclusion (GESI) in the country's health policies, programs, and plans. Part of the government's GESI integration strategy is to make the Health Facility Operation and Management Committees (HFOMCs)—the local oversight bodies for health facilities (HFs)—more inclusive and equitable. The strategy seeks to increase the HFOMCs' responsibility for participatory planning, informed by the needs and demands of target groups, and to create trust between healthcare providers and communities through regular meetings and other interactions.

The United States Agency for International Development (USAID)'s Gender, Policy, and Measurement (GPM) Program partnered with the Suaahara Project, a community-focused organization in Nepal, and the GON to strengthen the HFOMCs by testing two capacity strengthening approaches. The two approaches are summarized in Table 1 below.

Table 1. Strengthening the HFOMC program intervention components

Approach A: GESI Training and Technical Support for the HFOMCs
1. HFOMC reformulation 2. Three-day training for the HFOMCs on operating and managing HFs 3. Two review meetings for HFOMC members conducted six and 11 months after the initial training 4. Technical support visits (quarterly)
Approach B: Approach A + Community Engagement Approach
1. All Approach A inputs. 2. Three-day CEA training for the HFOMCs a. Subactivity: One-day accompaniment to conduct community discussions with DAGs, analyze results, and prepare for a participatory planning meeting. b. Subactivity: One-day accompaniment to hold a meeting to develop a workplan that incorporates community and DAGs' feedback and plans for implementing the workplan. 3. One-day orientation for community mobilizers (e.g., heads of mother's groups and youth clubs, female community health volunteers [FCHVs], HFOMC members) on how to raise awareness of health services; the roles and responsibilities of the HFOMCs; obtaining input from the community; and representing the community's voice during monthly HFOMC meetings. 4. Quarterly meetings between community mobilizers and the HFOMC.

Evaluation Design

The objective of the impact evaluation was to understand the value-added of each capacity strengthening approach to health outcomes at household (HH) and community levels, and on healthcare utilization by women and children under two years of age in the intervention districts. Investigators compared the two approaches with the standard capacity building program already being implemented by the HFOMCs as part of the GON's HFOMC Program. The primary questions the evaluation sought to answer were the following:

1. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with the HFOMCs compared with the impact of the standard capacity strengthening activities with the HFOMCs on the following:
    a. Use of maternal and child nutrition and health services
    b. Health service quality

2. Does the integration of GESI and community involvement processes into capacity strengthening activities with the HFOMCs have a greater impact than do the standard capacity strengthening activities on the following:
    a. Use of maternal and child nutrition and health services
    b. Health service quality

Methods

To answer the evaluation questions, MEASURE Evaluation employed a quasi-experimental design using the difference-in-difference (DID) model with baseline (2014) and end line (2016) quantitative surveys of the following:

1. Households
2. Mothers with children under 2 years of age
3. Community leaders

For the qualitative research component, baseline and end line data included:

1. Client exit interviews with maternal, newborn, and child health/family planning (MNCH/FP) clients
2. Waiting room observations at HFs
3. Observations and/or review of HFOMC meeting minutes
4. In-depth interviews (IDIs) with female and DAG HFOMC members
5. Key informant interviews (KIIs) with HF staff and district-level stakeholders
6. Focus group discussions (FGDs) with mothers and fathers of children under two years of age

At end line, qualitative data also included:

7. KIIs with community leaders and program staff, and FGDs with HFOMC members
8. Review of intervention monitoring data, including data on implementation costs

Results

Program Implementation

The reformulation of the HFOMCs was well coordinated and adhered to the model. Female and DAG HFOMC members appreciated the training for both approaches; however, many HFOMC members could not recall the content of the training or confused it with training on other topics. The two-day review meetings were often remembered by HFOMC members, and were considered an effective means of monitoring the HFs. The technical support visits were the most challenging component to implement. Many were not completed because of the need for the participation of district-level government staff and their workload challenges. The extent to which periodic interaction between community mobilizers and the HFOMCs occurred in the CEA areas was unclear.

Many intervention activities were carried out according to plan, although delays occurred because of unforeseen political events and severe weather challenges. The delays meant that the HFOMCs in Baglung and Syangja were not exposed to the program for as long as anticipated at baseline. Selected intervention components were not completed in all areas, and there were some intervention components for which there was no program monitoring data to show evidence of completion.

Impact on MNCH/FP Service Use, Quality, and Selected Health Outcomes

Table 2 presents a summary of indicator trends and results from the DID analysis. The analysis shows statistically significant, positive program impact, as follows:

- Reporting of having a skilled attendant at birth increased more in Baglung, compared with the control areas.

- Postnatal care (PNC) decreased less for newborns in Baglung and Syangja, compared with the control areas; the impact was slightly higher in Syangja than in Baglung.

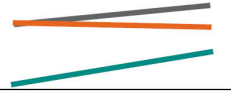
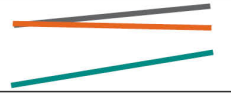
- The percentage of mothers reporting having their child's health ever checked increased as did reporting of having children's health checked in the past six months. DID results showed a positive impact on these indicators in both program areas, with a higher impact in Baglung.

- Reporting of a health professional discussing a child's growth at last child health visit increased more in Baglung and Syangja, per DID results, compared with the control areas; the impact in Baglung was greater than in Syangja.

- The percentage of mothers reporting having ever been counseled on healthy timing and spacing of pregnancy (HTSP) decreased in all districts; it decreased less in Syangja, compared with the control areas, suggesting a positive protective program effect per the DID analysis.

Table 2. Summary of service use indicator trends and DID results

Legend: + Positive impact; o no impact; **+** indicates higher impact; N/A "not applicable," because sample sizes were too small to estimate an impact

Service Use Indicators	Baglung		Syangja		Parbat		Trend	Program Impact	
	Baseline	Endline	Baseline	Endline	Baseline	Endline		Baglung	Syangja
Four or more ANC visits, among all women	70.1	74.8	75.5	77.7	84.0	89.0		o	o
Health facility birth, among all women	44.3	53.1	68.8	76.2	69.3	83.3		o	o
Mother: PNC within 48 hours, among all women delivering at home	1.7	5.2	2.0	12.8	4.8	15.3		N/A	N/A
Child: PNC within 48 hours, among all children delivered at home	2.5	2.7	2.3	4.8	6.3	8.1		N/A	N/A
Mother: PNC before leaving facility, among all women delivering at health facility	83.8	74.7	87.4	83.0	90.9	84.6		o	o
Child: PNC before leaving facility, among all children delivered at health facility	78.1	77.0	78.1	82.6	88.6	77.2		+	+
Among children with diarrhea in past two weeks, proportion who sought treatment/advice	70.9	54.9	73.2	59.4	75.4	53.1		o	o
Among children with cold and rapid/difficult breathing in past two weeks, sought treatment/advice	73.1	54.9	74.8	62.5	77.6	62.7		o	o
Among children with fever in past two weeks, sought treatment/advice	80.0	81.5	88.6	80.2	82.5	84.7		o	o
Child's health ever checked, among all children	75.6	71.3	86.6	79.9	92.8	80.3		+	+
Child's health checked within the past six months, among all children	67.0	66.5	76.5	74.1	82.5	74.7		+	+
Quality Indicators									
Skilled attendant at birth, among all women	31.0	52.5	68.8	70.7	68.8	81.9		+	o
Ever counseled on HTSP, among all women	19.1	7.0	18.4	12.2	30.7	13.5		o	+
Child's weight ever measured, among all children	93.3	93.9	97.1	97.2	98.4	98.8		o	o
Child's weight measured within the past six months, among all children	64.1	78.0	67.2	82.7	77.1	89.0		o	o
Health professional discussed child's growth at last visit, among all children	17.8	12.4	20.5	16.3	36.2	19.3		+	+
Health Outcomes Indicators									
Health facility births (proxy for maternal morbidity and mortality), among all women	44.3	53.1	68.8	76.2	69.3	83.3		o	o
Skilled attendant at birth (proxy for maternal morbidity and mortality), among all women	31.0	52.5	68.8	70.7	68.8	81.9		+	o
Exclusive breastfeeding, under 6 months, among all children	91.6	92.2	83.1	87.5	89.1	89.9		o	o
Minimum acceptable diet, breastfeeding children, among all children	44.2	39.1	53.7	40.7	51.0	42.4		o	o

HFOMC Functioning and Accountability

The qualitative data indicate that the HFOMCs in Baglung and Syangja were slightly more active at end line than at baseline, compared with Parbat. HFOMCs in Baglung and Syangia were also more aware of their roles and responsibilities and of the services available at their HFs, compared with baseline and the control areas. Some females and DAGs in the program areas also reported increased confidence to voice their concerns at meetings. In program village development committees (VDCs), where HFOMCs had identified issues and made plans to address them, they highlighted the inability of government agencies to respond to their needs. This negatively affected HFOMC morale, the communities' perspectives on the utility of the HFOMCs, and the accountability of health facilities. Qualitative data showed no major differences between Baglung and Syangja.

Relationships among HFOMCs, the Community, and Health Facilities

Improvements in communication and coordination between the HFOMCs and communities were seen in program areas, compared with baseline and the control areas. Individual HFOMC members made outreach attempts; however, they were ad hoc. Like at baseline, however, there still was no effective public platform for community-HFOMC interaction. Community awareness of the HFOMCs remained low according to the qualitative data, and results of the women's quantitative survey showed a decrease in awareness for all districts. Moreover, no changes were observed in communication and coordination between the HFOMCs and HF staff. There were no differences between Baglung and Syangja.

Cost-Effectiveness

We looked at the cost-effectiveness of Approach B (in Baglung) compared with Approach A (in Syangja) for the positive DID outcomes in which Approach B showed greater impact than Approach A. The incremental cost-effectiveness ratio (ICER) represents the average incremental cost to achieve one additional unit of improvement in an outcome. For example, it cost an additional Nepalese Rupee (Rs) 1,319,560 to achieve an additional 1 percent of children under the age of two getting their health checked in Baglung, compared with Syangja (Table 3).

Table 3. Cost-effectiveness results

Outcome	Incremental Cost-Effectiveness Ratio (ICER) (Approach B versus A)
Child's health ever checked	Rs 1,319,560
Child's health checked in past six months	Rs 860,582
Health provider discussed child's growth at last health check	Rs 1,522,568

The 2016 gross domestic product (GDP) in Nepal is 21.144 billion USD (Rs.2,248.691 billion) and the GDP per capita in Nepal is 733.665 USD (Rs.77,988.550). According to the Government of Nepal's 2015–2016 Economic Survey, produced by the Ministry of Finance, the health sector's share of the GDP was an average of 1.735 percent. Because poor health has negative economic impacts, investments in health can contribute to economic development and the GDP. It is widely held that interventions that have ICERs that are less than 3 times the per capita GDP are considered cost-effective; ICERs less than one time the per capita GDP are very cost-effective (Robinson, Hammitt, Chang, & Resch, 2016). Given

the GDP per capita of Nepal, the ICER for Approach B (compared to Approach A) would be considered very cost-effective using this threshold.

Discussion

Evaluation of Strengthening HFOMCs reveals improvements in selected quantitative health service use and quality outcomes, most notably those related to child wellness promotion. These results occur with both program approaches; however, it is not clear which approach fares better. Qualitative data show slight improvements in the HFOMCs' functioning and communication with the communities under both program approaches, as indicated by the greater confidence of DAGs and women, and evidence of increased collaboration and communication with the communities to organize outreach events and share information about services. The evaluation also identifies ongoing barriers to the HFOMCs' functioning, accountability, and relationships with other stakeholders, such as district authorities. Political challenges, and delays in program design and implementation led to a short intervention exposure time for a complex program with a long causal pathway. These unfortunate circumstances, along with contamination by another intervention—the community-based integrated management of neonatal and child illness (CB-IMNCI) program in Baglung— may have contributed to the mixed findings. Multiple anticipated steps on the path to outcomes did not regularly occur or occur at all with HFOMCs. The intervention is designed as a package; the missing components may have led to less significant impact than anticipated.

Furthermore, there is new 2017 MOH guidance that removes the 2014 requirement to include dalit and janajati members on HFOMCs (Ministry of Health, 2017). While it is unclear what influenced this change, it threatens to undermine the emerging improvements found in this evaluation.

Conclusions

- There was a small, plausible program impact demonstrated on the use of child growth monitoring services and their quality. Impact results for other outcomes were not systematic, and the triangulation of qualitative data does not explain these results. They may be due to contamination by other programs.

- There were small, but promising effects on the HFOMCs' functioning, communication and collaboration with the community, with no differences between Approaches A and B. The long causal pathways of both approaches likely need longer time to play out, given the short length of time of program implementation.

- Some women and DAGs reported increased confidence and participation in HFOMC meetings. The sharing of health service information with other DAGs and women were also noted. Greater effects will take longer to take shape.

- The HFOMC-level effects had already started to wane (e.g., decrease in meeting frequency) by the time of end line data collection.

- The CEA component cannot be effective with only the training events engaging the communities and the HFOMCs. Involving an external party to facilitate HFOMC-community interactions for a limited period after training would be helpful.

- While the HFOMCs made decisions, they require government support to implement them and a clear understanding of the processes they need to follow to get support.

- Given the GDP per capita of Nepal, the ICER for Approach B (compared to Approach A) is considered very cost-effective.

Recommendations

- Given the long causal pathways and the experience of similar studies (Gurung, 2013), HFOMC capacity building and CEA activities should allow intervention exposure times longer than one year.

- In order to achieve participation in HFOMC meetings, and sharing of health information by women and DAGs, programs and funders should engage in advocacy aimed at convincing the government to reestablish the GESI integration requirements for the HFOMCs, with participation from DAGs. The guidelines were recently revised and removed this requirement. Also, issues raised in HFOMC meetings should be recorded (what is the issue, who raised it, next action steps, etc.), and follow-up should be required and recorded.

- Capacity building should be implemented as a continuous process, with periodic follow-up, coaching, and refreshers. Follow-up should be more frequent in the initial one to two years, every one to two months, but then can be spaced out over time as HFOMCs show greater capacity.

- Consider adding a component to the CEA approach such that an external person co-leads several community outreach events with the HFOMCs for a period after the CEA training.

- To enable HFOMCs to obtain government support, future programs should set out clear processes and provide contact information, in collaboration with district health authorities, so that the HFOMCs may request support in implementation of their decisions.

INTRODUCTION

Background

Women, girls, and members of DAGs in Nepal face structural barriers and discrimination that affect their access to education, economic opportunities, healthcare, and ultimately health outcomes (Asian Development Bank [ADB], Department for International Development, & the World Bank, 2011; Pandey, Dhakal, Karki, Poudel, & Pradham, 2013). Recognizing these inequalities, the GON prioritized the incorporation of GESI in the country's health policies, programs, and plans (Ministry of Health and Population [Nepal] (MOHP, 2009). Part of the government's GESI integration strategy is to make the HFOMCs—the local oversight bodies for HFs—more inclusive and equitable. The strategy seeks to increase the HFOMCs' responsibility for participatory planning, informed by the needs and demands of target groups, and to create trust between healthcare providers and communities through regular meetings and other interactions.

The HFOMC guidelines dictate that the committees have broad participation and representation from the community, including women, Dalits, Janajatis, and other marginalized groups; however, many HFOMCs are not truly inclusive, consist primarily of men and community leaders, and do not fully empower disadvantaged members to voice their opinions. The Suaahara Project, described below, aimed to address these critical gaps in the scale up of the HFOMCs and is the subject of this impact evaluation.

The Program

The GPM Program was implemented by the Health Policy Project and MEASURE Evaluation, with support from USAID. From 2011 to 2016, GPM partnered with the Suaahara Project. Suaahara is a community-focused organization in Nepal, dedicated to improving the health of pregnant and lactating women and children less than two years of age. It worked closely with the GON to strengthen policies and programs that aim to improve health and nutritional status, strengthen health counseling and care services at HFs, and connect families to reproductive health and MNCH and FP services.

Suaahara and GPM integrated GESI and community participation components in GON guidelines, processes, and training for the HFOMCs. This effort was called the Strengthening HFOMCs through a Community Engagement Approach project (hereafter called Strengthening HFOMCs). Table 4 summarizes the project's two capacity strengthening approaches. Key definitions are given in Appendix 1. The theorized results chain for Approaches A and B, developed in consultation with the project, is provided in Appendix 2.

Table 4. Strengthening the HFOMC program intervention components

Approach A: GESI Training and Technical Support for the HFOMCs
1. HFOMC reformulation 2. Three-day training for the HFOMCs on operating and managing HFs 3. Two review meetings for HFOMC members conducted six and 11 months after the initial training 4. Technical support visits (quarterly)

Approach B: Approach A + Community Engagement Approach

5. All Approach A inputs.
6. Three-day CEA training for the HFOMCs
   a. Subactivity: One-day accompaniment to conduct community discussions with DAGs, analyze results, and prepare for a participatory planning meeting.
   b. Subactivity: One-day accompaniment to hold a meeting to develop a workplan that incorporates community and DAGs' feedback and plans for implementing the workplan.
7. One-day orientation for community mobilizers (e.g., heads of mother's groups and youth clubs, female community health volunteers [FCHVs], HFOMC members) on how to raise awareness of health services; the roles and responsibilities of the HFOMCs; obtaining input from the community; and representing the community's voice during monthly HFOMC meetings.
8. Quarterly meetings between community mobilizers and the HFOMC.

Setting

The intervention and evaluation took place in the Western Region of Nepal, in Baglung and Syangja districts, with Parbat district serving as the control (Figure 1). Syangja received Approach A and Baglung received Approach B. The three districts are geographically and culturally similar, however, and were formerly located in the Western development region and Western hill subregion of Nepal. There are some differences with respect to the marginalized populations in each district. In Baglung, 50.6 percent of the population is characterized as marginalized, whereas 34.5 percent is characterized as marginalized in Syangja, and 31.3 percent is characterized as marginalized in Parbat (National Planning Commission Secretariat, Central Bureau of Statistics, 2012).

Figure 1. Map of Nepal

EVALUATION PURPOSE AND QUESTIONS

Evaluation Objectives

The objective of this impact evaluation was to understand the value-added of each capacity strengthening approach to health outcomes at the HH and community levels and on healthcare utilization services by women and children under two years of age in the intervention districts. Investigators compared the two approaches with the standard capacity building program already being implemented by the HFOMCs as part of the GON's HFOMC Program.

Evaluation Questions

Table 5 lists the primary evaluation questions. Questions 1 through 10, were predominantly addressed through the quantitative component of the evaluation; the qualitative did also enrich the study team's understanding of these questions, however. The qualitative component focused on questions 11 through 14. The quantitative component and cost data from program monitoring was addressed by question 15.

Table 5. Evaluation questions

Primary evaluation questions
Use of MNCH services: 1. What is the impact of integrating GESI and community involvement processes in capacity strengthening activities with HFOMCs on use of maternal and child nutrition and health services by disadvantaged groups? 2. What is the impact of standard capacity-strengthening activities with HFOMCs on use of maternal and child nutrition and health services by disadvantaged groups? 3. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on use of maternal and child nutrition and health services for disadvantaged groups than standard capacity strengthening activities?
Health service quality: 4. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs on maternal and child nutrition and health service quality for disadvantaged groups? 5. What is the impact of standard capacity-strengthening activities with HFOMCs on maternal and child nutrition and health service quality for disadvantaged groups? 6. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on maternal and child nutrition and health service quality for disadvantaged groups than standard capacity-strengthening activities?

Secondary evaluation questions
7. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs on selected maternal and child nutrition and health outcomes for disadvantaged groups? 8. What is the impact of standard capacity-strengthening activities with HFOMCs on selected maternal and child nutrition and health outcomes for disadvantaged groups? 9. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on selected maternal and child nutrition and health outcomes for disadvantaged groups than standard capacity-strengthening activities? 10. For questions 1-9, we will also compare between disadvantaged groups and non-disadvantaged groups. 11. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect the functioning and accountability of HFOMCs and how does this compare to standard capacity strengthening activities with HFOMCs? 12. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect the use of maternal and child nutrition and health services and how does this compare to standard capacity strengthening activities with HFOMCs? 13. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect maternal and child nutrition and health service quality and how does this compare to standard capacity strengthening activities with HFOMCs? 14. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect the relationship between HFOMCs, the community, and health facilities and how does this compare to standard capacity strengthening activities with HFOMCs? 15. What is the cost-effectiveness of the GESI and community engagement integrated intervention compared to the standard capacity strengthening intervention?

Table 6 presents the primary and secondary outcomes of interest measured by the quantitative and qualitative evaluation components.

Table 6. Primary and secondary outcomes

Primary outcomes	Secondary outcomes
• Health facility births • MNCH service quality • Use of ANC services • Use of PNC services • Use of family planning (health timing and spacing of pregnancy) services • Well-child visits to health facilities • Health facility visits for child illness (diarrhea, ARI, etc.) • Use of growth monitoring services • Satisfaction with health services	• Functioning of HFOMCs • Accountability of HFOMCs • Infant and Young Child Feeding (IYCF) practices

METHODS

Evaluation Design

The evaluation team used a mixed methods approach, collecting quantitative, qualitative, program, HF monitoring, and cost data. The quantitative component used a quasi-experimental design, under which data for the baseline and end line surveys in the three districts were collected from HHs, women who have children under age two, and community leaders. The qualitative component collected data from HFOMC members, community leaders, HF STAFF, community members, and other stakeholders using several methods including FGDs, direct observation, and KIIs). Program monitoring data from the intervention and control areas were reviewed by the evaluation team. Cost data were likewise collected.

For details on ethical review, protection of human subjects, and the translation and refinement of study instruments, see Appendix 3.

Quantitative Methods

Sample Size Estimation and Sampling Methods

In consultation with USAID/Nepal, the evaluation team used the percentage of women reporting HF delivery for their most recent live birth as the main outcome to power the research. The sampling plan for the baseline quantitative component involved sampling all women with children under age two, but inflating the sample size to make sure that the subgroup of interest (DAGs) was large enough to maintain power to detect differences for that subgroup over time. Under this plan, we could look at differences between DAGs and non-DAGs. A detailed explanation of the sampling methods is provided in Appendix 3, covering calculation of sample sizes and the creation of the sampling frame.

Survey Instruments, Implementation, and Response Rates

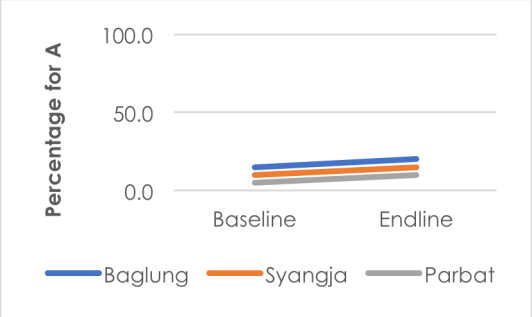
Three surveys—community, HH, and women—were administered in a face-to-face format at baseline and end line. All surveys were completed using pen and paper at baseline. At end line, the community survey was completed using pen and paper while the HH and women's surveys used a face-to-face Computer-Assisted

What is difference-in-difference?

The difference-in-difference (DID) technique identifies program impact as the difference between program participants and a comparison of non-participants in terms of the trends that each experienced in an outcome from baseline to endline. The basic assumption of DID is that the program group(s) would, in the absence of the program, have experienced a trend parallel to that of the comparison group; this is referred to as the "parallel trend assumption."

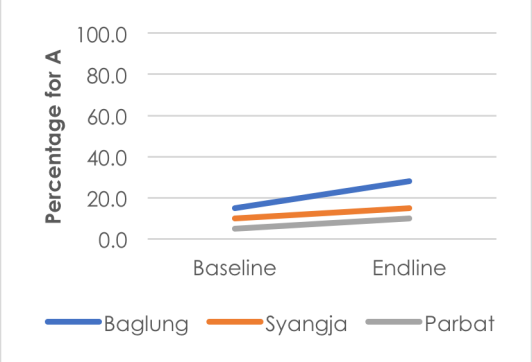
In other words, without the Strengthening HFOMCs program, we would expect changes in an example outcome in all three districts to look the same, as in Figure 2 below.

Figure 2. Expected change in outcome A with no program



However, if after the program, DID results showed the increase in outcome A was *greater* in one District than in comparison areas, as shown in Figure 3, this would indicate a positive program impact (see blue trend line).

Figure 3. Actual change in outcome A



Personal Interview. Additional information on the survey content, implementation, fieldwork, and training is given in Appendix 4. The full instruments used for each survey are included in Appendix 8.

A community survey was carried out with community leaders using a semi-structured group interview in all 325 wards at baseline and end line. There were 2,196 community survey respondents at baseline and 2,228 at end line.

The HH survey was administered to one or more HH members in a private interview, including the person identified as the head of the HH. The HH interviews had a response rate of 99.2 percent at baseline and 99.3 percent at end line.

The women's survey was conducted with all women having a child under two years of age in the sample HHs. Interviews were completed with 3,845 women at baseline, for a response rate of 97.5 percent. At end line, 3,902 out of 3,950 eligible women were interviewed, a response rate of 98.8%. Additional information on the number and characteristics of eligible women and HHs is provided in Appendix 6.

Quantitative Data Analysis

We conducted analysis of the baseline and end line data using STATA, a statistical analysis package. The impact of Strengthening HFOMCs on the use of services, their quality, and selected MNCH outcomes was determined using the DID technique, to compare change over time among the three districts. For additional details on the DID technique, see the text box on this page and Appendix 3.

Qualitative Methods

Sampling Methods

In each district, four VDCs were purposively selected (12 total) for the qualitative data collection. Data were collected from one HF per VDC (12 HFs in total). The VDCs and HFs were purposively selected to cover a mix of HF types (e.g., health post, sub-health post), DAG mapping results, and distance from the district headquarters (near and far). The VDCs were selected chosen from the list of corresponding enumeration areas (EAs) that had been selected for the quantitative data collection. Stratified purposive sampling methods were used to select the individual respondents for the qualitative components. The list of data collection sites is given in Appendix 10.

For each VDC and HF selected, the researchers conducted IDIs, FGDs, meeting and waiting room observations, KIIs, and client exit interviews. Table 7 summarizes the sampling methods and the number of IDIs, FGDs, etc. conducted.

Table 7. Summary of qualitative methods used at baseline and end line

Method	Number	
	Baseline	End line
Observations or review of meeting minutes from HFOMC meetings*	10	8
IDIs with HFOMC members	21	24
IDIs with community leaders	N/A	12
Observations at HFs	12	12
KIIs with HF staff	12	12

KIIs with project staff	N/A	6
Exit interviews with MNCH clients at HFs	133	122
FGDs with community members	24	24
KIIs with district-level stakeholders	6	6
FGDs with HFOMC members using the most significant change (MSC) method	N/A	8

* Meeting minutes or observations were not attainable for all HFOMCs

Details on the fieldwork, training, and topics covered by each of the qualitative methods are provided in Appendix 3. The tools used for each of the qualitative methods are attached in Appendix 9.

Program Implementation Monitoring

The focus of the process monitoring approach was on implementation, fidelity, dose, and reach in the Suaahara district. The evaluation team reviewed project HF monitoring data and other data from Strengthening HFOMCs program, and conducted KIIs with project staff, government staff, and HFOMC members. Details on the implementation process monitoring methods are provided in Appendix 4.

Cost-Effectiveness

Cost data were collected by the project for both intervention approaches. These data were used to calculate the costs of Approach A and Approach B. When combined with the outcome data from the evaluation, the cost data were used to calculate the ICER. Details on the cost-effectiveness methods are provided in Appendix 5.

Study Limitations

The evaluation design has several limitations, as follows:

Long causal pathways, combined with a short intervention exposure time and a short time between the intervention and end line: There are many behavior changes that need to take place in the causal pathway between the program inputs and the short- and long-term outcomes. Due to delays in the implementation of the intervention, the program exposure time was short (one to one and one-half years, depending on the community). In addition, approximately six months elapsed between implementation completion and end line data collection. Because of the complex, behavior change nature of the intervention, outcomes and impact on health service use and quality would likely take significant time to emerge. Therefore, the evaluation may show less impact because there was not a sufficiently long implementation period or sufficient time after the intervention to allow for essential behavior change steps to arise.

Contamination: In late 2015, Baglung district began a pilot of the GON's CB-IMNCI program. It is likely that this program directly affected the outcomes and acts as a contaminant in that study arm. There may have been other, new health initiatives launched in any of the three districts during the intervention period that were not known to the evaluation team or were not identified during qualitative data collection.

For the DID technique, the parallel trend assumption may not hold: To make the parallel trend assumption more plausible, the women's and communities' characteristics were used to control for the possibility that differences in the changing population structures of the intervention and control areas might have generated differences in trends in indicators between them, even in the event of identical intervention

exposure. However, it is possible that the population profiles diverged over time in ways that we did not observe and for which we could not adequately control.

Spillover: Survey data from Parbat show that respondents have relatives in the intervention districts and that they often visited HFs in the intervention districts. This means that the respondents in the control areas may have been exposed to the intervention (see Appendix 3). This could have caused the evaluation to find less of an impact in program areas than was the reality.

A higher percentage of the population in Baglung is marginalized or poor, compared with Syangja and Parbat. It is possible that this difference affected the outcomes. This could have lead us to conclude that the program did not make a difference when, in fact, it did, or that it did make a difference when, in fact, it did not.

Baseline and end line data were collected at different times of the year: Data collection at end line occurred in December and January, whereas baseline data collection was done in July and August. The types of responses may have been influenced by the time of year that participants were interviewed. For example, the types and amounts of foods available may have differed and influenced MAD values. Moreover, the types of participants available for exit interviews at HFs may have differed because the end line was conducted during the dry season, whereas the baseline survey was conducted during the rainy season. For example, at end line, more client exit interviews were done on immunization days because it was difficult to gather clients on other clinic days.

Postnatal care questions added at end line yielded more accurate end line data, compared to baseline: Several additional questions on PNC for mother and child were added at end line to correct for an incorrect skip pattern at baseline. The additional questions may have prompted respondents memory, affecting their performance at end line and yielding more accurate PNC. This phenomenon may account for some of the decline in PNC observed for mother and child.

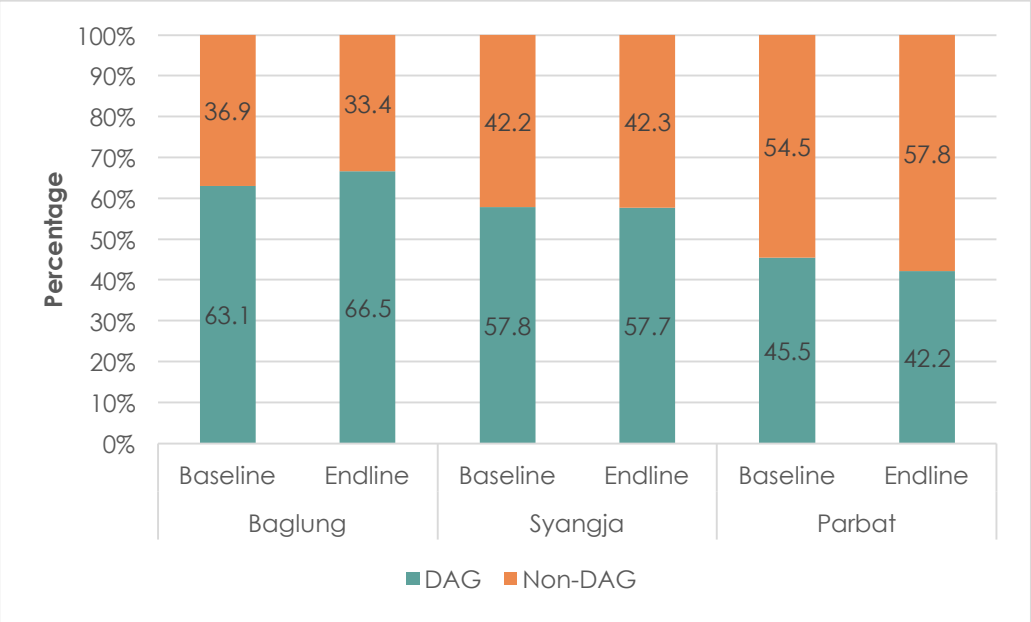
RESULTS

This section describes the quantitative participants' characteristics, the program context, trends in primary outcomes over time, and impact results from the DID analysis. The outcomes and DID results are presented by evaluation question and by topic area under that. Although the DID analysis looked at differences by DAG status, there were no outcomes for which DAG status was statistically significant. Therefore, DID results tables show only the overall results (i.e., DAG and non-DAGs combined). Results from the qualitative data collection are also covered.

Quantitative Survey Participant Characteristics

The HH survey data showed that the demographic characteristics of HHs did not vary greatly between baseline and end line. For both survey waves, there was a higher proportion of DAGs in Baglung, compared with Syangja and Parbat (Figure 4).

Figure 4. Distribution of social status of HHs, by district and survey wave, from HH survey



Across the three districts, 79 percent to 84 percent of HHs were headed by men. The mean HH size was between six and seven for all districts and for both survey waves (Table 39). Agriculture was the main HH livelihood in all districts, with foreign employment being the second most common (Table 41). Additional information on the characteristics of HHs may be found in Appendix 6, Table 38, Table 40, Table 42, Table 43, Table 44, and Figure 18.

Per the women's survey, nearly 100 percent of women were married at both timepoints. The main religion in the three districts was Hindu, with a minority being Buddhist. Women from DAGs generally had less education than non-DAG women at baseline and end line (Table 45).

Program Context

The following section summarizes the main findings from program implementation monitoring documents and the qualitative components of the evaluation. It provides context for the findings of the impact evaluation.

Strengthening HFOMCs community discussion (Photo credit: Suaahara)

Implementation and Timeline of Program Activities

Many intervention activities were carried out according to plans, although there were delays because of unforeseen challenges. All HFOMC capacity building training was conducted in both districts, as was the CEA training in Baglung, held six months after the initial HFOMC training. However, review meetings and technical support visits were not completed as planned, and it is unclear whether quarterly interactions between the HFOMCs and community mobilizers took place. Summary information on the implementation status of intervention status are in Table 8.

Table 8. Summary of program component implementation completion**

Program component	Syangja (68 VDCs total)	Baglung (61 VDCs total)
HFOMC reformulation	***64/68***	61/61
Basic HFOMC training	***64/68***	61/61
2-day review meetings	***61/68***	61/61
1-day review meetings	***53/68***	***45/61***
Technical support visits	***8 for 2016; no 2015 data***	***10 in 2016; no 2015 data***
CEA training		61/61
1-day community mobilizer orientations		61/61
Quarterly interaction between the HFOMCs and community mobilizers		***No program data***

Data in ***bold italics* indicate a component that was either not completed as planned or for which data are lacking to support that completion occurred.

There was a wide range of dates within which HFOMCs were reformulated, and the training, review meetings, and other program activities occurred over a long period of time. The first HFOMC reformulations were completed in December 2014 and the last in January 2016. Unforeseen delays, such as extreme weather, a fuel shortage crisis, and political unrest are the main reasons for this timeline. Several program field staff who were interviewed noted that the delays in the initial reformulation activities had a negative impact on the timing of the other activities, thus shortening the program exposure implementation period. They believed that this meant that it was too early to see evidence of change attributable to the intervention.

Reformulation of the HFOMCs

Key informants felt that the reformulations were well-coordinated and adhered to the model. In general, HFOMCs in Baglung and Syangja were reformed through the deliberate selection of members and consensus. They were reformed through meetings, by picking people who were actively involved in various community activities. The in-charge and VDC secretary selected the HFOMC members based on their availability and fulfillment of the criteria.

In some areas, officials engaged in the reformulations faced challenges because the chairpersons and members who have been serving for a long time were unwilling to leave their positions and resisted the reformulation. This challenge occurred in Syangja and Baglung. In Syangja, four HFOMCs did not undergo reformulations, while in other areas in both districts, implementation of the reformulation was delayed.

> *The people who came to provide us training were very trained and whatever they taught cannot be said by us because we are not able to remember all of that.*
>
> **KII, HFOMC, female member, Baglung**
>
> *It [HFOMC training] was done but I have already forgotten everything. We brought the book, but we do not study it.*
>
> **KII, HFOMC female member, Baglung**

HFOMC GESI Enhanced Training

The three-day basic HFOMC training was generally of high quality, according to the quality standard checklist that assessed fidelity to the training guidelines. The one area reportedly lacking was group discussion of community health problems and their presentation. However, fitting all the elements of the training in the three-day timeframe was difficult. There was a desire for more time to reflect on the past work of the HFOMCs in Baglung.

Interviews with female and DAG HFOMC members showed that they appreciated the training and felt that the trainers were very knowledgeable; however, most of them had difficulty understanding and remembering the content of the training, and they sometimes confused the training with other training on issues related to maternal and child health and sanitation. Only a few of the DAG and female HFOMC members interviewed at end line could remember the topics related to the roles and responsibilities of the committee, and their understanding was superficial. End line knowledge of these topics was similar to baseline. Program officials felt that the level of engagement of DAG and female members in the training was low, in terms of their attendance and concentration during the training. Other HFOMC members felt that "forced" involvement may have negatively impacted their participation.

Figure 5. CEA manual cover

CEA Training (Baglung Only)

In Baglung (Approach B), the CEA orientation and skills building sessions were generally viewed as being of high quality. They succeeded in bringing together community mobilizers, FCHVs,

and the HFOMCs on local health issues and creating local action plans. HFOMC members could recall the CEA training, noting that they had visited the community, informed people, and discussed problems with the community.

Two-Day and One-Day Review Meetings

The two-day review meetings were often remembered by HFOMC members, and were an effective means of monitoring the HF. This review meeting was considered a more practical approach to building capacity of HFOMC members because they could understand and use the process. The review of plans developed in the GESI and CEA training also helped members refresh their agendas and revisit decisions made. Program monitoring data from the two-day review meetings showed that most of the required topics were covered. However, when there were gaps, they tended to be on issues related to social mapping/community needs assessment.

Because of delays in the HFOMC reformulations and training, the one-day review meetings were not fully implemented.

> *The review was done once, during that time we visited wards for inspection to see whether the clinic is operating well and recording the patient flow. Advantage is that we can fulfill the responsibility and we also get to know the concerns of people and they also can be informed.* (KII, HFOMC, male DAG member, Baglung)

Technical Support Visits

Support visits were originally scheduled to occur bi-monthly; however, political unrest, government staff schedules and workload, fuel shortages, poor weather, and strikes interfered with monitoring on this schedule. Instead, supportive monitoring was conducted every four to six months, as possible. Program staff who were interviewed stated that the technical support visits were the most challenging component to carry out, mainly because of the need for the participation of district government staff.

Impact on the Use of MNCH Services

This section primarily uses data from the women's survey, supplemented by qualitative data, to address results related to the following evaluation questions:

1. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs on use of maternal and child nutrition and health services by disadvantaged groups?
2. What is the impact of standard capacity-strengthening activities with HFOMCs on use of maternal and child nutrition and health services by disadvantaged groups?
3. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on use of maternal and child nutrition and health services for disadvantaged groups than standard capacity-strengthening activities?

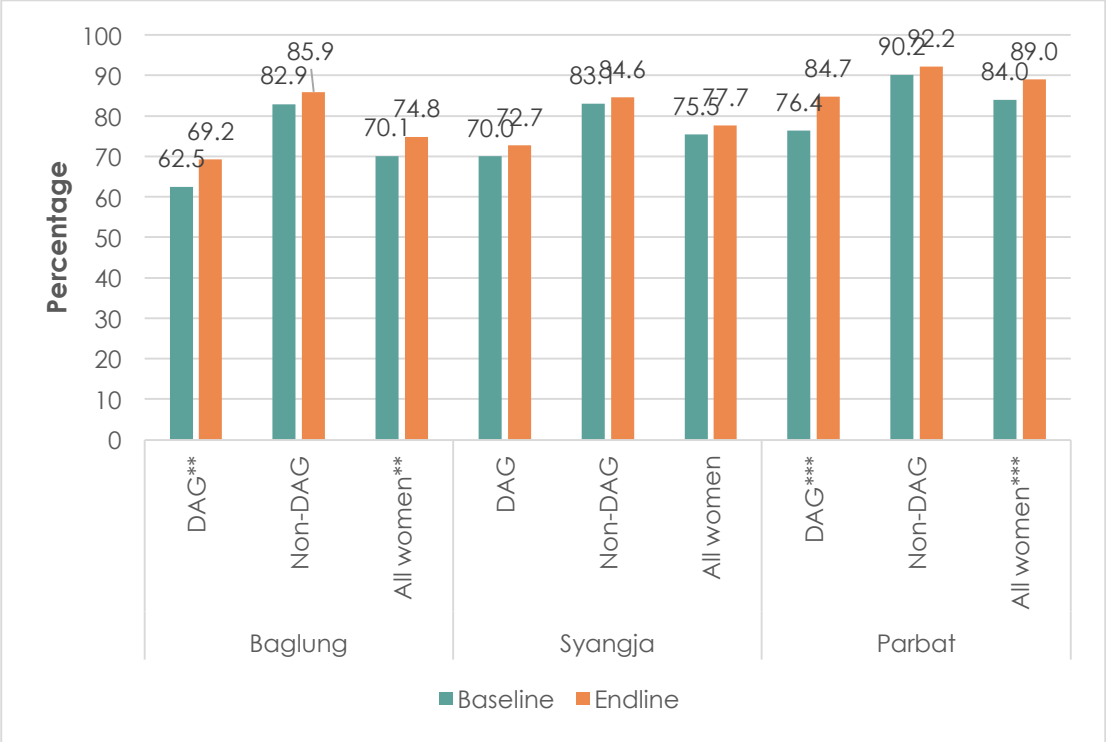
12. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect the use of maternal and child nutrition and health services and how does this compare to standard capacity strengthening activities with HFOMCs?

Antenatal Care

The women's survey data showed an increase in the percentage of women reporting four or more ANC visits across all districts and subgroups. Chi-squared tests showed that the increase was statistically significant for Baglung and Parbat districts overall, and for the DAGs in these two districts (Figure 6).

However, the DID results showed that this increase in women reporting four or more ANC visits was the same in the program and control areas.

Figure 6. Percentage of women reporting four or more ANC visits during last pregnancy, by district, survey wave, and social status

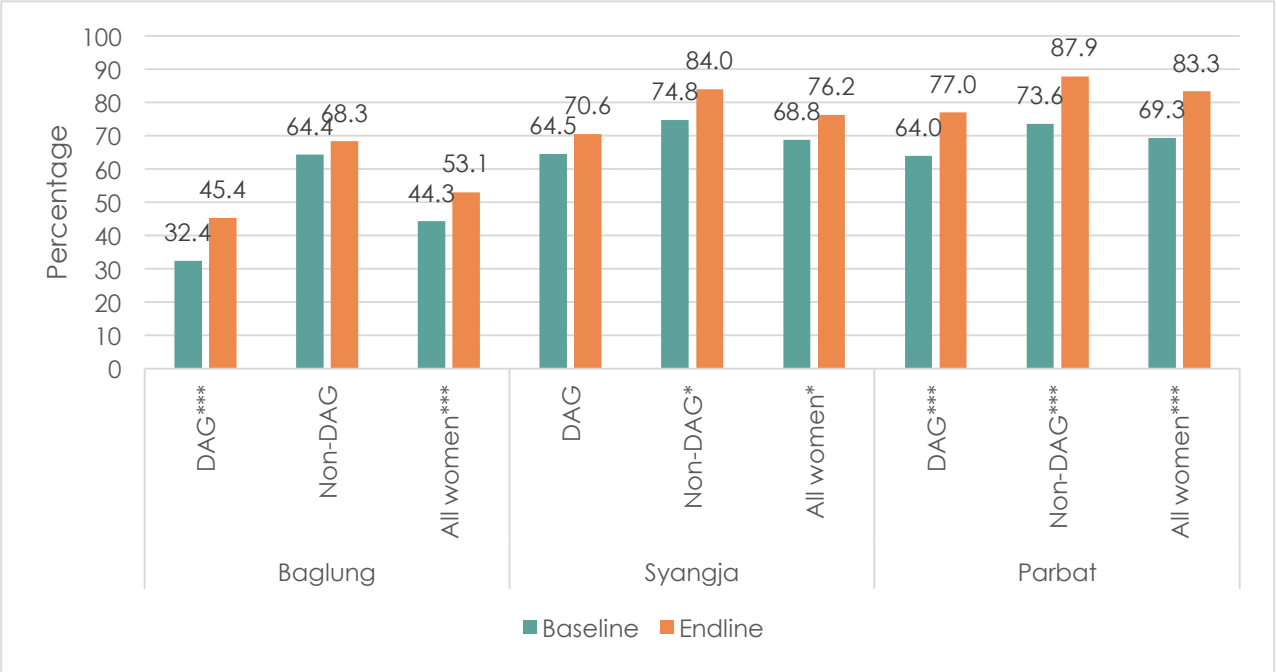


Levels of significance: **p<.01; *** p <.001

Childbirth

There was a statistically significant increase in the percentage of women reporting birth at a HF in all districts between baseline and end line, among disadvantaged women and among all women. In Syangja and Parbat, there was also a significant increase in HF births among non-disadvantaged women (Figure 7).

Figure 7. Percentage of women reporting birth at a HF, by social status, district, and survey wave



Levels of significance: *** p <.001; * p <.05

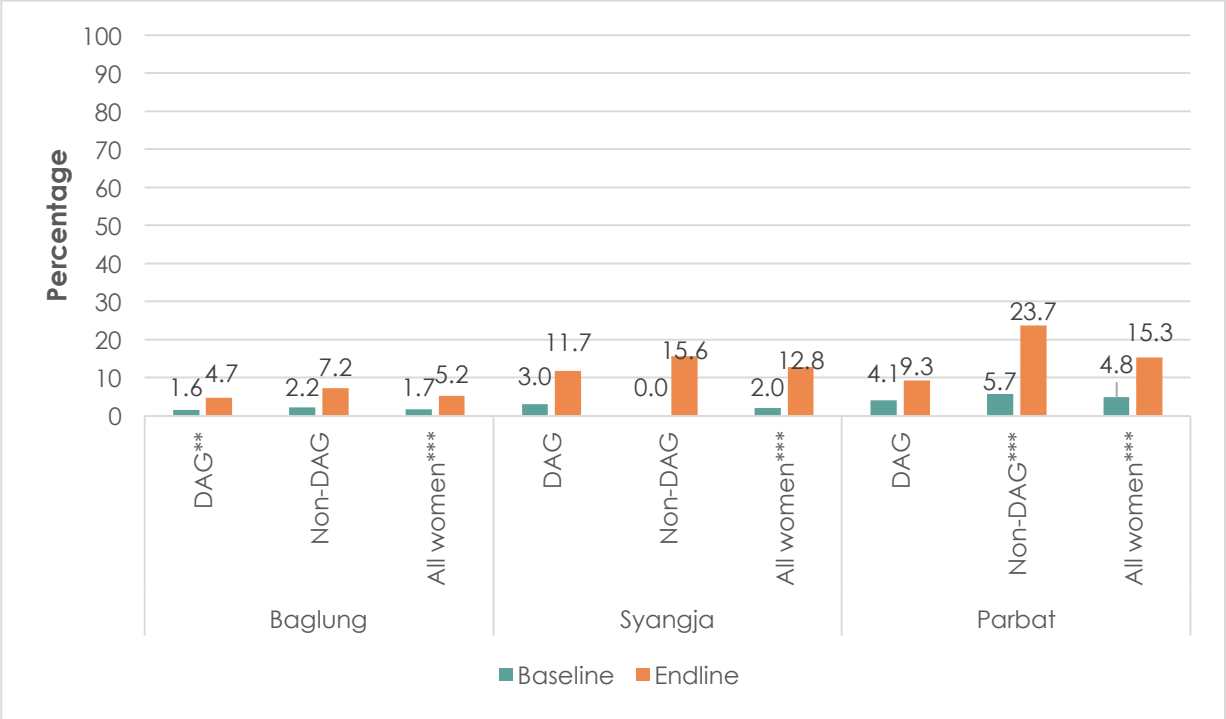
The DID results showed that the increases in Syangja and Baglung were the same as in the control district. There was therefore no program impact.

Postnatal Care

Women's PNC

Although the proportions were small, there were significant increases in the percentage of women who reported being checked by a health professional within 48 hours of home delivery in all districts and among all groups, with the most significant increases seen in Syangja and Parbat (Figure 8). The sample sizes were too small (fewer than five women) for non-DAGs in Syangja and Baglung, such that statistical tests of significance could not be done.

Figure 8. Percentage of women checked within 48 hours of delivery among home births, by district, social status, and survey wave+

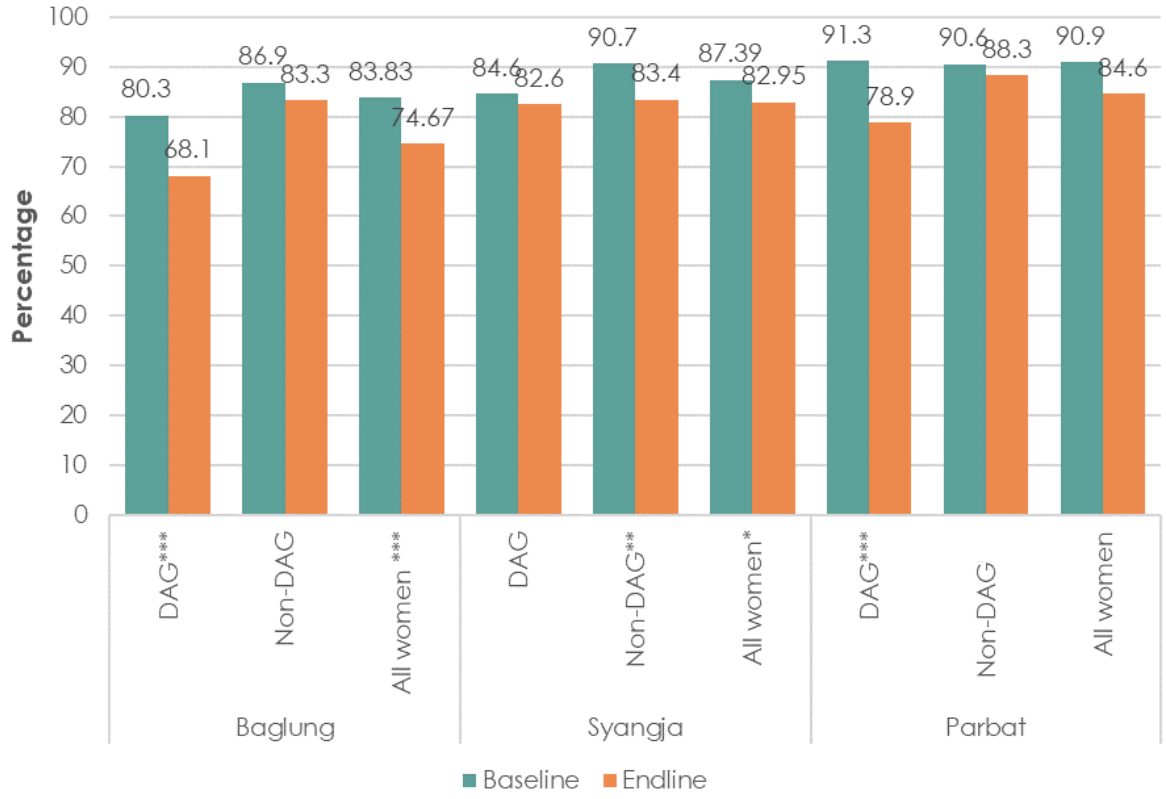


Levels of significance: **p<.01; ***p<.001

+Tests could not be done for Syangja DAGS and non-DAGS because the cell sizes were too small (less than 5)

Among women giving birth at a HF, the trend was a smaller proportion reporting that they had their health checked before leaving the facility. Decreases in Baglung among disadvantaged and all women, and among DAGs in Parbat, were the most significant (Figure 9). DID results showed, however, no significant difference between program and control areas. Therefore there was no program impact.

Figure 9. Percentage of women reporting HF births whose health was checked by a provider before leaving the facility, by social status, district, and survey wave

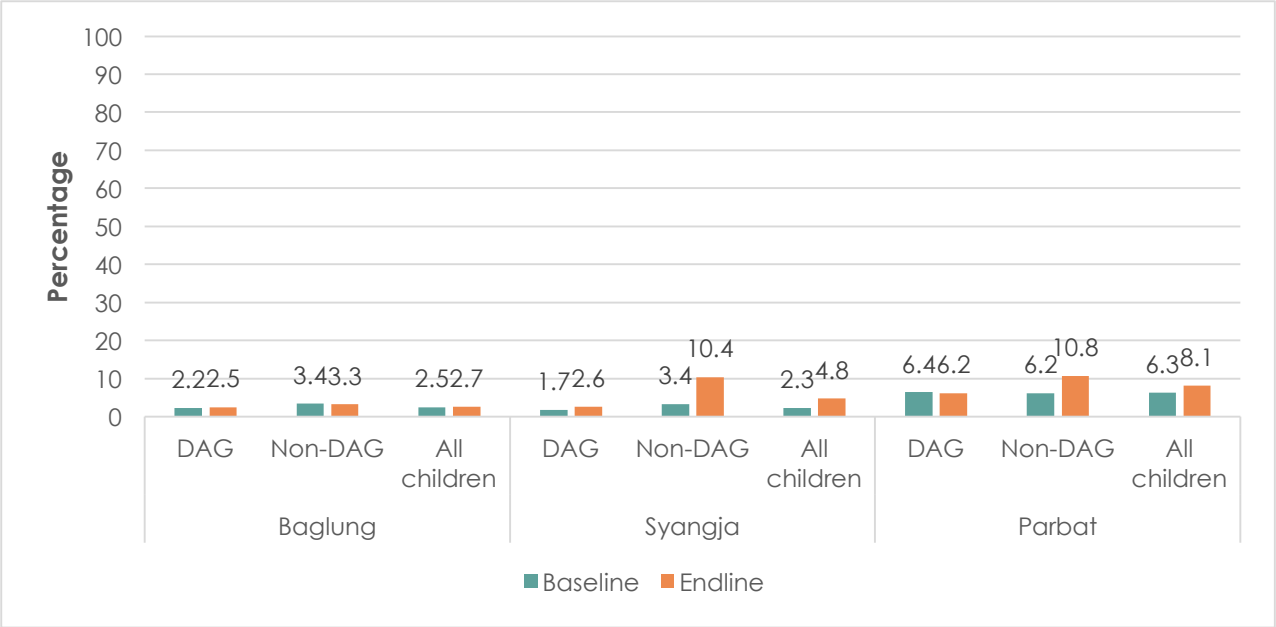


Levels of significance: * p <.05; **p<.01; ***p<.001

Children's PNC

Among women who gave birth at home, there were no statistically significant changes in the proportion of children who were checked within 48 hours after delivery (Figure 10). The sample sizes were too small (fewer than five women reporting for some cells) in Syangja, such that statistical tests of significance could not be done for that district.

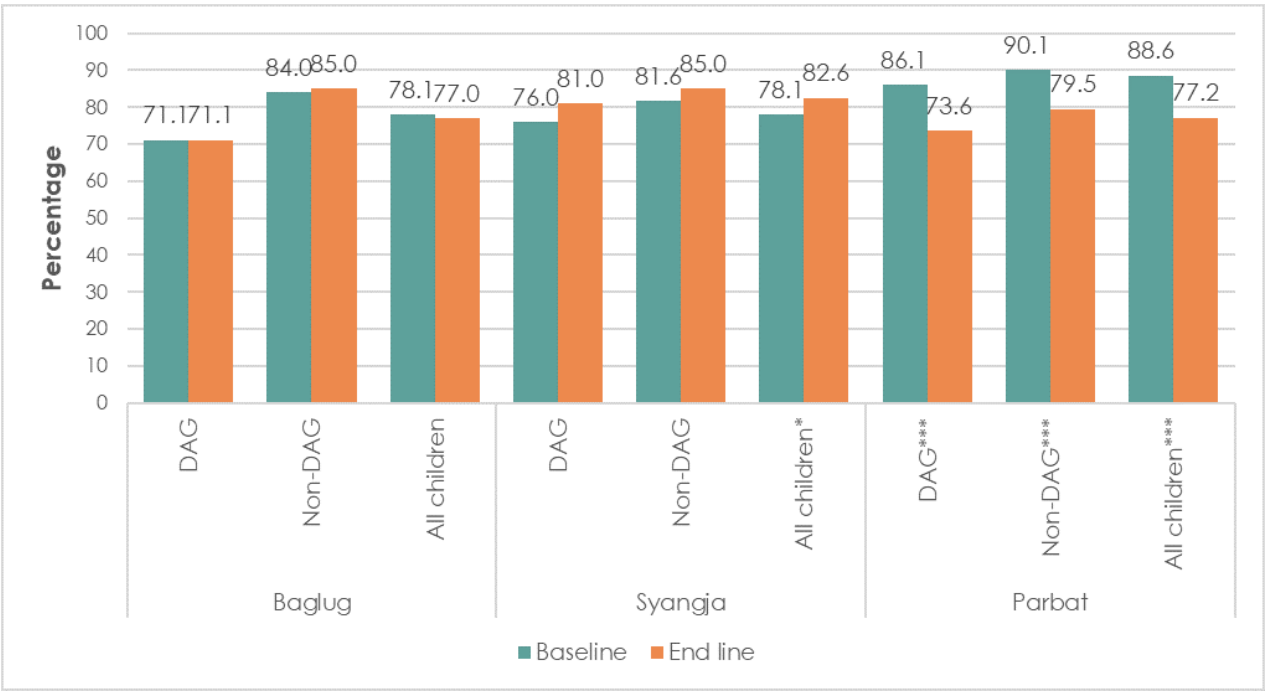
Figure 10. Percentage of children checked within 48 hours after birth among home births, by district, social status, and survey wave



Note: No statistically significant differences between baseline and end line.

Among facility births, there was a small decline in the percentage of women who reported that their children's health was checked before leaving the HF in Parbat and a small increase in the percentage of women reporting the same in Syangja (Figure 11).

Figure 11. Among HF births, percentage for which child's health was checked by provider before leaving the facility, by social status, district, and survey wave



Levels of significance: * p <.05; **p<.01; ***p<.001

The DID results showed positive program impact of a small increase in PNC for children of facility births in Syangja; Baglung's maintenance of similar rates over time, compared to Parbat's decrease, meant a protective effect of the program in Baglung (Table 9).

Sample sizes for PNC among home births were too small for DID analysis.

Table 9. DID results for use of postnatal care

	Program Impact	
	Baglung	**Syangja**
Child: PNC before leaving facility, among HF births	Positive**	Positive**^

The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different (**p<0.01) from the change in the use rate in control areas.

^The magnitude of this impact was larger than that in Baglung.

Child Health

Between baseline and end line, there was a significant decrease in the percentage of women who reported that their child's health had ever been checked in the three districts and for all groups, except for non-disadvantaged women in Syangja. There were no major shifts in the proportion of women who reported having their child's health checked within the last six months in Baglung and Syangja, but there were significant decreases in Parbat (Table 10).

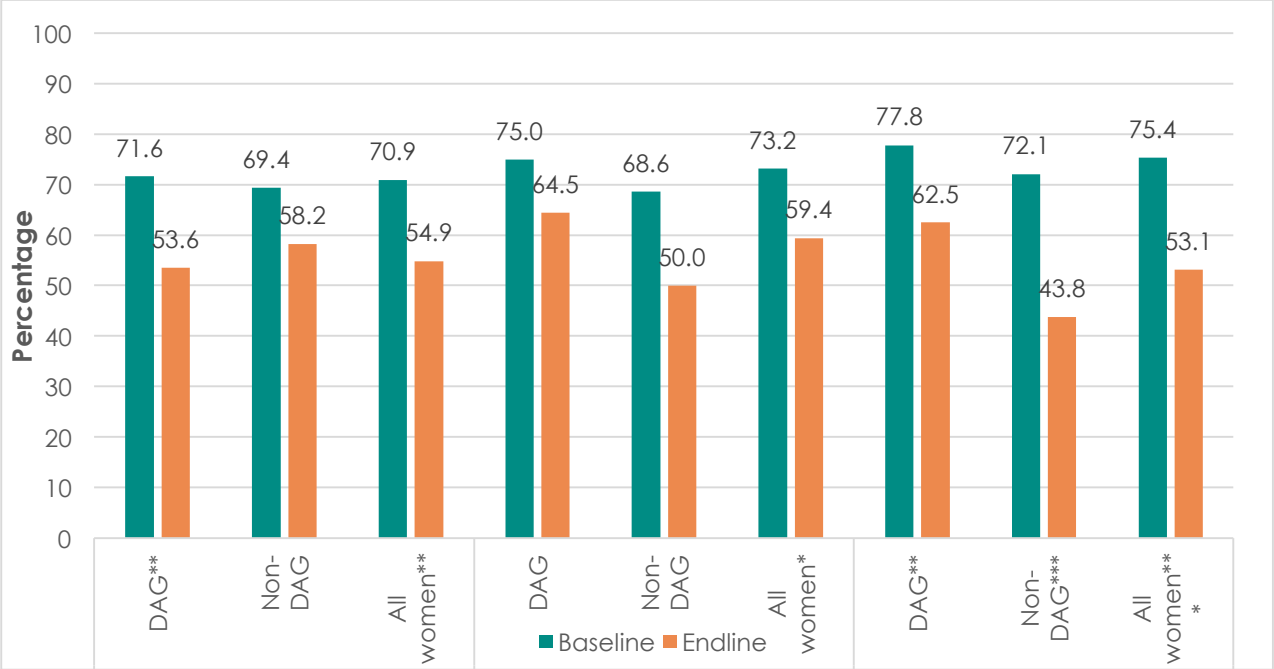
Table 10. Percentage of women reporting use of child health check services, by district, social status, and survey wave

	Baseline			End line		
	DAG%	**Non-DAG%**	**All Women%**	**DAG%**	**Non-DAG%**	**All Women%**
Baglung						
Health ever checked	71.7	82.3	75.6	67.0*	79.7	71.3*
Checked in last six months	63.0	73.0	67.0	61.4	76.4	66.4
Syangja						
Health ever checked	85.4	88.4	86.6	78.2**	82.3**	79.9*
Checked in last six months	76.5	76.5	77.0	73.0	76.0	74.1
Parbat						
Health ever checked	91.2	94.2	92.8	80.4***	80.3***	80.3***
Checked in last six months	82.0	83.3	82.5	74.3**	75.0***	74.7***

Levels of significance: * p <.05; **p<.01; ***p<.001

There was an overall decrease over time in the percentage of women who reported seeking advice or treatment for their children who experienced diarrhea in the last two weeks, among all groups in the three districts, although the most significant decreases were in Parbat (Figure 12).

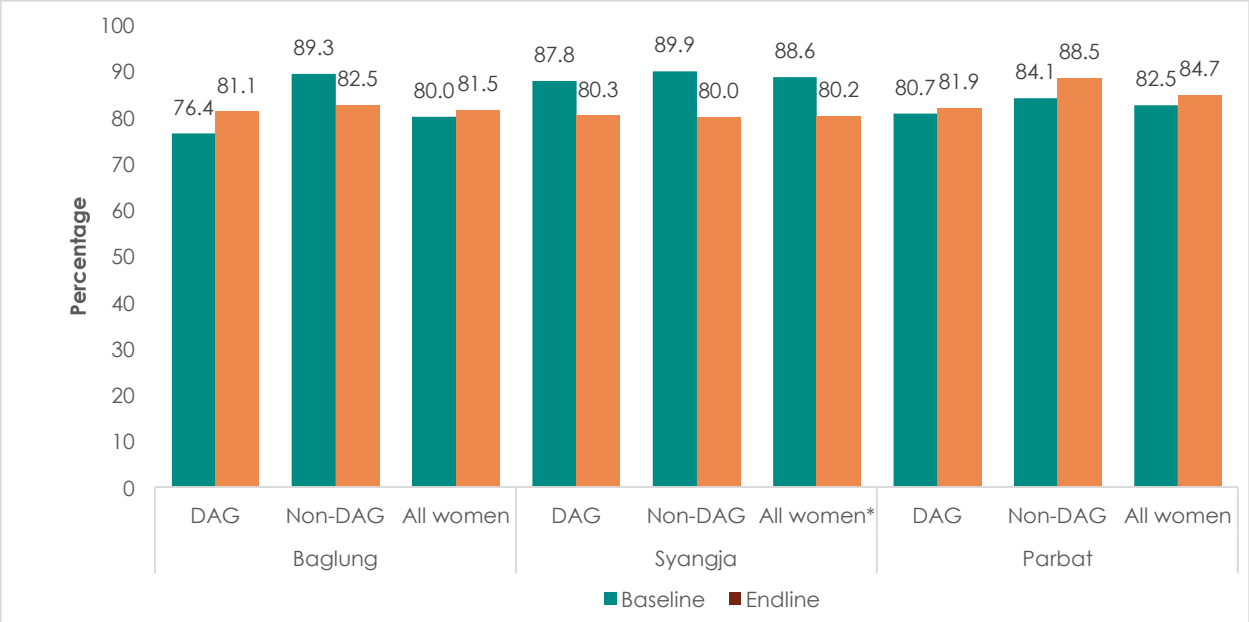
Figure 12. Percentage of women seeking treatment for children with diarrhea in the last two weeks, by district, social status, and survey wave



Levels of significance: * p <.05; **p<.01; ***p<.001

Among women who reported that their children had a fever in the last two weeks and got treatment, there were no major changes between baseline and end line, although there were statistically significant decreases among all women in Syangja ($p<0.05$) (Figure 13).

Figure 13. Percentage of women seeking treatment for child fever in last two weeks, by district, social status, and survey wave



Levels of significance: * p <.05

Although there were decreases in reports that a child's health had ever been checked and in the child's health being checked in the last six months, the decrease in Baglung was less than that in the control areas, showing a positive program impact. Similarly, the program showed a protective, positive impact in Syangja, compared with the control group. The magnitude of the impact was greater in Baglung than in Syangja (Table 11). There were no program impacts for other child health service use outcomes.

Table 11. DID results for use of child health services

	Program Impact	
	Baglung	**Syangja**
Among children with diarrhea in last two weeks, sought treatment/advice	None	None
Among children with fever in last two weeks, sought treatment/advice	None	None
Among children with cold and rapid/difficult breathing in last two weeks, sought treatment/advice	None	None
Child's health ever checked	Positive* ^	Positive*
Child's health checked within the last six months	Positive **^	Positive*

The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different (* p< 0.05; ** p<0.01) from the change in the use rate in control areas.
^The magnitude of this impact was greater in Baglung than in Syangja.

Perceptions of Program Influence on Service Use

In interviews and FGDs with HFOMC members and HF in-charges, respondents believed that the increased involvement of the HFOMCs at the facility level had led to an increase in demand for health services. However, this opinion was not reflected in the community FGDs or in community interviews using the MSC method.

Impact on Health Service Quality

This section uses a mix of quantitative data from the women's survey and qualitative data. It addresses results related to the following evaluation questions:

1. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs on maternal and child nutrition and health service quality for disadvantaged groups?
2. What is the impact of standard capacity-strengthening activities with HFOMCs on maternal and child nutrition and health service quality for disadvantaged groups?
3. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on maternal and child nutrition and health service quality for disadvantaged groups than standard capacity-strengthening activities?
4. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect maternal and child nutrition and health service quality and how does this compare to standard capacity strengthening activities with the HFOMCs?

Antenatal Care

Client exit interviews at end line showed that, similar to baseline, most women who received ANC were taking folic acid supplements. There was also an increase in those who reported having had tetanus shots, compared with baseline. The content of provider-client consultations did not change; nutrition and pregnancy complications were the most frequently discussed (roughly one-third of consultations), and breastfeeding and FP were discussed in only a few consultations.

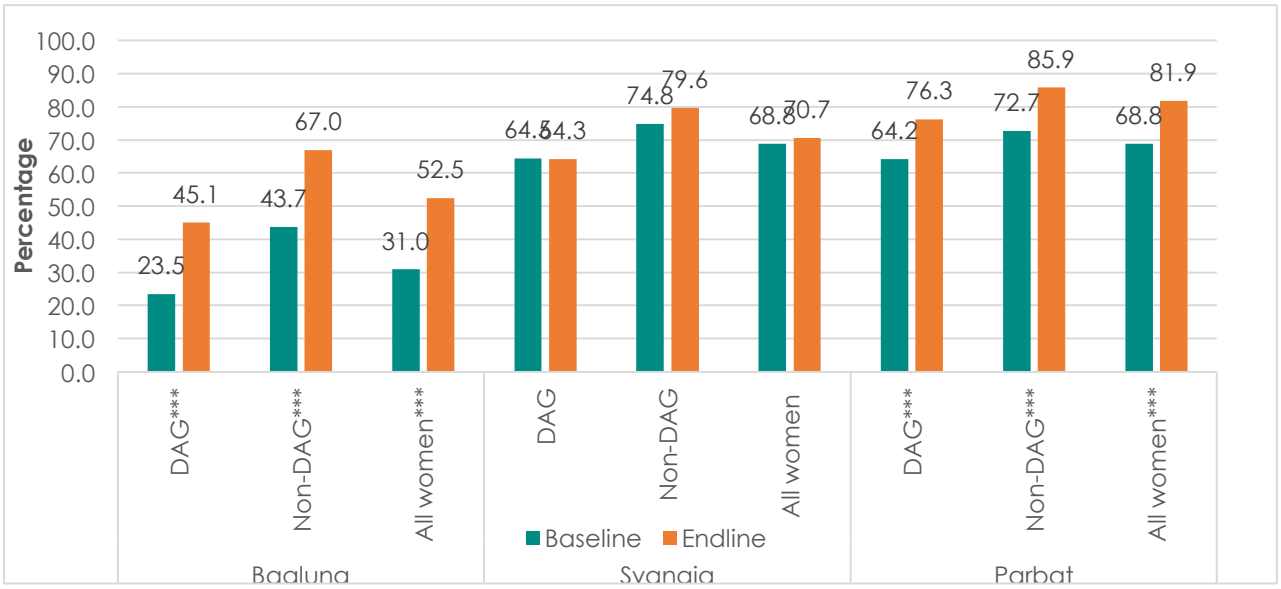
Looking at the women's survey data on ANC service satisfaction, there was a slight decrease in the percentage of women saying that they were "very satisfied," compared with an increase in the percentage reporting that they were "somewhat satisfied," across all districts and groups (see Appendix 6, Figure 24).

Childbirth

Women's satisfaction with childbirth services was high at baseline and end line, in all districts and among all women; however, there was a shift from women being "very satisfied" with services to being "somewhat satisfied." This shift was seen in several aspects of childbirth services in the three districts, including how attentive, friendly, respectful, and knowledgeable staff were (Table 58).

In Baglung and Parbat, there was an increase in the use of a skilled attendant at birth; this increase was statistically significant among all women, disadvantaged women, and non-disadvantaged women (Figure 14).

Figure 14. Percentage of women reporting assistance of a skilled health professional during childbirth, by social status, district, and survey wave



Levels of significance: ***p<.001

The DID analysis showed that the increase in the percentage of women reporting being assisted by skilled birth attendants in Baglung was greater than in the control areas, indicating a positive program impact (Table 12).

Table 12. DID results for quality of birth services

	Program Impact	
	Baglung	**Syangja**
Skilled attendant** at birth	Positive*	None

*The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different ($p < 0.05$) from the change in the use rate in control areas.

** Doctor, nurse, or midwife.

Postnatal Care

Among women who gave birth at a HF, approximately three-quarters received counseling on breastfeeding within one hour of delivery at baseline. This figure declined significantly in Baglung and Parbat at end line (Appendix 6, Table 51).

Women's satisfaction with postnatal services for themselves was high at baseline and end line in the three districts, with 98 to 100 percent of women saying that they were "very satisfied" or "somewhat satisfied." Most mothers (DAG and non-DAG) rated staff as "very" or "mostly" attentive, respectful, friendly, and knowledgeable in the three districts. However, in Parbat, the proportion of women who were very satisfied with their own PNC care declined from baseline to end line. (Appendix 6, Table 59).

Among HF births, 15 percent of women in Baglung and 18 percent in Syangja and Parbat reported that their infants had received essential services, such as checking the child's cord and temperature, within two days of birth. Among home births, the number of infants getting this care was fewer than 1 percent in all districts (Appendix 6, Table 57). These data were available at end line only.

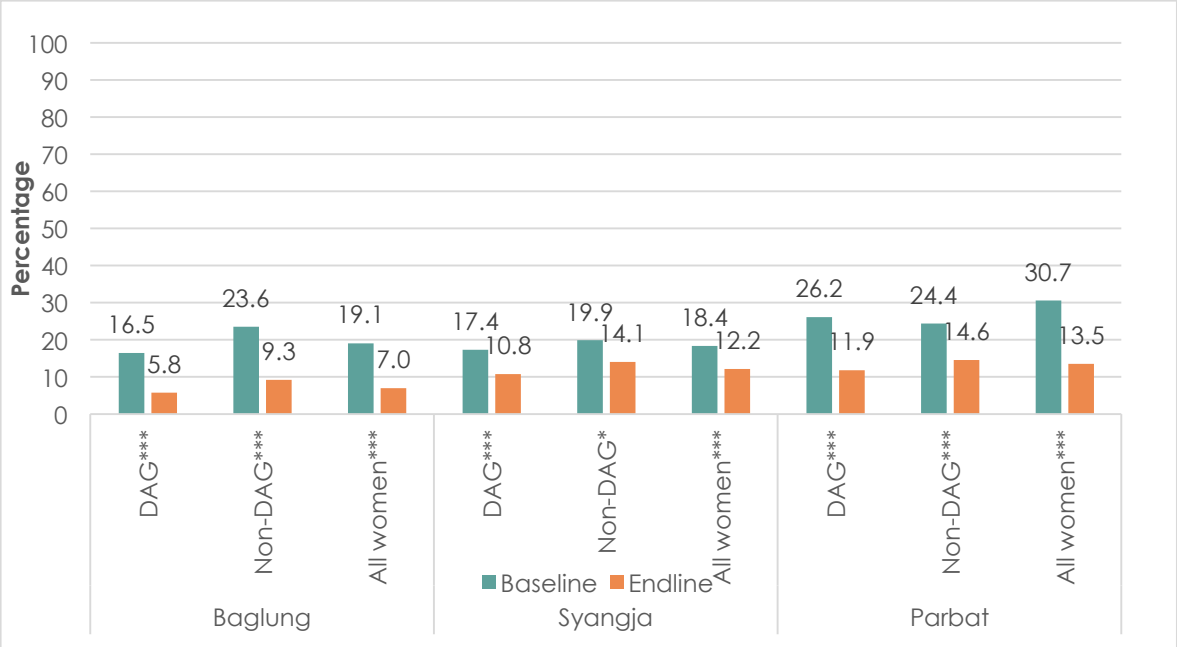
For PNC care of children, women reported high levels of satisfaction at baseline and end line in the three districts. However, there was a decrease from baseline to end line in the proportion of women in Baglung reporting that staff were "very" attentive. In Parbat, the proportion of women reporting that staff were "very" attentive likewise declined from baseline to end line. There was a similar decline in the proportion rating the staff as "very" respectful, attentive, friendly, and knowledgeable in Parbat, while respondents in Baglung and Syangja were more consistent in their ratings between baseline and end line (see Appendix 6, Table 60).

Family Planning

There were highly significant decreases in the percentage of women reporting having ever been counseled on HTSP, for all groups and in all districts ($p<0.001$ in Baglung and Parbat, and $p<0.01$ in Syangja) (Figure 15). At baseline, more than half of the women reported being counseled at the time of their postnatal visits; the percentage declined in Baglung at end line and increased in Syangja (Appendix 6, Table 61).

Satisfaction with counseling on HTSP was generally high in all districts at baseline and end line; however, similar to the levels of satisfaction with other services presented above, there was a substantial shift from nearly two-thirds of the women in all districts at baseline saying that they were "very satisfied," to saying at end line that they were "somewhat satisfied" (Appendix 6, Table 62).

Figure 15. Percentage of women reporting having ever been counseled on HTSP, by district, social status, and survey wave



Levels of significance: * p <.05; **p<.01; ***p<.001

While the proportion of women who reported receiving counseling on HTSP declined in all areas, the decrease was less in Syangja than in Parbat, indicating that the program had a positive, protective impact in Syangja (Table 13).

Table 13. DID results for the quality of FP services

	Program Impact			
	Baglung		Syangja	
	All women	DAGs	All women	DAGs
Ever counseled on HTSP	None	None	Positive***	None

***The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different (p< 0.001) from the change in the use rate in control areas.

Child Health

Between baseline and end line, there was an increase in the percentage of disadvantaged women, non-disadvantaged women, and all women in the three districts reporting that their child's weight had been measured in the last six months (p<0.001). However, an overall decrease was seen at end line in the percentage of women reporting that a health professional had talked to them about their child's growth, with the most significant changes occurring among disadvantaged women and all women in Baglung and among all groups in Parbat (p<0.001). Syangja had less substantial declines in this area at end line (p<0.05) (Table 14).

Table 14. Well-child visits/use of growth monitoring services, by district, social status, and survey wave

	Baseline			End line		
	DAG %	Non-DAG%	Total%	DAG %	Non-DAG%	Total%
Baglung						
Weight ever measured	91.1	97.1	93.3	92.2	97.3	93.9
Weight measured in last six months	63.0	66.1	64.1	76.0***	82.0***	77.8***
Health professional talked about growth	15.7	20.8	17.8	9.3**	17.5	12.4**
Syangja						
Weight ever measured	95.9	98.7	97.1	96.1	98.8!	97.2
Weight measured in last six months	66.2	69.0	67.2	81.0***	86.0***	83.0***
Health professional talked about growth	16.8	25.4	20.5	14.6	18.4	16.3*
Parbat						
Weight ever measured	97.9	98.8	98.4	98.2	99.2	98.8***
Weight measured in last six months	77.3	77.0	77.1	87.2***	90.2*	89.0***
Health professional talked about growth	28.4	42.6	36.2	12.9***	24.0*	19.3***

Levels of significance: * p <.05; **p<.01; ***p<.001

DID results showed no program impact on child's weight having been measured in the last six months or ever. However, the results showed positive impact on whether the health professional discussed the child's growth during the consultation. While reports of these discussions declined everywhere, the DID results indicated that they decreased less in Syangja and Baglung, compared with Parbat. The magnitude of this impact was greater in Baglung than in Syangja (Table 15).

Table 15. DID results for the quality of child healthcare services

	Program Impact			
	Baglung		Syangja	
	All women	DAGs	All women	DAGs
Child's weight ever measured	None	None	None	None
Child's weight measured within the last six months	None	None	None	None
Health professional discussed child's growth at last visit	Positive***^	None	Positive*	None

The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different (**= p< 0.001 and *= p<0.05) from the change in the use rate in control areas.

^ The magnitude of this impact was greater in Baglung than in Syangja.

General Perceptions of Quality

In client exit interviews, respondents reported that providers paid attention, listened carefully, and gave adequate time to their concerns at both points in time and in all districts. Clients also expressed high levels of satisfaction with the services provided. In Baglung and Syangja, clients reported that health workers were more likely to treat them without judgment, compared with baseline and control areas (Table 64). Also, FGDs with community members documented positive attitudes towards health workers in all districts, compared with baseline.

Availability and Accessibility

Between baseline and end line, women across all districts reported increases in awareness of MNCH services available at their local HF (Table 66).

FGDs with community members identified an important difference since baseline, namely, the change in HF hours from four hours of operation (10 a.m. to 2 p.m.) to six hours (10 a.m. to 4 p.m.). Although this change was introduced through national-level regulations, HFOMC members highlighted their role in enforcing the regulations at their HFs.

> *Yes, we have made rules and regulations. We are monitoring that the health facility should be opened from morning 10 a.m. to 4 p.m. We have been monitoring.* (KII, HFOMC DAG Member, Baglung)

According to client exit interviews, the proportion of clients who had to wait once they arrived at the facility did not change compared to baseline for Baglung and Syangja (49 percent). However, the proportion increased significantly in Parbat (47 percent at baseline to 64 percent at end line). The amount of time spent waiting for service at end line was not significantly different, compared with baseline in the three districts. At end line, the waiting time was 23 minutes for Syangja and Baglung, on average, and 17 minutes for Parbat (data not shown).

HF observation data showed no change in the availability of medicines at end line, compared with baseline, and no differences between the control areas and the two program areas. Out of 32 medicines/devices, 25 were available (range of 20 to 29 medicines/devices) at baseline and end line across all HFs. Similarly, no improvement was seen in the physical environment of the facilities or respectfulness of service delivery provision (data not shown).

Impact on Selected MNCH Outcomes

This section uses data from the women's survey to address results related to the following evaluation questions:

1. What is the impact of integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs on selected maternal and child nutrition and health outcomes for disadvantaged groups?
2. What is the impact of standard capacity-strengthening activities with HFOMCs on selected maternal and child nutrition and health outcomes for disadvantaged groups?
3. Does integrating GESI and community involvement processes into capacity-strengthening activities with HFOMCs have a higher impact on selected maternal and child nutrition and health outcomes for disadvantaged groups than standard capacity-strengthening activities?

Maternal Health Outcomes

It was beyond the scope of this evaluation to measure the program's impact on maternal mortality and morbidity; however, skilled birth attendance and HF births are sometimes seen as proxy measures for maternal health outcomes (Berhan & Berhan, 2014). The DID analysis found no program impact on HF births, but it did show that the program had a positive impact in Baglung in terms of women reporting having a skilled attendant at birth (Table 16).

Table 16. DID results for selected maternal health outcomes

	Program Impact			
	Baglung		Syangja	
	All women	DAGs	All women	DAGs
HF births (proxy for maternal morbidity and mortality)	None	None	None	None
Skilled attendant at birth (proxy for maternal morbidity and mortality)	Positive*	None	None	None

*The DID model found that the change in the use rate in project areas between 2015 and 2017 was statistically different ($p<0.05$) from the change in the use rate in control areas.

Infant and Young Child Feeding Outcomes

Approximately 90 percent of women reported exclusively breastfeeding their children until age six months at baseline and end line, although there were small statistically significant increases among disadvantaged women in Syangja. There were significant decreases in the proportion of children getting the minimal acceptable diet (MAD) from baseline to end line in the three districts (Table 17).

Table 17. Exclusive breastfeeding and MAD, by survey wave, social status, and district[1]

	Baseline			End line		
	DAG%	Non-DAG %	Total %	DAG %	Non-DAG%	Total%
Baglung						
Exclusively breastfed age 0 to 6 months	93.7	87.6	91.6	93.9	89.0	92.2
MAD: Proportion of breastfeeding children 6 to 23 months of age who receive a minimum acceptable diet (apart from breast milk)	46.2	40.9	44.2	40.2*	37.0	39.1*
Syangja						
Exclusively breastfed age 0 to 6 months	80.8	87.0	83.1	87.4	87.7	87.5
MAD: Proportion of breastfeeding children 6 to 23 months of age who receive a minimum acceptable diet (apart from breast milk)	51.7	56.3	53.7	40.3***	41.1***	40.7***
Parbat						
Exclusively breastfed age 0 to 6 months	92.6	85.8	89.1	91.7	88.6	89.9
MAD: Proportion of breastfeeding children 6 to 23 months of age who receive a minimum acceptable diet (apart from breast milk)	47.7	53.6	51.0	40.8**	43.6**	42.4***

Levels of significance: * p <.05; **p<.01; ***p<.001

[1] Exclusive breastfeeding assessed by the questions," Are you still breastfeeding?" "Do you currently offer your child complementary foods?" Did [NAME] drink anything from a bottle with a nipple yesterday or last night?" and "Did [NAME] eat any solid, semi-solid, or soft foods yesterday during the day or night?"

Table 18. DID results for MAD and exclusive breastfeeding

	Program Impact			
	Baglung		Syangja	
	All women	DAGs	All women	DAGs
Exclusively breastfed age 0 to 6 months	None	None	None	None
MAD: Proportion of breastfeeding children 6 to 23 months of age who receive a minimum acceptable diet (apart from breast milk)	None	None	None	None

The DID analysis showed no program impact on the infant and young child feeding outcomes (Table 18).

Functioning and Accountability of the HFOMCs

This section summarizes results from the qualitative data related to the following evaluation question:

11. How does integrating GESI and community involvement processes into capacity strengthening activities with HFOMCs affect the functioning and accountability of HFOMCs and how does this compare to standard capacity strengthening activities with HFOMCs?

> *I can speak out my ideas in HFOMC meetings. Although I have not solely made demands but together with other committee members I raise my points.*
>
> **KII, HFOMC Female Member, Baglung**

Regular Meetings and Extent of Participation

Immediately after the training in Syangja and Baglung, committee members started to meet on a regular basis. The number of meetings increased for a short period. They became less frequent over time, with a few exceptions. Only two of eight HFs in Baglung and Syangja sampled for the qualitative component had a meeting in the month preceding data collection.

> *The meeting was supposed to be held every month, but it has been five to six months that none of the meetings have been held.* (HFOMC female member, Baglung)

Participation during meetings did not vary greatly between baseline and end line. For some HFOMCs, the meetings continued to be dominated by a handful of members, such as the in-charge and VDC secretary. Program monitoring data from five randomly chosen sites in Baglung suggested that the participation of DAG committee members remained a challenge; only two of five HFOMC meetings had the active participation of DAG members, and only one of five meetings had a DAG proposing an agenda item. However, some female and DAG members in the program areas reported increased confidence in being able to raise their voices during the HFOMC meetings.

HFOMC members reported several barriers to their attendance at meetings. In the three districts, they reported being unaware of meetings and attended only if they been informed or invited by the HF. The participation of some women and DAG members was also hindered by psychological and logistical barriers.

For example, some members felt that their lack of higher education led to a power imbalance. Others also felt that their voices were not heard at the meetings.

> *This is what happens there [in the meeting] sir. They include my issues [in the discussion]. I had said one thing that an awareness [education] program should be given to the Dalit village in any case. They have not focused on it a bit.* (KII, HFOMC, female member, Baglung)

There were also constraints on members' time. Because female and Dalit members were nominated based on their involvement in other community groups, they were often overextended. The time the HFOMC took away from work and domestic responsibilities (especially for female members) also resulted in their limited participation.

> *I do participate a little bit when there is a discussion in related topic. [laughing] Well as a female I have a lot of household activities to attend to. So, I can't go out to other places for office work.* (HFOMC, female member, Syangja)

CEA Activities (Baglung Only)

Very few community engagement activities took place after the training. They were confined to informing the community about immunization days and cleanliness, and were done as a part of the individual efforts of selected HFOMC members rather than by the HFOMCs as a whole.

> *Since we do not have meetings regularly, and people from far don't come regularly, there has been no such community mobilization program, but we do inform them when there are programs, like immunization or national health program like elephantiasis.* (KII, HF in-charge, male, Baglung)

Awareness of Roles and Responsibilities

Interviews with program staff and HFOMC members in Baglung and Syangja showed that awareness of roles and responsibilities of the HFOMCs improved, compared with baseline and the control areas. DAG members were more aware of their responsibilities for representing their communities at end line. HFOMC members highlighted their role in disseminating information about available health services and free health services, and in encouraging community members to access and utilize the available health services.

> *Talking about the committee's responsibilities, since I am from the Janjati group, my residence is also in the Janjati community, so, if there are health related problems in the ethnic group, then I am responsible to advise those things. … I tell them to go for checkup if anyone has fallen ill or if there are any problems. I also tell women to go to the birthing center for delivery and check-up. Since there is illiteracy, there is a trend of going to Lamas, traditional healers, so half people go to such places even though I advise them not to go.* (KII, HFOMC member, male DAG, Syangja)

Compared with the baseline and the control areas, there was also an increase in members reporting that they needed to play a role in monitoring the HF.

HFOMC Awareness of HF Services

As compared with Parbat, in Baglung and Syangja, HFOMC members reported that, like their communities, they were unaware of the services and functioning of the HFs. Both trainings and the HFOMC activities increased their knowledge about these topics.

> *We did not know about the services that were given by the health post before [the program] but now I know about that.*
>
> **KII, HFOMC member, female, Baglung**

Coordination and Communication between the HFOMCs and District Authorities/Government

The HFOMCs in all areas reported interacting with the District Public Health Office (DPHO) on issues related to medicines, facilities, and human resources. Interviews with program staff and district-level authorities indicated an enthusiasm on the part of the district-level authorities to work with the HFOMCs. However, the HFOMCs reported trying to communicate and make demands, only to receive limited support from government officials. In program VDCs, in cases where the HFOMCs had identified issues and had made plans to address them, the inability of government agencies, such as the DPHO, District Development Committee (DDC), and other higher authorities to fulfill their needs was highlighted. The HFOMCs were also often unaware of who to contact at a higher level to resolves issues. The lack of adequate support from higher-level stakeholders led to a reluctance among HFOMC members to meet, bring up new issues, and have further discussions about issues.

> *It is like … those medicines directed by government to provide are not given. They [clients] come here but medicines are not available, such things also happen. HF informs HFOMC that such medicines are available there. We also ask them [HF staff] why we have to buy medicines when estimated amount should be there, but sometimes the health post lacks medicines as government does not provide medicines. Therefore, people talk about us negatively that "what is this committee for? It tells lies." (HFOMC member, female DAG, Baglung)*

HFOMC Transparency

HF observation data showed no difference in HFOMC-linked transparency initiatives (e.g., posting committee membership or meeting information at HFs), compared with baseline. The results in the three districts were similar.

Relationships among HFOMCs, the Community, and HFs

This section uses qualitative and program monitoring data; data from the women's survey are also presented. The section addresses results related to the following evaluation question:

14. How does integrating GESI and community involvement processes in capacity strengthening activities with HFOMCs affect the relationship between HFOMCs, the community, and health facilities and how does this compare to standard capacity strengthening activities with HFOMCs?

Communication and Coordination between the HFOMCs and Health Workers

Health workers presented their needs and demands to HFOMC members, particularly when related to the equipment and facilities. The HFOMCs interacted primarily with the HF in-charge who was present at the meeting, and reportedly monitored staff attendance at the HFs. Communication between HFOMC members and health workers was limited because of the lack of a mechanism for sharing information and discussion. In some cases, this led to feelings of dissatisfaction on both sides about each other's work.

Communication and coordination between the HFOMCs and health workers at end line were similar to baseline in the three districts.

> *Mostly the communication with the HFOMC is during the time of meeting. During the meeting, we discuss about the inadequacy of medicines and equipment. We fill the demand form, which is then taken to the district.* (HF in-charge, male, Syangja)

The HFOMCs did not collaborate with health staff to oversee monitoring and supervision, data collection, and community engagement activities, as predicted by the program results chain.

Communication and Coordination between the HFOMCs and the Community

Compared with baseline and the control areas, the qualitative data showed some improvements in the program areas in terms of HFOMC communication and collaboration with the community. HFOMC members were sporadically engaged in giving information to community members; women reported giving information to other women; and Dalits reported giving information to other Dalits. The HFOMCs also collaborated occasionally with the community to organize specific events, such as immunization days and outreach clinics, on behalf of the HFs. However, these types of activities appear to have decreased over time since the intervention.

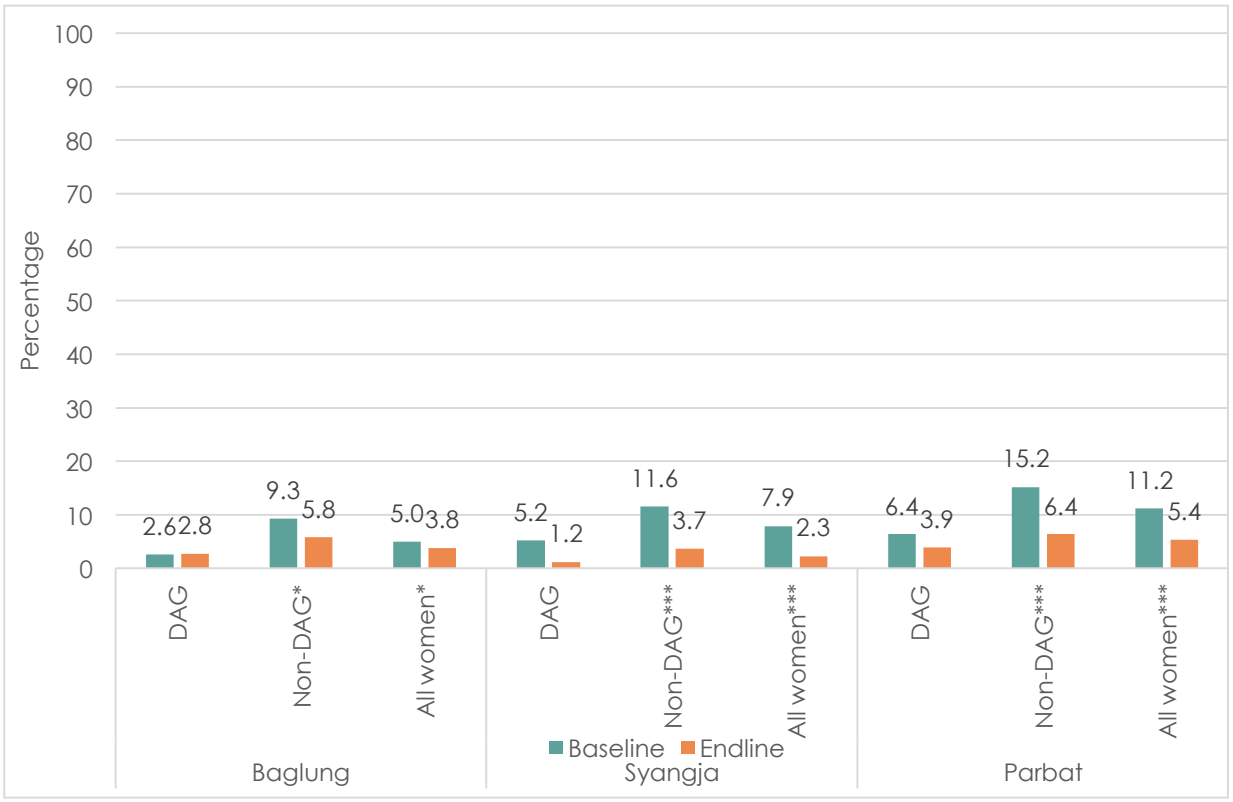
> *Earlier when the committee was formed then they used to work, taking interest in doing good for the community, like in every outreach clinic the committee used to go for inspection…It was operating like that and the committee was doing a good job. Presently the committee is not doing that well, I don't see them conducting meetings these days.* (Community leader, male, Baglung)

Similar to the baseline findings, there was no arrangement for public interaction with the HFOMCs in all districts. Discussions revealed that the HFOMCs and the communities considered it essential to have a means for people to communicate directly with their representatives.

Awareness of the HFOMCs in the Community

Data from the women's survey showed low awareness of the HFOMCs. Between baseline and end line, there were significant decreases in the percentage of women who reported that they had ever heard of the HFOMCs, in the three districts and among all groups, except disadvantaged women in Baglung (Figure 16).

Figure 16. Percentage of women reporting awareness of the HFOMCs, by district, social status, and survey wave



Levels of significance: * p <.05; **p<.01; ***p<.001

FGDs with community members in the three districts underscored this low awareness. Participants indicated that they were not aware of the HFOMCs and their activities. They did not recognize members and could not recall any communication or encounters with the HFOMCs. They had heard only about some people who served on the committee going to the HF for meetings. The FGDs showed no difference among the three districts in terms of community members' awareness of the HFOMCs.

Instead of the HFOMCs, community members were more connected with the FCHVs, who served as an interface between the community and the HF, primarily by delivering information and urgent supplies from the HF to their respective community.

> *If there is anything, FCHVs provides information. For health camps, they come here on every 14th and 23rd of the Nepali calendar for immunization and measuring the weight of the baby.* (FGD, women, Parbat)

Data from the KIIs with community leaders in all districts likewise showed low awareness of the HFOMCs.

Cost-Effectiveness

This section uses program cost monitoring data and DID analysis to address the following evaluation question:

15. What is the cost-effectiveness of the GESI and CEA interventions compared with the standard capacity strengthening intervention?

> *We have heard about the existence of such committees [HFOMCs] but we don't know about the persons that are in there. They come for the meetings but we don't know who is in the meetings.*
>
> **FGD, mothers, Baglung**

Cost Estimate Calculations

Table 20 below summarizes the estimated costs of Approach A and Approach B. The total cost for Approach A was estimated at Rs 4,840,558 across Syangja district; the total cost for Approach B was Rs 8,813,793 across Baglung district.

Table 19. Estimated costs for Approach A (Syangja) and Approach B (Baglung), by level and activity

Level and Activity	Approach A (Syangja)	Approach B (Baglung)
National HFMOC TOT[1]	Rs 213,238	Rs 213,238
National CEA TOT[2]		Rs 82,150
District HFMOC TOT[3]	Rs 105,900	Rs 105,900
District CEA TOT		Rs 222,611
VDCs[4]	Rs 4,521,420	Rs 8,189,894
Total	Rs 4,840,558	Rs 8,813,793

[1] There were two national-level TOTs for HFMOCs. The total costs were split between Approach A and Approach B.

[2] The estimated cost of one national CEA TOT was Rs 46,943. A second training was conducted because of poor attendance, but the cost data were not collected from this second training. It is assumed that the cost of the second training was 75 percent of the cost of the first training (Rs 35,207), because the second training was not as well attended as the first training. The total cost of the two training events is Rs 82,105.

[3] The cost of the District NFMOC TOT was estimated for Approach B in Baglung but not for Approach A in Syangja, so the figure for Approach B HFMOC was used for Approach A.

[4] There are 66 VDCs in Syangja and 65 VDCs in Baglung. The cost estimation of activities only occurred in 11 VDCs, which were all Approach B sites. They were selected randomly.

If a national rollout of either program occurs, the cost estimate will require some assumptions. Syangja and Baglung represent an average district in terms of population (289,148 and 269,613, respectively) and the number of VDCs (66 and 65, respectively.) The 75 districts in Nepal range considerably in population (from 6,536 in Manang to 1.7 million in Kathmandu) and in the number of VDCs (from nine in Kanchanpur to 96 in Saptari).

The estimated cost of a national rollout of Approach A is Rs 233,434,346 or approximately US$2.3 million. The estimated cost of the national rollout of Approach B is Rs 438,884,713 or approximately US$4.4 million. Nepal's national health budget for 2014-5 was Rs 40.5 billion. The scale-up of Approach A is almost sixth-tenths of one percent of the national health budget (0.0058); Approach B is slightly more than one percent (0.0108). These amounts may seem inexpensive, but there are reasons to be cautious about this cost estimate. If one of these programs is rolled out nationwide, refresher training and additional

supervisory visits and coaching sessions are likely necessary. None of these potential extra costs are included. Nepal has limited financial latitude to expand health interventions. The public sector's health expenditure per capita in 2014–2015 was only $13, among the lowest in the world. Approximately one-quarter of its support comes from foreign assistance, in the form of basket funds.

Table 20. Calculation of estimated cost of national scale-up

	Approach A	Approach B	Factor[12]	Approach A (Product)	Approach B(Product)
National[9]	Rs 213,238	Rs 295,388	5	Rs 1,066,190	Rs 1,476,940
District[10]	Rs 105,900	Rs 328,511	75	Rs 7,942,500	Rs 24,638,325
Average cost per VDC[11]	Rs 68,506	Rs 125,998	3,276	Rs 224,425,656	Rs 412,769,448
Total Estimate of National Scale-Up				Rs 233,434,346	Rs 438,884,713
Health Budget 2014-5				Rs 40,563,027,000	
Percentage of Health Budget, 2014-5				0.58%	1.08%

[9] At the national level, the figure for Approach B is the sum of the costs of HFOMC and CEA activities at the national level (Rs 213,238 + Rs 82,150).

[10] At the district level, the figure for Approach B is the sum of the HFOMC and CEA activities at the district level (Rs 105,900 + Rs 222,611).

[11] At the VDC level, the figure for Approach A is the average cost of HFOMC activities, which is computed as the average cost across the 11 VDCs (Rs 753,570/ 11). The figure for Approach B is the average cost of the HFOMC and CEA activities, which is computed as the average cost across the 11 VDCs (Rs 1,385,982/ 11).

[12] Factor refers to the number of subnational units at the district (75) or VDC levels (3,276). In the case of the national level, factor refers to the number of times that the training would need to be held for a national rollout, which is assumed to be five. If the sessions are held five times and if at least15 trainers are in attendance, the training would cover the district level, which has 75 districts. This number may be low, but the contribution to the total cost of training at the national level is insignificant.

Table 21. Cost-effectiveness calculation inputs

Outcome	Difference between impact of approaches (B–A)	Difference between cost of approaches B and A (B–A)
Child's health ever checked	3.0%	Rs 3,973,235
Child's health checked in past six months	4.6%	Rs 3,973,235
Health provider discussed child's growth at last health check	2.6%	Rs 3,973,235

Table 22. Cost-effectiveness results

Outcome	Incremental Cost-Effectiveness Ratio (ICER) (Approach B versus A)
Child's health ever checked	Rs 1,319,560
Child's health checked in past six months	Rs 860,582
Health provider discussed child's growth at last health check	Rs 1,522,568

Appendix 5 provides details on the cost estimates and cost-effectiveness methods and assumptions.

DISCUSSION

This impact evaluation of Strengthening HFOMCs reveals improvements in selected outcomes related to health service use and quality under both program approaches, but mixed evidence of which approach fares better. Qualitative data show a slight improvement in the HFOMCs' functioning and communication with communities under both program approaches. The evaluation also identifies ongoing barriers to the HFOMCs' functioning, accountability, and relationships with health workers and the community. Challenges and delays in program implementation and design, and the presence of other health service interventions in Baglung, may have contributed to the mixed findings.

Impact on Service Use

There was a trend of child PNC among HF births staying the same or slightly declining. This trend may be caused, in part, by additional checks on PNC at end line, compared to baseline. However, this discrepency would be expected to affect all districts similarly, and so would not tarnish the DID results. DID results show that the program is protective against the decline among children. Women delivering at HFs in Baglung and in Syangja report a smaller decrease than the control areas for child PNC; surprisingly, however, the impact is slightly greater for child PNC in Syangja (0.13) than in Baglung (0.12). Although minor, it is possible that the difference is related to new health service delivery interventions. Near the time of baseline data collection, Baglung was selected by the GON as a CB-IMNCI district. In the CB-IMNCI districts, neonatal and child illness work has been combined and staff responsibilities have shifted. FCHVs are now tasked only with health promotion, field distribution of selected supplements and medicines, and referrals for health service to health workers (DOHS, 2017). PNC has been shifted to other trained health workers. The GON reported that in 2015 (DOHS, 2016), there were challenges with HF staff not wanting to do field visits because of the lack of per diem. It is possible that the CB-IMNCI program activity in Baglung changed the services enough such that the DID parallel trend assumption is invalid for Baglung, in comparison with Syangja and Parbat.

The DID results show positive program impacts on child wellness checks and growth monitoring. In general, there is a decline in all districts among women reporting child health checks, and health professionals discussing the child's growth, mirroring trends in national data on registration for growth monitoring (DOHS, 2017). Results show that the program is slightly protective against this decline in Syangja and Baglung. The protective effect is greater in Baglung than in Syangja, which suggests the added benefit of Approach B over Approach A. Qualitative results at end line find a difference in program areas, whereby HFOMC members conducted slightly more outreach than at baseline and compared with the control district. It is possible that this encourages women to take their children for wellness checks. However, the qualitative data show no difference between Syangja and Baglung; therefore, it is not clear why the impact is greater in Baglung. Given that Baglung is a CB-IMNCI district, the CB-IMNCI program may have contributed to child wellness checks.

Impact on Service Quality

The data show an increase in skilled attendance at birth in the three districts, although the increase is greater in Baglung, compared with the control districts indicating a positive program effect for Approach B. HF births also increased in all districts, but no program effect is found. Baglung's CB-IMNCI program may have contributed to the increase in skilled attendants at birth, because there is no other evidence from the qualitative data to explain why there is a differential impact in Baglung versus Syangja. There is a substantial decrease in women reporting ever receiving counseling on HTSP, although Syangja saw a smaller decrease than the control areas, and the DID analysis shows a positive program impact. One

possible explanation for the overall decrease in counseling is the changes in who is providing the services, and HTSP not being emphasized. While the DOHS does not report on HTSP counseling, there has been a gradual decrease in the number of FP methods distributed by FCHVs and a general sense that they are overburdened. The fact that HTSP counseling is not reported in the GON reporting system also means that staff are not held accountable for it. With the new CB-IMNCI program activities in Baglung, it is possible that HTSP is receiving less attention there, compared with Syangja.

The women's survey data show a decrease in satisfaction with services across all primary outcomes. There is a general shift downward from "very satisfied" to "somewhat satisfied" in all districts. However, this finding is not corroborated by the client exit interview data, which find improvements in client satisfaction, generally, and statistically significant improvements in specific program areas, such as clients reporting health workers to be less judgmental, compared with baseline and the control areas. The different survey mode (client exit interview versus HH survey) may account for the more positive results found in the client exit interviews. However, it could be that clients feel pressure to respond positively, given that the interview was conducted at the facility and the clients may have had knowledge of the program.

The general trend of declines in service use, quality, and satisfaction across multiple outcomes is disconcerting, but consistent with national data for some issues. For example, DOHS reported that the percentage of diarrhea cases treated with oral rehydration solution (ORS) or zinc declined over the past few reporting years, possibly due to unavailability of ORS and Zinc. This could explain the trend of a smaller % of mothers reporting seeking treatment for diarrhea; knowing medicines are unavailable could affect one's motivation to go to the health center. (DOHS, 2017). Nepal has experienced political upheaval, a fuel shortage crisis, and an earthquake in the past two years. It is likely that these shocks negatively impacted health service access and quality. The DID analysis controlled for such shocks, and would therefore not be affected by them; however, the general trend data are not similarly cushioned.

Impact on Health Outcomes

As discussed above, there is no evidence of program impact on health outcomes, other than skilled attendant at birth.

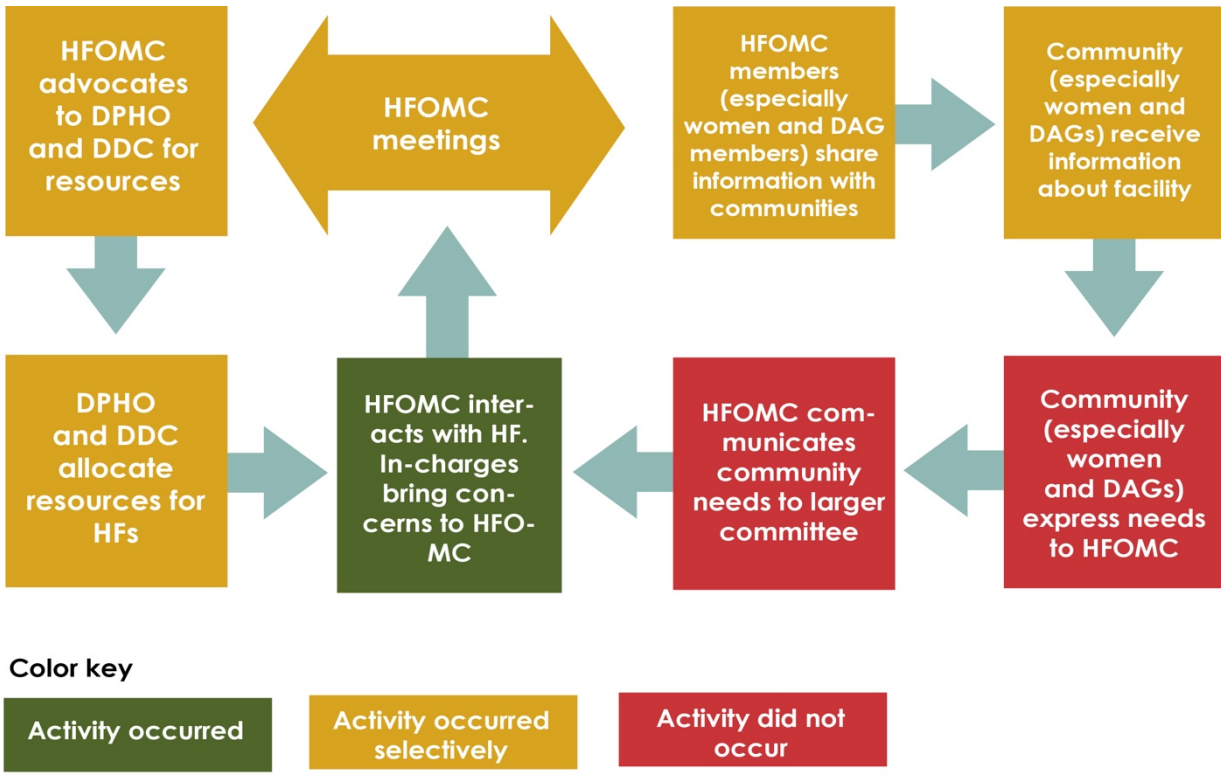
HFOMC-Level Processes and Outcomes

The qualitative data show that the HFOMCs' functioning, accountability, and community collaboration improved slightly in program areas, compared with the control area and baseline, although challenges remain. Meeting frequency increased initially after the training, but dropped off over time. There is an increase in the HFOMC members' awareness of their roles and responsibilities in program areas, compared with the control areas and baseline. Some female and DAG members report increased confidence in being able to raise their points during the HFOMC meetings. Some DAG members also have greater awareness of their responsibility to represent the interests of their marginalized communities. There are also more reports of community collaboration for community events on behalf of HFs in program areas, compared with baseline and the control areas. Nevertheless, community members' awareness and knowledge of the HFOMCs did not change since baseline. There are no differences between Syangja and Baglung concerning any of these issues.

The qualitative and process monitoring data show that many of the anticipated HFOMCs' activities, the essential processes on the path to desired outcomes, did not occur regularly or did not occur at all. This may have contributed to the evaluation's mixed results. Figure 17 illustrates how the major functions of the HFOMCs were implemented, according to the evaluation data. The social accountability components (see red in figure below) are notably lacking. Other studies of HF committees find similar challenges with the data collection and information sharing components of such interventions (Lodenstein, et al., 2017), even in

the face of HFOMC and community statements of the need for such a mechanism. The other activities (in yellow) did happen, but on an ad hoc basis only, and they were typically undertaken by individual HFOMC members.

Figure 17. Performance of essential HFOMC functions according to qualitative data



Program implementation challenges and local resource constraints may have contributed to activities and outcomes not occurring systematically. Political issues and extreme weather led to delays in program implementation and, in some cases, incomplete implementation. HFOMC members report that government agencies were unable to respond to the resource demands that they placed. The program was designed as a set of activities that were required to affect change in short and long-term outcomes, as outlined in the results chain for Approaches A and B (Appendix 2. Results chain for components A and B). The missing program inputs presumably negatively affect the downstream results.

Implementation delays meant decreased time between the end of the program and end line data collection. In consultation with the program and USAID/Nepal, the dates for end line data collection were rescheduled to allow for a minimum of six months of HFOMC activity after the conclusion of program implementation (May 2016). It was assumed that this would allow time for the HFOMCs to implement the processes in each approach, leading to changes in outcomes. However, it is possible that this time was not sufficient for the processes to roll out because HFOMC members were occupied with other responsibilities, and district health officials have big workloads, as the qualitative and program data indicate. Approach B is more complex because it involves greater community mobilization and coordination. It is therefore understandable that Approach B would be more sensitive to the timeline than Approach A.; it is possible this contributed to the minimal differences seen in the outcomes of the two approaches.

In general terms, the program approach may not have offered sufficient ongoing support, especially for the more demanding CEA component, including reinforcement of essential concepts and roles to ensure that the HFOMCs could follow through on their own. The results show that HFOMC members typically could

not recall the content of the training, and that there were limited changes in HFOMC activities and community awareness, compared with baseline and the control. The program tried to manage a delicate balance of 1) minimizing resources and effort so that program activities could be scaled up and sustained, and 2) affecting positive change. It is possible that the program erred too much on the side of resource minimization, given the educational and workload barriers reported by respondents. Other HFOMC capacity building work in Nepal has shown greater improvement in HFOMC functioning and GESI outcomes, but was implemented over a three-year period, with monthly HFOMC visits during the first two years; visits were spaced out to three- to four-month intervals in the final year (Gurung, 2013). Also, a systematic review of similar interventions suggests that having an external party available to facilitate HFOMC interactions with the community for a limited period after training may be helpful (McCoy, Hall, & Ridge, 2012).

The lack of resources for activities proposed by the HFOMCs is also a major limitation. HFOMC members expressed frustration about making requests for changes that required funds or other resources and being told that the government did not have what was requested. Although trained by the program, many HFOMC members do not know who to contact at a higher level to resolve issues. This, in turn, soured HFOMC members' commitment to their work and the communities' trust in the HFOMCs as a bridge to health services. Nepal has been stalled in its operationalization of decentralization. Assuming decentralization rolls out, however, this could shift more resources towards HFOMCs and alleviate the challenges with resources.

Changing Structure of HFOMCs

There is new 2017 MOH guidance removing the 2014 requirement of including dalit and janajati members on HFOMCs (MOH 2017). This change comes after limited effort had been made to implement the former policy to support the new DAG members on HFOMCs. It is unclear what influenced this change, but it threatens to undermine the emerging improvements found in this evaluation.

Cost-Effectiveness Results

Estimates of costs, cost-effectiveness analyses, and ICERs can be used to provide guidance to policy makers in the following ways:

1. When the effect or outcome is specified by policy makers, the ICER can help understand how to minimize expenditures needed to achieve the target effect or outcome specified.
2. When a budget constraint is specified by policy makers, the ICER can help understand how to maximize health benefits while keeping within budget.
3. When policy makers are able to specify a threshold for what should be considered cost-effective, (i.e., the amount of money the GON is willing to spend to gain one unit of the outcome) the ICER can be compared to that specified threshold.

Without reference to such specifications or decisions, ICERs cannot be used independently to make recommendations to policy makers on investment decisions. However, since Approach B has been deemed more cost-effective, in the context of a fixed budget, we could say that it would yield more health benefit (more children with health ever checked, more children with their health checked in the past six months, and an increase in health providers discussing child's growth at last health check) than with Approach A.

Although health officers and officials want to see outcomes improved, cost-effectiveness is only one criterion for the ministry, government, or donor. The Government of Nepal and Ministry of Health and Population have limited financial and human resources to dedicate to a list of interventions that must be implemented. The 2016 GDP in Nepal is 21.144 billion USD (Rs. 2,248.691 billion) and the GDP per

capital in Nepal is 733.665 USD (Rs. 77,988.550). According to the Government of Nepal's 2015–2016 Economic Survey, produced by the Ministry of Finance, the health sector's share of the GDP was an average of 1.735 percent. Because poor health has negative economic impacts, investments in health can contribute to economic development and the GDP. It is widely held that interventions that have ICERs that are less than 3 times the per capita GDP are considered cost-effective; ICERs less than one time the per capita GDP are very cost-effective (Robinson, Hammitt, Chang, & Resch, 2016). Given the GDP per capita of Nepal, the ICER for Approach B (compared to Approach A) would be considered very cost-effective using this threshold.

CONCLUSIONS

- The evaluation documents a small plausible program impact on the use of child growth monitoring services and their quality. However, the higher impact in Baglung, compared with Syangja, may be due to the former's exposure to other health interventions. The results for other outcomes are not systematic, and triangulation of the qualitative data does not explain them. It is possible that they are due to contamination by other ongoing health service interventions in the program areas, such as the CB-IMNCI program.
- Qualitative data show that the intervention had small, but promising effects on the HFOMCs' functioning, communication, and collaboration with the communities. There are no differences between Approaches A and B. Both approaches have long causal pathways, especially Approach B. There may not have been sufficient time for the effects to play out, given the short length of the program (roughly one year).
- Although the impact analysis shows no significant difference in outcomes by DAG status, changes were observed by the qualitative component at the HFOMC level related to GESI integration. Some women and DAGs reported increased confidence and participation in HFOMC proceedings, sharing of health service information with others in the community, and awareness of their role in representing the needs of marginalized persons. It is likely that larger effects require more time to take shape.
- The HFOMC-level effects had already started to wane (e.g., decreases in meeting frequency) by the time of end line data collection. Many HFOMC members reported not remembering the content of training.
- The CEA component cannot be effective with only the training events engaging communities and the HFOMCs. Community meetings were supposed to assist with community engagement, but they rarely occurred. It may not be feasible for HFOMC members to handle community meetings alone at the beginning, when the effort and learning are greatest, and because of competing workloads and educational barriers. A systematic review of similar interventions suggests that having an external party available to facilitate HFOMC interactions with the community for a limited period after training may be helpful (McCoy, Hall, & Ridge., 2012).
- While the HFOMCs made decisions, they require government support to implement their decisions, and a clear understanding of the processes they need to follow to get support. This support is essential to foster change and to maintain the HFOMCs' motivation and the communities' perception of accountability.

RECOMMENDATIONS

- Given the long causal pathways and the experience of similar studies (e.g., Gurung, 2013), HFOMC capacity building and CEA activities should allow intervention exposure times longer than one year.
- In order to achieve participation in HFOMC meetings and sharing health information by women and DAGs, programs and funders should advocate with the government to reestablish the GESI integration requirements for the HFOMCs, with participation from DAGs. The guidelines were recently revised and removed this requirement. Also, issues raised in HFOMC meetings should be recorded (what is the issue, who raised it, next action steps, etc.) and follow-up should be required and recorded.
- Capacity building should be implemented as a continuous process with periodic follow-up, coaching, and refreshers. Follow-up should be more frequent in the initial one to two years, every one to two months, but then can be spaced out over time as HFOMCs show greater capacity.
- Consider adding a component to the CEA approach such that an external person co-leads several community outreach events with the HFOMCs for a period after the CEA training.
- To enable HFOMCs to obtain government support, future programs should set out clear processes and provide contact information, in collaboration with district health authorities, so that the HFOMCs may make requests for support in implementation of their decisions.

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APPENDIX 1. DEFINITIONS

The following are important definitions for understanding the intervention and its evaluation.

Gender equality: Gender equality is the state that provides women and men equal enjoyment of human rights, socially valued goods, resources and opportunities. True equality goes beyond parity in numbers or laws; it means that there are expanded freedoms and improved quality of life for everyone (IGWG, 2013).

Social inclusion: Social inclusion is the removal of institutional barriers and the improvement of incentives to increase the access of marginalized individuals and groups to development opportunities. In the health sector context, it means equal and equitable access to basic health services (MOHP, 2009).

DAGs: For the purposes of this study, DAGs are defined according to caste or ethnicity. Table 23 presents the specific castes/ethnicities included in the study definition.

Table 23. Castes/ethnicities included in the study definition of DAGs

Dalits
Hill Dalit
Kami, Damai/Dholi, Sarki, Badi, Gaine, and unidentified Dalits
Tarai/Madhesi Dalit
Chamar/Harijan, Musahar, Dushad/Paswan, Tatma, Khatwe, Dhobi, Baantar, Chidimar, Dom, and Halkhor
Janajati
Hill/Mountain Janajati
Tamang, Kumal, Sunuwar, Majhi, Danuwar, Thami/Thangmi, Darai, Bhote, Baramu/Bramhu, Pahari, Kusunda, Raji, Raute, Chepang/Praja, Hayu, Magar, Chyantal, Rai, Sherpa, Bhujel/Gharti, Yakha, Thakali, Limbu, Lepcha, Bhote, Byansi, Jirel, Hyalmo, Walung, Gurung, and Dura
Tarai Janajati
Tharu, Jhangad, Dhanuk, Rajbanshi, Gangai, Santhal/Satar, Dhimal, Tajpuriya, Meche, Koche, Kisan, Munda, Kusbadiya/Patharkata, and unidentified Adibasi/Janajati
Muslims
Madhesi Muslim and Churoute (Hill Muslim)

APPENDIX 2. RESULTS CHAIN FOR APPROACHES A AND B

Note: components in **blue apply only to Approach B.**

Inputs	Outputs	Short- to Medium-Term Outcomes	Outcomes/Impact
• HFOMC handover and orientation • HFOMC capacity self-assessment • Three-day GESI-enhanced HFOMC training • Follow-up and supportive monitoring • Promotional activities • Community engagement activities	• HFOMCs formed, with required quota of women and DAGs; handover and orientation carried out. • HFOMC capacity building needs identified. • HFOMCs trained on standard curriculum plus GESI components and community engagement. • Bi-monthly support meetings conducted to assist the HFOMCs with capacity strengthening and institutionalization of GESI. • Communication activities completed to create awareness among people about HFs, health services, and the HFOMCs. • Community engagement activities implemented, including community mapping and bridging the gap, and community-based organizations trained on the HFOMCs and community participation.	**Committee level:** HFOMCs have improved knowledge of HFs and services provided; they have greater capacity to mobilize resources, manage HF staff, evaluate service quality, incorporate GESI components, and conduct community engagement activities. HFOMCs have greater capacity to explore community needs via CEA, and are more responsive to reducing stigma and incorporating input from women and DAGs. **Community level:** Community members know the functions, members, and accountability mechanisms of the HFOMCs and the services provided by HFs. Women and DAGs participate in and feel empowered to contribute to monthly meetings with the HFOMCs; they feel that the HFOMCs are responsive and advocate for their needs. **HFOMC-community relations:** A bi-directional information flow helps the HFOMCs and communities to identify issues and develop action plans to address the needs of DAGs and women. **HF level:** HF staff know the functions, members, and accountability mechanisms of the HFOMCs. HFs are committed to improving MNCH/FP service quality and equity. **HFOMC-HF relations:** HFOMCs and HFs work together to address the needs of DAGs and women and improve quality of MNCH/FP services. HF staff support the HFOMCs in monitoring and supervision, data collection, and community engagement activities. **District level:** Stakeholders support the HFOMCs in their operations and management while helping them to overcome barriers to service provision at the district level.	Increased client satisfaction. Overall increased/improved quality and use of MNCH services. Improved provider performance in the delivery of MNCH services for DAGs. For DAGs, increase in the use of the following services: • Facility births • PNC • ANC • FP (HTSP) ○ Well-child visits ○ Child illnesses (diarrhea, acute respiratory infection, etc.) ○ Growth monitoring Improved infant and young child feeding practices among DAGs.

APPENDIX 3. COMPLETE METHODS

Ethical Review and Protection of Human Subjects

The University of North Carolina at Chapel Hill Institutional Review Board and the Nepal Health Research Council Review Board approved all components for the baseline and end line surveys. Approval was also obtained from the Family Health Division of the MOHP in Nepal, and from the Social Welfare Council of the GON for the quantitative surveys. Interviews and discussions were conducted only after obtaining informed consent from respondents. In the case of the few women who were under age 18, informed consent was obtained from the respondent and from a parent or guardian. All interviews and group discussions were held in private locations.

Translation and Refinement of the Data Collection Instruments

Translation and refinement of the data collection instruments were carried out through an iterative process, which involved an initial translation by a group of social scientists followed by multiple rounds of pretesting and revision. This rigorous process ensured that the translated instruments were easily understood by respondents and measured the concepts that the original English language questions intended to measure.

Quantitative Methods: Additional Details

Sample Size Estimation and Sampling Methods

The percentage of women reporting a HF delivery for their most recent live birth was selected as the main outcome to power the research. The sampling plan for the quantitative component of the baseline survey involved sampling everyone, but inflating the sample size to ensure that the subgroup of interest (DAGs/poor) was sufficiently large to detect differences for that subgroup over time. Under this plan, we could look at differences between DAGs/poor versus non-DAGs/poor to see if the gap between them has narrowed. The sample sizes given in Table 24 were calculated using a difference of 0.06 between each intervention group at end line. We chose 0.06 to keep the sample size large enough to maintain the option of using the DID technique for estimation of impact and to inflate the sample size.

Table 24. Sample size requirements

Indicator	Groups Sampled	Expected Values at End line			Sample Size <2 Needed per District	HHs Needed to Screen per District	Final Sample by Group per District		Total Sample Size <2 Needed	Total HHs Needed to Screen
		Parbat	Syangja	Baglung			Other	DAGs or Poor		
HF birth, last 2 years	All	0.43	0.49	0.55	1,400	9,311	529	871	4200	27,932

Notes: Assumptions:

1. Sample sizes calculated with power=0.8, alpha=0.05, and one-tailed test.
2. Sample size is for baseline only; end line is same size repeated in same communities.
3. Parbat values in tables reflect the 2011 Demographic and Health Survey (DHS) values in the Western Region (Western Hills region had too few people in the subgroups to be considered valid) (MOHP, New ERA, and ICF International Inc., 2012.); we assumed as the control that there will be negligible change from baseline to end line.
   DAG levels based on data from Dalits, Janajatis, and Muslims in 2011 Nepal DHS.
   Poor levels based on data from lowest wealth quintile in 2011 Nepal DHS.
4. Design effect of 1.6 applied.

The sampling frame for the intervention and control groups was created using the 2011 National Population and Housing Census data; voter registration lists; and confirmations from female community health workers, members of Ward Nagarik Manch (Ward Citizens' Forums), and other knowledgeable persons. The sampling frame for Approach A consisted of VDCs in Syangja. The sampling frame for Approach B consisted of VDCs in Baglung. The control group consisted of VDCs in Parbat, where there were no project activities. The sample was selected using a stratified, three-stage cluster design. For the first stage, in each approach area (district), VDCs were selected using the equal probability of selection method (EPSEM) sampling. We selected 19 VDCs in Baglung, 17 in Syangja, and 29 in Parbat. Equal probability of selection method sampling was then used to select five of the nine wards/census EAs in each VDC selected in the first stage (the number of required VDCs and wards/EAs was calculated based on the projected number of women with children under age two in each ward/EA, according to the 2011 Nepal DHS). In the final stage, all eligible women in a selected ward/EA were chosen for an interview. This ensured a self-weighted sample.

Table 25 summarizes the number of VDCs/municipalities and wards in each district.

Table 25. Number of VDCs/municipalities and wards, by district

District	Total Number of VDCs/Municipalities	Number of Selected VDCs/Municipalities	Number of Selected Wards
Baglung	60 (59+1)	19	95
Syangja	62 (60+2)	17	85
Parbat	55	29	145
Total	177	65	325

Table 26 presents the number of eligible HHs and women identified during the HH listing.

Table 26. Total number of HHs listed, eligible HHs, and eligible women, by district

District	Total Number of HHs listed		Number of HHs with at least one woman with a child under 2 years of age		Number of women with a child under 2 years of age	
	Baseline	**End line**	**Baseline**	**End line**	**Baseline**	**End line**
Baglung	8017	9247	1318	1389	1379	1447
Syangja	9193	9428	1134	1124	1175	1158
Parbat	8056	8976	1352	1307	1390	1345
Total	25266	27651	3804	3820	3944	3950

Quantitative Fieldwork and Training

Quantitative fieldwork and training for baseline and end line data collection were implemented at the local level by the Institute for Social and Environmental Research-Nepal (ISER-N) in collaboration with the Family Health Division of the GON, Social Welfare Council, the local community, and a consultant appointed by MEASURE Evaluation at the University of North Carolina at Chapel Hill. Baseline data collection took place between July and October 2014 in the three districts of Baglung, Syangja, and Parbat. End line data collection was conducted from November 20, 2016 through February 14, 2017.

Interviewer Training

ISER-N staff served as district managers and team leaders in each district. These staff were well trained in survey research methodology, and had worked for ISER-N for five to 20 years. Interviewers were recruited from local areas. They underwent a two-week training in general interviewing techniques and study-specific techniques. Topics covered included roles and responsibilities of interviewers, protection of human subjects, interviewing techniques, data recording/data entry procedures, data management, data collection protocol, and question by question objectives. The training allowed for field practice and practice interviews, with an average of 16 practice interviews for baseline training and 16 for end line training.

Survey Content

Table 27 summarizes the content of the quantitative surveys.

Table 27. Quantitative instruments (modules)

Community Survey	HH Survey	Women's Survey
1. Basic community characteristics 2. Health service availability 3. List of health and FP workers 4. List of depot holders 5. List of doctors and pharmacies 6. Economic shocks	1. Demographics and HH composition 2. HH wealth/assets 3. Economic shocks and coping strategies 4. HH health expenditures	1. Demographics and child health 2. Infant and child feeding practices 3. Pregnancy, facility births, and postnatal care 4. FP 5. HFOMC and other health activity exposure and opinions 6. Women's decision making 7. HH food security and dietary diversity 8. Social inclusion and group membership 9. Access to information

Data Collection and Management

The baseline and end line surveys were implemented by a team consisting of one district manager, three team leaders, and 18 to 25 interviewers in each district. The HH and women's survey interviews were conducted by small teams of five to seven interviewers, with each team headed by a team leader. All interviews done as part of the women's survey were conducted by female interviewers.

Each completed questionnaire was thoroughly checked by the interviewer for completeness and consistency. Any discrepancies and incompleteness identified at this point were resolved by immediately revisiting the respondent.

At baseline, once the interviewer returned to the field office, the questionnaires were cross-checked by other interviewers. Twenty percent of completed questionnaires were then checked by the district manager. The questionnaires were forwarded to the central office in Chitwan for data entry.

Data entry was performed at ISER-N's data entry and processing department. All questionnaires were entered twice (double entry) to avoid keying errors and using a data entry program specifically designed for this purpose. All questionnaires were matched with the data collection control file following data entry to ensure that all were entered. A set of quality control tables was generated on a regular basis. Once data entry was completed, a standard codebook was prepared. Separate data files for community, HH, and women's survey interviews were created.

At end line, after checking by the interviewer, the community surveys were thoroughly checked by the district manager and any discrepancies were resolved. Data entry was performed at the ISER-N central office. As with the baseline data, questionnaires were matched with the data collection control file following data entry to ensure that all questionnaires were entered.

For the HH and women's surveys (both administered in Computer-Assisted Personal Interview), completed interviews were submitted online as soon as internet access was available. Submitted interviews were then checked by the team leader and district manager before being uploaded to the ISER-N server.

Quantitative Data Analysis

We conducted the analysis of baseline and end line data using Stata, the statistical analysis package. The impact of Strengthening HFOMCs on the use of services, their quality, and selected MNCH outcomes was determined using the DID model. This model identifies the impact of a program as the difference between a sample of participants and a control of non-participants in terms of the trends that each experienced in an outcome from baseline (before program implementation) to end line (after program implementation). The basic assumption of DID analysis is that the program group would, in the absence of the program, have experienced a trend parallel to that of the control group. This is referred to as the "parallel trend assumption."

If the parallel trend assumption is violated, the DID model may yield inaccurate inferences about program impact. As a solution, we controlled for differences in the trend experienced by the comparison group and what the program group would have experienced in the absence of the program. We did this with a regression version of the DID model that controls for changes in time in observed factors (such as community shocks and HH wealth) and that could cause deviation from the "no program" trend.

For our estimation of the average effect of treatment on the treated, we estimated the regression model:

$$Y_{ijt} = \beta_0 + \beta_1 \cdot P_j^B + \beta_2 \cdot P_j^S + \beta_3 \cdot t + \beta_4 \cdot P_j^B \cdot t + \beta_5 \cdot P_j^S \cdot t + \beta_6 \cdot X_{ijt} + \varepsilon_{ijt}$$

where

$$i \text{ indexes individual respondents}$$

$$j \text{ indexes their communities}$$

$$t = \begin{cases} 1 \text{ if the observation is drawn from the endline survey} \\ 0 \text{ if the observation if dra□n from the baseline survey} \end{cases}$$

$$P_j^B = \begin{cases} 1 \text{ if cluster } j \text{ is in Baglung} \\ 0 \text{ if cluster } j \text{ is not in Baglung} \end{cases}$$

$$P_j^S = \begin{cases} 1 \text{ if cluster } j \text{ is in Syangja} \\ 0 \text{ if cluster } j \text{ is not in Syangja} \end{cases}$$

and

$$X_{ijt} \text{ are individual, HH, and community characteristics relevant to woman } i \text{ in community } j \text{ at time } t.$$

The terms in this regression each offer a key control for the DID model. $\beta_1 \cdot P_j^B$ controls for fixed differences between Approach A in Baglung and the comparison group, and $\beta_2 \cdot P_j^S$ does the same between Approach B in Syangja and the comparison group. $\beta_3 \cdot t$ represents the common time trend between the program and comparison groups. $\beta_4 \cdot P_j^B \cdot t$ captures the program impact for Baglung (it is the difference in the observed trend between the program and comparison group) and $\beta_5 \cdot P_j^S \cdot t$ captures the program impact for Syangja. Finally, the $\beta_6 \cdot X_{ijt}$ controls for factors that might otherwise provide the source for a violation of the parallel trend assumption. In practice, we controlled for age, education, community shocks, access to ANC and delivery services, access to FP commodities, and

socioeconomic status. Impact evaluation results for the DAGs subgroup were generated by including interactions between indicator variables for membership in this subgroup and these first six terms. The following was added to the above equation:

$$+\gamma_0 \cdot DAG_{ijt} + \gamma_1 \cdot DAG_{ijt} \cdot t + \gamma_2 \cdot DAG_{ijt} \cdot P_j^B + \gamma_3 \cdot DAG_{ijt} \cdot P_j^S + \gamma_4 \cdot DAG_{ijt} \cdot P_j^B \cdot t$$

$$+\gamma_5 \cdot DAG_{ijt} \cdot P_j^S \cdot t$$

where

$$DAG_{ijt} = \begin{cases} 1 \; if \; woman \; i \; at \; time \; t \; i \square \; community \; j \; is \; a \; DAG \\ 0 \; otherwise \end{cases}$$

The impact evaluation models were estimated as a linear probability model. To address the heteroskedasticity problems inherent with the linear probability model, we estimated the standard errors by cluster-based bootstrapping.

Qualitative Methods: Additional Detail

Four VDCs were purposively selected in each of the three districts (12 total) for qualitative data collection at baseline and end line. We conducted data collection in one HF per selected VDC (12 HFs total). The VDCs and HFs were purposively selected to cover a mix of HF types (e.g., health post, sub-health post), DAG mapping results, and distance from the district headquarters (near and far). The VDCs were selected from the list of corresponding EAs that had been selected for the quantitative data collection. Individual respondents for the qualitative components were selected using stratified purposive sampling methods. The list of sites is provided in Appendix 9. Information sources.

Tool Content and Method Implementation

Baseline qualitative data were collected through FGDs with community members, KIIs with district-level stakeholders, KIIs with HF staff, client exit interviews with female clients coming for MNCH services, facility observations, and observations or meeting minutes from HFOMC meetings. At end line, qualitative data collection used the same methods as at baseline, with the addition of KIIs with program staff and FGDs with HFOMC members, which included the MSC method.

Community FGDs

Community FGDs were conducted at baseline and end line with groups of eight to ten mothers and fathers with children less than 2 years of age. Each FGD lasted 60 to 90 minutes. Respondents who fulfilled the selection criteria were chosen from randomly selected wards in each VDC. With the help of the HF in-charge, FCHVs, and local people, "1,000 days" mothers were identified and located in each ward selected. The identified participants were informed about the evaluation, the purpose of the FGDs, the time required, and other issues. The process ensured that the FGDs included women from all castes/ethnic groups in the community.

In-Depth Interviews

The IDIs were conducted with two members of the HFOMC in each HF, i.e., one DAG member of the HFOMC, and one female member of the HFOMC. Respondents were identified at the HF level. The interviews generally lasted 45 to 60 minutes. They explored individual HFOMC member's experience, understanding about her role, linkages between the HFOMC and the communities, HFOMC meetings and activities, and engagement with district-level staff. The IDIs yielded a comprehensive view of the behavior, attitudes, and motivation of female and DAG HFOMC members.

Key Informant Interviews

The KIIs were conducted with the DDC official, DPHO official, Nepal Health Technical Committee official, HF in-charge, HFMOC members, and Suaahara project staff. District-level officials were the officer-in-charge from the agencies responsible for the HFs. The selection of the HF in-charge was done at the HF level. The interviews were 45 to 60 minutes long. The purpose of these KIIs was to gauge district-level support for and engagement with the HFOMCs, and to determine whether this has brought about changes over time. The key domains covered in the interviews were interactions/engagement with the work of the HFOMCs; knowledge and understanding of the HFOMC's role and functions; attitudes towards health planning and the HFOMCs; perceptions about the inclusion of community priorities in health services; impact on healthcare use; and perceived quality and responsiveness of healthcare personnel at the selected HFs.

Client Exit Interviews

Client exit interviews were conducted with clients who used MNCH services in the 12 selected VDCs at baseline and end line. The 45-minute exit interviews collected information on service quality. The clients were identified on their arrival in the HF. The clients were selected "1,000 days" women who used MNCH services (ANC, PNC, delivery, growth monitoring, and treatment of sickness in children under 2 years), and female clients of reproductive age (including "1,000 days" women) who used FP services. The clients were contacted when they were leaving the HF following completion of treatment. They were informed about the study and their participation to obtain their oral consent. After obtaining oral consent, respondents were taken to a private location outside the HF for the interview. Key discussion domains included in the interview were coverage of MNCH, privacy, provider's attitude, client satisfaction with services, length of wait time and consultation, and cleanliness.

Observations (HF and HFOMC Meetings)

Observations at the HFs and at HFOMC meetings were conducted at baseline and end line. HF observations were done at all facilities visited during outpatient hours, from 10 a.m. until 2 p.m. The HF observations collected information on service quality by noting the patient wait time (especially if it varied by caste/ethnic group/etc.), noise level (and related privacy of provider-client discussions), staff interactions with clients, and the availability of free essential medicines and basic essential equipment.

The objective of observing HFOMC meetings was to examine how they were conducted and levels of participation (at baseline), and to observe any changes taking place in HFOMC functioning, capacity, and GESI integration (at end line). Observation of the meetings was done in their normal meeting setting, organized at a regular schedule, which lasted around one hour from beginning to end. The plan was to observe HFOMC meetings in all 12 sites; however, this was not possible because not all HFOMCs had meetings during the study period. At baseline, two HFOMC meetings were observed and meeting minutes

were obtained from another eight. At end line, observations were done at two HFOMC meetings and meeting minutes were obtained from another six.

Most Significant Change

The MSC method was used at end line only in the FGDs with HFOMC members. The objective was to explore the significant changes that had occurred in the lives of HFOMC members and the community members as a direct result of participating in the program or because of the program's interventions. Although the initial idea of administering this tool was to conduct FGDs with HFOMC members and to collect stories of change from the community, it did not happen as planned. For several reasons, such as the limited time of the HFOMC members and their limited skills in facilitating discussions, the Research Inputs and Development Action International (RIDA) staff themselves conducted the discussions with community members. RIDA then took the collected stories to the HFOMC members for group discussion.

Qualitative Fieldwork, Training, and Pilot Testing

Qualitative fieldwork and training were implemented by RIDA. Baseline data collection took place from July to August 2014 and end line data collection took place from December 2016 to January 2017.

For the baseline and end line surveys, RIDA's in-house researchers served as field supervisors. Additional staff were selected based on their qualifications to conduct qualitative evaluations. Twenty-one evaluators were selected for the baseline team and 19 for the end line team.

Interviewer training was conducted for baseline and end line data collection. Data collector training at baseline was a two-day training, which covered sessions on the objectives of the evaluation, gender and social inclusion, tool review, and human subjects research ethics. The training also included practice sessions to conduct mock IDIs and FGDs. At end line, data collector training consisted of an orientation meeting in November 2016 and a four-day training, during which the data collection tools and the timeline for data collection were reviewed.

After the training, pilot testing was conducted for the baseline and end line surveys. At baseline, four days of pilot testing was conducted in Waling Primary Health Center (PHC), Syangja. During pilot testing, all data collectors were provided with an opportunity to use at least one evaluation tool. After the pilot, the team also practiced transcribing and translating the discussions/interviews. Field notes and transcripts were thoroughly reviewed by RIDA and the MEASURE Evaluation team, and the evaluators were provided with feedback to sharpen their skills and prepare for data collection.

At end line, pilot testing was conducted in Putalibazaar municipality, in Karendanda, Syangja. All tools, except for the KII tool, were used in the pilot. End line pilot testing followed the same procedures as in baseline.

Data Collection and Management

Quantitative data collected on observation forms and in client exit interviews were entered in the Statistical Package for the Social Sciences (SPSS) software using a data entry template. Qualitative data collected through observations and client exit interviews, such as explanations/remarks, were compiled using a template developed in Microsoft Word. For qualitative tools, audio records were transcribed in Nepali and translated into English. To standardize transcription, the team held a transcription training. The transcriptions were all translated into English.

A data quality check and correction mechanism were initiated during training and continued throughout the data collection. This also served to build the capacity of the field team. The mechanism had four stages: pretesting, pilot testing, first round of data collection, and second round of data collection. During each stage, supervisors and central team members observed the evaluation procedure, noted important data quality checks/assurance points, and suggested corrective mechanisms accordingly.

Data Analysis and Report Writing

For the baseline and end line surveys, RIDA staff carried out the data analysis. They coded the qualitative transcripts at end line using the Atlas.ti software. RIDA staff synthesized the analysis and implementation information in a final qualitative report to MEASURE Evaluation. MEASURE Evaluation then synthesized the findings from the qualitative and quantitative reports in this report.

Limitations: Additional Information

Table 28 presents the data from the quantitative component in Parbat concerning women who had relations with persons and institutions in the two program areas.

Table 28. Women's report of having relations with Baglung and Syangja (Parbat only), by survey wave and social status

Baseline	DAG %	Non-DAG %	All women %
Any family, friends, relatives in Baglung/Syangja district?	56.1	65.7	61.3
Visit health institutions in Baglung/Syangja?	27.5	34.8	31.5
Any HH member work/have business in Baglung/Syangja?	4.3	6.4	5.5
End line	**DAG %**	**Non-DAG %**	**All women %**
Any family, friends, relatives in Baglung/Syangja district?	50.1	60.3	56.0
Visit health institutions in Baglung/Syangja?	28.4	29.2	28.8
Any HH member work/have business in Baglung/Syangja?	4.7	5.9	5.4

APPENDIX 4. IMPLEMENTATION PROCESS MONITORING METHODS

Objective

The objective of implementation process monitoring was to document the functioning of Strengthening HFOMCs' two approaches in practice, focusing on **implementation,** which includes **fidelity** (to the intervention approaches as planned), **dose** (intensity of the interventions delivered, including geographic variation in the project areas), and **reach** (extent of participation by the intended beneficiaries). We also gathered information on any adaptations made to the interventions. We sought to understand the context in which the interventions were conducted (e.g., knowledge and understanding of the HFOMCs' role and functions), and the mechanisms of action (e.g., interaction/engagement with and attitudes towards the HFOMCs). Our approach is based on the UK Medical Research Council (MRC) guidance for process evaluations of complex interventions (Moore, et al., 2015).

Approach

The implementation process monitoring was achieved through review of project HF monitoring data (i.e., service use), strengthening HFOMCs' monitoring data, and the KIIs with project field staff, government staff, and HFOMC members at end line. We reviewed the following documents:

- Findings of the HFOMC-CEA Program Monitoring in Baglung and Syangja Districts, report by Suaahara
- HFOMC Status Report for Syangja, Excel spreadsheet
- Record of the HFOMCs for the CEA component in Baglung, Excel spreadsheet
- HFOMC-CEA Progress Updates from October 2015, November 2015, and December 2015
- Notes from monitoring visits
- KIIs with district coordinators in Baglung and Syangja
- KIIs with field supervisors in Baglung and Syangja
- KIIs with program coordinators in Baglung and Syangja

Project Documents and Monitoring Data Reviewed

We systematically reviewed these materials to identify the specific intervention components that were planned and carried out. We then extracted as much information as possible on the description, dose, and reach of the interventions. We also extracted any available information on adaptations made and any pertinent information on the context in which the interventions were implemented.

The project experienced challenges in obtaining data from the field on several occasions, meaning that the process monitoring report did not cover the expected number of sites. Nevertheless, we synthesized detailed monitoring information from several sites, and developed a spreadsheet to track the implementation of the interventions of interest. Table 29 presents the types of data that we extracted.

Table 29. Types of data extracted for implementation process monitoring

Intervention	Fidelity			Context/Notes/ Questions
	Dose	Reach	Adaptations	
General: Incorporate GESI in HF and services to address existing inequalities in health outcomes among women and DAGs **Approach A:** Integrate GESI in HFOMC training and support **Approach B**: Integrate GESI in HFOMC training and support, and add the CEA training (Approach A + CEA)	Record **progress in the rollout of the intervention** concerning completeness of the intervention, as planned, including geographic reach.	Record progress in the rollout of the intervention concerning **beneficiaries** reached.	Describe any **adaptations made to the interventions**, when made, and why made.	Describe any known contextual factors mentioned in reports that may have impacted the implementation or the outcomes of the intervention.

APPENDIX 5. DETAILED COST-EFFECTIVENESS METHODS

Cost Estimate Calculations

Table 30 summarizes the estimated costs of Approach A and Approach B. The total cost for Approach A was estimated at Rs 4,840,558 across Syangja district; the total cost for Approach B was Rs 8,813,793 across Baglung district.

Table 30. Estimated costs for Approach A (Syangja) and Approach B (Baglung), by level and activity

Level and Activity	Approach A (Syangja)	Approach B (Baglung)
National HFMOC training of trainers (TOT)	Rs 213,238	Rs 213,238
National CEA TOT		Rs 82,150
District HFMOC TOT	Rs 105,900	Rs 105,900
District CEA TOT		Rs 222,611
VDCs	Rs 4,521,420	Rs 8,189,894
Total	**Rs 4,840,558**	**Rs 8,813,793**

More than 90 percent of the total costs were concentrated at the subdistrict (VDC) level for both interventions. The cost data were collected from 11 VDCs in Baglung, which all implemented Approach B. The 11 VDCs were randomly selected. The costs were not correlated to the number of HHs in the VDC or to the distance from the district's administrative center. The costs were disaggregated into two categories: activities of Approach A and activities of Approach B. The sets of cost data were used to estimate the cost across both districts, Syangja (Approach A) and Baglung (Approach B).

If a national rollout of either program occurs, the cost estimate will require some assumptions. Syangja and Baglung represent an average district in terms of population (289,148 and 269,613, respectively) and the number of VDCs (66 and 65, respectively.) The 75 districts in Nepal range considerably in population (from 6,536 in Manang to 1.7 million in Kathmandu) and in the number of VDCs (from nine in Kanchanpur to 96 in Saptari).

Cost data exist at every level of government training for both programs. It is assumed that the national training would be repeated five times to familiarize central ministry staff with the intervention and to train trainers. If the sessions are held five times and if at least 15 trainers are in attendance, the training would cover the district level, which has 75 districts. While this assumption may be low, the cost of national training is negligible to the overall cost. At the district level, it is assumed that the cost in one district would be multiplied by the number of districts: 75. At the VDC level, which accounts for more than 90 percent of the total cost, the average cost per VDC in the 11 costed VDCs is multiplied by the total number of VDCs nationwide: 3,276. For Approach A, the average cost per VDC is Rs 68,502; for Approach B, the average cost per VDC is Rs 125,770.

Table 31 presents the calculations. The estimated cost of a national rollout of Approach A is Rs 233,434,346 or approximately US$2.3 million. The estimated cost of the national rollout of Approach B is Rs 438,884,713 or approximately US$4.4 million. Nepal's national health budget for 2014-5 was Rs 40.5 billion. The scale-up of Approach A is almost sixth-tenths of one percent of the national health budget (0.0058); Approach B is slightly more than one percent (0.0108). These amounts may seem inexpensive, but there are reasons to be cautious about this cost estimate. If one of these programs is rolled out nationwide, refresher training and additional supervisory visits and coaching sessions are likely necessary. None of these potential extra costs are included. Nepal has limited financial latitude to expand health interventions. The public sector's health expenditure per capita in 2014–2015 was only $13, among the lowest in the world. Approximately one-quarter of its support comes from foreign assistance, in the form of basket funds.

Table 31. Calculation of estimated cost of national scale-up

	Approach A	—Approach B	Factor	Approach A (Product)	Approach B (Product)
National	Rs 213,238	Rs 295,388	5	Rs 1,066,190	Rs 1,476,940
District	Rs 105,900	Rs 328,511	75	Rs 7,942,500	Rs 24,638,325
Average cost per VDC	Rs68,506	Rs 125,998	3,276	Rs 224,425,656	Rs 412,769,448
Total Estimate of National Scale-Up				Rs 233,434,346	Rs 438,884,713
Health Budget 2014-5				Rs 40,563,027,000	
Percentage of Health Budget, 2014-5				0.58%	1.08%

Both interventions involved a series of training sessions. Not surprisingly, nearly half of the estimated costs at the VDC level was per diem payments given to training participants, as shown in Table 32. This was true of both intervention: 43.8 percent of the total costs of Approach A at the VDC level were for per diem. The figure was 44.4 percent for Approach B. Donors have grown increasingly frustrated with the practice of paying per diem to training participants, which they view as a hidden labor subsidy. MOHs around the world tacitly accept the practice; they acknowledge that the payment of per diem offers an opportunity to augment the low salaries of their health workers, especially if donors are funding them. If the MOH chooses to roll out Approach A or Approach B nationwide, it might consider a review of its per diem policy.

Table 32. Per diem paid to participants as a share of the total cost at the VDC level for Approach A and Approach B (estimates for missing data are not included)

	Approach A		Approach B	
VDC	**Per diem paid to participants**	**Total Costs**	**Per diem paid to participants**	**Total Costs**
Bobang	Rs 18,800	Rs 47,065	Rs 37,000	Rs 86,475
Damek	Rs 6,400	Rs 43,193	Rs 25,300	Rs 86,278
Devistang	Rs 22,400	Rs 45,597	Rs 54,200	Rs 104,174
Dhudhilabhati	Rs 24,800	Rs 49,950	Rs 73,700	Rs 129,100
Hafiya	Rs 28,400	Rs 58,595	Rs 48,800	Rs 115,365
Hila	Rs 20,400	Rs 44,147	Rs 31,200	Rs 69,107
Kharga	Rs 22,000	Rs 45,083	Rs 43,900	Rs 93,963
Lekhani	Rs 25,200	Rs 59,857	Rs 53,500	Rs 131,375
Malma	Rs 22,000	Rs 45,333	Rs 36,400	Rs 82,618
Ranasinkiteni	Rs 24,000	Rs 54,180	Rs 37,200	Rs 96,470
Sukhaura	Rs 23,600	Rs 50,350	Rs 42,800	Rs 95,350
Totals	Rs 238,000	Rs 543,350	Rs 484,000	Rs 1,090,275
Ratio	43.8%		44.4%	

Additional details and assumptions for the cost estimate calculations are provided in Table 33.

Table 33. Estimated costs for Approach A (Syangja) and Approach B (Baglung), by level and activity

Level and Activity	Approach A (Syangja)	Approach B (Baglung)
National HFMOC TOT[1]	Rs 213,238	Rs 213,238
National CEA TOT[2]		Rs 82,150
District HFMOC TOT[3]	Rs 105,900	Rs 105,900
District CEA TOT		Rs 222,611
VDCs[4, 6]	Rs4,521,420	Rs 8,189,894
Total	Rs 4,840,558	Rs 8,813,793

Notes:
[1] There were two national-level TOTs for HFMOCs. The total costs were split between Approach A and Approach B.

[2] The estimated cost of one national CEA TOT was Rs 46,943. A second training was conducted because of poor attendance, but the cost data were not collected from this second training. It is assumed that the cost of the second training was 75 percent of the cost of the first training (Rs 35,207), because the second training was not as well attended as the first training. The total cost of the two training events is Rs 82,105.

[3] The cost of the District NFMOC TOT was estimated for Approach B in Baglung but not for Approach A in Syangja, so the figure for Approach B HFMOC was used for Approach A.

[4] There are 66 VDCs in Syangja and 65 VDCs in Baglung. The cost estimation of activities only occurred in 11 VDCs, which were all Approach B sites. They were selected randomly.

Table 34 provides a breakdown of the costs for Approach A in the 11 VDCs. The costs of the following activities were estimated: a) the reformulation of the HFMOCs; b) a three-day training of the HFMOCs; c) a two-day review of the HFMOCs; d) a one-day review of the HFMOCs; and e) a technical support visit to the HFOMCs. The costs of these activities were estimated, except for the technical support visit to the HFOMCs, which was estimated at Rs 8,834 per VDC (see note 5 below). The total cost of Approach A activities in the 11 VDCs was Rs 753,570. To calculate the costs across the Syangja district, the total cost of Approach A activities in the 11 VDCs was multiplied by 66/11, for a total of Rs 4,521,420.

Equation: (Cost of HFMOC activities in 11 VDCs) * Ratio 66 /11 = Total Cost of Approach A at the VDC level

Rs 753,570 * 66/11 = Rs 4,521,420

Table 34. Cost data for HFMOC activities in 11 VDCs

	Re-formulation of the HFOMCs	3-day rollout GESI HFOMC training	2-day review of the HFOMCs	1-day review of the HFOMCs	First technical support visit to the HFOMCs[5]	Total
Bobang	Rs 4,500	Rs 16,700	Rs 25,865	Rs 9,000	Rs 8,834	Rs 64,899
Damek	Rs 4,500	Rs 23,137	Rs 14,200	Rs 15,556	Rs 8,834	Rs 66,277
Devistang	Rs 4,500	Rs 27,522	Rs 13,575	Rs 5,900	Rs 8,834	Rs 60,331
Dhudhilabhati	Rs 4,800	Rs 31,250	Rs 20,450	Rs 13,900	Rs 8,834	Rs 79,234
Hafiya	Rs 6,200	Rs 28,700	Rs 23,695	Rs 10,545	Rs 8,834	Rs 77,974
Hila	Rs 4,485	Rs 26,289	Rs 13,373	Rs 3,300	Rs 8,834	Rs 56,281
Kharga	Rs 4,500	Rs 23,683	Rs 16,900	Rs 9,000	Rs 8,834	Rs 62,917
Lekhani	Rs 3,300	Rs 35,105	Rs 21,452	Rs 10,501	Rs 8,834	Rs 79,192
Malma	Rs 3,500	Rs 31,875	Rs 9,958	Rs 7,300	Rs 8,834	Rs 61,467
Ranasinkiteni	Rs 5,600	Rs 30,515	Rs 18,065	Rs 13,100	Rs 8,834	Rs 76,114
Sukhaura	Rs 4,200	Rs 26,130	Rs 20,020	Rs 9,700	Rs 8,834	Rs 68,884
Total						Rs 753,570

Notes:

[5] No cost data were collected for the first technical support visit to the HFOMCs. The following assumptions were therefore used:

- Two MOH personnel, one senior level and one mid-level, participated in the visit, at a daily salary of Rs 320 and Rs 290, respectively. These salary levels were reported in the cost estimate for the National HFOMC training.
- A driver with petrol was included, at Rs 224 per day. This data point was reported in the cost estimate for the National HFOMC training.
- Each participant was paid a per diem of Rs 400 during the visit. This rate was consistent throughout the training activities. The average number of participants paid per diem at the one-day review HFOMC meeting in the 11 VDCs was 14.3, and the median number was 15. Therefore, 15 was figure selected for the number of participants paid per diem. The total amount of per diem paid was Rs 6,000.
- Twenty units of refreshment were purchased for the visit, at Rs 100 per unit, for a total of Rs 2,000. The cost of refreshments was consistent throughout the training activities. There was a pattern of the number of refreshments or lunches being slightly more than the number of per diems; this pattern was followed here.
- The total cost for this activity is the sum of all elements described above:

Rs 320 + Rs 290 + Rs 224 + Rs 6,000 + Rs 2,000 = Rs 8,834

- This figure was used for the 11 VDCs.

Table 35 provides the costs of the CEA activities in the 11 VDCs. Approach B activities were all Approach A activities plus a three-day training on the CEA for the HFOMCs, a one-day CEA training for community mobilizers, and a coaching visit for community mobilizers. Of the specific activities for Approach B sites, no cost data were collected for the coaching visit. Please see note 8 for an explanation of the estimation of this cost. The cost of Approach B activities in the 11 VDCs is the sum of the HFOMC activities (Rs 753,570) and the CEA activities (Rs 632,412), for a total of Rs 1,385,982. To calculate the costs across

Baglung district, the cost of Approach B activities in the 11 VDCs was multiplied by 65/11, which equals Rs 8,189,894. Please refer to the following equations:

Equation: (Cost of HFOMC activities in 11 VDCs) + (Cost of CEA activities in 11VDCs) = Total Cost of Approach B in 11 VDCs

Rs 753,570 + Rs 632,412 = Rs 1,385,982

Equation: (Cost of HFOMC & CEA activities in 11 VDCs) * Ratio 65 /11 = Total Cost of Approach B at the VDC level

Rs 1,385,982 * 65/11 = Rs 8,189,894

Table 35. Cost data for the CEA activities in 11 VDCs

VDC	3-day CEA training for HFOMCs	1-day CEA training for community mobilizers[7]	First coaching visit for community mobilizers[8]	Total
Bobang	Rs 19,510	Rs 10,900	Rs 13,834	Rs 44,020
Damek	Rs 28,885	Rs 14,200	Rs 13,834	Rs 56,695
Devistang	Rs 42,677	Rs 10,000	Rs 13,834	Rs 66,287
Dhudhilabhati	Rs 58,700	Rs 20,450	Rs 13,834	Rs 92,760
Hafiya	Rs 36,225	Rs 10,000	Rs 13,834	Rs 59,835
Hila	Rs 19,560	Rs 2,100	Rs 13,834	Rs 35,270
Kharga	Rs 24,080	Rs 15,800	Rs 13,834	Rs 53,490
Lekhani	Rs 39,617	Rs 21,400	Rs 13,834	Rs 74,627
Malma	Rs 27,645	Rs 2,340	Rs 13,834	Rs 43,595
Ranasinkiteni	Rs 29,190	Rs 11,659	Rs 13,834	Rs 54,459
Sukhaura	Rs 25,900	Rs 9,400	Rs 13,834	Rs 48,910
Total-CEA				Rs 632.412
Total-HFOMC				Rs 753,570
Total				Rs 1,385,982

Notes:

[7] Data for Ranasinkiteni VDC was missing for this activity. The cost was estimated as the average of the other ten VDCs (Rs 11,659).

[8] No cost data were collected on the first coaching visit for community mobilizers. The following assumptions were therefore used:

- Two MOH personnel, one senior level and one mid-level, participated in the visit, at a daily salary of Rs 320 and Rs 290, respectively. These salary levels were reported in the cost estimate for the National HFOMC training.
- A driver with petrol was included, at Rs 224 per day. This data point was reported in the cost estimate for the National HFOMC training.
- Each participant was paid a per diem of Rs 400 during the visit. This rate was consistent throughout the training activities. The average number of participants paid per diem at the three-day and one-day CEA training events in the 11 VDCs was 24.6. Therefore, 25 participants was the figure selected for the number of per diem recipients. The total amount of per diem paid was Rs10,000.
- Thirty units of refreshments were purchased during the visit, at Rs 100 per unit, for a total of Rs 3,000. The cost of refreshments was consistent throughout the training activities. There was a pattern of the number of refreshments or lunches being slightly more than the number of per diems paid. This pattern was followed here.
- The total cost for this activity is the sum of all the elements:
  Rs 320 + Rs 290 + Rs 224 + Rs 10,000 + Rs 3,000 = Rs 13,834
- This figure was used for the 11 VDCs.

Table 36. Calculation of estimated cost of national scale-up

	Approach A	Approach B	Factor[12]	Approach A (Product)	Approach B(Product)
National[9]	Rs 213,238	Rs 295,388	5	Rs 1,066,190	Rs 1,476,940
District[10]	Rs 105,900	Rs 328,511	75	Rs 7,942,500	Rs 24,638,325
Average cost per VDC[11]	Rs68,506	Rs 125,998	3,276	Rs 224,425,656	Rs 412,769,448
Total Estimate of National Scale-Up				Rs 233,434,346	Rs 438,884,713
Health Budget 2014-5				Rs 40,563,027,000	
Percentage of Health Budget, 2014-5				0.58%	1.08%

Notes:

[9] At the national level, the figure for Approach B is the sum of the costs of HFOMC and CEA activities at the national level (Rs 213,238 + Rs 82,150).

[10] At the district level, the figure for Approach B is the sum of the HFOMC and CEA activities at the district level (Rs 105,900 + Rs 222,611).

[11] At the VDC level, the figure for Approach A is the average cost of HFOMC activities, which is computed as the average cost across the 11 VDCs (Rs 753,570/ 11). The figure for Approach B is the average cost of the HFOMC and CEA activities, which is computed as the average cost across the 11 VDCs (Rs 1,385,982/ 11).

[12] Factor refers to the number of subnational units at the district (75) or VDC levels (3,276). In the case of the national level, factor refers to the number of times that the training would need to be held for a national rollout, which is assumed to be five. If the sessions are held five times and if at least15 trainers are in attendance, the training would cover the district level, which has 75 districts. This number may be low, but the contribution to the total cost of training at the national level is insignificant.

Cost-Effectiveness Calculations

The ICER was calculated as the difference in costs between Approach B and Approach A, divided by the difference in the impact (from DID results) of the two interventions. Table 38 shows the inputs for the calculation of each outcome.

Table 37. Cost-effectiveness calculation inputs

Outcome	Difference between impact of approaches (B-A)	Difference between cost of approaches B and A (B-A)
Child's health ever checked	3.0%	Rs 3,973,235
Child's health checked in past six months	4.6%	Rs 3,973,235
Health provider discussed child's growth at last health check	2.6%	Rs 3,973,235

APPENDIX 6. ADDITIONAL TABLES AND FIGURES

Characteristics of Quantitative Survey Participants

Table 38. Social status of HH, by survey wave and district, per HH survey

Baseline	Baglung		Syangja		Parbat		All women	
	No.	%	No.	%	No.	%	No.	%
DAGs	830	63.1	648	57.8	608	45.5	2,086	55.3
Dalit	469	35.6	211	18.8	371	27.7	1,051	27.8
Hill Janajati	355	27.0	436	38.9	219	16.4	1,010	26.8
Terai Janajati	1	0.1	0	0.0	7	0.5	8	0.2
Muslims	3	0.2	0	0.0	11	0.8	14	0.4
Other lower castes	2	0.2	1	0.1	0	0.0	3	0.1
Non-DAGs	486	36.9	474	42.2	729	54.5	1,689	44.7
Brahman, Chhetri	448	34.0	434	38.7	683	51.1	1,565	41.5
Newar	25	1.9	33	2.9	24	1.8	82	2.2
Terai Madhesi, other castes	13	1.0	7	0.6	22	1.6	42	1.1
Total	1,316	100.0	1,122	100.0	1,337	100.0	3,775	100.0
End line	**Baglung**		**Syangja**		**Parbat**		**All women**	
	No.	%	No.	%	No.	%	No.	%
DAGs	915	66.4	644	57.7	549	42.2	2,108	55.6
Dalit	508	36.9	221	19.8	352	27.1	1,081	28.5
Hill Janajati	394	28.6	420	37.6	188	14.5	1,002	26.4
Terai Janajati	0	0.0	3	0.3	4	0.3	7	0.2
Muslims	3	0.2	0	0.0	5	0.4	8	0.2
Other lower castes	10	0.7	0	0.0	0	0.0	10	0.3
Non-DAGs	462	33.6	472	42.3	751	57.8	1,685	44.4
Brahman, Chhetri	442	32.1	431	38.6	698	53.7	1,571	41.4
Newar	13	0.9	36	3.2	22	1.7	71	1.9
Terai Madhesi, other castes	7	0.5	5	0.4	31	2.4	43	1.1
Total	1,377	100.0	1,116	100.0	1,300	100.0	3,793	100.0

Figure 18. Mean HH size, by survey wave, district, and social status, per HH survey

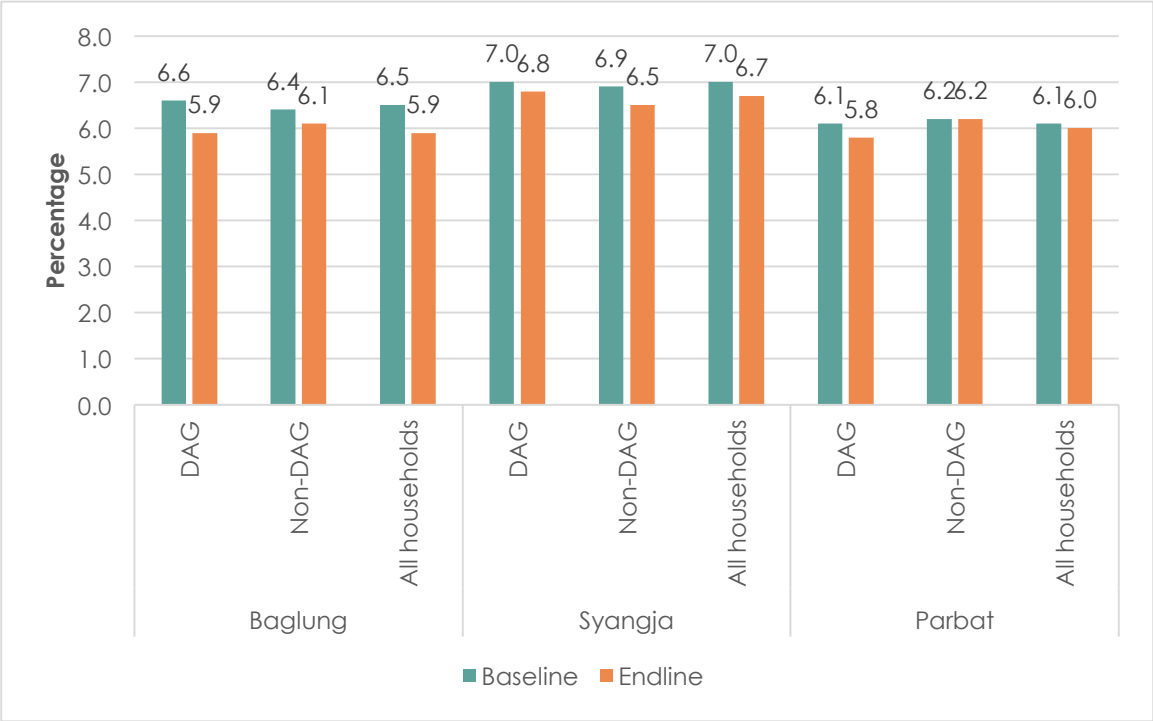


Table 39. Head of HH and HH size, by survey wave, district, and social status, per HH survey

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs%
Head of HH									
Male	54.0	30.1	84.1	46.3	32.6	78.9	39.3	43.9	83.2
Female	9.0	6.8	15.9	11.5	9.6	21.1	6.2	10.6	16.8
HH Size, Mean	6.6	6.4	6.5	7.0	6.9	7.0	6.1	6.2	6.1
End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %
Head of HH									
Male	55.3	26.3	81.6	43.6	32.7	76.3	35.2	47.8	83.1
Female	11.2	7.3	18.4	14.1	9.6	23.7	7.0	9.9	16.9
HH Size, Mean	5.9	6.1	5.9	6.8	6.5	6.7	5.8	6.2	6.0

Table 40. Age and sex distributions in HH, by survey wave, district, and social status, per HH survey

Baseline									
	Baglung			Syangja			Parbat		
	M	F	All	M	F	All	M	F	All
DAGs %									
Age 0-4	6.7	6.5	13.1	5.6	5.3	10.9	5.2	4.9	10.1
Age 5-9	2.4	3.5	5.9	2.1	2.2	4.3	1.5	2.1	3.6
Age 10-14	1.5	2.6	4.2	1.3	2.1	3.5	1.4	1.5	2.9
Age 15-19	2.0	3.4	5.4	1.5	3.0	4.6	1.3	2.5	3.7
Age 20-24	4.4	5.6	10.1	3.3	5.4	8.7	2.9	3.9	6.8
Age 25-29	4.3	3.2	7.4	4.3	3.4	7.8	2.9	2.6	5.5
Age 30-34	2.1	1.4	3.5	2.8	1.6	4.4	2.0	0.8	2.8
Age 35-39	1.2	0.8	2.0	1.5	0.7	2.2	0.9	0.7	1.6
Age 40-44	1.0	1.0	2.0	0.7	0.9	1.5	0.4	0.6	1.0
Age 45-49	0.8	1.2	2.0	0.8	1.0	1.8	0.5	0.7	1.3
Age 50-54	1.0	1.1	2.1	0.8	1.3	2.1	0.7	0.8	1.5
Age 55-59	0.8	1.0	1.8	0.7	0.9	1.6	0.5	0.6	1.1
Age 60-64	1.0	0.9	1.8	0.9	1.0	1.9	0.7	0.7	1.4
Age 65-69	0.5	0.4	1.0	0.6	0.6	1.3	0.5	0.3	0.8
Age 70-74	0.5	0.3	0.8	0.5	0.4	0.9	0.3	0.2	0.5
Age 75-79	0.2	0.1	0.3	0.3	0.2	0.5	0.1	0.1	0.2
Age 80 and above	0.2	0.3	0.4	0.2	0.3	0.5	0.2	0.2	0.3
Non-DAGs %									
Age 0-4	3.8	3.6	7.4	4.4	3.7	8.1	5.8	5.6	11.4
Age 5-9	1.0	1.5	2.5	1.2	2.0	3.2	1.8	2.3	4.1
Age 10-14	0.7	0.9	1.6	0.7	1.3	2.0	0.9	1.5	2.4
Age 15-19	0.6	1.4	2.0	0.8	1.3	2.1	1.0	1.9	3.0
Age 20-24	1.8	3.7	5.5	1.9	3.8	5.8	2.4	5.6	7.9
Age 25-29	3.2	2.3	5.5	2.9	2.8	5.7	4.2	3.2	7.4
Age 30-34	1.9	0.7	2.6	2.9	1.4	4.3	3.2	1.3	4.6
Age 35-39	0.8	0.3	1.1	1.4	0.4	1.8	1.4	0.5	2.0
Age 40-44	0.3	0.4	0.7	0.5	0.3	0.8	0.7	0.5	1.2
Age 45-49	0.4	0.6	1.0	0.3	0.6	0.9	0.3	1.1	1.4
Age 50-54	0.5	0.9	1.4	0.4	1.1	1.6	0.9	1.4	2.3
Age 55-59	0.6	0.8	1.4	0.7	0.8	1.5	0.8	1.2	2.0
Age 60-64	0.7	0.7	1.4	0.7	0.8	1.4	1.0	0.8	1.8
Age 65-69	0.5	0.3	0.7	0.6	0.5	1.1	0.6	0.7	1.4
Age 70-74	0.4	0.2	0.6	0.4	0.2	0.7	0.6	0.4	1.1
Age 75-79	0.2	0.1	0.3	0.2	0.2	0.4	0.3	0.2	0.5
Age 80 and above	0.1	0.1	0.3	0.2	0.1	0.4	0.2	0.3	0.5

End line									
	Baglung			Syangja			Parbat		
	M	F	All	M	F	All	M	F	All
DAGs %									
Age 0-4	7.5	6.8	14.3	5.7	5.4	11.1	4.5	4.5	9.0
Age 5-9	2.5	3.3	5.7	1.6	2.6	4.2	1.6	1.8	3.3
Age 10-14	1.7	1.7	3.4	1.6	1.5	3.1	1.0	1.1	2.0
Age 15-19	1.8	3.1	4.9	1.7	2.6	4.3	0.9	1.9	2.9
Age 20-24	4.5	5.9	10.4	3.3	5.4	8.7	2.7	3.9	6.6
Age 25-29	4.7	3.6	8.3	4.5	3.6	8.0	2.9	2.4	5.3
Age 30-34	2.4	1.5	3.9	3.1	1.7	4.8	2.1	1.2	3.2
Age 35-39	1.2	0.7	1.9	1.5	0.7	2.2	0.6	0.4	1.1
Age 40-44	0.7	0.9	1.7	0.7	0.8	1.4	0.5	0.6	1.1
Age 45-49	0.9	1.3	2.2	0.6	0.8	1.4	0.5	0.7	1.2
Age 50-54	1.3	1.1	2.5	1.0	1.4	2.5	0.5	0.7	1.2
Age 55-59	0.9	1.0	1.9	0.8	1.0	1.8	0.6	0.4	1.0
Age 60-64	0.7	1.1	1.9	0.9	1.1	2.0	0.5	0.6	1.1
Age 65-69	0.6	0.4	1.0	0.7	0.7	1.4	0.3	0.3	0.6
Age 70-74	0.5	0.5	1.1	0.5	0.5	1.1	0.2	0.2	0.4
Age 75-79	0.2	0.1	0.3	0.2	0.1	0.3	0.1	0.1	0.2
Age 80 and above	0.2	0.2	0.4	0.3	0.3	0.5	0.1	0.1	0.2
Non-DAGs %									
Age 0-4	4.0	3.3	7.3	4.3	3.9	8.1	6.8	6.0	12.8
Age 5-9	1.1	1.4	2.5	1.2	1.8	3.0	2.1	2.4	4.5
Age 10-14	0.6	0.9	1.5	0.9	1.0	1.9	1.0	1.3	2.3
Age 15-19	0.9	1.1	1.9	0.9	1.3	2.1	1.1	1.6	2.7
Age 20-24	1.6	3.4	5.0	1.6	3.8	5.4	2.3	6.0	8.3
Age 25-29	2.7	2.3	5.0	3.2	2.9	6.1	4.9	4.3	9.1
Age 30-34	1.7	0.7	2.4	2.6	1.2	3.8	3.9	1.5	5.3
Age 35-39	0.5	0.4	0.9	1.2	0.4	1.6	1.4	0.4	1.8
Age 40-44	0.3	0.5	0.8	0.5	0.3	0.9	0.6	0.6	1.2
Age 45-49	0.4	0.7	1.2	0.3	0.7	0.9	0.6	1.1	1.7
Age 50-54	0.5	1.0	1.6	0.6	1.2	1.8	0.6	1.6	2.2
Age 55-59	0.6	0.5	1.2	0.7	1.0	1.7	1.2	1.1	2.2
Age 60-64	0.6	0.6	1.3	0.8	0.8	1.6	1.0	0.9	1.9
Age 65-69	0.4	0.4	0.8	0.5	0.4	1.0	0.7	0.5	1.2
Age 70-74	0.4	0.2	0.6	0.4	0.2	0.6	0.6	0.5	1.0
Age 75-79	0.1	0.1	0.2	0.1	0.1	0.3	0.3	0.1	0.4
Age 80 and above	0.2	0.1	0.3	0.3	0.1	0.4	0.3	0.3	0.6

Table 41. HH livelihoods, by survey wave, district, and social status, per HH survey

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %
Agriculture	92.9	92.6	92.8	86.3	89.0	87.4	75.8	82.4	79.4
Foreign employment	50.1	53.1	51.2	59.6	60.1	59.8	46.5	47.3	47.0
Wage labor	24.6	5.8	17.6	19.8	5.1	13.5	33.6	5.3	18.2
Business	9.3	15.6	11.6	13.6	16.2	14.7	13.8	25.0	19.9
Salaried job	9.5	17.5	12.5	11.7	21.7	16.0	10.2	25.2	18.4
Pension	7.7	8.6	8.1	21.5	13.9	18.3	11.8	8.8	10.2
Elderly allowance	9.9	7.4	9.0	14.8	17.1	15.8	10.0	8.8	9.3
Sold property/borrowed money/interest income	2.9	3.3	3.0	1.5	0.6	1.2	1.2	1.6	1.4
Other	1.1	0.6	0.9	1.5	2.3	1.9	1.2	2.1	1.6
End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %
Agriculture	90.8	87.7	89.8	84.6	83.3	84.1	69.0	72.3	70.9
Foreign employment	48.3	54.8	50.5	56.2	61.7	58.5	43.9	46.7	45.5
Wage labor	35.3	8.7	26.4	26.6	8.3	18.8	37.7	7.6	20.3
Business	10.8	16.5	12.7	17.7	19.9	18.6	16.8	23.7	20.8
Salaried job	7.7	18.4	11.3	21.4	28.4	24.4	19.7	33.8	27.8
Pension	7.1	11.7	8.6	21.0	9.7	16.2	10.6	13.3	12.2
Elderly allowance	14.9	12.3	14.0	21.0	18.9	20.1	18.9	17.8	18.3
Sold property/borrowed money/interest income	18.0	14.5	16.8	16.0	11.0	13.9	21.7	20.2	20.8
Other	1.4	2.8	1.9	9.9	12.5	11.0	1.6	4.1	3.1

Table 42. Annual HH income, by survey wave, district and social status, per HH survey

Baseline									
Income (NPR)	**Baglung**			**Syangja**			**Parbat**		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %
None	1.4	1.9	1.6	0.2	1.5	0.7	1.0	0.5	0.7
Less than 10,000	8.9	4.3	7.2	3.4	3.0	3.2	4.3	4.0	4.1
10,000 to 25,000	11.9	8.4	10.6	5.2	4.9	5.1	8.9	7.8	8.3
25,000 to 50,000	28.7	21.4	26.0	18.1	15.6	17.0	20.9	18.7	19.7
50,000 to 100,000	26.1	31.1	28.0	30.9	23.2	27.6	30.8	25.1	27.7
100,000 to 250,000	16.7	21.2	18.4	26.2	31.2	28.3	23.7	27.7	25.9
250,000 to 500,000	5.2	7.8	6.2	11.0	13.7	12.1	7.6	11.4	9.6
More than 500,000	1.0	3.9	2.1	5.1	7.0	5.9	3.0	4.8	4.0
End line									
Income (NPR)	**Baglung**			**Syangja**			**Parbat**		
	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %	DAG %	Non-DAG %	All HHs %
None	2.5	1.9	2.3	0.9	1.1	1.0	0.5	0.1	0.3
Less than 10,000	3.2	0.4	2.3	0.8	0.4	0.6	1.3	0.7	0.9
10,000 to 25,000	8.3	5.4	7.3	0.3	0.4	0.4	2.7	1.2	1.8
25,000 to 50,000	26.6	21.0	24.7	3.1	2.3	2.8	12.2	8.3	9.9
50,000 to 100,000	29.0	24.9	27.6	9.8	7.4	8.8	26.0	19.4	22.2
100,000 to 250,000	21.0	21.6	21.2	26.1	21.6	24.2	30.2	30.1	30.2
250,000 to 500,000	7.7	14.1	9.8	36.3	33.5	35.1	16.8	24.4	21.2
More than 500,000	1.9	10.6	4.8	22.7	33.3	27.2	10.2	15.8	13.5

Table 43. HH drinking water, by survey wave, district, and social status, per HH survey

Baseline									
	Baglung			Syangja			Parbat		
	DAG	Non-DAG	All HHs	DAG	Non-DAG	All HHs	DAG	Non-DAG	Total
Main source of drinking water									
Improved source	89.3	89.3	89.3	92.1	92.0	92.1	84.9	85.7	85.3
Unimproved source	10.7	10.7	10.7	7.9	8.0	7.9	15.1	14.3	14.7
Do anything to make water safer to drink									
Water safety	24.7	38.7	29.9	40.7	44.9	42.5	36.7	46.9	42.3
If yes, safety measures									
Safe water: Boil	91.7	94.7	93.1	75.8	78.9	77.1	83.4	90.6	87.8
Safe water: Add bleach/chlorine	0.5	0.0	0.3	0.8	1.4	1.0	0.0	0.3	0.2
Safe water: Strain through cloth	11.2	4.8	8.1	34.5	25.8	30.6	7.6	2.9	4.8
Safe water: Water filter (ceramic/sand/composite/ etc.)	13.2	20.7	16.8	30.3	37.6	33.5	39.0	42.4	41.1
Safe water: Solar disinfection	1.5	0.5	1.0	0.0	0.0	0.0	2.2	0.9	1.4
Safe water: Let it stand and settle	9.3	7.4	8.4	1.5	1.9	1.7	5.8	4.1	4.8
Safe water: Other	1.0	0.0	0.5	0.0	0.0	0.0	0.9	0.3	0.5
End line									
	Baglung			Syangja			Parbat		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
Main source of drinking water									
Improved source	96.2	96.3	96.2	93.8	93.4	93.6	80.1	83.1	81.8
Unimproved source	3.8	3.7	3.8	6.2	6.6	6.4	19.9	16.9	18.2
Do anything to make water safer to drink									
Water safety	31.0	46.1	36.1	41.6	50.2	45.3	42.3	57.9	51.3
If yes, safety measures									
Safe water: Boil	96.5	98.6	97.4	88.1	93.2	90.5	91.8	96.8	95.1
Safe water: Add bleach/chlorine	2.1	0.5	1.4	1.1	0.8	1.0	1.3	0.7	0.9
Safe water: Strain through cloth	22.2	7.5	15.9	28.0	26.2	27.1	12.5	5.1	7.6
Safe water: Water filter(ceramic/sand/composite/etc.)	20.1	30.5	24.5	28.0	39.7	33.5	32.3	45.3	40.8
Safe water: Solar disinfection	1.4	2.3	1.8	4.1	3.8	4.0	2.6	0.9	1.5
Safe water: Let it stand and settle	6.7	4.2	5.6	5.2	5.1	5.1	6.0	2.3	3.6
Safe water: Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 44. HH sanitation, by type of toilet/latrine, and by survey wave, district, and social status, per HH survey

Baseline									
	Baglung			Syangja			Parbat		
	DAG (%)	Non-DAG (%)	All HHs (%)	DAG (%)	Non-DAG (%)	All HHs (%)	DAG (%)	Non-DAG (%)	All HHs (%)
Type of toilet									
Improved facility	98.1	98.5	98.3	93.1	95.3	94.0	99.1	99.0	99.1
Unimproved facility	1.9	1.5	1.7	6.9	4.7	6.0	0.9	1.0	0.9
End line									
	Baglung			Syangja			Parbat		
	DAG	Non-DAG	All HHs (%)	DAG	Non-DAG	All HHs (%)	DAG	Non-DAG	All HHs (%)
Type of toilet									
Improved facility	95.6	95.7	95.7	96.3	98.3	97.1	97.5	98.7	98.2
Unimproved facility	4.4	4.3	4.3	3.7	1.7	2.9	2.5	1.3	1.8

Figure 19. Sex distribution of community survey respondents, by district and survey wave

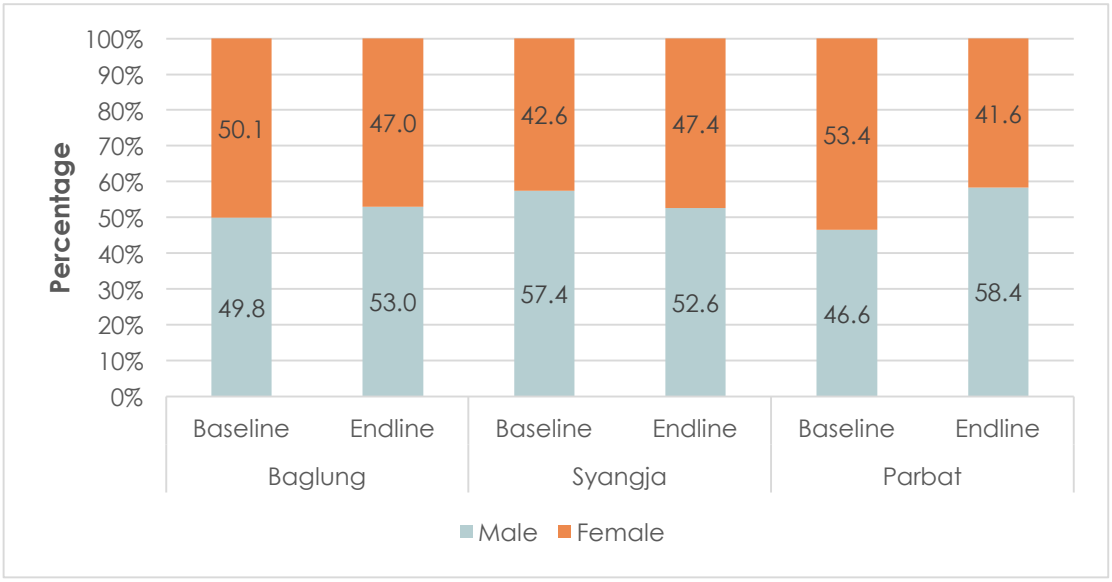


Table 45. Women's characteristics, by social status and survey wave

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Currently married	99.8	99.8	99.8	100.0	100.0	100.0	99.8	99.9	99.9
Religion									
Hindu	95.4	99.4	96.9	93.0	100.0	95.9	84.3	99.3	92.5
Buddhist	2.7	0.6	1.9	6.3	0.0	3.6	12.3	0.4	5.8
Muslim	0.3	0.0	0.2	0.0	0.0	0.0	1.8	0.0	0.8
Christian	1.6	0.0	1.0	0.8	0.0	0.4	1.5	0.1	0.7
Education									
No education	16.4	4.3	11.9	6.9	2.3	5.0	13.4	2.7	7.6
Primary education	29.0	8.7	21.5	20.0	6.3	14.3	18.0	5.4	11.1
Secondary education	34.8	34.1	34.6	51.5	38.9	46.2	45.3	31.9	38.0
School Leaving Certificate and above	19.7	53.0	32.1	21.7	52.4	34.5	23.2	59.9	43.3
End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DA G %	Non-DAG %	All women %
Currently married	99.9	99.6	99.8	99.8	100.0	99.9	99.6	99.6	99.6
Religion									
Hindu	95.6	99.6	96.9	93.1	99.6	95.8	87.7	99.7	94.7
Buddhist	2.8	0.2	1.9	6.5	0.4	3.9	9.3	0.1	4.0
Muslim	0.3	0.0	0.2	0.0	0.0	0.0	0.9	0.0	0.4
Christian	1.4	0.2	1.0	0.5	0.0	0.3	2.0	0.1	0.9
Education									
No education	11.9	2.5	8.7	3.3	2.1	2.8	9.6	1.0	4.7
Primary education	29.1	9.5	22.5	16.5	4.2	11.3	20.9	4.6	11.7
Secondary education	41.8	38.2	40.6	59.5	43.2	52.7	46.5	33.0	38.7
School Leaving Certificate and above	17.3	49.8	28.2	20.7	50.5	33.2	23.0	61.4	45.2

Figure 20. Distribution of women's social status, by survey wave and district

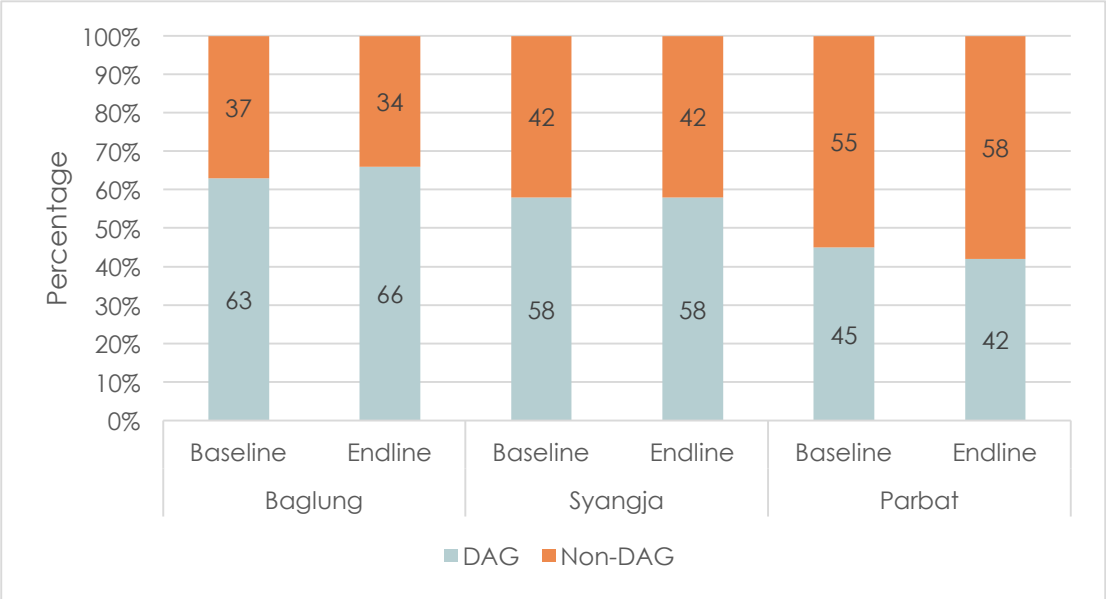


Figure 21. Distribution of women's age, by survey wave, and district

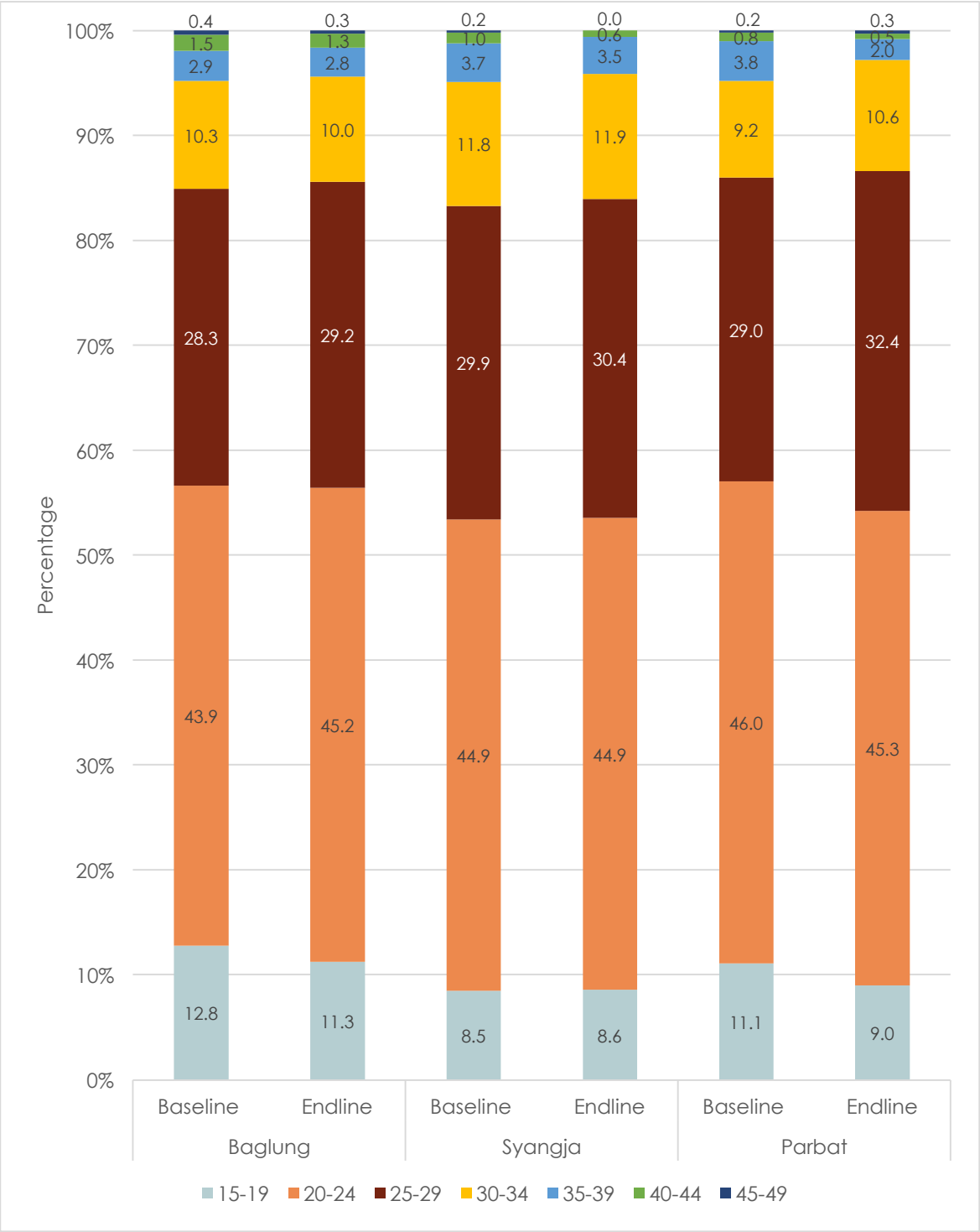


Table 46. Children's age and sex, by survey wave, district, and social status

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Sex									
Male	53.3	55.3	54.1	53.8	53.9	53.9	54.2	52.4	53.2
Female	46.7	44.7	45.9	46.2	46.1	46.1	45.8	47.6	46.8
Age									
< 6 months	26.9	23.6	25.7	23.3	20.5	22.1	23.6	21.1	22.2
6-11	27.5	26.6	27.2	27.4	25.8	26.7	28.0	23.9	25.8
12-17	23.2	24.2	23.6	22.9	23.5	23.1	25.5	26.8	26.2
18-24	22.2	25.4	23.4	26.4	30.2	28.0	22.9	28.0	25.7
End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All children %	DAG	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Sex									
Male	51.3	57.3	53.3	53.6	54.1	53.8	50.4	54.4	52.7
Female	48.7	42.7	46.7	46.4	45.9	46.2	49.6	45.6	47.3
Age									
< 6 months	24.6	25.7	24.9	28.2	22.5	25.8	24.2	23.3	23.7
6-11	25.9	22.4	24.7	22.2	27.0	24.2	23.5	26.2	25.1
12-17	27.4	27.6	27.5	27.0	27.0	27.0	29.2	25.6	27.1
18-24	22.0	24.3	22.8	22.5	23.5	22.9	23.0	24.9	24.1

Figure 22. Children's age groups, by survey wave and district, as reported by women

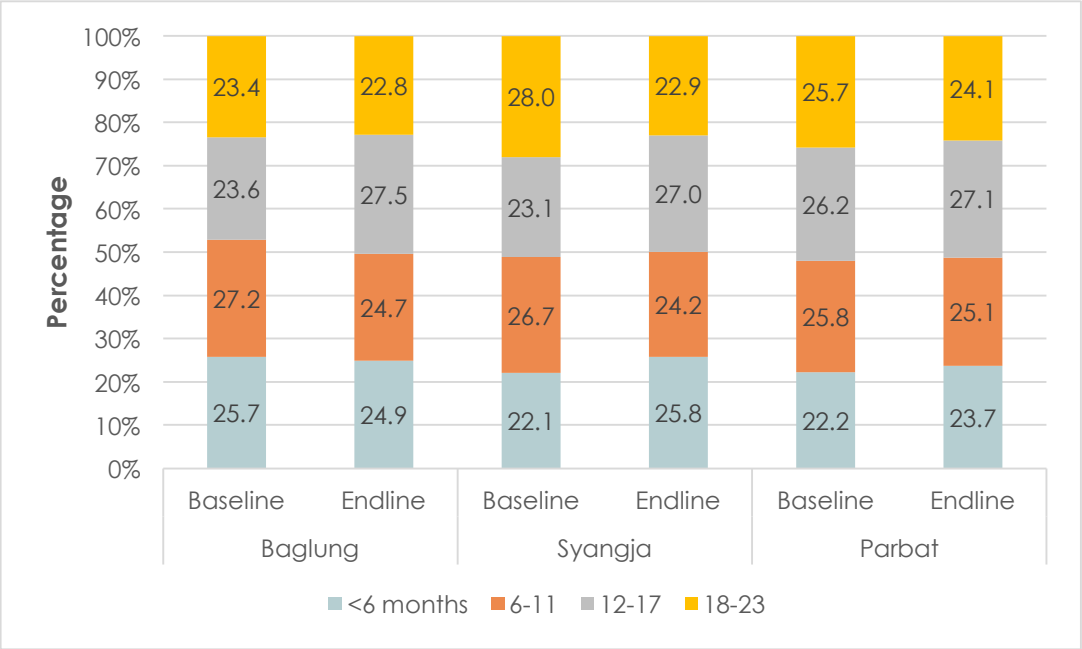


Table 47. Education levels of community informants, by survey wave, district, and sex

Baseline									
	Baglung %			Syangja %			Parbat %		
	Male	Female	All respon-dents	Male	Female	All respon-dents	Male	Female	All respon-dents
No education	2.9	4.5	3.7	2.2	5.9	2.2	2.5	13.6	8.4
Primary	31.2	39.9	35.6	38.4	39.0	38.4	31.9	34.4	33.2
Some secondary	26.4	27.8	27.1	27.7	38.1	27.7	22.8	26.8	25.0
SLC and above	39.6	27.8	33.7	31.8	17.0	31.8	42.8	25.2	33.4
End line									
	Baglung %			**Syangja %**			**Parbat %**		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
No education	3.4	6.7	5.0	3.1	4.6	3.8	1.7	5.5	3.3
Primary	31.3	42.0	36.3	35.2	36.4	35.7	26.5	29.8	27.9
Some secondary	28.1	23.7	26.1	32.8	37.5	35.0	21.4	24.6	22.7
SLC and above	37.2	27.6	32.7	29.0	21.6	25.5	50.3	40.1	46.1

Table 48. Women's reports of ANC visits for their last pregnancy, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Women receiving ANC	90.1	97.6	92.9	90.1	97.7	92.6
4 or more ANC visits	62.5	82.9	70.1	69.2[!]	85.9	74.8[!]
Saw a skilled health provider	85.4	92.3	87.9	86.9	94.6	89.5
Number of months pregnant at time of first ANC visit						
<4	40.4	54.3	45.6	42.5	56.4	47.2
4-5	37.5	38.4	37.8	39.9	38.0	39.2
6-7	10.2	4.7	8.2	6.7	3.1	5.5
8+	2.0	0.2	1.3	1.0	0.2	0.7
Number of months pregnant when first received ANC	4.0	3.0	4.0	4.0	3.0	3.0
Syangja						
Women receiving ANC	93.0	97.0	94.7	92.9	97.3	94.8
4 or more ANC visits	70.0	83.1	75.5	72.7	84.6	77.7
Saw a skilled health provider	91.5	96.0	93.4	90.1	95.4	92.3
Number of months pregnant at time of first ANC visit						
<4	56.6	63.6	59.5	57.8	74.8	65.0
4-5	30.0	29.4	29.8	29.0	21.2	25.7
6-7	4.9	4.0	4.5	5.6	1.2	3.7
8+	1.5	0.0	0.9	0.6	0.0	0.3
Number of months pregnant when first received ANC	3.0	3.0	3.0	3.0	3.0	3.0
Parbat						
Women receiving ANC	95.4	98.8	97.3	96.8	99.3	98.3
4 or more visits	76.4	90.2	84.0	84.7*	92.2	89.0*
Saw a skilled health provider	90.5	96.2	93.6	92.7	94.1	93.5
Number of months pregnant at time of first ANC visit						
<4	54.8	62.4	58.9	59.2	68.7	64.7
4-5	33.2	33.2	33.2	33.3	28.7	30.6
6-7	6.2	3.1	4.5	3.4	1.8	2.5
8+	1.1	0.0	0.5	0.9	0.1	0.5
Number of months pregnant when first received ANC	3.0	3.0	3.0	3.0	3.0	3.0

Levels of significance: * p <.001; ! p <.01; # p <.05

Table 49. Services received by women during childbirth, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Type of health professional seen						
Skilled health providers	23.5	43.7	31.0	45.1*	67.0*	52.5*
Where delivered						
Any HF	32.4	64.4	44.3	45.4*	68.3	53.1*
Home delivery	67.6	35.6	55.7	54.6	31.7	46.9
For HF births, type of facility						
Government	29.0	55.1	38.7	41.1	58.5	47.0
Nongovernmental organization(NGO)	0.3	0.6	0.4	0.0	0.0	0.0
Private medical	3.0	8.7	5.1	4.3	9.8	6.2
Received cash transport incentive	83.5	83.8	83.7	83.2	84.2	83.6
Caesarean delivery	11.1	14.7	13.0	9.6	17.0	12.8
Syangja						
Type of health professional seen						
Skilled health providers	64.5	74.8	68.8	64.3	79.6	70.7
Where delivered						
Any HF	64.5	74.8	68.8	70.6#	84.0*	76.2*
Home delivery	35.5	25.2	31.2	29.4	16.0	23.8
For HF births, type of facility						
Government	49.5	52.9	50.9	55.9	62.2	58.5
NGO	4.9	7.4	5.9	2.7	2.3	2.5
Private medical	10.1	14.6	12.0	12.0	19.5	15.2
Received cash transport incentive	77.1	101.4	88.2	71.9	70.8	71.4
Caesarean delivery	16.3	13.3	14.9	16.4	16.6	16.5
Parbat						
Type of health professional seen						
Skilled health providers	64.2	72.7	68.8	76.3*	85.9*	81.9*
Where delivered						
Any HF	64.0	73.6	69.3	77.0*	87.9*	83.3*
Home delivery	36.0	26.4	30.7	23.0	12.1	16.7
For HF births, type of facility						
Government	53.4	61.4	57.8	67.9	70.9	69.7
NGO	0.2	0.0	0.1	0.0	0.0	0.0
Private medical	10.5	12.2	11.4	9.1	16.9	13.6
Received cash transport incentive	86.4	86.5	86.5	85.6	80.0	82.2
Caesarean delivery	16.9	12.4	14.3	16.7	20.5	19.0

Levels of significance: * p <.001; ! p <.01; # p <.05

Table 50. Postnatal care of women, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
HF births	32.4	64.4	44.3	45.4	68.3	53.1
HF births: Mother received PNC before leaving facility	80.3	86.9	83.8	68.1*	83.3	74.7*
Home births	67.6	35.6	55.7	54.6	31.7	46.9
Home births: Mother received PNC within 48 hours	1.6	2.2	1.7	4.7!	7.2	5.2*
Home births: Healthcare provider checked on mother's health within one week after delivery	2.6	3.3	2.8	5.8	7.2	6.1
Home births: Healthcare provider checked on mother's health within six weeks after delivery	5.8	7.2	6.2	6.6	9.2	7.2
Home births: Mother received PNC any time after childbirth	8.6	11.6	9.3	7.0	9.2	7.5
Which health professional was seen?						
Skilled health provider	7.5	11.0	8.8	35.8	60.4	44.1
Doctor	6.6	9.3	7.6	11.0	22.0	14.7
Nurse/midwife	0.9	1.6	1.2	25.3	41.3	30.7
Auxiliary midwife	0.0	0.2	0.1	0.1	0.0	0.1
Other	0.5	1.2	0.7	0.5	0.6	0.6
Traditional birth attendant	0.0	0.0	0.0	0.0	0.0	0.0
Community health worker	0.5	1.2	0.7	0.5	0.4	0.5
Mother child health worker	0.0	0.0	0.0	0.0	0.2	0.1
All women: Supplements						
Given/buying folic acid/iron tablets	75.4	92.3	81.7	75.0	87.3	79.2
Received vitamin A	58.7	61.4	59.7	49.4*	59.3	52.8*
All women: How many times health worker visited after birth?						
None	55.3	45.5	51.6	71.3	72.2	71.6
One time	13.2	17.5	14.8	13.3	13.5	13.4
Two times	15.7	16.5	16.0	8.0	8.3	8.1
Three times	10.8	14.4	12.1	4.3	3.9	4.2
Four or more times	5.0	6.1	5.4	2.6	2.1	2.5
Syangja						
HF births	64.5	74.8	68.8	70.6	84.0	76.2
HF births: Mother received PNC before leaving facility	84.6	90.6	87.3	82.6	83.4!	83.0#
Home births	35.5	25.2	31.2	29.4	16.0	23.8
Home births: Mother received PNC within 48 hours	3.0	0.0	2.0	11.7*	15.6	12.8*

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Home births: Healthcare provider checked on mother's health within one week after delivery	3.4	0.0	2.3	12.8	16.9	13.9
Home births: Healthcare provider checked on mother's health within six weeks after delivery	6.4	5.9	6.3	15.3	19.5	16.5
Home births: Mother received PNC any time after childbirth	10.7	11.8	11.1	15.8	20.8+	17.2#
Which health professional was seen?						
Skilled health provider	9.9	8.9	9.5	63.1	73.6	67.5
Doctor	8.1	7.2	7.7	29.3	32.2	30.5
Nurse/midwife	1.8	1.7	1.8	35.9	44.7	39.6
Auxiliary midwife	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.3	0.4	0.4	1.8	1.0	1.5
Traditional birth attendant	0.0	0.0	0.0	0.0	0.0	0.0
Community health worker	0.3	0.2	0.3	1.2	0.8	1.0
Mother child health worker	0.0	0.2	0.1	0.6	0.2	0.4
All women: Supplements						
Given/buying folic acid/iron tablets	98.6	90.9	95.4	81.1	91.5	85.4
Received vitamin A	70.9	63.2	67.7	47.1!	56.5#	51.1*
All women: How many times health worker visited after birth?						
None	55.5	52.0	54.0	83.2	79.0	81.4
One time	18.0	17.3	17.7	6.5	10.2	8.0
Two times	14.2	17.8	15.7	6.2	6.0	6.1
Three times	8.1	8.2	8.1	2.6	2.7	2.6
Four or more times	4.3	4.7	4.4	1.7	2.1	1.8
Parbat						
HF births	64.0	73.6	69.3	77.0	87.9	83.3
HF births: Mother received PNC before leaving facility	91.3	90.6	90.9	78.9*	88.3!	84.6
Home births	36.0	26.4	30.7	23.0	12.1	16.7
Home births: Mother received PNC within 48 hours	4.1	5.7	4.8	9.3*	23.7*	15.3*
Home births: Healthcare provider checked on mother's health within one week after delivery	4.6	6.2	5.3	11.6	24.7	17.1
Home births: Healthcare provider checked on mother's health within six weeks after delivery	7.7	9.3	8.5	13.2	29.0	19.8
Home births: Mother received PNC any time after childbirth	9.1	12.4	10.6	14.0	29.0!	20.3!

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Which health professional was seen?						
Skilled health provider	8.5	10.1	9.4	63.8	81.6	74.1
Doctor	7.0	7.1	7.1	21.4	34.6	29.0
Nurse/midwife	1.5	3.0	2.3	44.4	53.5	49.6
Auxiliary midwife	0.0	0.0	0.0	0.4	0.3	0.3
Other	0.5	0.3	0.4	1.6	1.8	1.7
Traditional birth attendant	0.0	0.0	0.0	0.0	0.0	0.0
Community health worker	0.5	0.3	0.4	1.1	1.8	1.5
Mother child health worker	0.0	0.0	0.0	0.5	0.1	0.3
All women: Supplements						
Given/buying folic acid/iron tablets	84.9	95.5	90.7	86.6	95.0	91.5
Received vitamin A	73.3	84.8	79.6	55.8*	67.7*	62.7*
All women: How many times health worker visited after birth?						
None	67.6	59.2	63.0	71.3	72.6	72.1
One time	16.9	19.7	18.4	12.7	12.4	12.5
Two times	9.0	13.0	11.2	9.4	8.2	8.7
Three times	4.4	5.4	5.0	4.1	2.9	3.4
Four or more times	2.1	2.6	2.4	2.5	3.9	3.3

Levels of significance: * p <.001; ! p <.01; # p <.05

Table 51. Postnatal care of children, by survey wave, district, and social status, reported by women

	Baseline			End line		
	DAG %	Non-DAG %	All children%	DAG %	Non-DAG %	All children %
Baglung						
Child checked after birth: at facility	71.1	84.0	78.1	71.1	85.0	77.0
Among home births: child's health checked within 48 hours of delivery	2.2	3.4	2.5	2.5	3.3	2.7
Among home births: child's health checked within 7 days of delivery	6.2	8.3	6.7	6.0	11.8	7.3
Among home births: child's health checked within 6 weeks of delivery	25.8	32.6	27.4	9.9	16.3	11.4
Among home births: child's health checked any time after delivery	38.0	48.6	40.5	12.6	18.3	13.9
Checked by skilled health provider	94.7	93.5	94.3	97.2	98.3	97.7
Mother received counseling on breastfeeding within 1 hour of delivery	68.6	83.2	74.0	62.1	69.6	64.7
Syangja						
Child checked after birth: at facility	76.0	81.6	78.1	81.0	85.0	82.6#
Among home births: child's health checked within 48 hours of delivery	1.7	3.4	2.3	2.6	10.4	4.8
Among home births: child's health checked within 7 days of delivery	7.3	7.6	7.4	15.8	19.5	16.9
Among home births: child's health checked within 6 weeks of delivery	22.8	22.7	22.7	21.9	28.6	23.8
Among home births: child's health checked any time after delivery	42.5	53.8	46.3	25.5	29.9	26.7
Checked by skilled health provider	97.1	98.3	98.8	98.6	99.7	99.4
Mother received counseling on breastfeeding within 1 hour of delivery	78.9	85.1	81.5	68.6	72.5	70.2
Parbat						
Child checked after birth: at facility	86.1	90.1	88.6	73.6*	79.5*	77.2*
Among home births: child's health checked within 48 hours of delivery	6.4	6.2	6.3	6.2	10.8	8.1
Among home births: child's health checked within 7 days of delivery	11.8	12.9	12.3	17.1	22.6	19.4
Among home births: child's health checked within 6 weeks of delivery	37.7	41.8	39.6	24.8	32.3	27.9
Among home births: child's health checked any time after delivery	50.5	52.6	51.5	24.8	36.6	29.7
Checked by skilled health provider	97.7	95.3	97.6	99.7	96.3	97.0
Mother received counseling on breastfeeding within 1 hour of delivery	74.3	85.7	80.5	79.7	83.8	82.1

Levels of significance: * p <.001; ! p <.01; # p <.05

Figure 23. Percentage of children checked any time after birth among home births, by district, social status, and survey wave, as reported by women

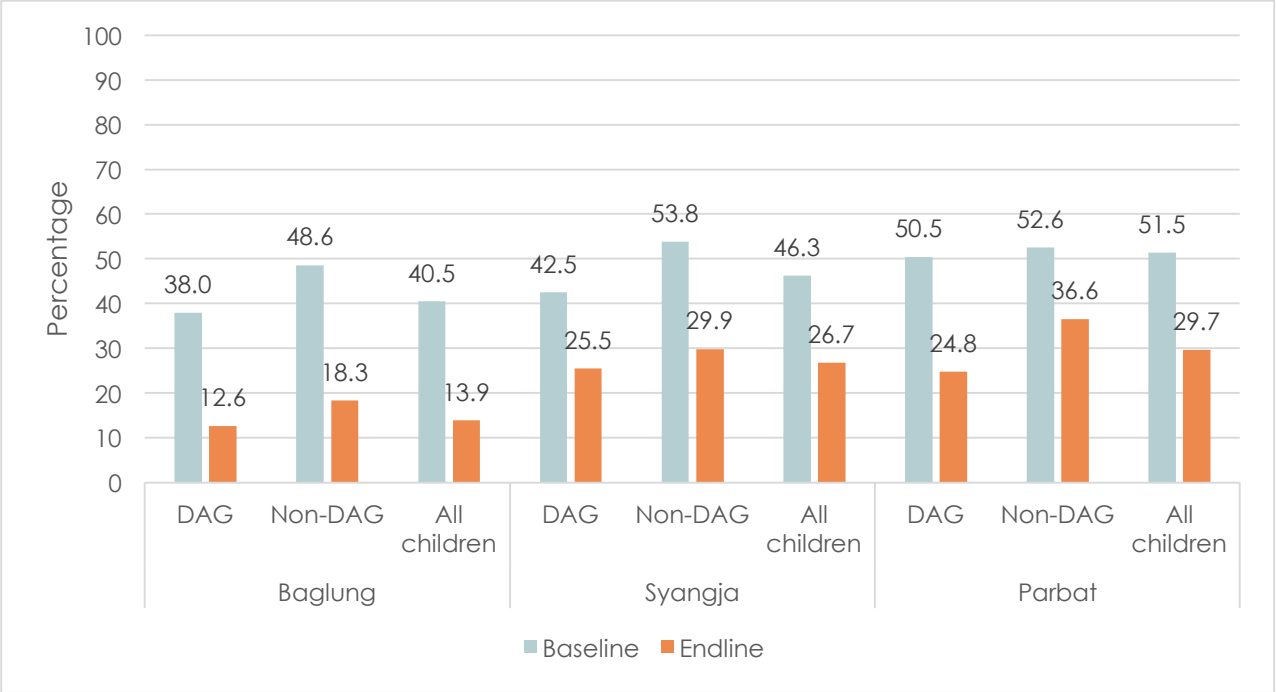


Table 52. Child diarrhea prevalence in last two weeks and source of advice/treatment, by survey wave, district, and social status, as reported by women

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Baglung						
Diarrhea in last two weeks	15.6	14.2	15.0	14.8	11.4	13.7
Sought advice/treatment *	71.6	69.4	70.9	53.6[!]	58.2	54.9[!]
Did not seek advice/treatment	28.4	30.6	29.1	46.4	41.8	45.1
All sources of advice/treatment						
Public Sector						
Government hospital	11.5	6.0	9.6	18.7	18.8	18.7
Government health services	33.3	36.0	34.2	22.7	15.6	20.6
Public pharmacy/chemist	0.0	2.0	0.7	0.0	0.0	0.0
Gov't community health worker	6.3	4.0	5.5	2.7	0.0	1.9
Satellite clinic	5.2	8.0	6.2	6.7	0.0	4.7
Private for-profit sector						
Private hospital	9.4	8.0	8.9	22.7	21.9	22.4
Private clinics	35.4	36.0	35.6	28.0	34.4	29.9
Private doctors/nurses	1.0	0.0	0.7	1.3	3.1	1.9

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Private pharmacy	5.2	10.0	6.8	5.3	6.3	5.6
Traditional healer	0.0	2.0	0.7	4.0	3.1	3.7
Other	1.0	2.0	1.4	1.3	3.1	1.9
What advice/treatment received						
ORS	53.1	48.0	51.4	40.0	50.0	43.0
Pills	6.3	10.0	7.5	8.0	3.1	6.5
Zinc	10.4	16.0	12.3	18.7	18.8	18.7
Syrup	77.1	72.0	75.3	88.0	90.6	88.8
Injection	1.0	2.0	1.4	4.0	3.1	3.7
Traditional medicines	1.0	2.0	1.4	8.0	6.3	7.5
Unsure	1.0	2.0	1.4	0.0	3.1	0.9
Pulse broth	6.3	8.0	6.8	6.7	6.3	6.5
Other	2.1	4.0	2.7	0.0	0.0	0.0
Both ORS and zinc	3.1	10.0	5.5	10.7	6.3	9.3
Syangja						
Diarrhea in last two weeks	14.0	7.4	11.2	9.3	7.1	8.4
Sought advice/treatment	75.0	68.6	73.2	64.5	50.0	59.4#
All sources of advice/treatment						
Public Sector						
Government hospital	8.7	4.2	7.5	5.0	11.8	7.0
Government health services	33.3	16.7	29.0	22.5	11.8	19.3
Public pharmacy/chemist	0.0	0.0	0.0	0.0	0.0	0.0
Gov't community health worker	0.0	0.0	0.0	0.0	0.0	0.0
Satellite clinic	4.3	0.0	3.2	12.5	23.5	15.8
Private for-profit sector						
Private hospital	15.9	4.2	12.9	25.0	11.8	21.1
Private clinics	42.0	75.0	50.5	40.0	41.2	40.4
Private doctors/nurses	0.0	0.0	0.0	0.0	0.0	0.0
Private pharmacy	0.0	4.2	1.1	2.5	0.0	1.8
Traditional healer	1.4	0.0	1.1	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
What advice/treatment received						
ORS	36.2	29.2	34.4	27.5	35.3	29.8
Pills	4.3	0.0	3.2	7.5	17.6	10.5
Zinc	4.3	12.5	6.5	0.0	0.0	0.0
Syrup	91.3	79.2	88.2	77.5	82.4	78.9

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Injection	2.9	0.0	2.2	0.0	0.0	0.0
Traditional medicines	1.4	0.0	1.1	0.0	0.0	0.0
Unsure	0.0	0.0	0.0	5.0	0.0	3.5
Pulse broth	2.9	0.0	2.2	2.5	5.9	3.5
Other	4.3	4.2	4.3	2.5	5.9	3.5
Both ORS and zinc	2.9	4.2	3.2	0.0	0.0	0.0
Parbat						
Diarrhea in last two weeks	13.3	8.3	10.5	11.4	8.3	9.6
Sought advice/treatment	77.8	72.1	75.4	62.5[!]	43.8*	53.1*
All sources of advice/treatment						
Public Sector						
Government hospital	19.0	20.5	19.6	17.5	21.4	19.1
Government health services	31.7	18.2	26.2	32.5	17.9	26.5
Public pharmacy/chemist	0.0	0.0	0.0	0.0	0.0	0.0
Gov't community health worker	0.0	4.5	1.9	2.5	3.6	2.9
Satellite clinic	0.0	0.0	0.0	2.5	7.1	4.4
Private for-profit sector						
Private hospital	23.8	18.2	21.5	20.0	28.6	23.5
Private clinics	31.7	43.2	36.4	17.5	28.6	22.1
Private doctors/nurses	0.0	0.0	0.0	0.0	0.0	0.0
Private pharmacy	1.6	0.0	0.9	7.5	0.0	4.4
Traditional healer	0.0	0.0	0.0	2.5	0.0	1.5
Other	0.0	0.0	0.0	0.0	3.6	1.5
What advice/treatment received						
ORS	58.7	59.1	58.9	50.0	50.0	50.0
Pills	11.1	11.4	11.2	12.5	10.7	11.8
Zinc	17.5	22.7	19.6	27.5	17.9	23.5
Syrup	57.1	56.8	57.0	57.5	64.3	60.3
Injection	0.0	0.0	0.0	5.0	0.0	2.9
Traditional medicines	0.0	0.0	0.0	2.5	0.0	1.5
Unsure	0.0	0.0	0.0	0.0	3.6	1.5
Pulse broth	6.3	4.5	5.6	5.0	3.6	4.4
Other	6.3	4.5	5.6	2.5	3.6	2.9
Both ORS and zinc	12.7	15.9	14.0	0.0	0.0	0.0

Levels of significance: * p <.001; ! p <.01; # p <.05

Table 53. Women's report of reasons for not seeking treatment of child diarrhea within the last two weeks, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
No permission from HH head	0.0	0.0	0.0	0.0	0.0	0.0
No permission from other HH member	2.6	0.0	1.7	1.5	0.0	1.1
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	5.3	0.0	3.3	4.6	0.0	3.4
Waiting to see	26.3	27.3	26.7	46.2	43.5	45.5
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	7.9	0.0	5.0	9.2	0.0	6.8
Did not think it was severe	10.5	4.5	8.3	38.5	26.1	35.2
Treated at home	50.0	68.2	56.7	49.2	56.5	51.1
Other	5.3	9.1	6.7	1.5	0.0	1.1
Syangja						
No permission from HH head	4.3	0.0	2.9	0.0	0.0	0.0
No permission from other HH member	4.3	0.0	2.9	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	0.0	0.0	0.0	4.5	0.0	2.6
Waiting to see	21.7	27.3	23.5	18.2	17.6	17.9
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	4.3	0.0	2.9	0.0	0.0	0.0
Clinic/HF too far away	4.3	0.0	2.9	0.0	0.0	0.0
Did not think it was severe	8.7	0.0	5.9	18.2	17.6	17.9
Treated at home	60.9	72.7	64.7	63.6	82.4	71.8
Other	8.7	9.1	8.8	4.5	5.9	5.1
Parbat						
No permission from HH head	0.0	0.0	0.0	0.0	0.0	0.0
No permission from other HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	0.0	0.0	0.0	0.0	0.0	0.0
Waiting to see	44.4	41.2	42.9	33.3	38.9	36.7
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	11.1	0.0	5.7	4.2	2.8	3.3
Did not think it was severe	0.0	0.0	0.0	41.7	36.1	38.3
Treated at home	55.6	52.9	54.3	45.8	61.1	55.0
Other	11.1	17.6	14.3	0.0	0.0	0.0

Table 54. Child fever prevalence in last two weeks and source of advice/treatment, by survey wave, district, and social status, as reported by women

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Baglung						
Fever in last two weeks	31.0	27.6	29.7	16.8	11.8	15.1
Sought advice/treatment	76.4	89.3	80.8	81.1	82.5	81.5
All sources of advice/treatment						
Public Sector						
Government hospital	5.9	8.0	6.7	9.3	6.4	8.5
Government health services	26.5	28.0	27.1	20.9	10.6	18.2
Public pharmacy/chemist	0.5	0.0	0.3	0.8	0.0	0.6
Gov't nursing maternity home	0.0	0.8	0.3	0.0	0.0	0.0
Gov't community health worker	2.9	2.4	2.7	1.6	4.3	2.3
Satellite clinic	6.4	8.0	7.0	4.7	6.4	5.1
Private non-profit sector	0.0	0.0	0.0	0.0	0.0	0.0
Private for-profit sector						
Private hospital	18.1	21.6	19.5	25.6	25.5	25.6
Private clinics	38.2	33.6	36.5	30.2	38.3	32.4
Private doctors/nurses	1.0	1.6	1.2	2.3	4.3	2.8
Private pharmacy	6.4	5.6	6.1	10.1	8.5	9.7
Traditional healer	1.0	0.8	0.9	3.9	2.1	3.4
Other	0.0	0.8	0.3	0.8	2.1	1.1
All reasons for not seeking advice/treatment						
No permission from HH head	0.0	0.0	0.0	0.0	0.0	0.0
No permission from other HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	6.3	0.0	5.1	3.3	0.0	2.5
Waiting to see	39.7	33.3	38.5	46.7	80.0	55.0
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	11.1	0.0	9.0	6.7	0.0	5.0
Did not think it was severe	3.2	0.0	2.6	50.0	20.0	42.5
Treated at home	42.9	66.7	47.4	50.0	50.0	50.0
Other	12.7	6.7	11.5	0.0	0.0	0.0
Syangja						
Fever in last two weeks	34.9	29.4	32.6	11.4	10.4	11.0
Sought advice/treatment	87.8	89.9	88.6	80.3	80.0	80.2#
Did not seek advice/treatment	12.2	10.1	11.4	19.7	20.0	19.8
Source of advice/treatment						

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Public Sector						
Government hospital	2.5	2.4	2.5	0.0	2.5	1.0
Government health services	30.8	18.4	26.1	24.6	25.0	24.8
Public pharmacy/chemist	0.0	0.8	0.3	0.0	0.0	0.0
Gov't nursing maternity home	0.0	0.0	0.0	0.0	0.0	0.0
Gov't community health worker	0.5	0.0	0.3	0.0	0.0	0.0
Satellite clinic	7.0	5.6	6.4	6.6	12.5	8.9
Private non-profit sector	0.0	0.8	0.3	0.0	0.0	0.0
Private for-profit sector						
Private hospital	12.9	9.6	11.7	21.3	12.5	17.8
Private clinics	48.3	60.8	53.1	42.6	45.0	43.6
Private doctors/nurses	0.0	0.0	0.0	0.0	0.0	0.0
Private pharmacy	0.0	2.4	0.9	3.3	0.0	2.0
Traditional healer	1.0	1.6	1.2	3.3	0.0	2.0
Other	0.5	0.0	0.3	1.6	0.0	1.0
All reasons for not seeking advice/treatment						
No permission from HH head	0.0	0.0	0.0	0.0	0.0	0.0
No permission from other HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	7.1	0.0	4.8	0.0	0.0	0.0
Waiting to see	39.3	14.3	31.0	33.3	40.0	36.0
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	3.6	0.0	2.4	0.0	0.0	0.0
Clinic/HF too far away	3.6	7.1	4.8	0.0	0.0	0.0
Did not think it was severe	14.3	0.0	9.5	33.3	10.0	24.0
Treated at home	42.9	71.4	52.4	46.7	40.0	44.0
Other	0.0	14.3	4.8	0.0	10.0	4.0
Parbat						
Fever in last two weeks	31.4	29.9	30.6	18.7	10.2	13.8
Sought advice/treatment	80.7	84.1	82.5	81.9	88.5	84.7
Did not seek advice/treatment	19.3	15.9	17.5	18.1	11.5	15.3
All sources of advice/treatment						
Public Sector						
Government hospital	17.4	14.1	15.6	12.8	17.4	14.8
Government health services	25.2	19.5	22.1	18.6	14.5	16.8
Public pharmacy/chemist	0.0	0.0	0.0	0.0	0.0	0.0
Gov't nursing maternity home	0.0	0.0	0.0	0.0	0.0	0.0
Gov't community health worker	0.0	0.0	0.0	1.2	4.3	2.6

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Satellite clinic	0.0	1.6	0.9	8.1	8.7	8.4
Private non-profit sector	0.0	0.0	0.0	0.0	1.4	0.6
Private for-profit sector						
Private hospital	30.3	24.9	27.4	30.2	29.0	29.7
Private clinics	36.8	43.8	40.6	33.7	30.4	32.3
Private doctors/nurses	1.9	1.6	1.8	0.0	1.4	0.6
Private pharmacy	0.6	2.2	1.5	2.3	2.9	2.6
Traditional healer	0.6	0.0	0.3	1.2	0.0	0.6
Other	0.0	1.1	0.6	0.0	0.0	0.0
All reasons for not seeking advice/treatment						
No permission from HH head	0.0	0.0	0.0	0.0	0.0	0.0
No permission from other HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	0.0	0.0	0.0	0.0	0.0	0.0
Waiting to see	35.1	34.3	34.7	36.8	11.1	28.6
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	5.4	8.6	6.9	5.3	0.0	3.6
Did not think it was severe	16.2	17.1	16.7	42.1	33.3	39.3
Treated at home	45.9	42.9	44.4	47.4	100.0	64.3
Other	18.9	20.0	19.4	0.0	0.0	0.0

Levels of significance: * p <.001; ! p <.01; # p <.05

Table 55. Child common cold in last two weeks and source of advice/treatment, by district, social status, and survey wave, as reported by women

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Baglung						
Had cold plus also had rapid breathing	48.3	38.4	44.5	55.5	41.6	51.3
Sought advice/treatment	73.8	71.8	73.1	52.7*	61.7	54.9***
All sources of advice/treatment						
Public Sector						
Government hospital	5.6	8.4	6.6	9.4	5.7	8.3
Government health services	28.3	27.1	27.9	22.8	18.9	21.7
Public pharmacy/chemist	0.6	0.0	0.3	0.0	0.0	0.0
Gov't community health worker	4.4	2.8	3.8	1.6	0.0	1.1
Private non-profit sector						
NGO hospital	0.0	0.0	0.0	0.0	0.0	0.0
Private for-profit sector						
Private hospital	14.4	16.8	15.3	24.4	39.6	28.9
Private clinics	38.3	32.7	36.2	37.0	34.0	36.1
Private doctors/nurses	1.7	0.9	1.4	0.8	0.0	0.6
Private pharmacy	8.3	6.5	7.7	3.9	3.8	3.9
Traditional healer	0.6	0.9	0.7	2.4	0.0	1.7
Other	0.0	0.9	0.3	0.8	1.9	1.1
All reasons for not seeking advice/treatment						
No permission from HH head	0.8	0.0	0.5	0.7	0.0	0.5
No permission from other HH member	0.8	0.0	0.5	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	2.5	0.0	1.5	2.2	0.0	1.5
Waiting to see	34.2	28.2	31.8	44.9	56.7	48.5
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	6.7	0.0	4.0	6.6	3.3	5.6
Did not think it was severe	10.8	2.6	7.6	36.8	35.0	36.2
Treated at home	57.5	74.4	64.1	63.2	53.3	60.2
Other	4.2	10.3	6.6	0.0	0.0	0.0
Syangja						
Had cold plus also had rapid breathing	45.5	32.9	40.5	42.8	38.8	41.4
Sought advice/treatment	74.2	76.1	74.8	62.5	62.5	62.5*
All sources of advice/treatment						
Public Sector						
Government hospital	5.8	2.1	4.2	1.1	3.9	2.1
Government health services	28.1	32.6	30.1	20.7	19.6	20.3

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Public pharmacy/chemist	0.0	1.1	0.5	0.0	0.0	0.0
Gov't community health worker	0.0	1.1	0.5	0.0	0.0	0.0
Private non-profit sector						
NGO hospital	0.0	0.0	0.0	0.0	0.0	0.0
Private for-profit sector						
Private hospital	8.3	7.4	7.9	21.7	7.8	16.8
Private clinics	55.4	50.5	53.2	52.2	43.1	49.0
Private doctors/nurses	0.0	0.0	0.0	1.1	2.0	1.4
Private pharmacy	0.8	2.1	1.4	0.0	0.0	0.0
Traditional healer	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	1.1	13.7	5.6
All reasons for not seeking advice/treatment						
No permission from HH head	1.1	0.0	0.7	0.0	0.0	0.0
No permission from HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	1.1	0.0	0.7	1.1	1.9	1.4
Waiting to see	44.6	17.8	35.8	26.3	21.2	24.5
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	0.0	0.0	0.0	0.0	0.0	0.0
Clinic/HF too far away	3.3	0.0	2.2	7.4	0.0	4.8
Did not think it was severe	9.8	13.3	10.9	48.4	40.4	45.6
Treated at home	50.0	73.3	57.7	61.1	71.2	64.6
Other	5.4	2.2	4.4	0.0	0.0	0.0
Parbat						
Common cold in last two weeks	33.4	32.5	32.9	24.8	23.5	24.0
Sought advice/treatment	61.3	61.9	61.6	38.1	41.1	39.8
Did not seek advice/treatment	38.7	38.1	38.4	61.9	58.9	60.2
Had cold plus also had rapid breathing	36.3	34.3	35.2	38.8	35.6	37.0
Sought advice/treatment	81.1	74.4	77.6	63.0*	62.5	62.7**
All sources of advice/treatment						
Public Sector						
Government hospital	15.2	9.5	12.1	18.9	9.5	13.4
Government health services	19.2	20.9	20.1	28.3	13.5	19.7
Public pharmacy/chemist	0.0	0.0	0.0	0.0	0.0	0.0
Gov't community health worker	0.8	0.7	0.7	1.9	2.7	2.4
Private non-profit sector						
NGO hospital	0.0	0.0	0.0	1.9	1.4	1.6
Private for-profit sector						
Private hospital	24.8	18.2	21.2	24.5	28.4	26.8
Private clinics	38.4	52.0	45.8	26.4	32.4	29.9

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Private doctors/nurses	2.4	0.0	1.1	0.0	2.7	1.6
Private pharmacy	0.8	0.7	0.7	0.0	0.0	0.0
Traditional healer	0.0	0.0	0.0	0.0	0.0	0.0
Other	1.6	2.0	1.8	1.9	1.4	1.6
All reasons for not seeking advice/treatment						
No permission from HH head	0.0	0.0	0.0	1.2	0.0	0.5
No permission from other HH member	0.0	0.0	0.0	0.0	0.0	0.0
No money for transportation	0.0	0.0	0.0	0.0	0.0	0.0
No money for treatment	2.5	0.0	1.2	0.0	0.9	0.5
Waiting to see	46.8	46.2	46.5	30.2	29.2	29.7
Did not trust health professionals	0.0	0.0	0.0	0.0	0.0	0.0
Did not get quality care	2.5	0.0	1.2	0.0	0.0	0.0
Clinic/HF too far away	1.3	3.3	2.4	1.2	2.8	2.1
Did not think it was severe	8.9	4.4	6.5	40.7	40.6	40.6
Treated at home	55.7	60.4	58.2	58.1	68.9	64.1
Other	6.3	12.1	9.4	0.0	0.0	0.0

Levels of significance: *** p <.001; ** p <.01; * p <.05

Table 56. Child vaccination status, by child's sex and by mother's social status, district, and survey wave, as reported by women

	Baseline				End line			
	DAG %		Non-DAG %		DAG %		Non-DAG %	
	Male	Female	Male	Female	Male	Female	Male	Female
Baglung								
Full vaccine coverage	93.9	96.1	84.2	86.7	90.6	94.3	93.1	94.3
Syangja								
Full vaccine coverage	95.3	95.4	98.6	96.5	96.5	94.3	99.2	99.1
Parbat								
Full vaccine coverage	95.3	97.3	98.6	98.4	96.6	93.9	98.6	97.7

Figure 24. Percent of women reporting satisfaction with ANC, by district and survey wave

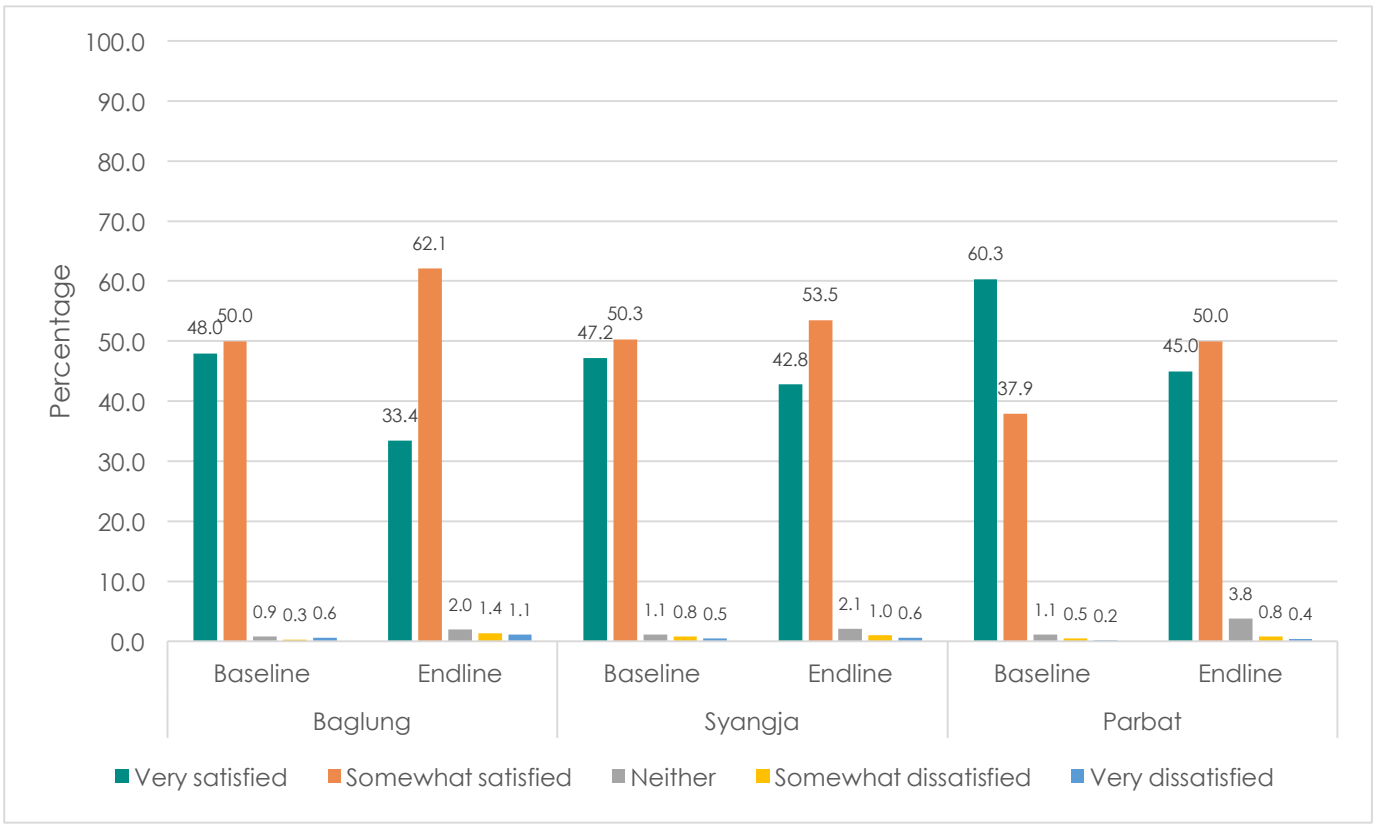


Figure 25. Women's report on the extent to which staff listened to concerns during ANC

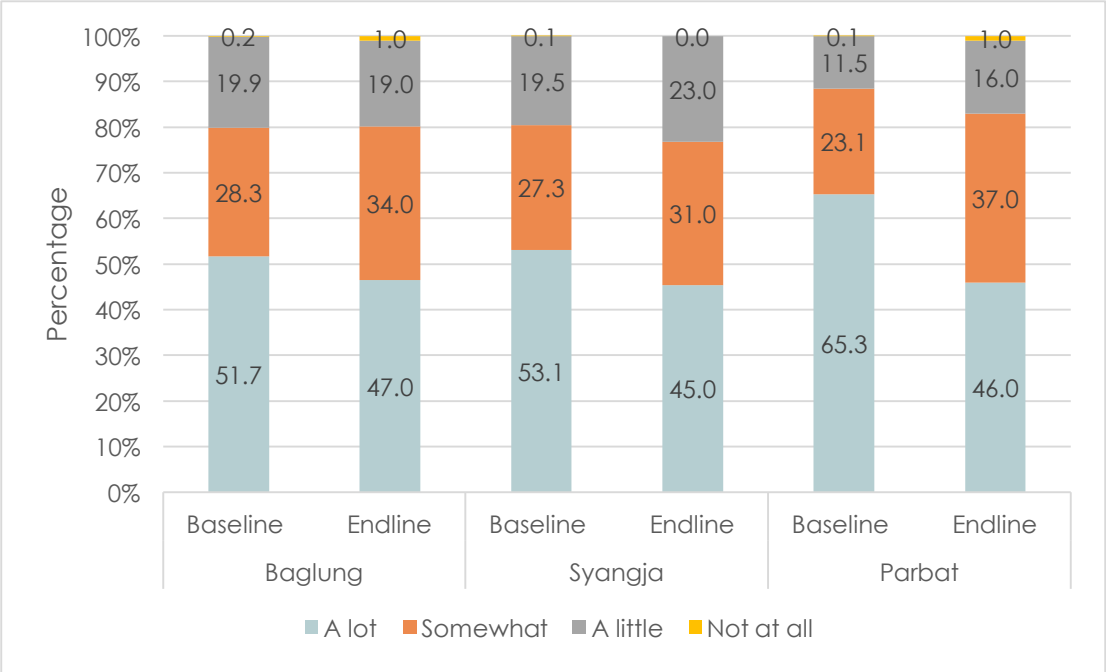


Table 57. Newborns receiving essential services within 2 days of birth at end line, by social status and district**

	End line		
	DAG %	Non-DAG %	All children %
Baglung			
Among facility births: newborns receiving essential services within 2 days of birth	14.3	16.8	15.5
Among home births: newborns receiving essential services within 2 days of birth	0.4	0.6	0.4
Syangja			
Among facility births: newborns receiving essential services within 2 days of birth	18.9	17.2	18.1
Among home births: newborns receiving essential services within 2 days of birth	0.5	1.5	0.8
Parbat			
Among facility births: newborns receiving essential services within 2 days of birth	14.4	21.1	18.4
Among home births: newborns receiving essential services within 2 days of birth	1.2	0.7	0.9

** Services were checked child's cord; measured temperature; counseled mother on danger signs for newborns; counseled mother on breastfeeding; and observed mother breastfeeding

Table 58. Women's satisfaction with childbirth services, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
How satisfied with the service?						
Very satisfied	63.1	59.9	61.4	44.8	49.2	46.7
Somewhat satisfied	35.8	36.7	36.3	51.5	47.7	49.9
Neither	0.7	0.9	0.8	1.6	1.8	1.7
Somewhat dissatisfied	0.4	0.9	0.7	0.2	1.2	0.7
Very dissatisfied	0.0	1.5	0.8	1.9	0.0	1.1
How attentive were staff?						
Very attentive	63.4	63.0	63.2	46.4	51.7	48.7
Somewhat attentive	35.1	35.2	35.1	50.3	44.7	47.9
Neither	1.1	1.2	1.2	2.6	3.0	2.8
Somewhat inattentive	0.4	0.3	0.3	0.5	0.3	0.4
Very inattentive	0.0	0.3	0.2	0.2	0.3	0.3
How friendly were staff?						
Very friendly	56.3	55.7	55.9	40.8	44.1	42.2
Somewhat friendly	41.9	41.3	41.6	54.5	52.9	53.8
Neither friendly nor unfriendly	1.4	2.1	1.8	3.3	1.8	2.6
Somewhat unfriendly	0.0	0.6	0.3	0.7	0.9	0.8
Very unfriendly	0.4	0.3	0.3	0.7	0.3	0.5
How respectful were staff?						
Very respectful	52.3	53.5	53.0	38.9	41.3	40.0
Somewhat respectful	47.0	44.6	45.7	56.6	55.9	56.3
Neither	0.4	0.6	0.5	2.3	1.2	1.8
Somewhat disrespectful	0.4	1.2	0.8	0.7	0.6	0.7
Very disrespectful	0.0	0.0	0.0	1.4	0.9	1.2
How knowledgeable were staff?						
Very knowledgeable	78.9	74.3	76.4	58.7	71.7	64.4
Somewhat knowledgeable	19.7	25.4	22.8	38.5	26.4	33.2
Neither knowledgeable nor unknowledgeable	1.4	0.3	0.8	1.9	1.5	1.7
Somewhat unknowledgeable	0.0	0.0	0.0	0.9	0.0	0.5
Very unknowledgeable	0.0	0.0	0.0	0.0	0.3	0.1
Extent to which staff listened to concerns?						
A lot	51.6	50.8	51.2	45.7	48.6	47.0
Somewhat	28.7	31.2	30.0	35.0	32.2	33.8
A little	19.4	16.8	18.0	18.6	18.8	18.7
Not at all	0.4	1.2	0.8	0.7	0.3	0.5
Services helpful for safe delivery?						
A lot	53.8	56.9	55.4	39.9	48.6	43.7
Somewhat	38.4	35.5	36.8	52.2	45.0	49.1
A little	7.9	7.3	7.6	7.5	5.5	6.6
Not at all	0.0	0.3	0.2	0.5	0.9	0.7

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Syangja						
How satisfied with the service?						
Very satisfied	59.8	61.9	60.7	51.9	53.0	52.4
Somewhat satisfied	39.2	37.6	38.5	45.5	41.8	43.8
Neither	0.0	0.0	0.0	2.3	3.2	2.7
Somewhat dissatisfied	0.7	0.6	0.6	0.0	1.2	0.6
Very dissatisfied	0.2	0.0	0.1	0.2	0.7	0.5
How attentive were staff?						
Very attentive	60.3	59.9	60.1	48.9	47.0	48.1
Somewhat attentive	38.5	38.7	38.6	43.8	45.5	44.6
Neither	0.9	0.3	0.6	7.2	7.2	7.2
Somewhat inattentive	0.0	0.6	0.3	0.0	0.0	0.0
Very inattentive	0.2	0.6	0.4	0.0	0.2	0.1
How friendly were staff?						
Very friendly	52.5	56.2	54.2	39.1	41.3	40.2
Somewhat friendly	46.1	40.7	43.6	48.9	50.0	49.4
Neither friendly nor unfriendly	1.2	1.7	1.4	10.6	8.4	9.6
Somewhat unfriendly	0.0	0.6	0.3	0.4	0.0	0.2
Very unfriendly	0.2	0.8	0.5	0.9	0.2	0.6
How respectful were staff?						
Very respectful	53.0	49.2	51.2	33.8	32.2	33.1
Somewhat respectful	45.4	49.4	47.2	58.7	62.9	60.6
Neither	1.2	0.8	1.0	6.8	3.7	5.4
Somewhat disrespectful	0.5	0.0	0.3	0.4	0.5	0.5
Very disrespectful	0.0	0.6	0.3	0.2	0.7	0.5
How knowledgeable were staff?						
Very knowledgeable	69.3	68.4	68.9	68.3	69.8	69.0
Somewhat knowledgeable	30.0	30.2	30.1	27.2	26.2	26.8
Neither knowledgeable nor unknowledgeable	0.5	0.8	0.6	4.3	4.0	4.1
Somewhat unknowledgeable	0.2	0.6	0.4	0.0	0.0	0.0
Very unknowledgeable	0.0	0.0	0.0	0.2	0.0	0.1
Extent to which staff listened to concerns?						
A lot	54.6	52.5	53.7	44.9	45.5	45.2
Somewhat	27.0	31.4	29.0	32.3	29.7	31.1
A little	18.2	15.5	17.0	22.6	24.3	23.3
Not at all	0.2	0.6	0.4	0.2	0.5	0.3
Services helpful for safe delivery?						
A lot	56.5	53.1	55.0	40.9	40.3	40.6
Somewhat	39.2	43.5	41.2	51.9	50.2	51.1
A little	4.3	3.1	3.7	7.0	9.4	8.1
Not at all	0.0	0.3	0.1	0.2	0.0	0.1
Parbat						

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
How satisfied with the service?						
Very satisfied	68.8	65.7	67.0	53.7	50.9	52.0
Somewhat satisfied	29.9	31.7	31.0	42.6	43.0	42.9
Neither	0.8	1.1	1.0	2.1	3.9	3.2
Somewhat dissatisfied	0.5	0.9	0.8	0.2	1.2	0.8
Very dissatisfied	0.0	0.6	0.3	1.4	1.0	1.2
How attentive were staff?						
Very attentive	66.2	64.4	65.2	50.2	49.7	49.9
Somewhat attentive	30.7	31.5	31.2	42.8	45.4	44.4
Neither	2.0	2.2	2.1	6.0	4.0	4.8
Somewhat inattentive	0.8	1.1	1.0	0.0	0.3	0.2
Very inattentive	0.3	0.7	0.5	0.9	0.6	0.7
How friendly were staff?						
Very friendly	56.8	61.4	59.5	41.7	45.0	43.7
Somewhat friendly	40.2	33.8	36.4	50.5	46.7	48.2
Neither friendly nor unfriendly	1.0	3.3	2.4	5.1	6.8	6.1
Somewhat unfriendly	1.5	0.9	1.2	1.4	0.7	1.0
Very unfriendly	0.5	0.6	0.5	1.4	0.7	1.0
How respectful were staff?						
Very respectful	53.2	53.7	53.5	39.1	39.0	39.1
Somewhat respectful	44.5	43.0	43.6	53.5	55.9	55.0
Neither	0.8	1.7	1.3	5.8	3.7	4.5
Somewhat disrespectful	0.5	0.7	0.6	0.7	0.1	0.4
Very disrespectful	1.0	0.9	1.0	0.9	1.2	1.1
How knowledgeable were staff?						
Very knowledgeable	78.8	73.6	75.8	67.6	63.9	65.4
Somewhat knowledgeable	20.7	24.5	22.9	27.5	32.2	30.4
Neither knowledgeable nor unknowledgeable	0.3	0.9	0.6	3.9	3.6	3.7
Somewhat unknowledgeable	0.0	0.2	0.1	0.5	0.1	0.3
Very unknowledgeable	0.3	0.7	0.5	0.5	0.1	0.3
Extent to which staff listened to concerns?						
A lot	60.1	60.3	60.2	47.0	45.1	45.8
Somewhat	25.3	25.3	25.3	32.6	40.2	37.3
A little	13.6	13.5	13.5	19.0	14.4	16.2
Not at all	1.0	0.9	1.0	1.4	0.3	0.7
Services helpful for safe delivery?						
A lot	60.9	63.1	62.2	42.6	45.5	44.4
Somewhat	33.5	32.3	32.8	48.1	47.3	47.6
A little	5.4	4.4	4.8	8.8	6.7	7.5
Not at all	0.3	0.2	0.2	0.5	0.4	0.5

Table 59. Mother's satisfaction with postnatal care for herself, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
How satisfied with the service?						
Very satisfied	47.8	46.8	47.3	43.3	51.4	47.1
Somewhat satisfied	50.7	53.2	51.9	55.8	46.2	51.3
Neither	0.0	0.0	0.0	0.9	2.1	1.5
Somewhat dissatisfied	1.4	0.0	0.8	0.0	0.3	0.2
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
How attentive were staff?						
Very attentive	49.3	54.8	51.9	43.0	50.3	46.4
Somewhat attentive	49.3	45.2	47.3	54.2	47.9	51.3
Neither	0.0	0.0	0.0	2.1	1.7	1.9
Somewhat inattentive	1.4	0.0	0.8	0.0	0.0	0.0
Very inattentive	0.0	0.0	0.0	0.6	0.0	0.3
How friendly were staff?						
Very friendly	47.8	54.8	51.1	40.3	44.4	42.2
Somewhat friendly	50.7	45.2	48.1	54.8	52.4	53.7
Neither friendly nor unfriendly	0.0	0.0	0.0	4.5	3.1	3.9
Somewhat unfriendly	1.4	0.0	0.8	0.0	0.0	0.0
Very unfriendly	0.0	0.0	0.0	0.3	0.0	0.2
How respectful were staff?						
Very respectful	56.5	50.0	53.4	35.8	40.6	38.0
Somewhat respectful	39.1	50.0	44.3	60.3	56.9	58.7
Neither	1.4	0.0	0.8	2.4	1.7	2.1
Somewhat disrespectful	0.0	0.0	0.0	1.2	0.0	0.6
Very disrespectful	2.9	0.0	1.5	0.3	0.7	0.5
How knowledgeable were staff?						
Very knowledgeable	66.7	79.0	72.5	60.3	68.4	64.1
Somewhat knowledgeable	33.3	19.4	26.7	36.4	29.5	33.2
Neither knowledgeable nor unknowledgeable	0.0	1.6	0.8	3.3	2.1	2.8
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Very unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	42.0	54.8	48.1	38.8	48.6	43.4
Somewhat	36.2	32.3	34.4	37.9	32.3	35.3
A little	21.7	12.9	17.6	23.0	18.8	21.0
Not at all	0.0	0.0	0.0	0.3	0.3	0.3
Syangja						
How satisfied with the service?						
Very satisfied	47.8	54.5	50.5	53.9	47.0	50.8
Somewhat satisfied	52.2	45.5	49.5	44.7	49.0	46.7

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Neither	0.0	0.0	0.0	0.9	2.8	1.8
Somewhat dissatisfied	0.0	0.0	0.0	0.2	0.8	0.5
Very dissatisfied	0.0	0.0	0.0	0.2	0.3	0.3
How attentive were staff?						
Very attentive	41.8	54.5	46.8	47.8	41.1	44.7
Somewhat attentive	58.2	45.5	53.2	46.6	53.3	49.6
Neither	0.0	0.0	0.0	5.6	5.7	5.7
Somewhat inattentive	0.0	0.0	0.0	0.0	0.0	0.0
Very inattentive	0.0	0.0	0.0	0.0	0.0	0.0
How friendly were staff?						
Very friendly	40.3	63.6	49.5	40.0	39.9	40.0
Somewhat friendly	56.7	36.4	48.6	50.4	51.3	50.8
Neither friendly nor unfriendly	1.5	0.0	0.9	8.9	8.2	8.6
Somewhat unfriendly	1.5	0.0	0.9	0.0	0.0	0.0
Very unfriendly	0.0	0.0	0.0	0.7	0.6	0.6
How respectful were staff?						
Very respectful	40.3	45.5	42.3	33.9	27.2	30.8
Somewhat respectful	59.7	54.5	57.7	62.6	68.6	65.3
Neither	0.0	0.0	0.0	3.3	2.5	3.0
Somewhat disrespectful	0.0	0.0	0.0	0.0	0.3	0.1
Very disrespectful	0.0	0.0	0.0	0.2	1.4	0.8
How knowledgeable were staff?						
Very knowledgeable	61.2	54.5	58.6	71.3	69.1	70.3
Somewhat knowledgeable	38.8	45.5	41.4	25.9	27.8	26.7
Neither knowledgeable nor unknowledgeable	0.0	0.0	0.0	2.8	3.1	3.0
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Very unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	58.2	52.3	55.9	45.2	44.2	44.7
Somewhat	28.4	40.9	33.3	32.9	30.3	31.7
A little	13.4	6.8	10.8	21.9	25.5	23.5
Not at all	0.0	0.0	0.0	0.0	0.0	0.0
Parbat						
How satisfied with the service?						
Very satisfied	74.5	71.1	72.5	51.5	52.8	52.3
Somewhat satisfied	23.6	25.0	24.4	44.8	43.6	44.0
Neither	0.0	3.9	2.3	3.1	2.1	2.4
Somewhat dissatisfied	0.0	0.0	0.0	0.3	1.1	0.8
Very dissatisfied	1.8	0.0	0.8	0.3	0.5	0.4
How attentive were staff?						
Very attentive	67.3	73.7	71.0	44.8	46.7	46.1

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Somewhat attentive	32.7	25.0	28.2	52.4	48.6	50.0
Neither	0.0	1.3	0.8	2.2	3.5	3.0
Somewhat inattentive	0.0	0.0	0.0	0.6	0.3	0.4
Very inattentive	0.0	0.0	0.0	0.0	0.8	0.5
How friendly were staff?						
Very friendly	65.5	72.4	69.5	43.5	40.5	41.6
Somewhat friendly	34.5	26.3	29.8	52.6	53.6	53.2
Neither friendly nor unfriendly	0.0	1.3	0.8	2.5	5.1	4.1
Somewhat unfriendly	0.0	0.0	0.0	0.6	0.2	0.3
Very unfriendly	0.0	0.0	0.0	0.8	0.6	0.7
How respectful were staff?						
Very respectful	63.6	63.2	63.4	38.4	41.0	40.1
Somewhat respectful	30.9	34.2	32.8	59.3	55.5	56.9
Neither	3.6	2.6	3.1	1.9	2.5	2.3
Somewhat disrespectful	0.0	0.0	0.0	0.3	0.2	0.2
Very disrespectful	1.8	0.0	0.8	0.0	0.8	0.5
How knowledgeable were staff?						
Very knowledgeable	87.3	80.3	83.2	64.3	62.5	63.2
Somewhat knowledgeable	12.7	17.1	15.3	33.4	34.3	34.0
Neither knowledgeable nor unknowledgeable	0.0	2.6	1.5	2.2	2.9	2.6
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.2	0.1
Very unknowledgeable	0.0	0.0	0.0	0.0	0.2	0.1
Extent to which staff listened to concerns?						
A lot	63.6	71.1	67.9	47.4	47.9	47.7
Somewhat	27.3	18.4	22.1	35.1	37.4	36.5
A little	9.1	10.5	9.9	17.0	14.3	15.3
Not at all	0.0	0.0	0.0	0.6	0.5	0.5

Table 60. Mother's satisfaction with child's postnatal care, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women%	DAG %	Non-DAG %	All women %
Baglung						
How satisfied with the service?						
Very satisfied	55.2	60.4	57.6	44.7	45.6	45.1
Somewhat satisfied	43.1	37.9	40.7	53.4	52.5	53.0
Neither	0.5	0.3	0.4	1.1	1.6	1.3
Somewhat dissatisfied	1.0	0.9	0.9	0.5	0.0	0.3
Very dissatisfied	0.2	0.6	0.4	0.3	0.3	0.3
How attentive were staff?						
Very attentive	57.3	62.1	59.5	43.0	43.6	43.3
Somewhat attentive	42.2	37.6	40.1	55.1	54.8	54.9
Neither	0.5	0.0	0.3	0.8	1.6	1.2
Somewhat inattentive	0.0	0.3	0.1	1.1	0.0	0.6
Very inattentive	0.0	0.0	0.0	0.0	0.0	0.0
How friendly were staff?						
Very friendly	50.1	60.7	55.0	37.8	39.0	38.4
Somewhat friendly	48.7	38.2	43.9	58.1	56.7	57.5
Neither friendly nor unfriendly	1.0	0.9	0.9	3.6	3.6	3.6
Somewhat unfriendly	0.2	0.3	0.3	0.0	0.0	0.0
Very unfriendly	0.0	0.0	0.0	0.5	0.7	0.6
How respectful were staff?						
Very respectful	49.4	58.1	53.4	37.8	38.0	37.9
Somewhat respectful	49.2	41.3	45.6	59.5	60.0	59.7
Neither	1.0	0.0	0.5	1.4	1.6	1.5
Somewhat disrespectful	0.2	0.3	0.3	0.5	0.3	0.4
Very disrespectful	0.2	0.3	0.3	0.8	0.0	0.4
How knowledgeable were staff?						
Very knowledgeable	70.8	78.3	74.3	58.6	65.9	61.9
Somewhat knowledgeable	28.9	21.1	25.3	39.5	32.1	36.1
Neither knowledgeable nor unknowledgeable	0.2	0.3	0.3	1.9	2.0	1.9
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Very unknowledgeable	0.0	0.3	0.1	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	43.9	57.0	49.9	44.1	47.2	45.5
Somewhat	34.5	28.8	31.9	36.2	34.1	35.2
A little	21.0	14.0	17.8	19.5	18.4	19.0
Not at all	0.7	0.3	0.5	0.3	0.3	0.3
Helped you take care of child?						

	Baseline			End line		
	DAG %	Non-DAG %	All women%	DAG %	Non-DAG %	All women %
A lot	35.4	40.7	37.9	23.3	31.1	26.9
Somewhat	50.6	48.4	49.6	58.4	54.8	56.7
A little	11.8	9.4	10.7	15.1	11.1	13.3
Not at all	2.2	1.4	1.8	3.3	3.0	3.1
Syangja						
How satisfied with the service?						
Very satisfied	57.1	59.2	58.1	56.1	52.0	54.3
Somewhat satisfied	41.5	39.0	40.4	41.8	45.0	43.3
Neither	0.7	0.6	0.7	1.9	1.9	1.9
Somewhat dissatisfied	0.2	1.2	0.7	0.0	0.8	0.4
Very dissatisfied	0.5	0.0	0.3	0.2	0.3	0.3
How attentive were staff?						
Very attentive	55.7	53.4	54.7	45.9	48.0	46.9
Somewhat attentive	43.6	45.7	44.6	50.8	47.7	49.4
Neither	0.5	0.6	0.5	3.0	4.1	3.5
Somewhat inattentive	0.2	0.3	0.3	0.0	0.3	0.1
Very inattentive	0.0	0.0	0.0	0.2	0.0	0.1
How friendly were staff?						
Very friendly	53.8	54.0	53.9	40.8	40.1	40.5
Somewhat friendly	45.0	45.7	45.3	50.1	52.0	51.0
Neither friendly nor unfriendly	0.7	0.0	0.4	8.6	7.6	8.1
Somewhat unfriendly	0.0	0.3	0.1	0.0	0.0	0.0
Very unfriendly	0.5	0.0	0.3	0.5	0.3	0.4
How respectful were staff?						
Very respectful	50.2	49.0	49.7	37.4	37.4	37.4
Somewhat respectful	48.8	50.4	49.5	56.8	59.3	58.0
Neither	0.9	0.0	0.5	5.1	2.4	3.9
Somewhat disrespectful	0.0	0.3	0.1	0.5	0.3	0.4
Very disrespectful	0.0	0.3	0.1	0.2	0.5	0.4
How knowledgeable were staff?						
Very knowledgeable	67.8	65.7	66.8	70.8	70.2	70.5
Somewhat knowledgeable	32.2	33.7	32.9	26.9	26.6	26.8
Neither knowledgeable nor unknowledgeable	0.0	0.3	0.1	2.3	3.3	2.8
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Very unknowledgeable	0.0	0.3	0.1	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	53.8	53.7	53.8	48.5	43.9	46.4
Somewhat	26.7	28.8	27.6	30.6	32.8	31.6
A little	19.5	17.5	18.6	20.9	23.3	22.0
Not at all	0.0	0.0	0.0	0.0	0.0	0.0

	Baseline			End line		
	DAG %	Non-DAG %	All women%	DAG %	Non-DAG %	All women %
Helped you take care of child?						
A lot	40.2	39.5	39.9	27.1	27.4	27.3
Somewhat	51.4	52.2	51.8	63.6	59.6	61.8
A little	7.1	6.8	7.0	8.1	10.6	9.3
Not at all	1.2	1.5	1.3	1.2	2.4	1.8
Parbat						
How satisfied with the service?						
Very satisfied	70.4	68.6	69.4	51.3	51.1	51.2
Somewhat satisfied	29.4	30.9	30.2	43.9	45.3	44.8
Neither	0.0	0.0	0.0	3.1	2.1	2.5
Somewhat dissatisfied	0.2	0.5	0.4	1.1	0.9	1.0
Very dissatisfied	0.0	0.0	0.0	0.6	0.7	0.6
How attentive were staff?						
Very attentive	67.6	72.0	70.1	45.9	46.7	46.4
Somewhat attentive	31.5	27.3	29.1	51.3	49.4	50.1
Neither	0.5	0.2	0.3	2.5	3.3	3.0
Somewhat inattentive	0.2	0.2	0.2	0.0	0.2	0.1
Very inattentive	0.2	0.4	0.3	0.3	0.5	0.4
How friendly were staff?						
Very friendly	59.0	64.0	61.8	40.8	43.7	42.6
Somewhat friendly	40.6	35.1	37.4	54.6	51.3	52.6
Neither friendly nor unfriendly	0.5	0.5	0.5	3.4	4.3	3.9
Somewhat unfriendly	0.0	0.2	0.1	0.3	0.3	0.3
Very unfriendly	0.0	0.2	0.1	0.8	0.3	0.5
How respectful were staff?						
Very respectful	55.7	60.1	58.2	38.3	44.6	42.2
Somewhat respectful	44.1	38.3	40.8	57.2	52.0	53.9
Neither	0.2	0.9	0.6	3.7	2.9	3.2
Somewhat disrespectful	0.0	0.2	0.1	0.3	0.0	0.1
Very disrespectful	0.0	0.5	0.3	0.6	0.5	0.5
How knowledgeable were staff?						
Very knowledgeable	81.6	79.9	80.6	64.5	64.7	64.6
Somewhat knowledgeable	17.5	19.4	18.6	31.3	33.3	32.5
Neither knowledgeable nor unknowledgeable	0.5	0.4	0.4	3.7	1.9	2.6
Somewhat unknowledgeable	0.2	0.4	0.3	0.3	0.2	0.2
Very unknowledgeable	0.2	0.0	0.1	0.3	0.0	0.1
Extent to which staff listened to concerns?						
A lot	61.5	66.1	64.2	51.3	49.4	50.1
Somewhat	25.6	22.6	23.9	32.7	39.1	36.7

	Baseline			End line		
	DAG %	Non-DAG %	All women%	DAG %	Non-DAG %	All women %
A little	12.4	11.1	11.6	15.5	11.3	12.9
Not at all	0.5	0.2	0.3	0.6	0.2	0.3
Helped you take care of child?						
A lot	49.9	52.0	51.1	28.7	30.4	29.7
Somewhat	43.4	41.6	42.4	54.1	56.9	55.9
A little	6.3	6.0	6.1	14.9	10.3	12.0
Not at all	0.5	0.4	0.4	2.3	2.4	2.3

Table 61. Details on women receiving counseling about HTSP among those counseled, by survey wave, social status, and district

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Who counseled woman? (all sources)						
Doctor	31.7	42.5	36.6	30.9	26.7	29.0
Nurse/midwife	36.6	38.3	37.4	45.5	60.0	52.0
Health assistant	0.7	1.7	1.1	5.5	2.2	4.0
AHW	0.0	0.8	0.4	0.0	2.2	1.0
FCHV	57.7	52.5	55.3	63.6	64.4	64.0
Trained TBA	1.4	2.5	1.9	0.0	0.0	0.0
Un-trained TBA	0.0	0.0	0.0	0.0	0.0	0.0
Mother's group member	0.7	0.8	0.8	0.0	2.2	1.0
Relative/Friend/Neighbor	9.2	10.8	9.9	18.2	17.8	18.0
Mother child health worker	2.8	1.7	2.3	0.0	0.0	0.0
Other	3.5	2.5	3.1	0.0	0.0	0.0
When woman counseled? (all sources)						
Antenatal visit	46.5	60.0	52.7	47.3	51.1	49.0
Postnatal visit	57.0	50.0	53.8	43.6	40.0	42.0
Routine visit to clinic	16.9	16.7	16.8	20.0	33.3	26.0
Community health volunteer visits	7.0	6.7	6.9	7.3	6.7	7.0
Other	0.7	0.8	0.8	0.0	0.0	0.0
Syangja						
Who counseled woman? (all sources)						
Doctor	40.4	39.4	39.9	33.3	30.9	32.1
Nurse/midwife	44.7	51.1	47.6	45.8	51.5	48.6
Health assistant	0.9	1.1	1.0	0.0	0.0	0.0
AHW	0.0	0.0	0.0	0.0	1.5	0.7
FCHV	44.7	47.9	46.2	52.8	58.8	55.7
Trained TBA	0.0	1.1	0.5	0.0	1.5	0.7

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Un-trained TBA	0.0	0.0	0.0	0.0	0.0	0.0
Mother's group member	0.0	0.0	0.0	0.0	0.0	0.0
Relative/Friend/Neighbor	10.5	8.5	9.6	8.3	17.6	12.9
Mother child health worker	3.5	2.1	2.9	0.0	0.0	0.0
Other	6.1	0.0	3.4	0.0	4.4	2.1
When woman counseled? (all sources)						
Antenatal visit	43.0	61.7	51.4	25.0	38.2	31.4
Postnatal visit	57.0	50.0	53.8	63.9	61.8	62.9
Routine visit to clinic	17.5	24.5	20.7	16.7	13.2	15.0
Community health volunteer visits	3.5	4.3	3.8	5.6	4.4	5.0
Other	0.0	1.1	0.5	0.0	1.5	0.7
Parbat						
Who counseled woman? (all sources)						
Doctor	41.3	36.4	38.3	28.4	36.6	33.5
Nurse/midwife	49.4	51.0	50.4	59.7	54.5	56.4
Health assistant	0.6	0.0	0.2	1.5	3.6	2.8
AHW	0.6	2.8	1.9	3.0	3.6	3.4
FCHV	39.4	43.1	41.6	56.7	54.5	55.3
Trained TBA	0.0	0.8	0.5	1.5	1.8	1.7
Un-trained TBA	0.0	0.0	0.0	0.0	0.0	0.0
Mother's group member	0.0	0.0	0.0	0.0	0.0	0.0
Relative/Friend/Neighbor	8.1	5.9	6.8	17.9	15.2	16.2
Mother child health worker	0.6	4.7	3.1	1.5	2.7	2.2
Other	1.9	2.0	1.9	0.0	0.0	0.0
When woman counseled? (all sources)						
Antenatal visit	37.5	41.1	39.7	41.8	46.4	44.7
Postnatal visit	65.0	63.2	63.9	53.7	50.0	51.4
Routine visit to clinic	18.8	20.6	19.9	31.3	20.5	24.6
Community health volunteer visits	1.9	2.8	2.4	9.0	12.5	11.2
Other	2.5	2.0	2.2	0.0	0.0	0.0

Table 62. Women's satisfaction with HTSP counseling, by survey wave, district, and social status

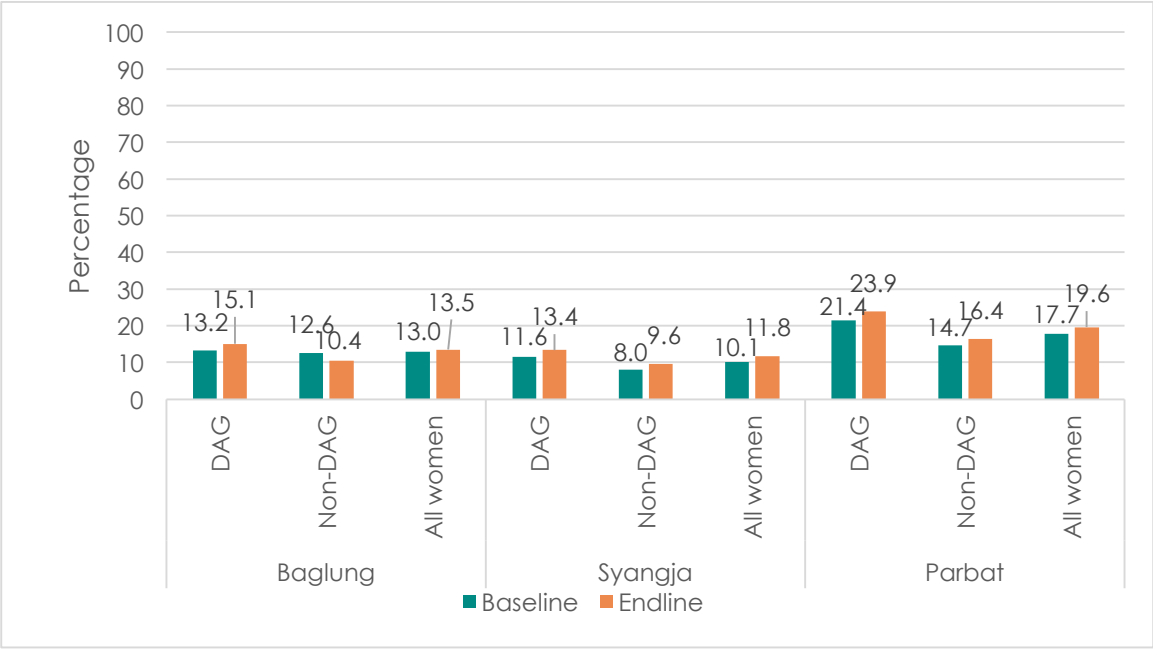
	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
How satisfied with counseling?						
Very satisfied	69.5	52.8	61.7	41.9	36.8	40.0
Somewhat satisfied	30.5	45.8	37.7	48.4	63.2	54.0
Neither satisfied nor dissatisfied	0.0	0.0	0.0	6.5	0.0	4.0

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Somewhat dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Very dissatisfied	0.0	0.0	0.0	3.2	0.0	2.0
How responsive were staff?						
Very responsive	53.7	44.4	49.4	45.2	47.4	46.0
Somewhat responsive	45.1	54.2	49.4	48.4	47.4	48.0
Neither responsive nor unresponsive	1.2	0.0	0.6	0.0	5.3	2.0
Somewhat responsive	0.0	1.4	0.6	6.5	0.0	4.0
Very unresponsive	0.0	0.0	0.0	0.0	0.0	0.0
How friendly were staff?						
Very friendly	58.5	51.4	55.2	48.4	31.6	42.0
Somewhat friendly	41.5	48.6	44.8	45.2	68.4	54.0
Neither friendly nor unfriendly	0.0	0.0	0.0	3.2	0.0	2.0
Somewhat unfriendly	0.0	0.0	0.0	3.2	0.0	2.0
Very unfriendly	0.0	0.0	0.0	0.0	0.0	0.0
How respectful were staff?						
Very respectful	57.3	52.8	55.2	45.2	31.6	40.0
Somewhat respectful	41.5	45.8	43.5	54.8	68.4	60.0
Neither respectful nor disrespectful	1.2	0.0	0.6	0.0	0.0	0.0
Somewhat disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
Very disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
How knowledgeable were staff?						
Very knowledgeable	68.3	58.3	63.6	54.8	36.8	48.0
Somewhat knowledgeable	31.7	41.7	36.4	41.9	63.2	50.0
Neither knowledgeable nor unknowledgeable	0.0	0.0	0.0	3.2	0.0	2.0
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Very unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	57.3	55.6	56.5	48.4	47.4	48.0
Somewhat	30.5	30.6	30.5	32.3	31.6	32.0
A little	12.2	13.9	13.0	19.4	21.1	20.0
Not at all	0.0	0.0	0.0	0.0	0.0	0.0
Syangja						
How satisfied with counseling?						
Very satisfied	60.0	63.6	61.6	69.0	48.1	58.9
Somewhat satisfied	40.0	34.8	37.7	27.6	44.4	35.7
Neither satisfied nor dissatisfied	0.0	0.0	0.0	3.4	7.4	5.4
Somewhat dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
How responsive were staff?						
Very responsive	61.2	56.1	58.9	48.3	48.1	48.2
Somewhat responsive	37.6	40.9	39.1	48.3	48.1	48.2
Neither responsive nor unresponsive	1.2	1.5	1.3	0.0	3.7	1.8

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Somewhat responsive	0.0	0.0	0.0	0.0	0.0	0.0
Very unresponsive	0.0	0.0	0.0	3.4	0.0	1.8
How friendly were staff?						
Very friendly	65.9	59.1	62.9	44.8	29.6	37.5
Somewhat friendly	32.9	39.4	35.8	37.9	70.4	53.6
Neither friendly nor unfriendly	1.2	0.0	0.7	13.8	0.0	7.1
Somewhat unfriendly	0.0	0.0	0.0	0.0	0.0	0.0
Very unfriendly	0.0	0.0	0.0	3.4	0.0	1.8
How respectful were staff?						
Very respectful	58.8	50.0	55.0	37.9	40.7	39.3
Somewhat respectful	40.0	50.0	44.4	62.1	51.9	57.1
Neither respectful nor disrespectful	1.2	0.0	0.7	0.0	7.4	3.6
Somewhat disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
Very disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
How knowledgeable were staff?						
Very knowledgeable	70.6	60.6	66.2	65.5	59.3	62.5
Somewhat knowledgeable	28.2	36.4	31.8	34.5	33.3	33.9
Neither knowledgeable nor unknowledgeable	1.2	1.5	1.3	0.0	3.7	1.8
Somewhat unknowledgeable	0.0	0.0	0.0	0.0	3.7	1.8
Very unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	61.2	54.5	58.3	51.7	40.7	46.4
Somewhat	23.5	27.3	25.2	31.0	29.6	30.4
A little	15.3	16.7	15.9	17.2	29.6	23.2
Not at all	0.0	0.0	0.0	0.0	0.0	0.0
Parbat						
How satisfied with counseling?						
Very satisfied	70.9	67.3	68.7	62.2	55.9	58.3
Somewhat satisfied	24.3	29.6	27.5	37.8	40.7	39.6
Neither satisfied nor dissatisfied	0.0	1.3	0.8	0.0	1.7	1.0
Somewhat dissatisfied	3.9	0.6	1.9	0.0	1.7	1.0
Very dissatisfied	1.0	1.3	1.1	0.0	0.0	0.0
How responsive were staff?						
Very responsive	72.8	64.2	67.6	32.4	49.2	42.7
Somewhat responsive	24.3	34.6	30.5	62.2	47.5	53.1
Neither responsive nor unresponsive	1.0	0.6	0.8	2.7	1.7	2.1
Somewhat responsive	1.0	0.6	0.8	0.0	0.0	0.0
Very unresponsive	1.0	0.0	0.4	2.7	1.7	2.1
How friendly were staff?						
Very friendly	66.0	67.3	66.8	48.6	42.4	44.8
Somewhat friendly	33.0	32.1	32.4	43.2	52.5	49.0

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Neither friendly nor unfriendly	0.0	0.6	0.4	8.1	5.1	6.3
Somewhat unfriendly	1.0	0.0	0.4	0.0	0.0	0.0
Very unfriendly	0.0	0.0	0.0	0.0	0.0	0.0
How respectful were staff?						
Very respectful	61.2	76.7	70.6	40.5	47.5	44.8
Somewhat respectful	37.9	22.6	28.6	56.8	49.2	52.1
Neither respectful nor disrespectful	1.0	0.6	0.8	2.7	3.4	3.1
Somewhat disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
Very disrespectful	0.0	0.0	0.0	0.0	0.0	0.0
How knowledgeable were staff?						
Very knowledgeable	84.5	78.0	80.5	56.8	59.3	58.3
Somewhat knowledgeable	14.6	22.0	19.1	40.5	40.7	40.6
Neither knowledgeable nor unknowledgeable	0.0	0.0	0.0	2.7	0.0	1.0
Somewhat unknowledgeable	1.0	0.0	0.4	0.0	0.0	0.0
Very unknowledgeable	0.0	0.0	0.0	0.0	0.0	0.0
Extent to which staff listened to concerns?						
A lot	70.9	67.9	69.1	45.9	52.5	50.0
Somewhat	18.4	22.6	21.0	40.5	42.4	41.7
A little	10.7	9.4	9.9	13.5	5.1	8.3
Not at all	0.0	0.0	0.0	0.0	0.0	0.0

Figure 26. Women reporting use of modern FP, by district, social status, and survey wave



*There were no significant differences between baseline and end line.

Table 63. Client exit interview feedback on service provision, by district and survey wave

	Average health service rating scores (1-5)					
	Baglung		Syangja		Parbat	
	Baseline	End line	Baseline	End line	Baseline	End line
You felt comfortable asking your provider questions.	4.4	4.5	4.1	4.8	4.1	4.7
Your provider was attentive to your needs.	4.2	4.7	4.4	4.7	4.4	4.6
Your provider took your concerns seriously.	4.1	4.7	4.3	4.6	4.4	4.6
You believe that your provider made decisions in your best interest.	4.2	4.6	4.3	4.4	4.2	4.6
Your provider was friendly.	4.2	4.8	4.6	4.8	4.4	4.5
Your provider was respectful.	4.1	4.8	4.5	4.7	4.3	4.7
You believe that your provider treated you fairly.	4.1	4.8	4.5	4.6	4.4	4.5
You felt that your provider treated you without judgment.	4.2	4.8	4.3	4.7	4.4	4.6
You felt that the provider explained things well.	4.3	4.9	4.4	4.8	4.6	4.8
You felt welcomed at the HF.	4.1	4.7	4.2	4.6	4.1	4.5
You felt safe at the HF.	4.1	4.6	4.4	4.6	4.1	4.6
You felt that the staff worked to protect your privacy.	4.2	4.7	3.9	4.4	3.8	4.5
The room where you received services was clean.	4.5	4.8	4.4	4.60	4.1	4.8
Overall, you were satisfied with the services you received today.	4.4	4.7	4.6	4.82	4.2	4.7
You would recommend this facility to a friend.	4.4	4.7	4.5	4.81	4.4	4.6

Table 64. Women's report of access to government HF, by survey wave, district, and social status

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Time to government HF: On foot (mean, in minutes)	76.1	45.2	64.7	45.9	44.4	45.3	44.3	38.7	41.3
Did not report (%)	1.4	2.4	1.8	12.8	16.5	14.3	3.6	5.3	4.5
15 minutes or less (%)	19.3	27.4	22.3	24.4	24.1	24.3	25.9	26.8	26.4
16 to 30 minutes (%)	20.1	31.5	24.3	26.5	24.9	25.9	35.5	38.0	36.9
31 to 60 minutes (%)	21.1	21.1	21.1	19.4	19.5	19.4	21.3	19.6	20.3
More than 60 minutes (%)	38.1	17.7	30.5	16.9	15.0	16.1	13.7	10.3	11.9
Time to government HF: By bus (mean, in minutes)	151.9	88.3	120.1	51.6	44.8	48.2	46.9	55.6	52.7
End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Time to government HF: On foot (mean, in minutes)	67.8	44.7	60.0	48.5	38.2	44.4	37.7	34.9	36.0
Did not report (%)	0.4	1.2	0.7	23.1	30.4	26.2	5.7	5.3	5.5
15 minutes or less (%)	19.4	28.8	22.6	16.7	23.7	19.6	29.9	25.6	27.4
16 to 30 minutes (%)	23.3	31.7	26.1	22.2	20.8	21.6	35.8	42.1	39.5
31 to 60 minutes (%)	26.2	24.3	25.6	20.9	15.2	18.5	18.0	21.1	19.8
More than 60 minutes (%)	30.7	13.9	25.0	17.1	10.0	14.1	10.5	5.9	7.8
Time to government HF: By bus (mean, in minutes)	90.9	39.6	59.9	48.4	45.6	47.1	33.5	35.1	34.4

Table 65. Women's report of service availability at local HF, by survey wave, district, and social status

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
ANC	41.5	50.6	44.9	45.1	46.7	45.8	58.8	57.7	58.2
Delivery services	17.9	35.8	24.5	11.6	17.1	13.9	17.7	26.2	22.3
PNC	6.6	10.6	8.1	10.5	12.1	11.2	8.3	12.9	10.8
FP	39.1	40.0	39.4	21.6	22.0	21.8	19.1	16.3	17.6
Routine health visit	17.9	23.6	20.0	18.1	18.2	18.2	25.5	28.9	27.4

Child health visit	13.6	21.1	16.4	11.6	15.4	13.2	43.2	48.4	46.0
Immunizations	78.6	76.6	77.9	87.0	85.4	86.4	66.9	66.7	66.8
Curative care	15.1	18.3	16.3	27.9	28.8	28.3	21.6	19.2	20.3
Other	3.6	1.6	2.8	4.4	3.4	4.0	4.4	5.2	4.8
Don't know	0.2	0.4	0.3	0.3	0.0	0.2	0.8	0.7	0.7
End line									
	Baglung			**Syangja**			**Parbat**		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total	DAG	Non-DAG	Total
ANC	77.0	78.0	77.4	81.8	77.8	80.1	83.4	84.9	84.3
Delivery services	54.7	66.8	58.8	26.0	28.5	27.0	42.6	46.2	44.7
PNC	31.0	38.2	33.4	42.0	41.0	41.6	34.4	41.6	38.6
FP	44.8	53.5	47.7	50.9	51.1	51.0	38.5	42.2	40.7
Routine health visit	37.9	45.0	40.3	36.2	38.0	37.0	34.6	39.1	37.2
Child health visit	33.1	40.7	35.7	33.6	33.5	33.6	38.5	41.5	40.2
Immunizations	87.7	88.6	88.0	96.2	96.5	96.3	87.2	86.7	86.9
Curative care	38.5	41.5	39.5	22.1	29.3	25.1	55.1	53.3	54.1
Other	0.2	0.0	0.1	0.3	0.4	0.3	1.1	0.7	0.8
Don't know	0.1	0.2	0.1	0.2	0.0	0.1	0.2	0.4	0.3

Table 66. Availability of services, by survey wave, district, and social status, as reported by women

Baseline									
	Baglung			**Syangja**			**Parbat**		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Convenience of service hours									
Very convenient	41.5	52.8	45.7	44.1	47.8	45.6	56.1	60.1	58.3
Somewhat convenient	47.5	39.6	44.6	48.0	46.9	47.6	37.8	35.5	36.5
Neither	9.9	6.9	8.8	7.2	4.2	5.9	4.4	3.1	3.7
Somewhat inconvenient	0.5	0.4	0.4	0.3	0.4	0.4	0.7	0.5	0.6
Inconvenient	0.7	0.4	0.6	0.5	0.6	0.5	1.0	0.8	0.9
Seen immediately									
Less than 30 minutes	45.6	51.2	47.7	43.3	35.1	39.9	54.7	50.3	52.3
30 minutes to one hour	38.9	35.0	37.5	43.3	48.8	45.6	34.9	35.6	35.3
One to two hours	10.6	9.8	10.3	10.5	12.7	11.4	8.0	11.4	9.9
More than two hours	4.3	3.1	3.9	2.3	3.0	2.6	2.3	2.0	2.2

Availability of health professionals									
Always available	43.7	48.8	45.6	41.5	39.7	40.7	48.9	46.3	47.5
Mostly available	31.6	34.4	32.7	43.1	47.8	45.1	36.7	41.2	39.1
Neither	24.0	16.1	21.1	15.4	12.3	14.1	13.6	12.0	12.7
Mostly unavailable	0.7	0.6	0.7	0.0	0.2	0.1	0.8	0.5	0.7
Unavailable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicine availability									
Always available	29.8	27.0	28.8	33.7	33.2	33.5	35.8	31.7	33.6
Mostly available	26.1	32.3	28.4	35.5	38.3	36.7	34.4	33.6	33.9
Neither	40.3	35.4	38.5	29.7	26.6	28.4	27.0	31.9	29.7
Mostly unavailable	3.7	4.3	3.9	1.1	1.7	1.3	2.8	2.3	2.5
Unavailable	0.0	1.0	0.4	0.0	0.2	0.1	0.0	0.5	0.3
Adequacy of staff									
Very adequate	28.1	29.9	28.8	27.1	24.5	26.0	33.2	26.8	29.7
Mostly adequate	28.6	36.6	31.6	42.2	46.3	43.9	33.1	35.2	34.2
Neither	38.2	30.3	35.3	28.8	26.8	28.0	31.4	34.5	33.1
Mostly inadequate	4.2	2.8	3.7	1.8	2.1	1.9	2.3	3.4	2.9
Inadequate	0.7	0.4	0.6	0.0	0.0	0.0	0.0	0.1	0.1
Don't know	0.2	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
End line									
	Baglung			**Syangja**			**Parbat**		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Convenience of service hours									
Very convenient	37.8	50.2	42.0	45.8	50.9	48.0	44.0	52.9	49.2
Somewhat convenient	54.3	44.6	51.0	45.9	40.1	43.5	51.0	42.5	46.1
Neither	6.6	4.6	5.9	6.9	7.7	7.2	3.4	3.4	3.4
Somewhat inconvenient	0.4	0.4	0.4	0.9	0.0	0.5	0.5	0.9	0.8
Inconvenient	1.0	0.2	0.7	0.5	1.2	0.8	1.1	0.3	0.6
Seen immediately									
Less than 30 minutes	56.7	58.5	57.3	49.2	43.2	46.7	59.2	63.2	61.5
30 minutes to one hour	34.3	34.0	34.2	39.6	44.9	41.8	33.7	30.2	31.7
One to two hours	7.0	5.4	6.4	9.5	9.1	9.3	3.6	4.4	4.1
More than two hours	1.2	1.9	1.4	1.5	1.9	1.7	2.1	1.4	1.7
Availability of health professionals									
Always available	36.0	36.5	36.2	46.4	50.1	48.0	41.5	40.9	41.2

Mostly available	43.0	47.9	44.6	44.7	37.8	41.8	47.6	49.7	48.8
Neither	19.9	14.9	18.2	8.6	11.6	9.9	10.7	8.9	9.6
Mostly unavailable	1.1	0.6	0.9	0.3	0.4	0.3	0.2	0.5	0.4
Unavailable	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Medicine availability									
Always available	16.3	11.0	14.5	29.1	29.3	29.2	22.8	20.9	21.7
Mostly available	21.7	31.1	24.9	30.8	30.6	30.7	37.1	38.1	37.7
Neither	55.7	50.6	54.0	36.6	35.6	36.2	37.4	36.2	36.7
Mostly unavailable	5.6	5.6	5.6	3.0	3.5	3.2	2.5	4.3	3.5
Unavailable	0.7	1.7	1.1	0.5	1.0	0.7	0.2	0.5	0.4
Adequacy of staff									
Very adequate	17.9	17.0	17.6	32.0	29.1	30.8	26.4	21.5	23.6
Mostly adequate	36.0	45.6	39.2	47.1	41.6	44.8	45.1	50.2	48.0
Neither	41.9	34.0	39.2	18.0	26.0	21.4	26.4	24.9	25.5
Mostly inadequate	3.7	3.3	3.6	2.7	3.3	3.0	2.1	3.1	2.7
Inadequate	0.5	0.0	0.4	0.2	0.0	0.1	0.0	0.3	0.2

Table 67. Women's sources of information about services available at local HF, by social status, district, and survey wave

Baseline									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
HF staff	16.1	28.0	20.5	23.5	27.7	25.2	38.5	47.0	43.1
FCHV	72.9	72.6	72.8	65.9	70.0	67.6	53.7	59.0	56.6
Friend	58.1	50.2	55.1	66.2	62.4	64.6	57.9	48.6	52.9
Community meeting	2.1	5.3	3.3	1.8	3.4	2.5	1.3	2.9	2.2
NGO/CBO meeting	0.2	0.4	0.3	0.0	0.0	0.0	0.0	0.1	0.1
HFOMC member	0.0	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1
Radio/FM	3.7	7.7	5.2	4.0	4.2	4.1	9.2	13.6	11.6
TV	0.8	2.8	1.5	3.4	3.8	3.5	2.1	6.1	4.3
Other	5.9	4.5	5.4	6.6	6.3	6.5	11.5	10.2	10.8

End line									
	Baglung			Syangja			Parbat		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG	All women %	DAG %	Non-DAG %	All women %
HF staff	47.0	60.6	51.6	30.6	33.5	31.8	55.3	60.0	58.0
FCHV	76.3	75.3	76.0	70.9	67.8	69.6	53.8	57.4	55.9
Friend	78.4	78.4	78.4	74.3	70.1	72.5	71.1	67.5	69.1
Community meeting	6.5	8.3	7.1	1.2	1.7	1.4	2.0	3.3	2.7
NGO/CBO meeting	0.4	0.8	0.6	0.2	0.4	0.3	0.2	0.3	0.2
HFOMC member	0.5	1.5	0.8	0.0	0.0	0.0	0.0	0.9	0.5
Radio/FM	5.5	5.0	5.3	4.4	5.6	4.9	8.6	12.6	10.9
TV	0.8	1.7	1.1	1.4	6.0	3.3	4.8	8.3	6.9
Other	1.0	0.8	0.9	1.2	1.7	1.4	2.9	2.7	2.8

Table 68. Women's concerns (all reported) regarding the services provided at local HF, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Lack of medicine or supplies	9.8	13.6	11.2	22.4	25.5	23.5
Poor availability of staff	7.0	9.6	8.0	7.5	6.2	7.1
Lack of certain health service(s)	7.9	4.9	6.8	6.5	10.0	7.6
Inconvenient facility hours	4.8	2.4	3.9	5.3	2.7	4.4
Long wait time for treatment	3.5	4.5	3.9	8.8	8.7	8.8
Charges for free medicines	1.4	2.4	1.8	4.4	6.8	5.3
Lack of necessary medical instruments	2.4	3.5	2.8	3.3	3.5	3.4
Charges for free services	0.7	1.6	1.0	1.7	2.9	2.1
Poor treatment	2.4	3.7	2.9	2.8	6.2	3.9
Disrespect, discrimination by facility staff	0.3	0.4	0.4	1.0	1.0	1.0
Lack of same-sex health provider	0.3	0.4	0.4	0.8	0.6	0.8
Lack of privacy or confidentiality at facility	0.0	0.0	0.0	0.6	0.4	0.6
Other	3.0	2.2	2.7	1.3	0.4	1.0
No concerns	79.0	78.1	78.7	71.0	69.9	70.6
Syangja						
Lack of medicine or supplies	9.3	12.5	10.6	21.9	27.7	24.3
Poor availability of staff	9.1	10.6	9.7	8.7	14.3	11.1
Lack of certain health service(s)	18.6	25.4	21.4	12.8	18.3	15.1
Inconvenient facility hours	4.0	5.7	4.7	13.1	13.7	13.3
Long waiting time for treatment	7.0	8.7	7.7	6.3	5.2	5.8
Charges for free medicines	3.7	7.4	5.2	3.3	6.9	4.8
Lack of necessary medical implements	2.4	4.4	3.3	10.5	11.6	11.0
Charges for free services	2.9	2.3	2.7	1.4	0.8	1.1
Poor treatment	4.1	6.8	5.2	5.9	9.6	7.4
Disrespect, discrimination by facility staff	0.5	0.4	0.4	1.4	0.8	1.1
Lack of same-sex health provider	3.2	4.7	3.8	0.9	1.7	1.2
Lack of privacy or confidentiality at facility	0.0	0.0	0.0	0.2	0.0	0.1
Other	3.0	7.0	4.7	0.5	1.0	0.7
Parbat						

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Lack of medicine or supplies	11.0	9.9	10.4	11.8	12.0	11.9
Poor availability of staff	9.5	10.1	9.8	6.2	9.3	8.0
Lack of certain health service(s)	3.9	6.3	5.2	5.5	8.6	7.3
Inconvenient facility hours	3.9	2.3	3.0	2.9	2.9	2.9
Long waiting time for treatment	4.1	3.9	4.0	5.5	5.2	5.3
Charges for free medicines	1.5	1.5	1.5	2.0	1.3	1.6
Lack of necessary instruments	3.6	4.2	3.9	6.2	8.1	7.3
Charges for free services	1.1	0.5	0.8	1.1	0.8	0.9
Poor treatment	2.6	4.9	3.9	3.6	5.3	4.6
Disrespect, discrimination by facility staff	0.2	0.7	0.4	1.1	1.2	1.1
Lack of same-sex health provider	2.6	1.6	2.1	0.5	1.3	1.0
Lack of privacy or confidentiality at facility	0.0	0.1	0.1	0.2	0.1	0.2
Other	4.9	4.8	4.8	0.4	0.4	0.4
No concerns	77.4	78.1	77.8	82.0	79.8	80.7

Table 69. Women's report of all sources of health and nutrition information, by survey wave, district, and social status

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Health information						
Baglung						
Radio	31.7	44.9	36.6	32.3	39.8	34.8
Television	19.4	39.2	26.7	23.2	41.3	29.3
Brochure, leaflet	19.9	21.5	20.5	9.6	20.5	13.3
Billboards	20.1	16.9	18.9	8.6	17.8	11.7
Flipcharts	17.8	8.7	14.4	4.1	10.0	6.1
Counseling card	18.1	12.8	16.1	5.5	11.2	7.4
Theater/cinema	18.2	9.4	15.0	12.4	16.6	13.8
Village gatherings	22.0	30.1	25.0	16.8	17.4	17.0
Religious meetings	3.8	9.8	6.1	6.0	5.0	5.7
Mother's groups	18.0	25.8	20.9	17.5	16.2	17.0
Street drama	3.8	6.5	4.8	1.9	3.1	2.3
HF	28.8	39.4	32.7	21.8	28.4	24.0
FCHV	41.7	47.4	43.8	26.3	29.9	27.5
Newspaper	7.7	15.2	10.4	5.4	11.6	7.5

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Other	0.9	1.2	1.0	0.8	2.5	1.4
Syangja						
Radio	29.6	39.5	33.7	24.3	35.6	29.0
Television	33.2	49.5	40.0	41.0	54.1	46.5
Brochure, leaflet	12.2	27.5	18.6	12.6	23.5	17.2
Billboards	11.1	19.9	14.8	13.1	19.1	15.6
Flipcharts	5.3	12.3	8.2	3.6	8.7	5.8
Counseling card	10.8	16.9	13.4	10.7	15.4	12.6
Theater/cinema	13.9	18.0	15.6	19.2	17.9	18.7
Village gatherings	20.4	21.8	21.0	10.7	14.3	12.2
Religious meetings	4.1	7.6	5.6	2.3	4.8	3.3
Mother's groups	16.5	21.8	18.7	10.1	12.9	11.2
Street drama	3.5	5.3	4.3	1.4	3.5	2.3
HF	43.8	48.4	45.7	30.3	34.5	32.1
FCHV	38.0	45.2	41.0	23.1	25.4	24.1
Newspaper	11.6	22.4	16.1	6.9	19.3	12.1
Other	0.9	1.5	1.2	3.6	7.5	5.2
Parbat						
Radio	33.9	51.6	43.6	28.5	41.6	36.1
Television	34.5	54.1	45.2	32.6	51.1	43.3
Brochure, leaflet	15.9	31.1	24.2	11.9	26.1	20.1
Billboards	15.2	25.3	20.7	12.3	22.4	18.1
Flipcharts	8.0	14.8	11.7	5.9	8.9	7.6
Counseling card	14.4	22.1	18.6	12.8	17.3	15.4
Theater/cinema	13.3	11.3	12.2	13.5	16.8	15.4
Village gatherings	14.9	23.1	19.4	9.8	12.0	11.1
Religious meetings	4.6	9.2	7.1	5.2	6.4	5.9
Mother's groups	18.2	23.0	20.8	10.0	11.6	10.9
Street drama	6.5	9.1	7.9	3.4	4.4	4.0
HF	47.6	53.3	50.7	28.3	34.6	31.9
FCHV	41.4	46.5	44.2	22.6	26.1	24.6
Newspaper	13.7	26.2	20.6	7.5	19.9	14.7
Other	1.1	1.8	1.5	2.1	4.0	3.2
Nutrition information						
Baglung						
Any source (=yes)	67.6	77.6	71.3	57.9	71.0	62.3
Radio	28.8	43.5	34.3	30.7	39.0	33.5
Television	16.7	36.0	23.9	19.5	36.9	25.4

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Brochure, leaflet	20.4	20.9	20.6	8.9	20.3	12.8
Billboards	20.2	16.5	18.8	8.4	17.6	11.5
Flipcharts	30.1	9.4	22.4	4.6	9.8	6.3
Counseling card	19.3	15.0	17.7	5.4	13.1	8.0
Theater/cinema	17.7	8.7	14.3	11.4	13.3	12.1
Village gatherings	19.9	29.9	23.6	15.1	12.2	14.2
Religious meetings	3.6	9.3	5.7	4.3	4.6	4.4
Mother's groups	16.6	23.6	19.2	14.9	12.7	14.2
Street drama	3.5	6.1	4.5	1.7	2.3	1.9
HF	28.5	38.6	32.2	20.3	29.9	23.5
FCHV	43.9	47.6	45.3	23.0	29.9	25.3
Newspaper	7.5	12.6	9.4	4.9	10.2	6.7
Other	0.7	0.6	0.7	1.0	1.0	1.0
Syangja						
Radio	26.5	38.9	31.7	19.7	31.0	24.4
Television	31.1	48.0	38.2	33.9	46.8	39.3
Brochure, leaflet	12.5	26.4	18.3	11.6	20.0	15.1
Billboards	11.7	18.2	14.4	8.7	15.4	11.5
Flipcharts	5.0	12.9	8.3	3.2	7.7	5.1
Counseling card	11.0	16.5	13.3	8.6	12.9	10.4
Theater/cinema	12.7	16.5	14.3	12.9	16.4	14.4
Village gatherings	19.7	20.3	19.9	9.0	10.8	9.8
Religious meetings	3.8	7.0	5.1	2.1	3.3	2.6
Mother's groups	15.7	20.7	17.8	7.2	8.7	7.8
Street drama	3.4	4.4	3.8	1.4	2.5	1.8
HF	43.8	47.4	45.3	27.0	31.0	28.7
FCHV	38.4	43.3	40.5	20.4	21.2	20.7
Newspaper	11.6	19.5	14.9	5.9	17.5	10.7
Other	0.5	0.2	0.4	1.2	4.4	2.5
Parbat						
Radio	33.4	51.2	43.1	23.9	38.3	32.2
Television	32.9	51.5	43.1	28.3	46.4	38.8
Brochure, leaflet	14.9	31.0	23.7	11.8	24.6	19.2
Billboards	14.2	23.9	19.5	12.1	19.6	16.4
Flipcharts	8.0	14.4	11.5	7.5	9.8	8.8
Counseling card	15.2	22.7	19.3	11.1	16.6	14.2
Theater/cinema	12.4	10.9	11.6	9.4	12.3	11.1
Village gatherings	13.6	20.7	17.4	9.3	10.4	9.9

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Religious meetings	3.9	8.7	6.5	4.6	5.5	5.1
Mother's groups	14.7	21.7	18.6	8.6	10.4	9.6
Street drama	7.0	7.7	7.4	2.5	3.3	2.9
HF	45.7	51.9	49.1	29.1	33.5	31.6
FCHV	39.6	44.8	42.5	20.9	21.4	21.2
Newspaper	12.8	24.6	19.2	6.4	17.7	13.0
Other	0.7	1.8	1.3	1.2	3.4	2.5

MNCH Health Outcomes

Table 70. Infant and young child feeding practices, by district, social status, and survey wave, as reported by women

	Baseline			End line		
	DAG %	Non-DAG %	All children %	DAG %	Non-DAG %	All children %
Baglung						
Ever breastfed	99.5	99.2	99.4	99.9	99.8	99.9
Mother's breastfeeding: immediately	41.3	42.3	41.7	40.8	45.3	42.3
Mother's breastfeeding: within one hour of birth	76.0	75.2	75.7	84.3	86.3	85.0
Exclusively breastfed age 0 to 6 months	93.7	87.6	91.6	93.9	89.0	92.2
Women who introduced complementary food to children at 6 to 8 months of age	83.9	82.9	83.5	60.5	77.2	66.1
Minimum Meal Frequency (MMF)						
Currently breastfeeding: Proportion of children 6 to 23 months of age who receive food a minimum number of times or more (6 to 8 months, 2 times; 9 to 23 months, 3 times) during the previous day	61.4	51.6	50.5	51.9	47.9	50.5
Minimum Dietary Diversity (MDD)						
Proportion of children 6 to 23 months of age who receive food from 4 or more food groups	64.0	64.3	64.1	58.1	58.8	58.3
Syangja						
Ever breastfed	99.7	99.4	99.6	99.5	99.8	99.7
Mother's breastfeeding: immediately	24.1	25.6	24.7	33.6	33.1	33.4
Mother's breastfeeding: within one hour of birth	69.2	71.9	70.3	80.0	82.3	81.0
Exclusively breastfed age 0 to 6 months	80.8	87.0	83.1	87.4	87.7	87.5
Women who introduced complementary food to children at 6 to 8 months of age	75.0	75.1	75.0	59.1	59.8	59.4
Minimum Meal Frequency (MMF)						
Currently breastfeeding: Proportion of children 6 to 23 months of age who receive food a minimum number of times or more (6 to 8 months, 2 times; 9 to 23 months, 3 times) during the previous day	69.0	71.3	70.0	55.9	55.8	55.8
Minimum Dietary Diversity (MDD)						

Proportion of children 6 to 23 months of age who receive food from 4 or more food groups	69.3	76.5	72.4	57.9	60.2	58.9
Parbat						
Ever breastfed	99.3	99.5	99.4	99.5	99.3	99.4
Mother's breastfeeding: immediately	39.8	43.1	41.6	48.2	46.3	47.1
Mother's breastfeeding: within one hour of birth	66.1	71.5	69.0	85.6	82.5	83.8
Exclusively breastfed age 0 to 6 months	92.6	85.8	89.1	91.7	88.6	89.9
Women who introduced complementary food to children at 6 to 8 months of age	82.2	82.0	82.1	74.1	77.7	76.2
Minimum Meal Frequency (MMF)						
Currently breastfeeding: Proportion of children 6 to 23 months of age who receive food a minimum number of times or more (6 to 8 months, 2 times; 9 to 23 months, 3 times) during the previous day	65.1	65.5	65.3	51.8	56.4	54.5
Minimum Acceptable Diet (MAD)						
Currently breastfeeding: Proportion of children 6 to 23 months of age who receive a minimum acceptable diet (apart from breast milk)	47.7	53.6	51.0	40.8	43.6	42.4

Table 71. Women's report of exclusive breastfeeding, by child age group, among infants under six months old, by survey wave, social status, and district[1]

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
0-1 month	99.1	96.6	98.3	98.5	91.3	96.4
2-3 months	100.0	95.7	98.6	92.0	83.0	89.4
4-5 months	94.3	93.3	94.0	87.1	69.5	81.5
0-3 months	99.1	92.6	96.9	90.7	76.8	86.5
Total	82.0	77.8	80.6	66.7	49.3	60.9
Parbat						
0-1 month	98.6	97.2	97.9	97.4	95.6	96.5
2-3 months	97.3	95.2	96.3	95.7	82.6	88.8
4-5 months	96.0	91.5	93.7	84.2	69.9	76.5
0-3 months	96.0	92.7	94.4	93.3	79.6	86.0
Total	83.2	77.3	80.2	70.9	51.2	59.6
Syangja						
0-1 month	96.2	98.8	97.2	96.7	92.2	95.4
2-3 months	93.3	96.6	94.6	93.7	79.7	89.2
4-5 months	88.1	90.3	89.0	84.1	67.0	78.4
0-3 months	90.0	95.5	92.1	90.8	74.7	85.5
Total	72.4	73.7	72.9	69.5	44.0	59.7

[1] Exclusive breastfeeding assessed by the questions," Are you still breastfeeding?" "Do you currently offer your child complementary foods?" Did [NAME] drink anything from a bottle with a nipple yesterday or last night?" and "Did [NAME] eat any solid, semi-solid, or soft foods yesterday during the day or night?"

Figure 27. Mean number of modern FP methods known by women, by district, social status, and survey wave

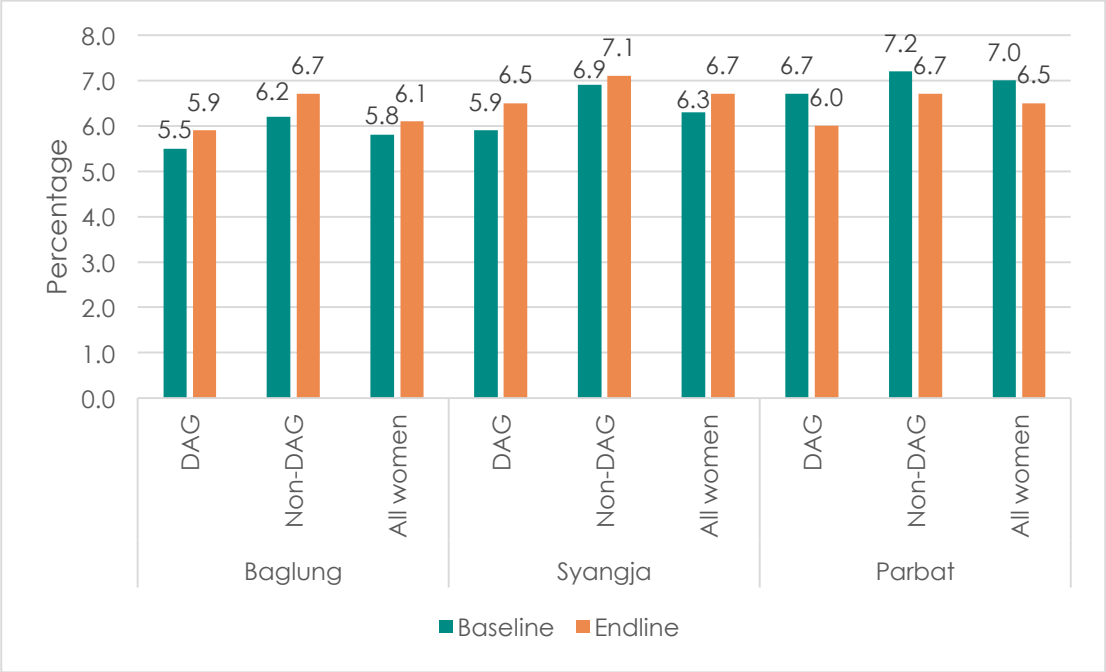


Table 72. Among women using FP, methods used, by social status, district, and survey wave

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Any modern method						
Female sterilization	0.0	4.5	1.7	1.4	3.9	2.1
Male sterilization	0.0	1.5	0.6	0.7	2.0	1.0
IUD	2.6	6.1	3.9	2.1	2.0	2.1
Injectables	47.8	22.7	38.7	55.2	52.9	54.6
Implants	4.3	6.1	5.0	10.5	9.8	10.3
Pill	21.7	30.3	24.9	21.7	21.6	21.6
Condom	23.5	30.3	26.0	9.8	11.8	10.3
Female condom	0.0	0.0	0.0	0.0	0.0	0.0
Diaphragm	0.0	0.0	0.0	0.0	0.0	0.0
Foam/jelly	0.0	0.0	0.0	0.0	0.0	0.0
Other modern method	0.0	0.0	0.0	0.0	0.0	0.0
Any non-modern method	0.3	1.0	0.6	0.0	0.2	0.1
Syangja						
Any modern method						
Female sterilization	10.4	2.4	7.6	3.4	8.5	5.1
Male sterilization	0.0	0.0	0.0	0.0	0.0	0.0
IUD	2.6	4.9	3.4	0.0	4.3	1.5
Injectables	48.1	29.3	41.5	55.1	42.6	50.7

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Implants	3.9	4.9	4.2	7.9	6.4	7.4
Pill	26.0	29.3	27.1	25.8	27.7	26.5
Condom	7.8	24.4	13.6	11.2	8.5	10.3
Female condom	0.0	0.0	0.0	0.0	0.0	0.0
Diaphragm	0.0	0.0	0.0	0.0	0.0	0.0
Foam/jelly	0.0	0.0	0.0	0.0	0.0	0.0
Other modern method	0.0	0.0	0.0	0.0	0.0	0.0
Any non-modern method	0.3	0.6	0.4	0.2	0.2	0.2
Parbat						
Any modern method						
Female sterilization	5.1	7.1	6.0	3.7	7.6	5.6
Male sterilization	0.0	0.0	0.0	0.7	0.8	0.7
IUD	10.3	7.1	8.9	7.4	5.3	6.4
Injectables	49.3	42.9	46.4	54.4	37.4	46.1
Implants	3.7	5.4	4.4	12.5	15.3	13.9
Pill	18.4	24.1	21.0	11.0	15.3	13.1
Condom	11.0	16.1	13.3	10.3	14.5	12.4
Female condom	0.7	0.0	0.4	0.0	0.0	0.0
Diaphragm	0.0	0.0	0.0	0.0	0.0	0.0
Foam/jelly	0.0	0.0	0.0	0.0	0.0	0.0
Other modern method	0.0	0.0	0.0	0.0	0.0	0.0
Any non-modern method	0.8	1.0	0.9	0.7	0.7	0.7

Relationships among the HFOMCs, Community, and HF

Table 73. Perceived roles of the HFOMC, among women who have heard of the HFOMCs, by district, social status, and survey wave

	Baseline			End line		
	DAG %	Non-DAG %	Total %	DAG %	Non-DAG %	Total %
Baglung						
Managing the HF staff	40.9	57.4	52.2	50.0	50.0	50.0
Managing/maintaining the physical infrastructure	40.9	14.9	23.2	15.4	21.4	18.5
Managing the availability of medicines and equipment	54.5	48.9	50.7	11.5	25.0	18.5
Developing solutions to the problems women face in accessing health services	9.1	6.4	7.2	7.7	21.4	14.8
Developing solutions to the problems that poor/disadvantaged people face in accessing health services	4.5	4.3	4.3	7.7	10.7	9.3

	Baseline			End line		
	DAG %	Non-DAG %	Total %	DAG %	Non-DAG %	Total %
Identifying those people who do not have access to health services	9.1	10.6	10.1	0.0	10.7	5.6
Managing/mobilizing resources/funds to support health services	13.6	8.5	10.1	3.8	10.7	7.4
Conducting facility audits	9.1	12.8	11.6	11.5	25.0	18.5
Conducting monthly meetings of the committee	13.6	6.4	8.7	15.4	28.6	22.2
Conducting social audits	4.5	4.3	4.3	0.0	7.1	3.7
Other	4.5	10.6	8.7	0.0	0.0	0.0
Don't know	27.3	10.6	15.9	42.3	28.6	35.2
Syangja						
Managing HF staff	67.6	45.5	53.9	37.5	38.9	38.5
Managing/maintaining the physical infrastructure	11.8	10.9	11.2	0.0	16.7	11.5
Managing the availability of medicines and equipment	35.3	36.4	36.0	12.5	22.2	19.2
Developing solutions to the problems women face in accessing health services	2.9	0.0	1.1	37.5	22.2	26.9
Developing solutions to the problems that poor/disadvantaged people face in accessing health services	2.9	5.5	4.5	37.5	16.7	23.1
Identifying those people who do not have access to health services	8.8	7.3	7.9	12.5	22.2	19.2
Managing/mobilizing resources/funds to support health services	17.6	14.5	15.7	37.5	16.7	23.1
Conducting facility audits	17.6	20.0	19.1	0.0	11.1	7.7
Conducting monthly meetings of the committee	8.8	14.5	12.4	0.0	5.6	3.8
Conducting social audits	0.0	1.8	1.1	0.0	0.0	0.0
Other	14.7	12.7	13.5	0.0	5.6	3.8
Don't know	2.9	5.5	4.5	0.0	16.7	11.5
Parbat						
Managing HF staff	59.0	62.5	61.6	45.5	63.3	57.7
Managing/maintaining physical infrastructure	10.3	15.2	13.9	31.8	32.7	32.4
Managing availability of medicines and equipment	64.1	55.4	57.6	45.5	36.7	39.4
Developing solutions to the problems women face in accessing health services	5.1	7.1	6.6	4.5	12.2	9.9

	Baseline			End line		
	DAG %	Non-DAG %	Total %	DAG %	Non-DAG %	Total %
Developing solutions to the problems that poor/disadvantaged people face in accessing health services	12.8	3.6	6.0	9.1	12.2	11.3
Identifying those who don't have health access	12.8	17.0	15.9	13.6	20.4	18.3
Managing/mobilizing resources/funds to support health services	0.0	6.3	4.6	18.2	24.5	22.5
Conducting facility audits	23.1	17.0	18.5	22.7	26.5	25.4
Conducting monthly meetings of committee	0.0	13.4	9.9	18.2	24.5	22.5
Conducting social audits	0.0	4.5	3.3	22.7	16.3	18.3
Other	7.7	18.8	15.9	0.0	0.0	0.0
Don't know	12.8	6.3	7.9	22.7	26.5	25.4

Table 74. HFOMC has capacity to perform roles/functions, among women who have heard of the HFOMCs, by district, social status, and survey wave

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Capacity to perform roles						
Yes, completely	25.0	19.0	20.7	13.3	25.0	20.0
Yes, somewhat	75.0	81.0	79.3	80.0	75.0	77.1
No	0.0	0.0	0.0	6.7	0.0	2.9
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Know a HFOMC member's name	59.1	38.3	44.9	42.3	50.0	46.3
Syangja						
Capacity to perform roles						
Yes, completely	24.2	25.0	24.7	0.0	20.0	13.0
Yes, somewhat	75.8	71.2	72.9	100.0	80.0	87.0
No	0.0	1.9	1.2	0.0	0.0	0.0
Don't know	0.0	1.9	1.2	0.0	0.0	0.0
Know a HFOMC member's name	29.4	25.5	27.0	50.0	33.3	38.5
Parbat						
Capacity to perform roles						
Yes, completely	38.2	34.3	35.3	35.3	30.6	32.1
Yes, somewhat	58.8	64.8	63.3	64.7	69.4	67.9
No	2.9	1.0	1.4	0.0	0.0	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Know a HFOMC member's name	33.3	42.0	39.7	45.5	44.9	45.1

Table 75. HFOMC information posted at local HF, among women who have heard of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG	Non-DAG	Total	DAG	Non-DAG	Total
Baglung						
HFOMC information posted at local HF	59.1	74.5	69.6	46.2	57.1	51.9
Types of information posted						
HFOMC meeting minutes	7.7	2.9	4.2	8.3	12.5	10.7
HFOMC meeting agenda	0.0	17.1	12.5	0.0	25.0	14.3
List of HFOMC members	15.4	2.9	6.3	0.0	12.5	7.1
Information on funding	0.0	5.7	4.2	0.0	6.3	3.6
HFOMC work plan	7.7	2.9	4.2	0.0	6.3	3.6
Citizen charter	23.1	5.7	10.4	0.0	25.0	14.3
Information on key decisions made	0.0	5.7	4.2	0.0	12.5	7.1
Information on vaccination	92.3	88.6	89.6	83.3	93.8	89.3
Other	38.5	22.9	27.1	16.7	6.3	10.7
Syangja						
HFOMC information posted at local HF	64.7	52.7	57.3	37.5	77.8	65.4
Types of information posted						
HFOMC meeting minutes	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC meeting agenda	9.1	10.3	9.8	0.0	14.3	11.8
List of HFOMC members	0.0	3.4	2.0	0.0	14.3	11.8
Information on funding	4.5	0.0	2.0	0.0	0.0	0.0
HFOMC work plan	0.0	3.4	2.0	0.0	0.0	0.0
Citizen charter	0.0	3.4	2.0	0.0	0.0	0.0
Information on key decisions made	0.0	6.9	3.9	0.0	0.0	0.0
Information on vaccination	95.5	89.7	92.2	66.7	85.7	82.4
Other	45.5	27.6	35.3	33.3	14.3	17.6
Parbat						
HFOMC information posted at local HF	69.2	73.2	72.2	68.2	55.1	59.2
Types of information posted						
HFOMC meeting minutes	7.4	12.2	11.0	13.3	18.5	16.7
HFOMC meeting agenda	11.1	28.0	23.9	6.7	33.3	23.8
List of HFOMC members	0.0	4.9	3.7	0.0	11.1	7.1
Information on funding	3.7	0.0	0.9	0.0	3.7	2.4
HFOMC work plan	7.4	2.4	3.7	0.0	11.1	7.1
Citizen charter	0.0	1.2	0.9	0.0	7.4	4.8
Information on key decisions made	3.7	9.8	8.3	6.7	14.8	11.9
Information on vaccination	88.9	86.6	87.2	93.3	92.6	92.9
Other	25.9	23.2	23.9	13.3	11.1	11.9

Figure 28. Among women reporting having heard of the HFOMCs, percentage who know how to get assistance from their HFOMC, by district, social status, and survey wave

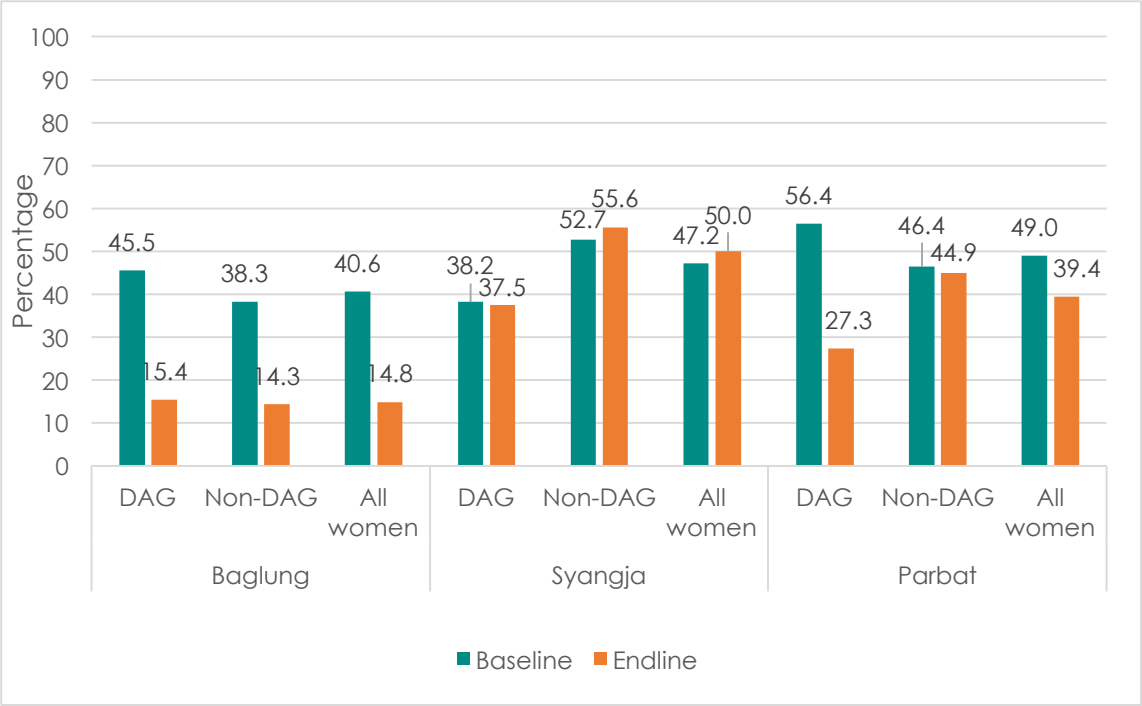


Table 76. Knowledge of how to take health service concerns to the HFOMCs, among women who have heard of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG (%)	Non-DAG (%)	All women (%)	DAG (%)	Non-DAG (%)	Total (%)
Baglung						
How to get assistance?						
Attend a meeting	70.0	55.6	60.7	0.0	75.0	37.5
Through community mapping	70.0	44.4	53.6	50.0	75.0	62.5
Through community awareness centers	10.0	11.1	10.7	0.0	50.0	25.0
Through Ward Citizen's Forum	20.0	0.0	7.1	0.0	75.0	37.5
Through mother's group	40.0	33.3	35.7	75.0	50.0	62.5
Other	20.0	16.7	17.9	0.0	0.0	0.0
Syangja						
How to get assistance?						
Attend a meeting	92.3	65.5	73.8	0.0	60.0	46.2
Through community mapping	15.4	37.9	31.0	66.7	40.0	46.2
Through community awareness centers	0.0	0.0	0.0	0.0	20.0	15.4
Through Ward Citizen's Forum	0.0	3.4	2.4	0.0	30.0	23.1
Through mother's group	30.8	20.7	23.8	0.0	10.0	7.7
Other	7.7	10.3	9.5	33.3	10.0	15.4

	Baseline			End line		
	DAG (%)	Non-DAG (%)	All women (%)	DAG (%)	Non-DAG (%)	Total (%)
Parbat						
How to get assistance?						
Attend a meeting	86.4	80.8	82.4	83.3	86.4	85.7
Through community mapping	36.4	46.2	43.2	16.7	40.9	35.7
Through community awareness centers	0.0	7.7	5.4	0.0	31.8	25.0
Through Ward Citizen's Forum	4.5	5.8	5.4	16.7	4.5	7.1
Through mother's group	31.8	17.3	21.6	33.3	9.1	14.3
Other	0.0	17.3	12.2	16.7	9.1	10.7

Table 77. Opinions about the HFOMC's work and its knowledge of community concerns about health services, of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Satisfaction with the work of the HFOMC						
Very satisfied	27.3	27.7	27.5	19.2	21.4	20.4
Somewhat satisfied	72.7	66.0	68.1	57.7	71.4	64.8
Neither satisfied nor dissatisfied	0.0	2.1	1.4	15.4	3.6	9.3
Somewhat dissatisfied	0.0	2.1	1.4	7.7	3.6	5.6
Very dissatisfied	0.0	2.1	1.4	0.0	0.0	0.0
HFOMC knows the community's concerns about health services						
Yes, completely	27.3	19.1	21.7	11.5	21.4	16.7
Yes, somewhat	68.2	76.6	73.9	80.8	78.6	79.6
No	4.5	2.1	2.9	7.7	0.0	3.7
Don't know	0.0	2.1	1.4	0.0	0.0	0.0
HFOMC adequately addresses the community's concerns about health services						
Yes, completely	18.2	19.1	18.8	15.4	14.3	14.8
Yes, somewhat	77.3	78.7	78.3	65.4	82.1	74.1
No	4.5	0.0	1.4	19.2	3.6	11.1
Don't know	0.0	2.1	1.4	0.0	0.0	0.0
HFOMC knows women's specific concerns about health services						
Yes, completely	40.9	29.8	33.3	15.4	25.0	20.4
Yes, somewhat	54.5	68.1	63.8	69.2	67.9	68.5
No	4.5	0.0	1.4	15.4	7.1	11.1
Don't know	0.0	2.1	1.4	0.0	0.0	0.0
HFOMC adequately addresses women's specific concerns about health services						
Yes, completely	31.8	19.1	23.2	15.4	14.3	14.8
Yes, somewhat	63.6	74.5	71.0	73.1	85.7	79.6
No	4.5	4.3	4.3	11.5	0.0	5.6
Don't know	0.0	2.1	1.4	0.0	0.0	0.0
HFOMC knows marginalized people's specific concerns about health service						
Yes, completely	27.3	27.7	27.5	23.1	14.3	18.5
Yes, somewhat	63.6	63.8	63.8	50.0	75.0	63.0
No	9.1	6.4	7.2	26.9	10.7	18.5
Don't know	0.0	2.1	1.4	0.0	0.0	0.0

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
HFOMC adequately addresses marginalized people's specific concerns about health services						
Yes, completely	27.3	25.5	26.1	7.7	7.1	7.4
Yes, somewhat	63.6	66.0	65.2	76.9	82.1	79.6
No	9.1	6.4	7.2	15.4	10.7	13.0
Don't know	0.0	2.1	1.4	0.0	0.0	0.0
Syangja						
Satisfaction with the work of the HFOMC						
Very satisfied	23.5	25.5	24.7	0.0	16.7	11.5
Somewhat satisfied	73.5	70.9	71.9	87.5	72.2	76.9
Neither satisfied nor dissatisfied	2.9	1.8	2.2	12.5	5.6	7.7
Somewhat dissatisfied	0.0	1.8	1.1	0.0	5.6	3.8
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC knows the community's concerns about health services						
Yes, completely	17.6	18.2	18.0	12.5	22.2	19.2
Yes, somewhat	76.5	72.7	74.2	87.5	77.8	80.8
No	0.0	9.1	5.6	0.0	0.0	0.0
Don't know	5.9	0.0	2.2	0.0	0.0	0.0
HFOMC adequately addresses the community's concerns about health services						
Yes, completely	23.5	16.4	19.1	0.0	38.9	26.9
Yes, somewhat	70.6	81.8	77.5	100.0	61.1	73.1
No	5.9	1.8	3.4	0.0	0.0	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC knows women's specific concerns about health services						
Yes, completely	26.5	18.2	21.3	0.0	22.2	15.4
Yes, somewhat	70.6	78.2	75.3	100.0	77.8	84.6
No	2.9	3.6	3.4	0.0	0.0	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC adequately addresses women's specific concerns about health services						
Yes, completely	29.4	9.1	16.9	12.5	11.1	11.5
Yes, somewhat	64.7	89.1	79.8	87.5	83.3	84.6
No	5.9	1.8	3.4	0.0	5.6	3.8
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC knows marginalized people's specific concerns about health service						
Yes, completely	20.6	21.8	21.3	0.0	16.7	11.5

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Yes, somewhat	70.6	72.7	71.9	100.0	72.2	80.8
No	8.8	5.5	6.7	0.0	11.1	7.7
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC adequately addresses marginalized people's specific concerns about health services						
Yes, completely	17.6	12.7	14.6	0.0	5.6	3.8
Yes, somewhat	76.5	83.6	80.9	87.5	83.3	84.6
No	5.9	3.6	4.5	12.5	11.1	11.5
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Parbat						
Satisfaction with the work of the HFOMC						
Very satisfied	33.3	24.1	26.5	27.3	14.3	18.3
Somewhat satisfied	61.5	71.4	68.9	54.5	75.5	69.0
Neither satisfied nor dissatisfied	5.1	2.7	3.3	13.6	10.2	11.3
Somewhat dissatisfied	0.0	0.0	0.0	4.5	0.0	1.4
Very dissatisfied	0.0	0.9	0.7	0.0	0.0	0.0
HFOMC knows the community's concerns about health services						
Yes, completely	28.2	17.0	19.9	31.8	22.4	25.4
Yes, somewhat	61.5	79.5	74.8	68.2	75.5	73.2
No	7.7	2.7	4.0	0.0	2.0	1.4
Don't know	2.6	0.9	1.3	0.0	0.0	0.0
HFOMC adequately addresses the community's concerns about health services						
Yes, completely	17.9	17.9	17.9	27.3	14.3	18.3
Yes, somewhat	79.5	78.6	78.8	72.7	81.6	78.9
No	2.6	3.6	3.3	0.0	4.1	2.8
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC knows women's specific concerns about health services						
Yes, completely	41.0	29.5	32.5	36.4	14.3	21.1
Yes, somewhat	59.0	68.8	66.2	50.0	83.7	73.2
No	0.0	1.8	1.3	13.6	2.0	5.6
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
HFOMC adequately addresses women's specific concerns about health services						
Yes, completely	25.6	19.6	21.2	18.2	14.3	15.5
Yes, somewhat	71.8	78.6	76.8	72.7	79.6	77.5
No	2.6	0.9	1.3	9.1	6.1	7.0
Don't know	0.0	0.9	0.7	0.0	0.0	0.0

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
HFOMC knows marginalized people's specific concerns about health service						
Yes, completely	33.3	22.3	25.2	13.6	24.5	21.1
Yes, somewhat	64.1	75.0	72.2	77.3	69.4	71.8
No	0.0	2.7	2.0	9.1	6.1	7.0
Don't know	2.6	0.0	0.7	0.0	0.0	0.0
HFOMC adequately addresses marginalized people's specific concerns about health services						
Yes, completely	28.2	15.2	18.5	13.6	10.2	11.3
Yes, somewhat	69.2	75.9	74.2	86.4	83.7	84.5
No	2.6	8.9	7.3	0.0	6.1	4.2
Don't know	0.0	0.0	0.0	0.0	0.0	0.0

Figure 29. Percentage who have attended a HFOMC meeting, among women who have heard of the HFOMCs, by survey wave, social status, and district

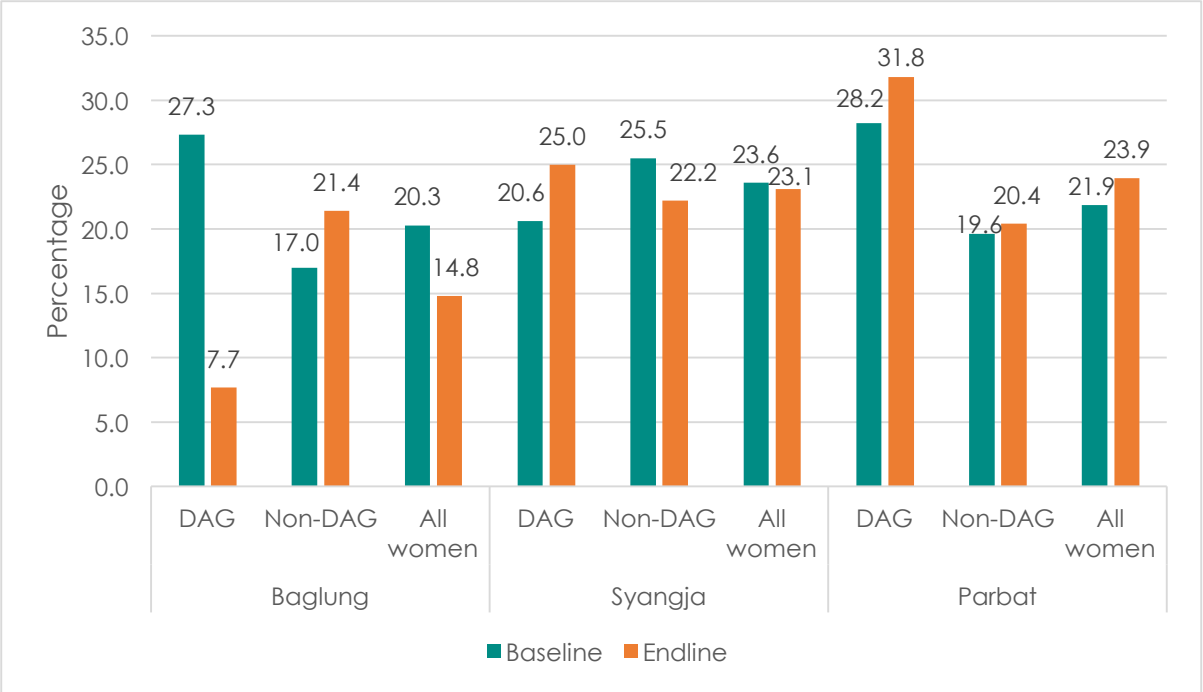


Table 78. Topics discussed at HFOMC meetings, among women who have heard of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Topics discussed in the meeting						
Management of HF staff	66.7	50.0	57.1	50.0	50.0	50.0
Managing and maintaining the physical infrastructure	66.7	0.0	28.6	0.0	16.7	12.5
Availability of medicines and equipment	66.7	37.5	50.0	0.0	33.3	25.0
Problems women face in accessing and using health services	50.0	25.0	35.7	50.0	33.3	37.5
Problems excluded/marginalized groups face in accessing and using health services	0.0	0.0	0.0	0.0	0.0	0.0
Identifying those who do not have access to health services	0.0	12.5	7.1	0.0	0.0	0.0
Managing and mobilizing resources/funds to support health services	0.0	0.0	0.0	0.0	16.7	12.5
Facility audit	0.0	12.5	7.1	0.0	16.7	12.5
Conducting social audit	0.0	0.0	0.0	0.0	0.0	0.0
Other	33.3	25.0	28.6	0.0	0.0	0.0
Syangja						
Topics discussed in the meeting						
Management of HF staff	28.6	28.6	28.6	0.0	25.0	16.7
Managing and maintaining the physical infrastructure	14.3	21.4	19.0	0.0	0.0	0.0
Availability of medicines and equipment	28.6	21.4	23.8	0.0	50.0	33.3
Problems women face in accessing and using health services	14.3	21.4	19.0	0.0	25.0	16.7
Problems excluded/marginalized groups face in accessing and using health services	14.3	7.1	9.5	0.0	0.0	0.0
Identifying those who do not have access to health services	14.3	0.0	4.8	0.0	25.0	16.7
Managing and mobilizing resources/funds to support health services	0.0	14.3	9.5	50.0	0.0	16.7
Facility audit	28.6	21.4	23.8	0.0	0.0	0.0
Conducting social audit	14.3	0.0	4.8	0.0	25.0	16.7
Other	42.9	35.7	38.1	100.0	25.0	50.0
Topics discussed in the meeting						
Parbat						

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Management of HF staff	45.5	36.4	39.4	28.6	60.0	47.1
Managing and maintaining the physical infrastructure	18.2	22.7	21.2	28.6	60.0	47.1
Availability of medicines and equipment	36.4	45.5	42.4	28.6	50.0	41.2
Problems women face in accessing and using health services	9.1	18.2	15.2	28.6	40.0	35.3
Problems excluded/marginalized groups face in accessing and using health services	9.1	4.5	6.1	0.0	10.0	5.9
Identifying those who do not have access to health services	9.1	9.1	9.1	0.0	10.0	5.9
Managing and mobilizing resources/funds to support health services	0.0	9.1	6.1	0.0	10.0	5.9
Facility audit	54.5	0.0	18.2	0.0	30.0	17.6
Conducting social audit	9.1	4.5	6.1	14.3	0.0	5.9
Other	18.2	45.5	36.4	0.0	10.0	5.9

Table 79. Submission of a concern to an HFOMC, among women who have heard of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
Presented a concern	22.7	10.6	14.5	0.0	7.1	3.7
Concerns presented						
Management of HF staff	40.0	40.0	40.0	0.0	0.0	0.0
Managing and maintaining the physical infrastructure	60.0	40.0	50.0	0.0	50.0	50.0
Managing the availability of medicines and equipment	20.0	20.0	20.0	0.0	0.0	0.0
Identifying/developing solutions to problems women face	40.0	0.0	20.0	0.0	0.0	0.0
Identifying/developing solutions to problems poor and disadvantaged groups face	0.0	60.0	30.0	0.0	0.0	0.0
Identifying those who do not have access to health services	20.0	40.0	30.0		0.0	0.0
Managing and mobilizing resources/funds to support health services	20.0	20.0	20.0	0.0	50.0	50.0

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Conducting facility audits	20.0	0.0	10.0		50.0	50.0
Conducting social audits	20.0	0.0	10.0	0.0	0.0	0.0
Syangja						
Presented a concern	5.9	14.5	11.2	0.0	5.6	3.8
Concerns presented						
Management of HF staff	0.0	37.5	30.0	0.0	0.0	0.0
Managing and maintaining the physical infrastructure	0.0	0.0	0.0	0.0	100.0	100.0
Managing the availability of medicines and equipment	0.0	25.0	20.0	0.0	0.0	0.0
Identifying/developing solutions to problems women face	50.0	50.0	50.0	0.0	0.0	0.0
Identifying/developing solutions to problems poor and disadvantaged groups face	0.0	12.5	10.0	0.0	0.0	0.0
Identifying those who do not have access to health services	50.0	25.0	30.0	0.0	0.0	0.0
Managing and mobilizing resources/funds to support health services	50.0	12.5	20.0	0.0	0.0	0.0
Parbat						
Presented a concern	17.9	17.0	17.2	0.0	14.3	11.3
Concerns presented						
Management of HF staff	28.6	21.1	23.1	0.0	42.9	50.0
Managing and maintaining the physical infrastructure	0.0	5.3	3.8	0.0	14.3	25.0
Managing the availability of medicines and equipment	28.6	47.4	42.3	0.0	42.9	50.0
Identifying/developing solutions to problems women face	71.4	15.8	30.8	0.0	42.9	37.5
Identifying/developing solutions to problems poor and disadvantaged groups face	14.3	5.3	7.7	0.0	42.9	37.5
Identifying those who do not have access to health services	28.6	31.6	30.8	0.0	28.6	37.5
Managing and mobilizing resources/funds to support health services	0.0	15.8	11.5	0.0	14.3	25.0
Conducting facility audits	28.6	36.8	34.6	0.0	28.6	37.5
Conducting social audits	0.0	10.5	7.7	0.0	14.3	12.5
Other	0.0	26.3	19.2	0.0	0.0	0.0

Table 80. Satisfaction with outcome of concerns submitted to the HFOMCs, among women who have heard of the HFOMCs, by survey wave, social status, and district

	Baseline			End line		
	DAG %	Non-DAG %	All women %	DAG %	Non-DAG %	All women %
Baglung						
HFOMC addressed concerns	100.0	60.0	80.0	0.0	100.0	100.0
How satisfied?						
Very satisfied	40.0	33.3	37.5	0.0	50.0	50.0
Somewhat satisfied	60.0	66.7	62.5	0.0	50.0	50.0
Neither satisfied nor dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Somewhat dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Syangja						
HFOMC addressed concerns	50.0	75.0	70.0	0.0	100.0	100.0
How satisfied?						
Very satisfied	100.0	33.3	42.9	0.0	0.0	0.0
Somewhat satisfied	0.0	66.7	57.1	0.0	100.0	100.0
Neither satisfied nor dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Somewhat dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Parbat						
HFOMC addressed concerns	71.4	73.7	73.1	0.0	85.7	75.0
How satisfied?						
Very satisfied	60.0	50.0	52.6	0.0	33.3	33.3
Somewhat satisfied	40.0	50.0	47.4	0.0	66.7	66.7
Neither satisfied nor dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Somewhat dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0
Very dissatisfied	0.0	0.0	0.0	0.0	0.0	0.0

Community Survey Results

Table 81. Mean distance (KM) to the nearest urban center and markets, by survey wave, and district, as reported in community survey

Baseline						
	Baglung		Syangja		Parbat	
	Urban Center	Daily Market	Urban Center	Daily Market	Urban Center	Daily Market
Distance						
<1 km	3.2	21.1	9.4	5.9	21.4	36.6
1-4.9 km	36.8	38.9	27.1	41.2	46.9	40.7
5-9.9 km	26.3	21.1	22.4	21.2	15.2	9.7

10km or more	23.2	9.5	29.4	22.4	13.8	10.3
Don't know	10.5	9.5	17.6	9.4	2.8	2.8
End line						
	Baglung		**Syangja**		**Parbat**	
	Urban Center	Daily Market	Urban Center	Daily Market	Urban Center	Daily Market
Distance						
<1 km	12.6	66.3	9.4	35.3	26.9	29.0
1-4.9 km	47.4	24.2	40.0	41.2	58.6	56.6
5-9.9 km	25.3	8.4	30.6	20.0	12.4	12.4
10km or more	14.7	1.1	20.0	3.5	2.1	2.1
Don't know	0.0	0.0	0.0	0.0	0.0	0.0

Table 82. Distance to nearest services, by survey wave, and district, as reported in community survey

Baseline						
	Baglung		**Syangja**		**Parbat**	
	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)
Schools						
Primary school	68.4	1.1	64.7	2.0	53.8	1.2
Coed high school	5.3	2.3	3.5	2.3	3.4	2.5
Other services						
Post office	15.8	2.7	8.2	3.7	11.0	2.6
Cinema	1.1	17.3	0.0	47.4	0.7	19.4
End line						
	Baglung		**Syangja**		**Parbat**	
	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)	Mean Distance if Outside Ward (km)	Within Ward (%)
Schools						
Primary school	78.9	1.9	60.0	2.0	1.2	43.4
Coed high school	7.4	2.1	3.5	2.9	2.6	5.5
Other services						
Post office	15.8	2.2	8.2	3.8	3.2	9.7
Cinema	0.0	41.7	0.0	55.4	22.9	0.7

Table 83. Distance to nearest FP and maternal health services, by survey wave, and district, as reported in community survey

Baseline						
	Baglung		Syangja		Parbat	
	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)
FP						
Norplant provider	3.2	6.9	2.4	14.1	4.1	13.0
Pill provider	78.9	2.2	69.4	3.1	86.2	1.8
Injectables provider	24.2	2.5	24.7	4.7	9.0	2.6
IUD provider	2.1	9.1	1.2	16.0	2.8	13.2
Vasectomy provider	0.0	31.5	1.2	26.5	0.0	23.6
Tubectomy provider	0.0	31.5	1.2	26.5	0.0	23.2
Maternal health						
ANC provider	20.0	2.4	24.7	6.0	9.7	2.3
Delivery provider	4.2	6.2	2.4	12.3	4.1	5.8
PNC provider	14.7	2.8	12.9	8.2	8.3	2.1
End line						
	Baglung		Syangja		Parbat	
	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)	Within Ward (%)	Mean Distance if Outside Ward (km)
FP						
Norplant provider	5.3	6.2	3.5	17.3	3.4	20.0
Pill provider	42.6	3.0	47.1	3.0	69.0	1.9
Injectables provider	10.6	3.1	22.4	3.3	20.7	2.1
IUD provider	4.3	13.0	0.0	19.7	1.4	19.3
Vasectomy provider	0.0	38.7	0.0	26.4	0.7	45.2
Tubectomy provider	0.0	38.7	0.0	26.4	0.7	45.2
Maternal health						
ANC provider	9.6	3.4	20.0	5.2	20.7	2.0
Delivery provider	6.4	3.6	2.4	11.1	5.5	6.7
PNC provider	10.6	2.9	18.8	4.5	11.0	2.0

Figure 30. Percentage of wards with availability of specific FP methods, by district and survey wave, as reported in community survey

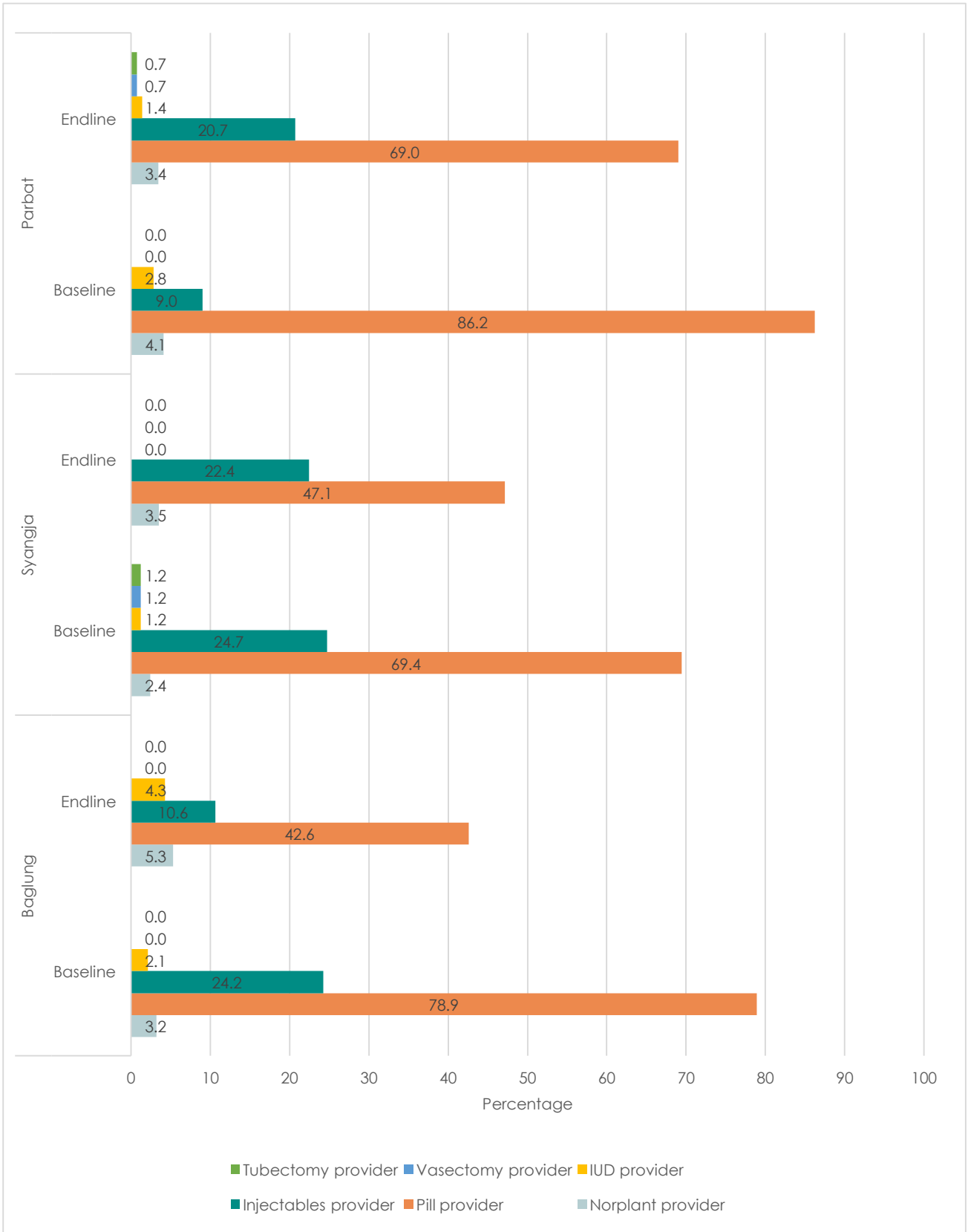


Figure 31. Mean travel time (minutes) to the nearest HF on foot, by survey wave, district and social status, as reported in community survey

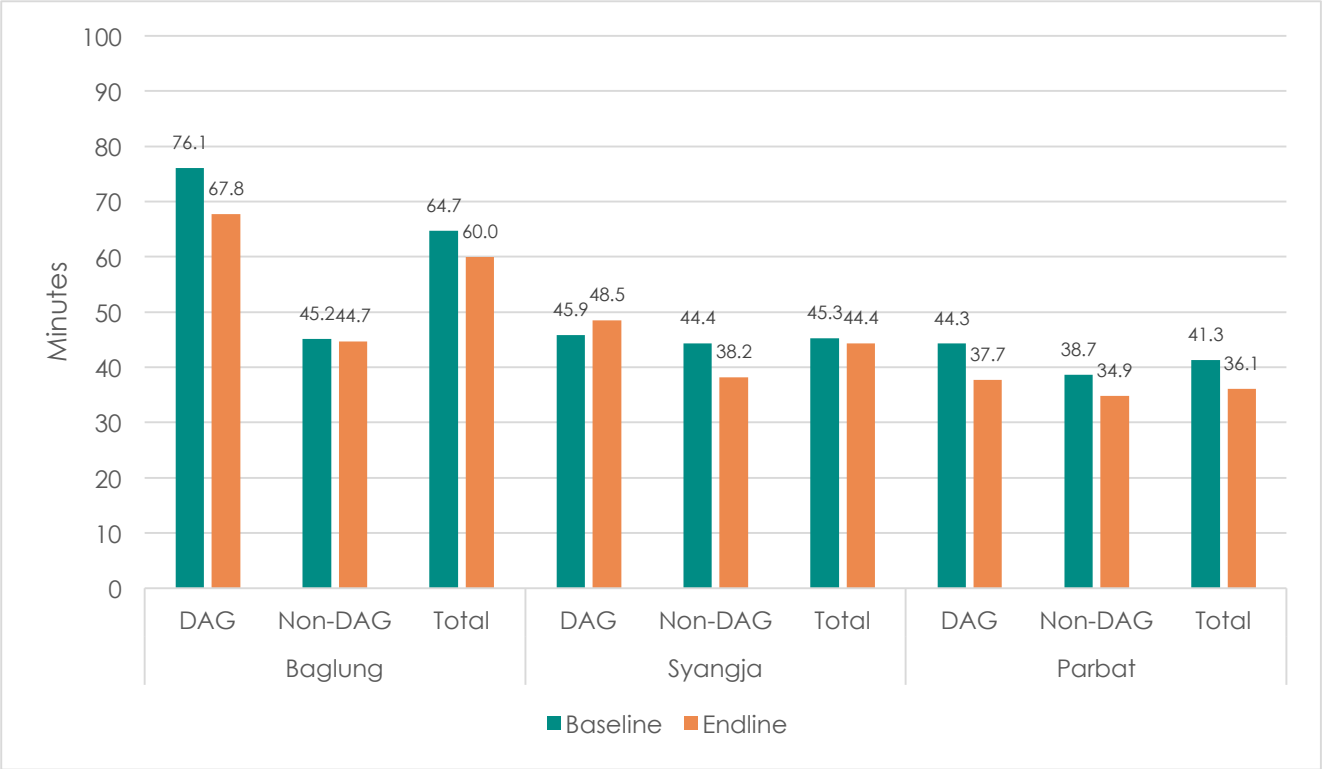


Table 84. Percent of communities reporting time to the urban center and district headquarters, by survey wave and district, as reported in community survey

	Baseline		End line	
	Urban Center	District Headquarters	Urban Center	District Headquarters
Baglung				
Less than 30 minutes	13.7	0.0	17.9	0.0
30-59 minutes	14.7	0.0	26.3	1.1
60-89 minutes	17.9	4.2	20.0	4.2
90 minutes and more	53.7	95.8	35.8	94.7
Syangja				
Less than 30 minutes	20.0	0.0	35.9	2.8
30-59 minutes	18.8	3.5	30.3	4.1
60-89 minutes	2.0	7.1	15.9	5.5
90 minutes and more	41.2	89.4	17.9	87.6
Parbat				
Less than 30 minutes	22.8	3.4	35.9	2.8
30-59 minutes	25.5	1.4	30.3	4.1
60-89 minutes	17.2	5.5	15.9	5.5
90 minutes and more	34.5	89.7	17.9	87.6

Table 85. Services provided by the nearest HFs, by survey wave and district, as reported in community survey

	Maternal Health (%)	Deli-very (%)	Delivery with Operation (%)	Child Health (%)	FP (%)	Nutri-tion (%)	General Health Checkup (%)	Other (%)	Don't know (%)
Baseline									
Baglung									
Hospital	93.7	97.9	83.2	85.3	90.5	71.6	100.0	0.0	0.0
Primary health clinic	94.7	93.7	3.2	66.3	78.9	70.5	100.0	2.1	0.0
Health post	81.1	81.1	0.0	48.4	78.9	66.3	100.0	0.0	0.0
Private clinic	20.0	9.5	0.0	34.7	52.6	29.5	95.8	5.3	0.0
Birthing center	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Syangja									
Hospital	97.6	91.8	60.0	94.1	96.5	75.3	95.3	14.1	0.0
Primary health clinic	80.0	92.9	10.6	69.4	98.8	54.1	97.6	11.8	0.0
Health post	47.1	75.3	1.2	63.5	89.4	48.2	100.0	2.4	0.0
Private clinic	20.0	14.1	0.0	40.0	72.9	17.6	97.6	14.1	0.0
Birthing center	1.2	1.2	1.2	0.0	1.2	1.2	1.2	1.2	0.0
Parbat									
Hospital	80.7	93.8	32.4	72.4	74.5	43.4	95.9	21.4	0.0
PHC	42.1	75.9	0.7	49.7	70.3	40.7	97.9	4.1	2.8
Health post	44.1	57.9	0.0	44.1	66.2	38.6	98.6	2.8	0.0
Private clinic	12.4	12.4	0.0	44.1	49.0	23.4	100.0	12.4	0.0
Other NGO clinic	6.9	9.7	2.8	6.2	10.3	1.4	15.2	13.1	0.0
Birthing center	1.4	2.1	0.0	1.4	0.7	2.1	2.1	2.1	0.0
End line									
	Maternal Health	**Deliv ery**	**Delivery with Operation**	**Child Health**	**FP**	**Nutritio n**	**General Health Checkup**	**Other**	**Don't know**
Baglung									
Hospital	100.0	100.0	100.0	96.8	100.0	97.9	100.0	4.2	0.0
PHC	100.0	100.0	25.3	88.4	98.9	80.0	100.0	2.1	0.0
Health post	92.6	85.3	0.0	66.3	93.7	63.2	98.9	0.0	0.0
Private clinic	17.9	16.8	0.0	30.5	54.7	16.8	100.0	3.2	0.0
Birthing center	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Syangja									
Hospital	100.0	100.0	89.4	100.0	100.0	100.0	100.0	41.2	0.0

	Maternal Health (%)	Deli-very (%)	Delivery with Operation (%)	Child Health (%)	FP (%)	Nutri-tion (%)	General Health Checkup (%)	Other (%)	Don't know (%)
PHC	100.0	100.0	22.4	83.5	100.0	95.3	100.0	58.8	0.0
Health post	88.2	30.6	0.0	40.0	100.0	81.2	100.0	35.3	0.0
Private clinic	30.6	12.9	0.0	36.5	90.6	14.1	100.0	20.0	0.0
Birthing center	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Parbat									
Hospital	97.9	97.9	81.4	86.2	98.6	66.9	99.3	17.2	0.0
PHC	94.5	97.2	0.0	70.3	97.2	26.9	100.0	9.7	0.0
Health post	88.3	37.9	0.0	58.6	99.3	18.6	99.3	5.5	0.0
Private clinic	30.3	4.1	0.0	40.7	73.8	13.8	100.0	3.4	0.0
Other NGO clinic	6.2	5.5	0.0	10.3	10.3	0.0	11.7	7.6	0.0
Birthing center	2.1	2.1	2.1	2.1	1.4	0.0	2.1	0.0	0.0

Figure 32. Main access route to ward, by district and survey wave, as reported in community survey

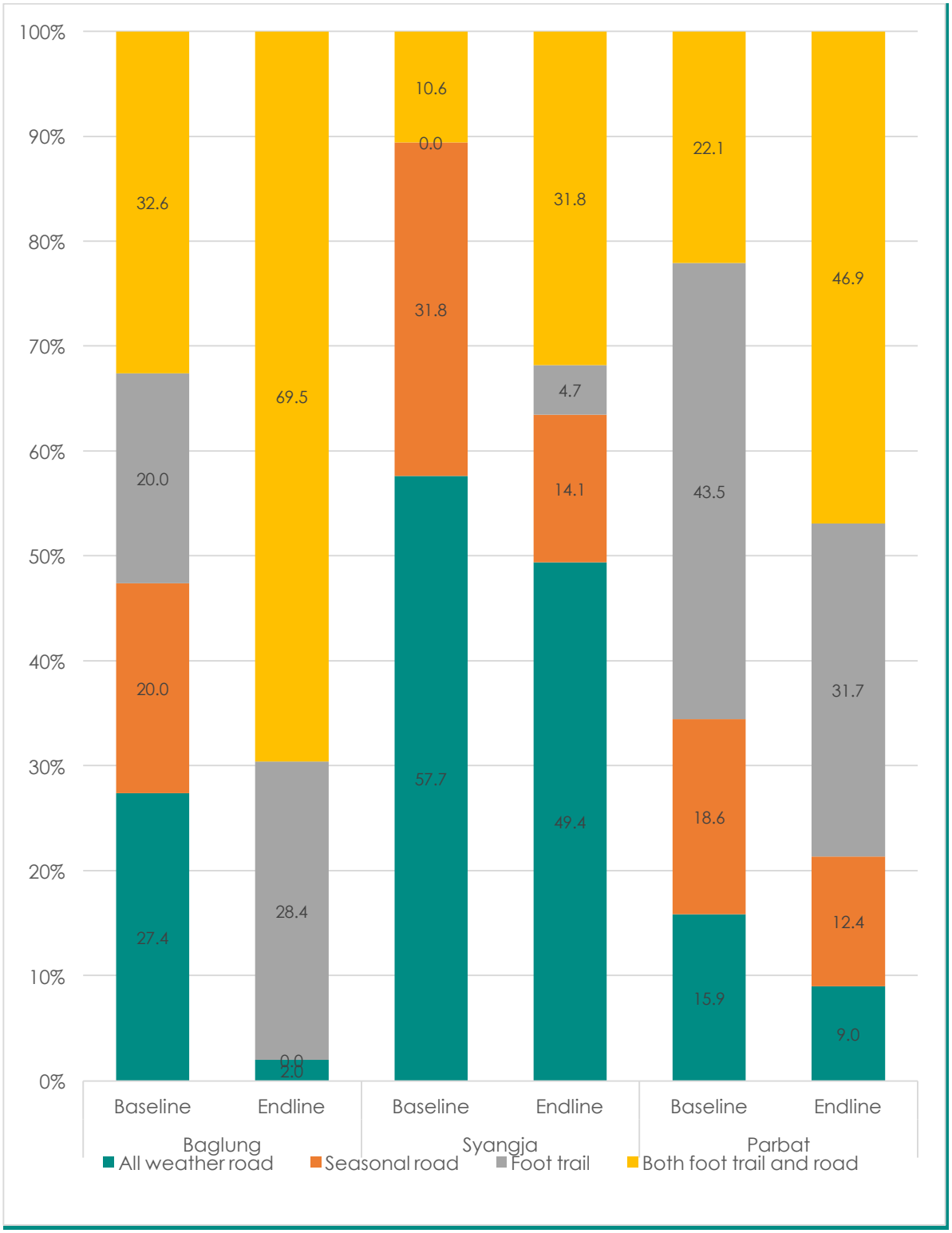


Table 86. Percentage of wards with access to the nearest doctors and pharmacies ("Yes - in or near ward"), by district and survey wave, as reported in community survey

	Baglung		Parbat		Syangja	
	Baseline	End line	Baseline	End line	Baseline	End line
Allopathic/Bachelor of medicine and bachelor of surgery (MBBS) doctors	0.0	0.0	11.7	10.3	4.7	1.2
Homeopathic doctors	2.1	0.0	0.7	3.4	0.0	1.2
Ayurvedic doctors	6.3	6.3	4.1	8.3	2.4	4.7
Pharmacies	7.4	17.9	35.9	7.6	15.3	7.1
Shops that sell pills/condoms	12.6	10.5	25.5	6.9	24.7	5.9
Skilled birth attendant	12.6	12.6	17.9	9.0	22.4	16.5

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