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TPO Nepal
PEACE OF MIND

Barefoot Counselling Service to Improve Mental Well-being of Unpaid Family Carers in Nepal

Bagmati Rural Municipality, Makawanpur District,
Bagmati Province

Report of Endline Evaluation
August 2025

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Acknowledgements

We would like to express our sincere gratitude to all those who contributed to the successful completion of this endline evaluation of the Barefoot Counselling Service for unpaid family Carers in Nepal.

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1 Baseline survey being carried out with unpaid family carer

Summary

The general objective of this evaluation is to evaluate the changes and impacts of the barefoot counselling service on Carers and to generate actionable insights for sustaining and scaling similar interventions in the future. The evaluation used a mixed-methods approach, combining structured quantitative surveys with qualitative interviews involving 66 Carers who completed both pre- and post-assessments. The study showed significant improvements in emotional and mental wellbeing, physical wellbeing, and reduced feelings of loneliness and isolation. There was also a statistically significant increase in Carers' confidence in advocacy, including their sense of civic participation and rights awareness. Although improvements in respite, control over one's life, and financial concerns were observed, these were not statistically significant, likely due to the program's limited capacity to address economic needs directly.

The intervention also had positive effects on community awareness and stakeholder engagement. Carers reported emotional relief, improved self-awareness, and behavioral changes following counseling. FCHVs, initially hesitant, gained confidence and new communication skills, leading to stronger relationships with Carers. Community attitudes toward caregiving and mental health became more supportive over time. However, Carers continue to face unmet needs such as financial hardship, lack of recognition, and limited access to sustained mental health support. FCHVs also highlighted the need for refresher training, better incentives, and system-level support for broader and more effective service delivery.

To sustain and scale the intervention, the report recommends enhancing community awareness, securing long-term funding, and integrating mental health into primary healthcare. Mobilizing local government resources, expanding FCHV training, and improving referral mechanisms are also crucial. Support for Carers should include both emotional and financial assistance, and public recognition of their role. Finally, expanding access to mental health services—through mobile units and telehealth—can help reach marginalized populations in remote areas, ensuring lasting impact and continuity of care.

1. Description of the Project

Unpaid family Carers[1] play a crucial yet often unrecognized role in supporting individuals with disabilities, chronic illnesses, psychosocial and mental health problems and age-related challenges, particularly in rural and marginalized areas. In the Bagmati Rural Municipality of Makawanpur, the baseline assessment was conducted by TPO Nepal before implementation of the program with 103 randomly selected participants and the study revealed that Carers, most of whom are women and girls, face a wide range of socio-economic and psychosocial burdens, including poverty, limited access to healthcare and education, social isolation, and gender-based inequality. The baseline survey also indicated more than 90% of Carers were having psychosocial problems/stress in their life. To address these challenges, Carers Worldwide, in partnership with TPO Nepal and community stakeholders, implemented a community-based support program. The intervention focused on empowering Carers through psychosocial support, skills development, and improved access to essential services through Female Community Health Volunteers (FCHV)[2]. The community-based intervention for Carers was co-created, contextualized and delivered. The multi-session intervention consisted of four phases i.e. 1) assessing social and family situation, building rapport and developing the environment for the psychosocial support, 2) exploring psychosocial issues, providing basic support and counseling and orienting the techniques for self-care, 3) regulating emotional processing, connecting with other resources in the community and continuing support and 4) reviewing and analyzing progress, developing termination plan and closing the session.

This endline evaluation assesses the overall effectiveness of the intervention, measures changes in key indicators, and gathers insights to inform future programming, sustainability strategies, and policy advocacy efforts.

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[1] A Carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

[2] Female community health volunteers (FCHV) are the backbone of Nepal's community-based health initiatives particularly on the child and maternal health. They are recruited locally and get training in basic primary healthcare.

1.1. Objective of the Study

The general objective of this evaluation is to evaluate the changes and impacts of the barefoot counselling service on Carers and to generate actionable insights for sustaining and scaling similar interventions in the future.

The specific objectives of this endline evaluation are:

- To measure the impact of psychosocial support services on the psychosocial well-being of Carers.
- To identify gaps, challenges, and lessons learned during program implementation to guide future interventions and policy recommendations targeting unpaid Carers

2 Female Community Health Volunteers during training

2. Evaluation Design

The baseline study employed a mixed-methods approach, combining quantitative and qualitative methodologies. Quantitative data were collected from 103 respondents, while qualitative insights were gathered through interactions with key community stakeholders, including Female Community Health Volunteers (FCHVs) and community leaders. These baseline findings informed the design and contextualization of an intervention focused on supporting carers of individuals experiencing psychosocial and mental health challenges within the community.

The endline evaluation study is designed to assess the effectiveness of the barefoot counselling service intervention implemented following the baseline findings. Consistent with the baseline approach, the endline evaluation utilized a mixed-methods design. Quantitative data collection commenced with some of the same respondents who participated in the baseline study, regardless of whether they received services, the duration of their exposure, or the number of interactions. Following quantitative information, qualitative data collection has been undertaken to provide depth and context to numerical findings. This involved in-depth interviews (IDIs) with a selection of Carers to explore their lived experiences, perceived impacts of the intervention, and any emerging challenges. Additionally, key informant interviews (KIIs) conducted with relevant stakeholders, including FCHVs and community leaders, to capture broader perspectives on program implementation, community response, and sustainability considerations.

2.1. Sample Size

The quantitative sample for the endline evaluation consisted of the same 103 respondents who participated in the baseline study. This approach facilitated the comparison of changes over time. Additionally, it also allowed us to analyze how the number and duration of exposures are linked to the observed outcomes and ensured representativeness while maintaining alignment with the original study design. For the qualitative component, 7 key informant interviews (KIIs) were conducted with community stakeholders, including local leaders, Female Community Health Volunteers (FCHVs), and service providers, to gather broader, system-level insights on the program's effectiveness, community response, and potential for sustainability.

2.2. Sampling Procedure

In the baseline survey, a random sampling method was used to select participants. For the endline survey, we used a panel sampling approach by following up with the same 103 respondents from the baseline study. Of those 103 individuals, 66 were available to complete the evaluation questionnaire. For the qualitative component, a purposive sampling approach was used. Participants were identified based on their roles in caring or community support, their level of exposure to the program, and their relevance to the study objectives. This strategy ensures the inclusion of a diverse range of perspectives, with attention to gender, geographic distribution, and levels of program engagement, thereby enriching the depth and contextual relevance of the qualitative data.

2.3. Data Collection Tools

Quantitative data was collected using a structured questionnaire that is closely aligned with the baseline instrument to ensure consistency and enable direct comparison. The tool captured a range of information, including background characteristics, Carers wellbeing, household economic status, caregiving dynamics, and involvement in advocacy activities. For the qualitative component, separate checklists were developed for in-depth interviews (IDIs) and key informant interviews (KIIs). The IDI checklist was focused on topics such as caring role, personal wellbeing, and changes in social relationships resulting from the intervention. In contrast, the KII checklist explored stakeholders' experiences in supporting Carers, the influence of the program, and observed changes at the community and institutional levels attributable to the intervention.

2.4. Process of Data Collection

A team of two experienced female research assistants was mobilized to carry out the data collection. Prior to fieldwork, they underwent a comprehensive three-day training program covering the objectives of the evaluation, principles of mixed-methods research, sampling procedures, research ethics, and practical interviewing skills. The training incorporated interactive components such as discussions and role-play exercises to enhance learning. Special emphasis was placed on obtaining informed consent, building rapport with participants, maintaining confidentiality, and practicing effective communication. Additionally, the research assistants were also guided on the proper use of structured interview tools and digital devices to ensure accurate and efficient data collection.

The researchers were able to follow up with 66 respondents who participated in the baseline assessment. Each of these participants also received the Barefoot Counseling service. Those who could not be reached during follow-up were unavailable due to migration or death related to illness.

To maintain high data quality, the Project coordinator from TPO Nepal conducted field spot-checks and facilitated regular debriefing sessions with the data collection team. All quantitative data were collected using the ODK/ONA mobile-based application on Android devices, ensuring accuracy and efficiency. Meanwhile, qualitative interviews were audio-recorded with participants' consent.

2.5. Ethical Approval

All participants involved in the study were fully informed about the purpose of the research, its objectives, and the confidentiality of the information collected. Prior to conducting any interviews, written informed consent was obtained from each participant. Only individuals who voluntarily agreed to participate were included in the study. Participants were clearly informed of their right to decline participation or withdraw from the interview at any time without any consequences, ensuring that their involvement is entirely voluntary and ethically sound.

2.6. Data Analysis Plan

The qualitative data collected through in-depth interviews (IDIs) and key informant interviews (KIIs) were translated into English by professional translators. To ensure accuracy and fidelity to the original responses, the translations were cross-checked against the original transcripts by the research supervisor. The qualitative data were analyzed manually using a thematic approach, guided by a set of pre-determined themes aligned with the evaluation objectives. For the quantitative component, data were collected by research assistants using Android devices equipped with the ODK offline data collection application. Upon completion of fieldwork, the data were synced to the ODK server and subsequently downloaded by the TPO Nepal data team. The team conducted routine quality and consistency checks, providing timely feedback to the data collectors to address any discrepancies identified. Standard data cleaning procedures were applied, including range checks and verification of skip patterns, to ensure data integrity prior to analysis. The analysis was limited to participants who were successfully interviewed in both the pre- and post-assessments (n=66). Following data cleaning, variable generation and tabulations were performed using Stata version 14. To assess changes between baseline and end-line measurements, pair t-tests were conducted to identify statistically significant differences in key indicators.

3 TPO Nepal staff transcribing data collected during baseline survey

3. Results

3.1 Socio-Demographic and Household Characteristics of Carers

The post-assessment profile of 66 Carers shows that the majority were women (75.8%), with most falling into the middle-aged 41-59 years (48.5%) and elderly, 60 years and above (27.3%) age groups. A large proportion were married (81.8%), and the dominant ethnic group represented was Hill Janajati (81.8%). Education levels were generally low, with 63.6% being illiterate and only 9.1% having education beyond secondary level. Most Carers lived in small to medium-sized families, with over half (53%) living in households of 2 to 4 members.

In terms of economic status, around 44% of Carers were engaged in irregular, mostly agricultural work, while 41% had regular paid jobs or businesses. Annual household incomes varied, with one-third earning between NPR 60,000 and 120,000, while 26% earned less than NPR 12,000. All participants had accessed some form of financial support in the past two years, with 71.2% receiving it from non-bank sources and 28.8% from banks. Overall, the data reflects persistent challenges in wellbeing (the key focus of the intervention) as well as education and employment, with emerging trends in family and financial dynamics.

Table 1: Socio-demographic characteristics of carers

	Carer (N=66)
Gender	
Male	24.2
Female	75.8
Age group	
Youth (18 to 24)	4.5
Adult (25 to 40)	19.7
Middle-aged (41-59)	48.5
Elderly (60 years & above)	27.3
Caste/Ethnicity	
Hill Brahmin	1.5
Hill Chhetri	7.6
Hill Janajati	81.8
Hill Dalit	7.6
Newar	1.5

Level of Education	
Illiterate	63.6
Literate & Primary	9.1
Secondary	18.2
Higher than secondary	9.1
Family size	
2-4 members	53.0
5-7 members	43.9
8 and more	3.0
Have paid work?	
No	15.2
Yes, I have regular paid work (Job, Business)	40.9
Yes, but my work is not regular (Agricultural work)	43.9
Total annual income level of household (NPR)	
Less than 12000	25.8
12000-60000	28.8
60000-12000	33.3
more than 120000	12.1
Have any loans or a grant in past two years	
None	0
From Bank	28.8
Other source	71.2

3.2 Caregiving Roles and Responsibilities

The data highlights that a majority of caregiving recipients were male (62.1%), with a fairly even age distribution across groups. The largest group were middle-aged (27.3%), followed by elderly (25.8%). In terms of relationship to the Carer, sons or daughters (39.4%) and spouses/partners (37.9%) were the most common recipients of care (Table 2).

Caregiving was primarily driven by mental illness (53.0%), physical disabilities (39.4%), and multiple health conditions (30.3%), indicating complex and often overlapping care needs. Despite this, 53.0% of care recipients could be left alone for several hours, whereas 40.9% required constant supervision, and 6.1% could only be left alone briefly (up to one hour). These figures reflect the intensity of caregiving duties and the high level of dependency among many recipients, emphasizing the importance of consistent support and monitoring for Carers (Table 2).

Table 2: Caregiving Roles and Responsibilities

	Caregiving recipients (N=66)
Gender	
Male	62.1
Female	37.9
Age group	
Child and adolescents	12.1
Youth (18 to 24)	13.6
Adult (25 to 40)	21.2
Middle-aged (41-59)	27.3
Elderly (60 years & above)	25.8
Relation with carer	
Spouse/partner	37.9
Mother or father	6.1
Mother-in-law or father-in-law	12.1
Daughter or son	39.4
Another family member	4.5
Problems	
Physical disabilities	39.4
Mental Illness	53.0
Multiple illness	30.3
Can s/he be left alone?	
No, she/he needs someone with her/him all the time	40.9
Yes, she/he can easily be left alone for several hours (or more)	53.0
Yes, but not for more than one hour	6.1

3.3. Impact of Psychosocial Support Services

The impact of the Barefoot Psychosocial Counselling Service was assessed across six key themes: emotional and mental well-being, physical well-being, loneliness and isolation, respite and control over one's life, financial concerns, and confidence in advocacy.

a. Emotional and mental well-being: This domain was measured by evaluating participants' experiences with depression, anxiety, sleep difficulties, stress, and suicidal thoughts related to their caregiving role. Scores ranged from 0 to 20, with higher scores indicating more severe emotional and mental health challenges. The pre- and post-assessment results showed a **significant improvement in emotional and mental well-being following the counselling intervention** (p < 0.01) (Figure 1).

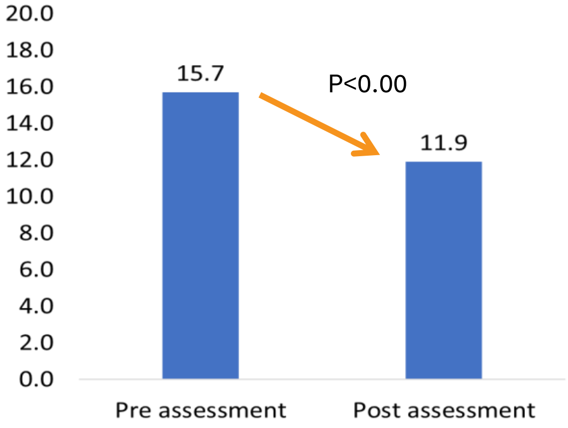

Figure 4: Emotional and mental wellbeing

After the intervention, there was a marked reduction in the proportion of participants who strongly agreed with negative emotional and mental health statements such as feeling depressed, anxious, stressed, or struggling to sleep due to their caring role. Correspondingly, the proportions of participants who strongly disagreed with these statements increased substantially, indicating improved emotional and mental well-being post-assessment (Table 3).

Table3: Pre- and Post-Intervention Assessment of Emotional and Mental Well-Being

Emotional and mental well-being		
I feel depressed due to caring	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Agree	50.0	18.2
Agree	43.9	42.4
Disagree	4.5	15.2
Strongly Disagree	1.5	24.2

My caring role makes me feel anxious		
Strongly Agree	51.5	19.7
Agree	40.9	45.5
Disagree	6.1	9.1
Strongly Disagree	1.5	25.8
I struggle to sleep because of the worry of caring		
Strongly Agree	50.0	18.2
Agree	36.4	34.8
Disagree	9.1	21.2
Strongly Disagree	4.5	25.8
I feel stressed as a result of caring		
Strongly Agree	53.0	16.7
Agree	39.4	42.4
Disagree	6.1	16.7
Strongly Disagree	1.5	24.2
I have had thoughts of ending my life due to my caring role		
Strongly Agree	9.1	1.5
Agree	28.8	16.7
Disagree	28.8	45.5
Strongly Disagree	33.3	36.4

b. Physical wellbeing: Physical well-being was assessed through indicators such as physical exhaustion, body pain, personal health concerns, and fears of health deterioration due to caregiving. Scores ranged from 0 to 20, with higher scores indicating more physical strain. The results revealed a **statistically significant improvement in physical well-being after the intervention** ($p < 0.01$) (Figure 2).

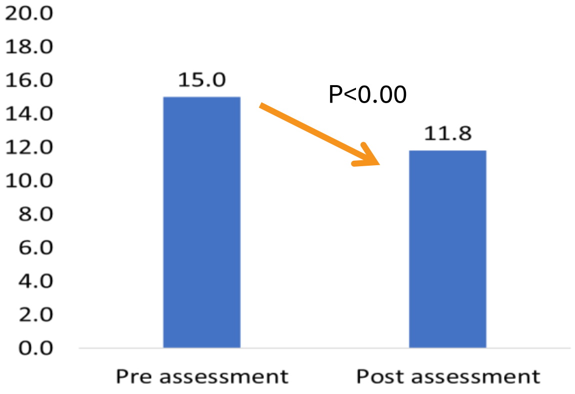

Figure 2: Physical wellbeing

After the intervention, the proportion of participants who strongly agreed that their caring role negatively impacted their physical well-being (e.g., exhaustion, aches, concerns about health) decreased substantially. At the same time, more participants strongly disagreed with these statements post-assessment, suggesting an improvement in perceived physical health and reduced physical strain from caregiving (Table 4).

Table 4: Pre- and Post-Intervention Assessment of Physical Well-Being

Physical well-being		
I am physically exhausted by caring	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Agree	37.9	10.6
Agree	45.5	39.4
Disagree	9.1	28.8
Strongly Disagree	7.6	21.2
I have aches and pains as a result of providing care		
Strongly Agree	31.8	12.1
Agree	50.0	39.4
Disagree	10.6	28.8
Strongly Disagree	7.6	19.7
I am concerned about my own physical health		
Strongly Agree	33.3	12.1
Agree	40.9	37.9
Disagree	18.2	24.2
Strongly Disagree	7.6	25.8
I am concerned about my caring role making my physical health worse		
Strongly Agree	28.8	12.1
Agree	42.4	31.8
Disagree	24.2	31.8
Strongly Disagree	4.5	24.2
I worry that one day I will have to stop caring due to my physical health deteriorating		
Strongly Agree	28.8	10.6
Agree	37.9	31.8
Disagree	25.8	30.3
Strongly Disagree	7.6	27.3

c. Loneliness and isolation: This theme evaluated feelings of social withdrawal, stigma, exclusion, loneliness, and the absence of supportive relationships due to caregiving responsibilities. Scores also ranged from 0 to 20, with higher scores representing greater loneliness and isolation. A **significant reduction in loneliness and isolation was observed between the pre- and post-assessment periods** ($p < 0.01$) (Figure 3).

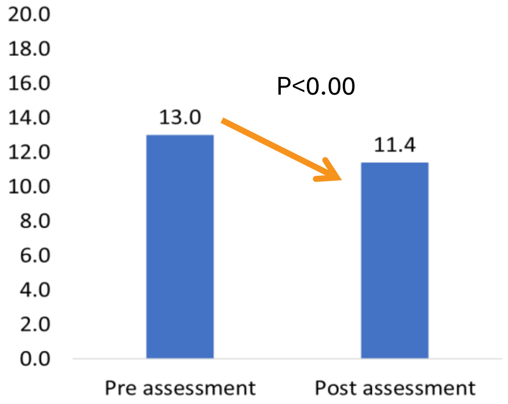

Figure 3: Loneliness and Isolation

Following the intervention, fewer participants strongly agreed with statements indicating loneliness, isolation, and stigma, while more participants disagreed with these statements, suggesting reduced feelings of social disconnection. Additionally, more participants reported having someone to discuss the challenges of caring with, indicating improved social support and connectedness post-assessment (Table 5).

Table 5: Pre- and Post-Intervention Assessment of Loneliness and isolation

Loneliness and isolation		
I lack companionship	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Agree	22.7	9.1
Agree	47.0	34.8
Disagree	10.6	39.4
Strongly Disagree	19.7	16.7
I am drifting apart from friends and family because of my caring responsibilities		
Strongly Agree	6.1	4.5
Agree	50.0	27.3
Disagree	21.2	50.0
Strongly Disagree	22.7	18.2
I feel excluded or stigmatized by others due to caring for a sick or disabled loved one		
Strongly Agree	6.1	1.5
Agree	45.5	19.7
Disagree	24.2	60.6
Strongly Disagree	24.2	18.2

I feel lonely		
Strongly Agree	25.8	6.1
Agree	45.5	31.8
Disagree	9.1	42.4
Strongly Disagree	19.7	19.7
I have a friend of family member I can discuss the challenges of caring with		
Strongly Agree	28.8	12.1
Agree	39.4	48.5
Disagree	16.7	27.3
Strongly Disagree	15.2	12.1

d. Respite and control of own life: This aspect focused on the availability of personal time, breaks, backup support, the ability to plan ahead, and participation in social events. Higher scores (range 0–20) indicated better respite and control. Although an improvement was noted post-intervention, the change was not statistically significant (Figure 4).

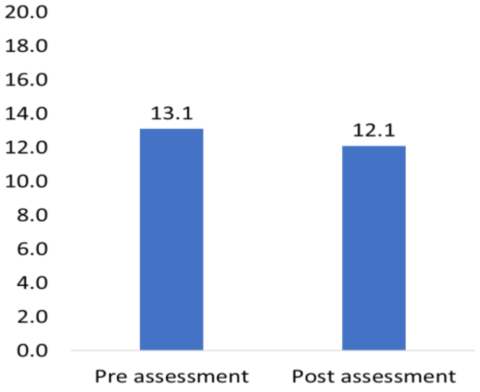

Figure 4: Respite and control of own life

After the intervention, the proportion of participants strongly agreeing that they lacked time for themselves, were unable to take breaks, or could not plan for the future because of caring responsibilities decreased notably. At the same time, more participants disagreed with these statements, indicating an **improvement in their sense of control over their lives and ability to find respite from their caregiving role** (Table 6)

Table 6: Pre- and Post-Intervention Assessment of Respite and control of own life

Respite and control of own life		
I do not have enough time to myself because of my caring responsibilities	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Agree	15.2	4.5
Agree	48.5	42.4
Disagree	24.2	37.9
Strongly Disagree	12.1	15.2

I am unable to take a break from caring		
Strongly Agree	18.2	6.1
Agree	50.0	45.5
Disagree	13.6	31.8
Strongly Disagree	18.2	16.7
I can ask and rely on another person to take over my caring duties if I have to attend to another matter		
Strongly Disagree	13.6	13.6
Disagree	27.3	30.3
Agree	33.3	50.0
Strongly Agree	25.8	6.1
I am unable to plan for the future because of my caring responsibilities		
Strongly Agree	19.7	6.1
Agree	48.5	45.5
Disagree	19.7	37.9
Strongly Disagree	12.1	10.6
I cannot attend social events due to caring role		
Strongly Agree	16.7	4.5
Agree	48.5	37.9
Disagree	19.7	42.4
Strongly Disagree	15.2	15.2

e. Financial concerns: Financial concerns were assessed by evaluating worries about financial stability, inability to save money, unmet household needs, caregiving-related expenses, and lack of community recognition of financial strain. Scores ranged from 0 to 20, with higher scores indicating greater financial stress. Despite no direct financial intervention, some improvement was observed—potentially due to awareness and linkages provided—but the change was not statistically significant (Figure 5).

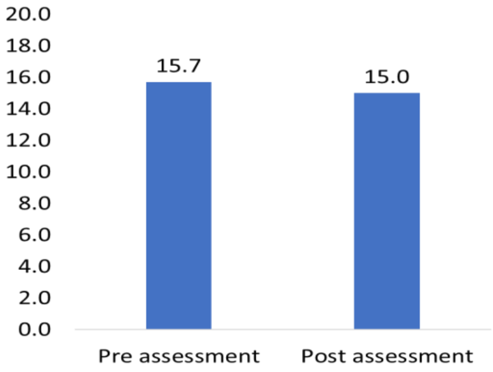

Figure 5: Financial concerns

After the intervention, participants strongly disagreed with statements about having enough money for household needs or covering the extra costs of caring, suggesting a modest improvement in perceived financial strain. However, concerns about saving money and feeling respected financially in the community remained high, indicating ongoing challenges in financial well-being despite some progress (Table 7).

Table 7: Pre- and Post-Intervention Assessment of Financial concerns

Financial concerns		
I constantly worry about the financial stability of my household	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Agree	65.2	33.3
Agree	31.8	43.9
Disagree	3.0	9.1
Strongly Disagree	0	13.6
I am able to save money regularly		
Strongly Disagree	45.5	31.8
Disagree	30.3	47.0
Agree	21.2	18.2
Strongly Agree	3.0	3.0
There is enough money in our house to pay for the things we need		
Strongly Disagree	12.1	19.7
Disagree	18.2	22.7
Agree	59.1	54.5
Strongly Agree	10.6	3.0
I have enough money to cover the extra costs of caring (e.g. trips to the hospital)		
Strongly Disagree	62.1	47.0
Disagree	27.3	39.4
Agree	7.6	10.6
Strongly Agree	3.0	3.0
My financial status is respected within the community		
Strongly Disagree	34.8	28.8
Disagree	43.9	50.0
Agree	19.7	18.2
Strongly Agree	1.5	3.0

F. Confidence in advocacy: This theme captured participants' confidence in self-expression, clarity of vision, civic participation, readiness to advocate, awareness of rights, and access to knowledge. Scores ranged from 7 to 28, with higher scores reflecting greater advocacy confidence. The **intervention led to a significant improvement in this area** (p < 0.01) (Figure 6).

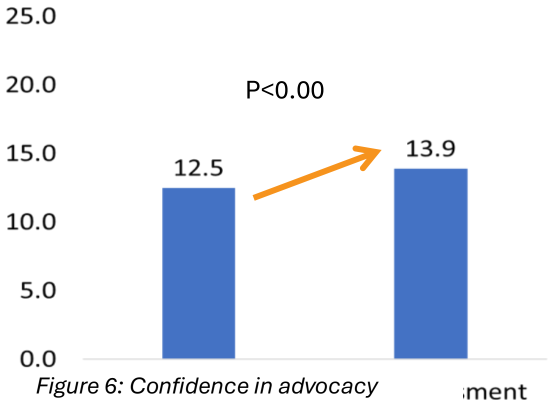

Figure 6: Confidence in advocacy

After the intervention, fewer participants strongly disagreed with statements about their ability to express their needs, describe desired changes, and understand or access their rights as carers, indicating some improvement in advocacy confidence. However, a majority still expressed low confidence in having their views considered in public decisions and knowing how to claim their rights, suggesting continued barriers to effective advocacy (Table 8).

Table 8: Pre- and Post-Intervention Assessment of Confidence in advocacy

Confidence in advocacy		
I can tell a clear story about what I need as a Carers and why I need it	***Pre-intervention (%)***	***Post-intervention (%)***
Strongly Disagree	34.8	18.2
Disagree	24.2	62.1
Agree	33.3	16.7
Strongly Agree	7.6	3.0
I can clearly describe the changes that I want to see for Carers		
Strongly Disagree	39.4	21.2
Disagree	25.8	56.1
Agree	28.8	19.7
Strongly Agree	6.1	3.0

I feel like my views as a Carers are considered in public discussions		
Strongly Disagree	47.0	24.2
Disagree	34.8	66.7
Agree	15.2	7.6
Strongly Agree	3.0	1.5
I feel like I am actively involved in public decisions that affect my life as a Carers		
Strongly Disagree	57.6	22.7
Disagree	37.9	66.7
Agree	3.0	9.1
Strongly Agree	1.5	1.5
I am prepared to take action to advocate for my needs as a Carers		
Strongly Disagree	31.8	15.2
Disagree	13.6	25.8
Agree	50.0	56.1
Strongly Agree	4.5	3.0
I am aware of what existing rights my household are entitled to		
Strongly Disagree	65.2	30.3
Disagree	30.3	60.6
Agree	4.5	9.1
I know who to approach/how to access my rights		
Strongly Disagree	65.2	31.8
Disagree	28.8	56.1
Agree	6.1	10.6
Strongly Agree	0.0	1.5

3.4 Perception of key stakeholders towards intervention

The key stakeholders, particularly Female Community Health Volunteers (FCHVs) and Carers, expressed largely positive perceptions towards the intervention introduced by TPO Nepal and Carers Worldwide. FCHVs reported that while they initially had limited understanding of the needs of Carers, the intervention helped them realize the significant emotional and physical burden Carers face. As one FCHV noted, *"After TPO Nepal came, we realized that* Carers *are also deeply affected."* They shared that their responsibilities increased (needing to visit Carers multiple times) but they felt personally transformed by learning how to listen and communicate empathetically. *"I learned how to talk to people in distress and that has changed me as well,"* said another FCHV, highlighting the impact of the training on their personal growth.

Carers

- Attitude improved over repeated interactions
- Emotional relief and satisfaction after counseling sessions.
- Behavioral changes due to improved communication and self-awareness.

FCHVs

- Gained confidence and communication skills through training.
- Initially doubted their capacity to work with carers but observed positive outcomes and built trust.
- Felt proud and motivated when carers showed progress and expressed gratitude.

Other community stakeholder

- Community members have become more aware and positive toward carers and mental health issues.

Carers and community members also showed a gradual shift in attitude, becoming more aware of and sympathetic to caring challenges. FCHVs observed that initial skepticism—such as assumptions that Carers "won't understand"—was replaced by openness and trust after repeated interactions. *"Even small positive changes in Carers after several meetings felt rewarding,"* one FCHV shared. Despite these improvements, Carers are still not fully respected within families or communities and continue to face financial and emotional difficulties. However, the emotional support offered by FCHVs made a significant difference. One Carers, after receiving counseling, expressed, *"I felt relieved, just knowing someone is there to listen to me."* Stakeholders emphasized the importance of sustaining the intervention, with a strong call for additional training and local government support. *"This program must continue because people now have hope,"* a participant urged, underlining the need for ongoing engagement and institutional backing to maintain and expand the program's impact.

3.5 Unmet Needs and Remaining Challenges

Despite the positive impacts of the intervention, key stakeholders highlighted several critical unmet needs that hinder the effectiveness and reach of psychosocial support efforts. One of the most pressing issues is the lack of consistent material and financial support for both Carers and those with mental health conditions. As one FCHV observed, "*When we visit patients, families expect us to bring something, even if just once. If the organization could provide basic items, it would make our visits easier.*" Carers often struggle with poverty and limited resources, which impacts their ability to care for others and themselves. The need for additional counseling, particularly group and family sessions, was also noted, as emotional strain extends beyond individual Carers. "*Carers are still not fully respected by their families or communities, and financial issues are clearly visible,*" one stakeholder explained.

Caregivers

- Financial hardship and no livelihood assistance
- Inadequate social recognition and family/community support
- Emotional stress and lack of psychological support

FCHVs

- Need for refresher training and advanced counseling skills
- Mental health not included in standard FCHV training curriculum
- Increased workload without compensation or incentives
- Limited ability to cover all needed households due to geographic spread

System Level

- Limited awareness among community leaders and institutions
- Weak referral mechanisms and poor case follow-up
- Risk of program discontinuity affecting trust and relapse prevention

There were also logistical challenges, especially in remote areas, where access to professional mental health services is limited. One FCHV mentioned, *"We referred a case, but the counselor couldn't come because the road was too difficult."* This highlights the need for better transportation and outreach infrastructure. Moreover, while FCHVs have received training, many felt it was insufficient for the complexity of cases they encounter. *"There is still more to learn, and we need further training to sharpen our skills,"* one FCHV stated. Finally, there was a strong call for broader community awareness initiatives to address persistent stigma and misconceptions around mental health. *"People still believe in shamans and traditional healers, but now some are beginning to visit health posts too,"* noted another FCHV. These insights underline the necessity for sustained, well-resourced, and community-integrated mental health interventions.

3.6 Limitations of the intervention

A key limitation of the intervention is its focus solely on psychosocial support and social linkages, without providing direct financial assistance to unpaid family Carers. While the counselling services led to significant improvements in emotional and mental wellbeing, many Carers continued to face severe financial hardship, which remained a major source of stress. Although the program facilitated some awareness and connections to financial services, the lack of concrete economic support—such as livelihood assistance or income-generating opportunities—limited its overall impact on Carers' quality of life.

The intervention's overall impact demonstrated positive outcomes and the potential for scaling it up; nonetheless, the small scale of the intervention and of the evaluation's sample size means it does not reflect the entire context of Carers. Additionally, because the evaluation team was unable to meet with every baseline participant, some information may have been overlooked in this assessment.

3.7 Recommendations for Future Programming and Policy

Based on the assessment findings, the following key recommendations are proposed to strengthen future mental health and psychosocial support programming:

- **Enhance Community Awareness and Engagement:** Implement targeted stigma-reduction campaigns and actively involve local leaders and influencers to foster community understanding. Disseminate culturally appropriate information to improve mental health literacy and promote positive attitudes toward Carers and care receivers.
- **Ensure Program Continuity and Sustainability:** Secure long-term funding mechanisms and integrate regular follow-up of active cases into community health structures. Strengthen local health systems to support the ongoing delivery of mental health services and targeted support for Carers.

- **Mobilize Local Government Support:** Advocate for dedicated budget allocations and policy integration of mental health services and Carer support services into primary health care. Expand the recruitment and deployment of Female Community Health Volunteers (FCHVs), especially in underserved and geographically challenging areas.
- **Expand Training and Incentive Systems for FCHVs:** Incorporate mental health and Carer support modules into the standard FCHV training curriculum and provide regular refresher sessions. Establish incentive structures—including financial and non-financial recognition—to maintain motivation and service quality.

- **Community Awareness & Engagement:** Involve local leaders, run stigma-reduction campaigns, share culturally relevant information
- **Ensure Program Continuity:** Secure long-term funding, monitor active cases, enrich community health systems to include mental health and Carer support
- **Mobilize Local Government Resources:** Allocate budgets, integrate mental health into primary care, recruit more FCHVs
- **Expand Training & Incentives for FCHVs:** Include mental health in FCHV curriculum; provide refresher training and compensation
- **Enhance Carer Support:** Offer psychosocial counseling, financial/material aid, and community recognition
- **Improve Access to Mental Health Services:** Strengthen referral systems, deploy mobile counselors, support remote access

- **Strengthen Support for Carers:** Offer comprehensive psychosocial counseling for Carers and their families. Provide financial or material support where possible and promote public recognition of Carers' roles to enhance their dignity and community standing.
- **Improve Access to Mental Health Services:** Strengthen referral pathways and coordination between community health workers and mental health professionals. Deploy mobile counseling units and leverage telehealth solutions to ensure access for remote or hard-to-reach populations.

The photos included in this report were taken by staff of TPO Nepal.