

Capacity Strengthening Planning Report for National Health, Education, Information and Communication Centre

Ministry of Health and Population

National Health, Education, Information and Communication Centre

June 5, 2014



Acknowledgement

The Health Communication Capacity Collaborative (HC3) Nepal was made possible by funding from the United States Agency for International Development (USAID). We are grateful for the generous financial and technical support provided by USAID for this work.

We are grateful for the time provided by NHEICC to engage their staff for the participatory workshop and one on one interviews which helped to generate information used in this report.

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Note: The contents of this report are the responsibility of the Health Communication Capacity Collaborative Nepal and do not necessarily reflect the view of USAID or the United States Government.

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Executive Summary

This report is based on the information collected as part of a capacity assessment and planning exercise under the Nepal – HC3. Information was collected through a desk review of key NHEICC documents, a participatory assessment and planning process, and in-depth interviews with internal staff at the central level.

The purpose of this report is to highlight key areas of strengths and weaknesses, provide recommendations for the immediate and long term, and provide a starting point for identifying next steps together with the NHEICC.

The primary goal of this capacity strengthening and planning exercise was to collect qualitative information to understand the capacity of the NHEICC from the perspective of current staff to lead and coordinate social and behavior change communication (SBCC) efforts in Nepal, including SBCC knowledge, coordinating mechanisms, and factors that facilitate and inhibit their health promotion and communication work.

The findings have been categorized under Institutional Capacity and Technical Capacity. Leadership, Human resources, Coordination and support, and Financial resources fall under Institutional capacity while Training in BCC and IEC interventions, Methodological Holistic Approach, Monitoring of BCC and IEC interventions, Evaluation of BCC and IEC interventions, and Knowledge Management are under Technical Capacity.

There is a need to strengthen NHEICC's technical capacity for methodological, holistic BCC and IEC interventions approach. The interventions should also be better monitored as they are implemented. BCC and IEC interventions technical trainings and better knowledge management are also seen to be beneficial to NHEICC staff centrally and at the districts. Institutionally, frequent leadership changes and weak linkages with program divisions, need for more human resources at the district level, insufficient financial resource allocation by the Ministry and need for better coordination with other divisions and with external stakeholders are seen as key gaps.

Based on the findings of the capacity assessment, the following key actions are recommended:

- Short term: provide SBCC training for NHEICC staff to strengthen their health communication strategy development skills;
- Medium term: work with the NHEICC to improve knowledge management capacity and facilities including resource center and website development; and,
- Long term: work with the NHEICC to position themselves to be able to advocate to the Ministry of Health and Population to ensure that health promotion is budgeted.

Introduction

Overview of the Health Communication Capacity Collaborative

The Health Communication Capacity Collaborative (HC3) is a five-year, global project funded by USAID. It is designed to strengthen developing country capacity to implement state-of-the-art social and behavior change communication (SBCC) programs. Among the important health areas addressed by HC3 are:

- Family planning and reproductive health
- Child survival
- Maternal and child health
- HIV and AIDS
- Malaria, TB and other infectious and non-communicable diseases

HC3 is designed to foster vibrant communities of practice at the national, regional and global level that support improved evidence-based programming and continued innovation. In addition, the project's specialized area of technical expertise uniquely positions it to complement, support or enhance SBCC projects already underway.

Strengthening the capacity of local organizations is at the heart of the Health Communication Capacity Collaborative (HC3). The project focuses on three levels: organizational, individual and national. HC3 supports skills-strengthening for a wide variety of audiences, including program managers, journalists, video and radio producers, health workers and counselors, health education units and local government staff. At the national level, HC3 helps local governments and key implementing partners design, update, or implement national health communication strategies to better coordinate ongoing efforts.

Overview of Nepal – Health Communication Capacity Collaborative

The US Government (USG)-supported Nepal Global Health Initiative (GHI) Strategy (2010) contributes to Government of Nepal (GON) efforts to meet Millennium Development Goals (MDGs) 4, 5 and 6 for improved maternal and child health and family planning, as well as to check the spread of HIV/AIDS. Additionally, the GHI strategy seeks to build capacity within the Nepal's health system to improve sustainability. USAID and the GON have identified the need to improve capacity in the area of social and behavior change communication (SBCC) within the Ministry of Health and Population (MOHP) National Health Education, Information and Communication Centre (NHEICC), particularly in the area of Family Planning (FP) communication.

HC3 Nepal is an extension of the global mechanism, with a specific focus on Nepal. It is the principal USAID vehicle for building capacity within the Government of Nepal NHEICC to design and implement large-scale family planning SBCC programs in coordination with national partners in the public, private and NGO sectors. As part of a comprehensive capacity building process, HC3 Nepal, in partnership NHEICC, will design, implement and evaluate strategic family planning SBCC campaigns with the goal of improving health outcomes in Nepal. The HC3 Nepal project is designed to achieve the following broad results:

Result 1: Strengthened SBCC program design, implementation and evaluation for family planning.

Result 2: Strengthened institutional capacity for the NHEICC and partners

In addition to the capacity strengthening of NHEICC and partners who will be 'learning by doing' linked to the Family Planning Campaigns, and as part of result area 2, HC3 Nepal will focus on institutional capacity building primarily of NHEICC but other partners as needed. The HC3 Nepal capacity strengthening approach is committed to:

- Building on existing capacity;
- Strengthening individuals and institutions;
- Focusing on public sector for advocacy and coordination of SBCC;
- Integrating SBCC and organizational development;
- Embedding systematic capacity strengthening in collaborative implementation; and,
- Blending a mix of methods for the most impact.

Overview of the National Health, Education, Information and Communication Centre

The NHEICC has gone through a number of transitions in an attempt to position themselves as a leader in social and behavior change communication. From the initial days and recognition of health communication in Nepal, the center has made tremendous strides in institutionalizing social and behavior change communication into health programming. In 2007 an assessment was conducted on the technical and management capacity of NHEICC with key recommendations.

Since 2007, a number of those areas identified in the assessment have been addressed, some are no longer relevant and others remain a challenge with added complexities as the role of social and behavior change communication becomes increasingly more important and complex in a country that has large migratory patterns and hard to reach populations, and also more refined as the practice continues to expand and grow into new areas such as information and communication technology.

In 2012 the NHEICC released the approved National Health Communication Policy that gives the NHEICC the mandate to lead, coordinate, plan and implement social and behavior change communication activities in Nepal. Although this is the case, and NHEICC is starting from a solid foundation of knowledge, experience and center leadership, in practice there is still much ground to gain.

Many of the general themes presented in the 2007 Assessment of Technical and Management Capacity of the National Health Education, Information and Communication Center were echoed during the participatory workshop and key informant interviews conducted this year. Some of these include technical capacity and human resource at both the central, regional and district level; insufficient coordination between NHEICC and bilateral donors, NGOs, private sector, and other stakeholders; and, concerns in coordination between NHEICC between the central, regional and district levels.

Vision, Goal and Objectives for the NHEICC

While conducting the planning exercise, workshop participants were asked what they saw as the **vision** for the NHEICC. Participants agreed that the vision for NHEICC is:

To elevate the role of health communication within the Ministry of Health and Population and among other government ministries and departments and for others to see the role and importance of social and behavior change communication.

Participants emphasized the need to remain within the Health Communication Policy and other government approved documents when setting the vision for the NHEICC.

The **goal** of the 2012 National Health Communication Policy is to sustain a healthy lifestyle of mass citizens by promoting health services, programs and health behavior; by preventing and controlling disease; and, by increasing accessibility and utilization of health services. NHEICC will do this specifically through the following **objectives**:

- Mobilize and use modern and tradition communication multi-media and methods in an extensive and proportionate manner to raise health awareness, knowledge and promote healthy behavior of mass citizens;
- Strengthen, expand and implement health communication programs at central, regional, district and community level through clear and strengthened cooperation, coordination and collaboration among individual, community, relevant organizations and communication media;
- Generate, collect and mobilize sufficient resources for the effective implementation of health communication programs at central, regional, district and community levels;
- Prevent unauthorized dissemination and duplication of health related messages or information and materials of different issues by maintaining quality, correctness, authorized, uniformity and appropriateness;
- Enhance capacity on health communication in order to develop, produce and disseminate quality, correct, authorized, uniform and appropriate messages or information, materials and programs; and,
- Provide quality health messages or information through appropriate media and method to the citizens, who have no access to health messages or information.

Mandate for the NHEICC

According to the 2007 Assessment of Technical and Management Capacity of the National Health Education, Information and Communication Center the mandate of the Center is to:

- Increase awareness and knowledge of people in health issues by providing correct and adequate messages using various channels of communication
- Increase positive attitudes towards health care
- Promote desired health behaviors
- Promote participation of the people in health interventions, with particular focus on gender and social exclusion among the priority groups
- Increase access to new information and technology on health and health programs

The Nepal Health Sector Program II, 2010-2015 prioritizes health communication programs with a need to provide an integrated approach to promote and increase utilization of all essential health services and programs. The 2012 Health Communication Policy expands upon this recognizing health education and communication as key components of preventative and promotive health services, pointing out the lack of health awareness among the general public as a main reason for people's poor health.

Structure of the NHEICC

The organizational structure of the NHEICC refers to both the physical location of the center and the network of regional and district offices (see Annex X for the structural organigram). The NHEICC is a center directly under the Ministry of Health and Population. The DOHS is divided into five centers, six divisions and three programs or sections.

Centers:

- 1.) National Public Health Laboratory (NPHL)
- 2.) National Tuberculosis Center (NTBC)
- 3.) National Health Training Center (NHTC)
- 4.) National Health Education, Information and Communication Center (NHEICC)
- 5.) National Centre for AIDS and STD Control (NCASC)

Divisions:

- 1.) Family Health Division (FHD)
- 2.) Child Health Division (CHD)
- 3.) Logistic Management Division (LMD)
- 4.) Management Division (MD)
- 5.) Epidemiology and Diseases Control Division (EDCD)
- 6.) Primary Health Service Division (PHSD)

Programs:

- 1.) Leprosy Control Program (LC)
- 2.) Personnel Administration Section (PAS)
- 3.) Finance Administration Section (FAS)

The NHEICC is mandated as the focal point for planning, implementation, monitoring and evaluation of health communication activities across the different centers, divisions and programs. There are also four sections that form the NHEICC. These sections are:

- 1) Reproductive and Child Health,
- 2) Environmental Health,
- 3) Tobacco and NCD, and
- 4) Health Promotion and Education.

Each section addresses the health communication needs of the specific health issues identified, with the Health Promotion and Education section being a catch-all.

The first level after the central level is the regional level. At the regional level there is a Regional and Health Training Centers who provide orientation and technical training for government staff. The Regional Health Training Centers do not conduct training in health communication. The NHEICC interacts directly with the Regional Health Directorates when planning and implementing health communication activities and each Regional Health Directorate has a position solely dedicated to health communication, although there are a number of vacancies.

Although Nepal is divided by zones, the NHEICC does not engage at this level. At the district level there are District Health/Public Health Offices that are responsible for coordinating the dissemination of health messages at the community level. Each District Health Office has an assigned Health Education Technician / IEC focal person who is tasked to implement these activities. The District level

communicates and works directly with the health posts, sub-health posts and community level volunteers. The FCHV are the community cadre of volunteers with minimum incentives supported by the government.

The 2012 National Health Communication Policy emphasizes the need for a decentralized system, with communication programs being implemented at the central, regional, district and community levels. The policy also recognizes the importance of coordination and collaboration with local bodies and stakeholders to be able to support a decentralized system.

The NHEICC stresses the need for a one-door system that provides continuity in planning and implementing health communication programs across the health services and programs. In 2012 the National Health Communication policy was released, establishing the mandate for the following coordination and technical committees at the central, regional district and local levels:

- **Health Communication Policy Direction Committee** under the chairmanship of the Secretary of Ministry of Health and Population. Government and non-government organizations, UN bodies, international donors, communication partners, and other relative stakeholders will participate. The purpose of this committee is to effectively implement the health communication policy, monitor, review and direct on implementation.
- **Health Communication Coordination Committee** under the chairmanship of the director of NHEICC at the central level. The committee will work to implement the policy and those decisions made by the Policy Direction committee.
- **Health Communication Technical Committee** under the chairmanship of director of NHEICC and with participation from relative stakeholders. The purpose of this committee is to provide consent to disseminate health messages or information and materials. This committee will be formed on an as needed basis at the regional, district and local level in coordination with NHEICC.

NHEICC Regional Level –

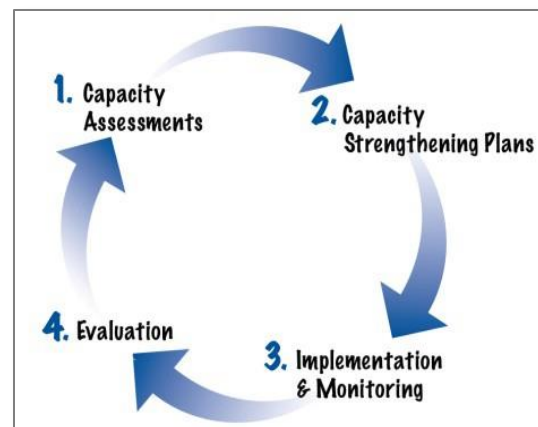
- Five (5) regions
- One (1) region covers approximately 15-16 districts
- Regional level trains all health personnel at the district
- Supervision and monitoring

NHEICC District Level -

- Covers health personnel at VDC level – District calls them based on demand and needs
- Supervise and monitor VDC
- Planning and implementation of activities
- HMIS training is happening now

The Capacity Strengthening Planning Process

HC3 Nepal takes a systematic approach to capacity strengthening, utilizing a capacity improvement cycle, which includes : 1) an participatory process that looks at organizational capacity; 2) capacity strengthening (CS) plans developed with stakeholders based on the assessments that identify and prioritize capacity strengthening needs by the organization and includes interventions to address these needs; 3) support for implementation based on a blend of learning approaches; and 4) monitoring and evaluation of health communication and capacity strengthening at different levels.



Overview of the SBCC-OST Planning Process

The SBCC-OST is the first step of the Capacity Improvement Cycle. It is a process for improving an institution's capacity to design, implement and evaluate social and behavior change communication programs. This tool also helps institutions to understand fundamental organizational requirements, management systems and structures to ensure long term sustainability of the institution.

A high quality SBCC institution delivers programs that respond to its clients' needs and is able to adapt within an ever-changing financial and technical environment, identifying trends and anticipating new gaps while remaining committed to its mission and purpose. When an institution is positioned to navigate a complex system and deliver effective social and behavior change interventions to meet desired outcomes, we view the institution as having *programmatic sustainability*.

In addition to focusing on programmatic sustainability, the SBCC-OST helps institutions focus on their management practices to improve services and make the organization institutionally and financially sustainable.

Unlike other assessments, where a consultant checks off boxes on an assessment instrument and then makes recommendations to the organization, this tool is a structured, participatory process that allows organizations to assess their own performance, select priorities based on their own goals and experiences, develop a concrete action plan for improvement, and carry out their plan. Because members at all levels of the organization are engaged, there is a richer picture of the current situation and more likelihood that the recommendations made by members within the organization itself will be carried out.

The Goal of the SBCC-OST Planning Process

The primary goal of this capacity strengthening and planning exercise was to collect qualitative information to understand the capacity of the NHEICC from the perspective of current staff to lead and coordinate social and behavior change communication (SBCC) efforts in Nepal, including SBCC knowledge, coordinating mechanisms, and factors that facilitate and inhibit their health promotion and communication work.

Understanding the Change Process

In order to strengthen the capacity of an institution they **must embrace the change process**. The change process comes from within the institution, as the result of an open exchange of views and a successful struggle to reach consensus. The SBCC-OST embodies four principles of managing organizational change, collected from literature on the subject:

- 1.) The change process must **meet a real organizational challenge**.
- 2.) The change process must be **“owned” and guided by key stakeholders**.
- 3.) Short-term results can be **milestones** on the way to broader, more substantive changes.
- 4.) The change process must be **supported by staff with clear roles and accountability**.

Principles of change underlie the entire process. A successful experience will bring about changes that begin during the workshop itself and continue long afterward.

Methods

To understand the capacity of the NHEICC in social and behavior change communication and to be able to better plan for capacity strengthening activities that will build upon NHEICC’s existing capacity, HC3 Nepal used a mixed method approach. Activities were comprised of the following: development and adaptation of SBCC-OST, orientation meeting, review of key documents, a one-day participatory workshop, and key informant interviews with staff.

1.) Development and adaptation of SBCC-OST

HC3 Nepal worked to develop and adapt several tools that were used during the process. The first tool was based on the C-Change Capacity Assessment tool with adaptations grounded in JHU-CCP’s P process (JHUCCP, 2003) and SBCC competency matrix. This first revision was implemented in Lesotho. The tool was then adapted in Malawi to address a government level health education department and questions were added to address coordination, collaboration, leadership, organizational management and positioning. Additionally, the SBCC technical areas were expanded to include crosscutting issues like social media, gender, knowledge management and research. Many of the questions were reframed to allow the opportunity for the facilitator to validate responses through discussion.

Under the HC3 global mechanism, this tool was again adapted to better combine MSH’s MOST tool for organizational development and the technical SBCC questions. The result of this is the SBCC-OST Planning Tool that was pre-tested during a five-day workshop in Pakistan with a local organization. For the NHEICC, HC3 Nepal revised the tool yet again to accommodate a one-day participatory workshop with follow-on key informant interviews. **Reducing a five-day workshop to a one-day workshop presented time challenges. As a result only key areas were addressed.**

The second tool that was developed was a Key Informant Interview Guide. This tool was used to guide discussions with the internal staff. The key informant interviews looked more closely at the leadership and coordination, knowledge management and organizational systems with NHEICC.

2.) Orientation meeting

Prior to conducting the participatory workshop, HC3 Nepal conducted an orientation meeting with NHEICC. The purpose of the orientation was to review the overall project, with an emphasis on the capacity strengthening process and to gain buy-in from NHEICC staff. During the orientation meeting the staff and leadership of NHEICC was introduced to HC3 Nepal, the key result areas and activities, HC3's approach to capacity strengthening and the SBCC-OST planning process.

HC3 Nepal recognized the existing capacity of NHEICC and emphasized the desire to build upon and strengthen this capacity through a mix of methods that includes "learning by doing", mentorship, training and other capacity strengthening activities. HC3 is committed to utilizing previous assessment results and working within the mandate of NHEICC and policy and vision of the Ministry of Health.

3.) Review of key documents

Prior to the assessment being carried out, several key documents were consulted in order to provide background information. These documents included reports on previous capacity building exercises of the NHEICC as well as previous work on SBCC. The National Health Policy and the National Health Communication Policy gave insights into the future direction of SBCC in Nepal. The key issues from the review have been integrated in relevant sections of this report, which highlight the key findings and recommendations. The full listing of documents reviewed is in the Annex.

4.) Participatory Workshop

HC3 Nepal worked with NHEICC to identify key individuals within the NHEICC to include in the participatory one-day workshop. 15 technical staff from NHEICC participated in the workshop, representing all four sections of NHEICC. The workshop started with a review of the orientation materials, agenda and objectives, setting of expectations, and clarifying the vision of NHEICC. The larger group was divided into three groups of 4-5 participants. Each group was asked to run through the tool and agree upon a stage and provide evidence to justify that stage. As groups moved through the tool they were asked to record their number and evidence on the flipcharts posted along the wall. Participants took about 2 hours to go through the 24 questions. Participants were fully engaged in the small group work. Results from the workshop are integrated into the findings of this report. The tool with summary notes can be found in the Annex.

5.) Key Informant Interviews

As mentioned above, a key informant interview guide was developed to address additional topics such as the leadership and coordination, knowledge management and organizational systems with NHEICC. Seven in-depth interviews based on questions submitted by Management Sciences for Health were conducted. The interviews lasted about one hour each and were with a cross-representation of staff from different sections and levels within NHEICC. Although the discussions were fruitful, there were some language barriers with some interviewees. The key information interview guide can be found in the Annex.

Findings

As stated, this participatory exercise was undertaken to understand the capacity of NHEICC to lead and coordinate social and behavior change communication (SBCC) efforts in Nepal, including SBCC knowledge, coordinating mechanisms, and factors that facilitate and inhibit their health promotion and communication work.

The following section is divided by key topic area. In order to compare to the results of a previous capacity assessment conducted in 2007, HC3 Nepal has outline the findings using the same categories. Each sub section provides an overview from the previous findings from other assessment, the current status as described by NEHICC staff during the HC3 Nepal participatory workshop and key informant interviews and recommendations that will move NHEICC towards their vision and goal, and to meet their mandate.

The findings and recommendations presented in this report are a starting point and may be revised based on future opportunities and challenges that present themselves. It is **expected that NHEICC will take the lead**, with support from HC3 Nepal, in implementing some of the recommendations. It is also expected that NHEICC will continue and grow the process beyond the life of HC3 Nepal.

Summary of Findings:

Institutional Capacity

Leadership

The 2007 Assessment of Technical and Management Capacity of the NHEICC stated that the NHEICC has a clear vision, mission and objectives and the vision is being put in action. At the time of the assessment, the NHEICC had reorganized their internal structure to meet external demands and carry out their mandate. The assessment cited that due to the authority of the NHEICC they were unable to hold programs, divisions and outside organizations accountable when they plan and implement social and behavior change interventions. In addition, frequent changes in leadership have impacted the cohesiveness of the Center. Recommendations at the time were to:

- Take a more pro-active public relations role with other divisions/programs and partners to advertise what the NHEICC has to offer, what it can learn, and what it is willing to do to help support SBCC efforts.
- Facilitate a systematic plan of coordination meetings to integrate NHEICC into the strategic planning and implementation process.
- Advocate for longer term limits for the director of the NHEICC to build a technical team and guide the implementation of SBCC activities.
- Hire future directors that are dynamic, technically competent and have strong leadership qualities to implement the mission, vision and objectives of the NHEICC.

In 2012 the NHEICC released the National Health Communication Policy that identifies the NHEICC as the focal point for health communication. This document provides a great opportunity for the NHEICC to take a leadership role in social and behavior change communication in Nepal. According to the NHEICC,

the institution is playing the leadership role in SBCC work and this role is recognized by a number of stakeholders. Stakeholders and external partners are beginning to view the NHEICC as the first point of call in the area of health promotion.

During the participatory planning exercise, NHEICC leadership was supportive, present and/or available during most of the exercise. The leadership appeared to have the technical capacity to implement social and behavior change programming and overall staff saw the current leadership as assets to NHEICC.

Some staff were concerned about the number of meetings outside of the NHEICC that pulled the leadership away from the Center and the immediate activities at hand. Staff felt they were a great resource but were not always available or accessible due to other demands on their time. When leadership was present at the Center, staff felt they were able to easily approach them. Staff would like to see more coordination within NHEICC and between senior, mid and entry level staff through sharing of information and updates on SBCC trends. Staff continued to express concern about leadership turnover.

Although the 2007 assessment stated that there were clear role and responsibilities that allowed for decentralized decision making, some staff felt authority is lying in one place and as a result timelines are impacted.

Facilitators

- The NHEICC has been given the mandate to lead in health communication activities.
- The NHEICC has developed a National Health Promotion Policy that aids in the leadership of NHEICC in SBCC activities.
- According to the central office there are mechanisms in place that allow for the sharing of information, such as policy changes.
- The leadership positions within the NHEICC are supportive and believe in the power of social and behavior change communication.
- The current leadership of the NHEICC envisions a strong role of the center and the role of social and behavior change communication in Nepal.
- The majority of current staff see the NHEICC leadership as positive and working towards the mandate and objectives of the Center.

Barriers

- Not all partners are aware of the National Health Communication Policy and the role of the NHEICC.
- Organizations and groups within the Ministry continue to work alone in implementation of SBCC activities. This work is often in haste and therefore quality is compromised.
- The NHEICC is not aware of all the partners doing SBCC work in Nepal, therefore is unable to act as a coordinating body.
- The NHEICC does not have a mechanism that allows them to facilitate coordination and collaboration among partners.

Current Recommendations

- **Conduct a mapping exercise** of all organizations working in SBCC both at national and district levels.

- Be proactive in engaging with partners on the offerings of the NHEICC.
- Maintain a positive learning environment for staff.
- Advocate for longer term limits for leadership roles in order to support full implementation of the 2012 Health Communication Policy.

Human Resource in the NHEICC

In discussing the human resources of the NHEICC, this section refers to the individuals who collectively make up the organization. Under the Leadership section, the 2007 Assessment of Technical and Management Capacity of the NHEICC reported that NHEICC has reorganized their internal structure in order to carry out the core activities of their mandate. Each position at the central level has a clear job description showing a clear delegation of roles and responsibilities, avoiding centralized decision-making. 33 positions were identified under the reorganization and at the time of the assessment most of those positions had been filled. Although NHEICC is on the right track, there were also challenges noted in the assessment, specifically the technical capacity of staff. Over half of the new staff felt they had hired had insufficient training or experience in SBCC. Under the Advocacy Policy section of the assessment, it was recommended that:

- The NHEICC advocate for the revival of the HET post, which had been abolished and to finalize the job qualifications for the RHEO so that they can fill those vacancies.
- Technical staff should remain at post for at least 3-4 years so that they are able to utilize their experience and training gained.

The 2012 National Health Communication Policy sets out a large but achievable goal for the NHEICC. The policy supports a decentralized system where there are teams at the regional and district level to implement coordinated and quality social and behavior change programming. It is expected that the Health Communication Policy will be implemented in a coordinated fashion through the regional health directorate, district health offices and the primary health centers or health posts at the community level. NHEICC is committed to providing additional human and technical resources required for health education and communication at the central, regional, district and community levels. The 2012 National Health Communication Policy states that the position of Health Education Technician/Officer at the regional level will be revived.

The Ministry of Health and Population is tasked with filling health vacancies within the government system. The MoHP tries to match vacancies with skill but this is not always possible. As a result, some staff are placed in positions with little or no experience or skill in that area. There are both permanent and temporary staff positions within the system. Permanent staff can be transferred throughout the government system while temporary staff felt a lack of job stability.

The NHEICC at the central level is well staffed with 34 positions, seen as an improvement from previous years. Although there has been an increase in the number of positions over the years, some current staff felt there were still not enough staff and it would be beneficial to add one additional person at management level and two additional health officers to sit at the central office. As the Center continues to grow it will be necessary to review the demands can be met by the current staff.

During the participatory planning exercise there was a concern about the availability of staff at the regional, district and community level to be able to plan and implement social and behavior change activities. Each Regional Directorate should have a Senior Health Education officer who is responsible for

all the health communication activities and a Health Education officer. There are five regions with 75 districts, which means that each Regional Directorate is responsible for an average of 15 districts, many of which are hard to reach. In general the feeling is that there should be 5-7 staff members at the regional level to be able to effectively plan, implement, supervise and monitor social and behavior change activities.

At the district and community level there is one Health Education Technician. There are about 40 districts who have HETs but in the other districts these responsibilities are being filled by other staff. At both the district and community level there are staff but their role is mainly technical in nature, although they are often tasked with health communication due to gaps in HC focal persons. Some of these positions include: Public Health Officer, Senior Assistant Health Worker and Auxiliary midwife. There is a hesitation to train non-SBCC focal persons because once they are trained they are transferred within the system but not as SBCC focal persons.

The NHEICC had successfully advocated for the hiring of Health Education Inspectors, who would be responsible at the district level for the implementation of health communication activities. At the time of the planning exercise, a number of these positions had been filled but the actual position had been cut from the overall budget.

Facilitators

- The NHEICC has a policy that supports matching the number of staff to the mandate of the organization.
- The central level leadership recognizes the need to re-evaluate staffing in anticipation of growth of the NHEICC.
- The NHEICC has grown at the central level and is able to provide some level of supervision support to the regional and district levels.
- Staff are aware of their roles and responsibilities.
- Overall staff feel there is a high level of expertise within the Center and that staff are committed to their work.
- Although not always filled, there are dedicated staff positions established at the regional, district and community level.

Barriers

- There are not always enough staff to balance the workload, especially at the regional, district and community level.
- There is not a budget available for hiring of new staff and some positions have been cut.
- There is a large turnover in permanent staffing due to transfers within the government system.

Current Recommendations

- Advocate for increased budget to allow for vacant positions to be filled.
- Advocate for extended placements of staff.

Policy and Advocacy

According to the 2007 Assessment of Technical and Management Capacity of the NHEICC, there are a number of policy directives regarding health issues expressed in various national plans and many of the

priority programs have their own policy and strategy documents that contain social and behavior change communication components. Although there seems to be some level of higher level policy that highlights SBCC at the time of the assessment there was no explicit health communication policy. The assessment recommended that:

- A health communication policy should be proposed using a comprehensive strategy drafted by the NHEICC.

Taking the primary recommendation from the 2007 assessment, a health communication policy was drafted and in 2012 the National Health Communication Policy was approved. This policy positions the NHEICC as the central organization within the Ministry of Health and Population for health communication activities. According to the policy, the Regional Health Directorate, District Health/Public Health Offices and primary health centers, health posts or sub-health posts are responsible for implementing this policy.

Facilitators

- There is an existing health communication policy that provides NHEICC with the mandate to plan and implement all health communication activities in Nepal.
- The 2012 Health Communication Policy provides the NHEICC with a document to facilitate coordination with internal and external partners.
- The policy is seen as a positive and needed addition to better facilitate the NHEICC.

Barriers

- Not all players or stakeholders recognize or know about the policy, therefore it is still challenging for the NHEICC to coordinate SBCC activities.
- Although the policy gives the mandate for the Regional Health Directorate, District Health/Public Health Offices and primary health centers, health posts or sub-health posts to implement the policy, there are gaps in staffing and capacity in leadership and technical SBCC.

Current Recommendations

- Provide leadership support and training at the regional and district level to be able to support the mandate given to the NHEICC through the Health Communication Policy.
- Review and update the Health Communication on a regular basis in order to keep up the SBCC trends and context of Nepal.

Coordination and Support

Coordination and support was highlighted as a key area for NHEICC. In order to fulfill their mandate, it is necessary for NHEICC to be recognized as a coordinating body that oversees the production of all SBCC materials and messages done by the divisions of the MoHP, as well as other external organizations. The purpose of this is to ensure correct and consistent messaging and to avoid duplication. **There is a national SBCC coordination committee hosted by the NHEICC and headed by the Director General of DoHS to provide policy guidance and support to different technical committees.** There are five technical committees with members of related divisions/centers, NGOs, and INGOs. The technical committees provide approval and guidance in health messaging.

The 2007 assessment stated that there are examples of good technical coordination between some of the divisions/programs, such as Family Health Division, Child Health Division, and some outside organizations. The assessment cited multiple examples of materials that have been developed as a result of successful coordination between the above bodies.

There is also a feedback reporting system to NHEICC from the district level on SBCC interventions. At the time of the assessment there were **two point persons who were tasked to respond to questions and concerns from the regional and district level.**

Although there are a number of examples of good coordination and there is a system in place between the central, regional and district level, there are also a number of challenges. At the central level many programs operate within vertical pillars and receive separate financial support from bilateral donors. At the regional level there were gaps in staffing, which resulted in an absent focal person. Reporting from the regional and district level is often delayed and feedback to NHEICC from the regional and district level is not constant and regular. Follow-up from the central level to the regional and district level was seen as inadequate. The 2007 assessment recommended the following:

- The SBCC Coordination Committee should be proactive and coordinate with non-government stakeholders.
- The production of any SBCC materials should be reviewed by one of the technical committees. NHEICC should utilize these technical committees to be able to produce and disseminate uniform, accurate, appropriate and adequate health messages.
- NHEICC should advocate for the assignment of RHE to fill the missing positions.
- The two point positions at the NHEICC should develop a coordination plan to be in constant contact with the regional and district levels to improve decision-making in management issues.
- The feedback reporting system to NHEICC from the district level on program activities should be optimized and HETs at the district level should provide the central level with a copy of the integrated report as well as a separate report on SBCC activities.
- NHEICC should follow-up with NCASC to better coordinate activities.

As mentioned in the 2012 Health Communication Policy, NHEICC is working towards a more coordinated “one-door” approach where the MoHP and NHEICC will be responsible for the policy, planning and implementation of all health related communication programs. In order to encourage an integrated effort, advocacy, community mobilization and behavior change programs will be implemented through health communication strategies and health communication programs of the different health services. Programs will be integrated through annual programming and budgeting of the MoHP. These programs will then be implemented by the NHEICC.

The National Policy aims to promote participation and coordination of relevant organizations and stakeholders through the health communication coordination committee comprised of stakeholders to assist in the implementation of the policy and decisions taken by the coordination committee. The

NHEICC wants to institutionalize a pre-consent form from the Government of Nepal to maintain quality, correct messaging, uniformity and appropriateness, while avoiding duplication.

According to the 2012 Health Communication Policy, the NHEICC would like to develop public private partnerships to encourage joint planning and investment, as well as expanding the dissemination of health messages and information.

During the participatory planning exercise NHEICC staff at the central level felt that coordination is necessary and very important. When coordination works targets are met, there is good implementation and support, and relationships are maintained. In general the staff at the central level felt that coordination between divisions is working but could be improved. There was still **a feeling that bi-lateral donors contribute to a lack of coordination by providing funding directly to some divisions.**

Coordination from the regional and district level to the central NHEICC has improved, although some reports are delayed. The regional level is under the direct authority of the DoHS so it is difficult to make requests. Some districts do not have internet but that does not seem to contribute to the delays. There was a feeling that this system still needs to be improved, looking beyond the perspective of the central level. During the interviews there was mention of the focal person at the central level but that the position did not exist.

The DoHS conducts regional review meetings and SBCC has a designated time on the agenda for discussion and every year the NHEICC has an SBCC review meeting at the regional level, with district participation. This review meeting is now conducted by the Regional health Training Centers and NHEICC participates.

Facilitators

- There is a National Health Communication Policy that mandates divisions/programs and organizations to coordinate with NHEICC.
- NHEICC is supportive of coordination and recognizes the importance.
- NHEICC has several structures in place to help facilitate coordination including the technical working groups and an “as needed” BCC working group.

Barriers

- Although there are several mechanisms in place, including the Health Communication Policy, there is still an overall feeling that many organizations and some divisions/programs are not working within that policy.
- Coordination between the central, regional and district office is functioning but there are still delays.
- There are not enough staff at the regional and district level to provide a consistent focal person for feedback.
- Central level staff are not able to provide a high level of supervision and feedback due to the number of districts and hard to reach areas.

- Budgets are often delayed which hinders districts ability to implement and report on activities in a timely manner.

Current Recommendations

- Engage the regional and district offices to fully assess coordination between central, regional and district.
- Explore mechanisms that would allow for real time reporting and feedback from the central, regional and district levels.
- Explore a platform that will allow regions and districts to have easy access to materials and information generated at the central level.
- Allow for and create more opportunities for the regional and district offices to be able to share best practices and apply new information to their work.
- Conduct a mapping exercise to identify where work is being done and by whom.
- Embrace a proactive stance on engaging new partners.
- Work with each of the divisions to establish terms of agreement on how to work best with each program/division.

Financial Resources

The 2007 Assessment looked at the financial resources of the NHEICC. According to the assessment there are two types of budget allocations, which include the regular budget received directly from the MoHP and the development program budget received from bi-lateral and internal funders who commit themselves to specific financial amounts before the NHEICC's program and budget request is sent to MoHP. MoHP budget amounts are reviewed, approved and presented in the "red book". NHEICC has seen an increase in external funding. The assessment also noted several challenges for NHEICC when it comes to financial resource. There is little flexibility in the MoHP budget line items which restricts NHEICC from responding to urgent line items that may arise. Also, the process for disbursement of funds to NHEICC is slow and untimely, which hinders activities at the regional and district level. At the time of the assessment the following recommendations were made:

- The individuals in charge of the disbursement process at NHEICC should be more aggressive in following up and preparing documentation to obtain the signed authorization letter from the Director General of the DoHS.
- NHEICC should plan well in advance with the majority of SBCC activities taking place after the first trimester to allow for delays in funding.
- NHEICC should submit the negotiated program components to funding partners in a timely fashion so they can place these requests in their own country plans.

The 2012 Health Communication Policy states that at least 2 percent of the annual budget from the Ministry of Health and Population should go to health communication efforts. The budget received from the Government of Nepal's annual program is the main source to implement the activities outlined in the Health Communication Policy and will be mobilized by NHEICC. Local government bodies are encouraged in the Policy to coordinate with the MOHP to allocate budgets for health communication. International donors and other development partners will be encouraged to contribute to and invest in health communication programs. In addition, the policy states that a tax will be levied on services or

commodities used by the general public that adversely affect health. A portion of that tax will be used for health communication.

The NHEICC will establish a “Health Message or Information Dissemination Management Fund” to produce messages, materials and services related to health communication and to disseminate those messages and materials or procure or conduct studies and research. The fund will be managed by the Health Message or Information Dissemination Fund Operation Committee.

Although there has been a 2% budget commitment, NHEICC stated they were only receiving about 1% and during the planning workshop staff continued to express their concern for the delay in funding as it impacts the work at the regional, district and community level.

Technical Capacity

Training in BCC and IEC Interventions

The knowledge and experience an individual has is important aspect to the success of his or her work. Although grounded in a history of theory and practice, the ability to access and receive current information and keep up with trends is an important aspect of SBCC. This is a dynamic field and the factors and trends that influence change in attitudes and practices keep changing. The 2007 Assessment recognizes that training is an essential component of any program to have qualified staff that can perform and have impact.

In the past the internal and bi-lateral donors have supported the training of NHEICC staff in SBCC and the production of materials. JHU-CCP conducted a workshop at the district level to support the foundation of district technical teams. There is also a National and Regional Training Center whose mandate is to organize all trainings that divisions/centers require for staff and field personnel.

The 2007 Assessment found that more training is needed at the central and district level and that more than half of the staff felt they needed further education. There were a number of areas that were identified including, strategic planning for SBCC and SBCC methodology. Other areas that were lacking included identifying behavioral barriers and facilitators, how to use formative research, how to mold and integrate content messages, and how to plan a holistic strategy. Many staff did not have experience in pre-testing and lacked the ability to monitor quality. At the district and community level the HETs and health service providers had not received any training in SBCC for at least five years prior to the 2007 assessment.

NHEICC had not developed a training package in SBCC and the NHTC have not received training to become Master Trainers for SBCC. NHTC had not been approached by NHEICC to see if this was possible. The recommendations made in the 2007 assessment included:

- New personnel should be trained in SBCC through an intensive training program.
- Select staff should have a refresher course on SBCC to be able to provide support to new staff.

- NHEICC should work with NHTC to let the NHTC know the training needs of NHEICC staff at the central, regional and district level.
- The NHEICC should coordinate with NHTC to incorporate SBCC into the training modules conducted by NHTC.
- A package should be developed by the NHEICC and NHTC for a Masters Training course.

The 2012 National Health Communication Policy supports the training of human capacity through orientation programs, workshops, observation visits, academic and professional trainings and programs. Included in that are health workers and journalists in health communication to support and encourage the sharing of accurate information. Programs will be conducted in coordination with academic institutions to encourage quality health programming through professional development and pre-orientation.

During the planning sessions staff expressed the concern that there is a constant transfer and hiring of staff, which makes training difficult. There is no onboarding process or induction training for staff hired by NHEICC to cover topics like government rules and regulations, technical or administrative. Those staff members who have been with the Center for a number of years have not received refresher training. One staff member felt that there was an informal mentorship that took place within the NHEICC.

Although staff appeared to be well-versed in many of the concepts in SBCC, when asked what their favorite campaign was they all presented individual activities. In addition, with advances in technology, social media and mobile communication have become key communication channels and there is a new push for knowledge management. Conducting research, showing impact and providing documentation to share has become a trend in SBCC.

Facilitators

- A number of staff members have received training in Social and Behavior Change Communication. This education has come in the form of formal classroom based training.
- Several officers at the central level have relevant education in areas like education or mass communications.
- The overall feeling of staff at the central level is one of learning and a desire to have access to professional development opportunities.
- There is a national training center the NHEICC can leverage to provide onboarding of staff and also SBCC if given the proper support.

Barriers

- There are gaps in SBCC skills due to lack of training amongst some NHEICC staff.
- Although a number of staff received an orientation to their work in SBCC, for most of these officers this orientation took place more than ten years ago.
- Some staff members have received some training or orientation but it was seen as basic.
- There are a number of officers who have not received any form of training or orientation in SBCC since they started their work.
- The NHEICC has not been able to explore new technology and social media with its SBCC work at the national and district levels.
- The NHEICC does not have staff skilled in new technology or the use of social media.

- The NHEICC does not have capacity to monitor the effectiveness of social media in Nepal.

Current Recommendations

- Encourage an environment of professional development and provide opportunities for staff to access current and relevant information, training and education such as the regional Leadership in Strategic Health Communication or annual Baltimore-based Leadership in Strategic Health Communication workshop.
- Examine the roles and responsibilities of senior level positions and hold staff accountable for increasing knowledge, and improving and updating of skills, including management, coordination, implementation, and monitoring of SBCC.
- Work with NHTC to be able to provide training to new staff in SBCC.
- Facilitate comprehensive SBCC training to all regional and district level health communication staff that have not been trained in SBCC.
- Provide training in ICT related areas.
- Develop a process for the NHEICC to be able to stay abreast of various developments in the field of SBCC.
- Identify and train staff members to use new technology and social media.

Methodological Holistic Approach

Knowing and understanding the core concepts of SBCC and how to design and implement a successful intervention is key to having impact. The 2007 Assessment found that NHEICC has a solid background in SBCC theory and methodology, as well as years of experience applying it. At the time of the assessment there was a core of experienced staff that had been trained in SBCC. In 2007 the NHEICC had yet to move from the idea of IEC to BCC (or SBCC). **Not enough weight was given to changing behaviors or to the holistic interventions that facilitate that change.** Formative research was limited and with the shift of technical staff, NHEICC is challenge to build a team of experts. In addition, NHEICC did not focus on the socio-cultural aspects when preparing materials and messages. Based on the 2007 assessment the following recommendations were made:

- Shift from IEC to BCC in order to better recognize the holistic view that supports behavior change.
- Update current NHEICC personnel on BCC methodology at the central, regional and district levels.
- Use any formative research conducted by external partners or programs to design SBCC interventions.

The NHEICC aims to use modern and traditional multimedia, interpersonal communication and social media based on the appropriateness of these channels. The 2012 policy supports the use of mixed media ranging from use of the government website(s), print materials, traditional and local folk art, carnivals and festival days, mobile radio, interpersonal communication, and radio and television. The 2012 Health Communication Policy also expresses a need for health communication standards for dissemination.

These standards must be present in the work of the NHEICC. Although the NHEICC has the knowledge and experience to implement SBCC activities, there are still a number of gaps that were identified during the interview process. **SBCC is still implemented as a number of activities rather than as a coordinated campaign.** In addition, some staff would like to see the NHEICC engage in a more participatory process with their audience during the design phase and also embrace innovation, applying the latest trends and trying new activities and tools at community level.

Facilitators

- The NHEICC recognizes the process necessary to develop effective and strategic SBCC programming.
- Most of the staff at the NHEICC have a solid foundation in SBCC and were able to discuss the key ingredients.
- There is a desire among some staff to be more creative and take some risk in the design and implementation of interventions.
- The NHEICC has worked with partners to conduct a number of research activities that contribute to SBCC programming.

Barriers

- The NHEICC still have a number of gaps in practice when it comes to how to design and implement a strategic SBCC intervention.
- There is a need to expand NHEICC's ability to conduct formative research and to integrate it into the process.
- There are a number of staff, especially at the district level, that could use training in SBCC.
- NHEICC does not have the expertise to integrate ICT into an SBCC intervention.

Current Recommendations

- Work with NHTC to develop a curriculum on SBCC for the orientation of new staff.
- Provide mentorship opportunities for staff either within the NHEICC or with external partners.
- Identify opportunities to "learn by doing" with partners organizations.
- Integrate a plan to explore and adopt new technology and social media into the overall communication strategy.
- Integrate new ideas into the work plans rather than transferring the same activities year to year.
- Engage in a participatory approach with stakeholders (including the audience) throughout the strategic process.

Monitoring of BCC and IEC Interventions

Monitoring program activities and progress is an important part of any successful program or intervention. According to the 2007 Assessment, there is an integrated monitoring/supervision system designed by the MoHP, which includes some SBCC indicators but not enough. The matrix does not track activities carried out at the health post, sub-health post and community level. At the time of the assessment it was felt that there were sufficient staff and a modest budget to provide monitoring and supervision but **there was concern on the training of the supervisory staff to be able to carefully look at SBCC indicators.** In addition, supervisory visits from the central to the district were few due to issues

such as transportation and limited budget. The 2007 Assessment made the following recommendations for monitoring of SBCC interventions:

- NHEICC should revise the HMIS SBCC indicators for routine monitoring.
- NHEICC should develop a complementary monitoring matrix of SBCC indicators to better capture the depth and breadth of the SBCC interventions. This should not duplicate HMIS but a tool that will capture the additional indicators needed to understand what is happening. The results should flow directly into programmatic decision-making.
- The central and regional level should increase the number and frequency of monitoring visits to the district level.
- The HEOs and HETs should report all SBCC activities to NHEICC based on supervisory and monitoring visits.

2012 National Health Communication Policy, monitoring and evaluation of health communication activities is a requirement of health communication activities. According to the policy:

- Health communication programs will be improved based on the results of monitoring and evaluation
- Orientation programs will be conducted with health communication workers at the central, regional, district and local levels and recording, monitoring and reporting will be improved based on feedback
- Research will be conducted to develop effective health communication programs, focusing on knowledge, attitudes and behavior to evaluate the effectiveness of programs
- Monitoring and evaluation will consider the public level to increase effectiveness and transparency

Facilitators

- The NHEICC recognizes the importance of monitoring in regards to SBCC.
- The NHEICC has a good network across the country through the district officers, some of whom are very committed and can prove to be a vital resource in monitoring SBCC activities at the district level.

Weaknesses

- NHEICC does not have a monitoring plan.

Current Recommendations

- Include and budget monitoring as part of all SBCC campaigns designed and implemented by NHEICC.
- Support the network of district officers to engage in monitoring activities and provide relevant feedback to the national level.

Evaluation of BCC and IEC Interventions

Like monitoring, evaluation is a key part of the SBCC process. Without evaluation it is impossible to know the impact of a program or intervention. The 2007 Assessment recognized a number of strong

evaluation studies that have been made by independent sources for the MoHP that showed the role of SBCC by looking at increased knowledge, awareness and response to desired behaviors. The district/regional and national performance review is also being used as a platform to look at SBCC activities. Although these evaluation activities are taking place, the assessment also notes the lack of technical capacity and infrastructure within the NHEICC to carry out or supervise a thorough evaluation. In addition, evaluation is costly and time and labor intensive. At the time of the assessment NHEICC did not have this as part of their budget. The 2007 assessment made the following recommendations:

- Impact evaluations should be conducted by an independent organization after a major SBCC intervention.
- Evaluation should be planned well in advance due to the time required to find funding and conduct the actual evaluation.

As described above in the monitoring section, the 2012 National Health Communication Policy highlights monitoring and evaluation of health communication activities is a requirement of health communication activities. The NHEICC sees evaluation of SBCC activities as an important step in the communication process. It is aware of the need to fully understand the knowledge, attitudes and practices of the population prior to planning and implementation.

Although the NHEICC realizes the importance of the evaluation of SBCC activities in Nepal, evaluation has been a challenge. Research is limited as the NHEICC is unable to fully utilize KAPS for strategy development and campaign design. The last assessment was done in XXXX and was conducted in collaboration with a partner organization. NHEICC relies on the Nepal Demographic Health Survey (NDHS), which is research sanctioned by the Ministry of Health. The NDHS comes out once every five years which means NHEICC has to wait to see study results.

The NHEICC would like to capture indicators that would demonstrate the change of behaviors. The existing data sources that are available e.g. the NDHS, are not able to show such this level of change. The NHEICC should be conducting or accessing organizations that are able to conduct, scientific monitoring and evaluation that would provide the evidence needed to conduct effective SBCC work.

Facilitators

- The NHEICC recognizes the importance of RM&E in regards to SBCC.
- The NHEICC has a good network across the country through the district officers, some of whom are very committed and can prove to be a vital resource in monitoring SBCC activities at the district level.
- The NHEICC appears to have some staff that may be able to provide input into a high level evaluation.

Weaknesses

- There is no budget available within NHEICC to conduct regular evaluations.
- NHEICC lacks the technical capacity to be able to implement a large-scale evaluation.
- To date NHEICC has not documented the success of their work, which hinders their ability to advocate for more funding and show themselves as the leader in SBCC.

Current Recommendations

- Train and mentor staff in data analysis skills.

- Build the capacity of the NHEICC in monitoring and evaluation, and ensure there is funding allocated in the budget for these activities.
- Continue to find ways to diversify the NHEICC's funding sources in order to have a more stable funding stream that allows for RM&E activities.
- Include and budget M&E as part of all SBCC campaigns designed and implemented by NHEICC.
- Support the network of district officers to engage in monitoring activities and provide relevant feedback to the national level.
- Work with partners to advocate and include SBCC questions in the NDHS and other national surveys.
- Leverage partner evaluations to include relevant SBCC questions that can be used in future planning of the NHEICC activities.

Knowledge Management

Knowledge Management is a new section that has been added to this report but cuts across a number of the items above. Good knowledge management can provide a platform for coordination, documentation of impact and best practices, and distribution of resources and information. During the planning exercise, NHEICC expressed their interest, and a gap in, knowledge management.

In terms of Knowledge Management, the NHEICC is in the process of populating their website. A full time librarian with web skills has been hired. Although NHEICC is mandated to be the home of health communication materials there is not a system that allows partners and stakeholders to access this information. NHEICC has a website for dissemination of materials but the site is new and not set up as a resource center. In addition there is current knowledge of existing partners and their work.

Facilitators

- The NHEICC is recognized as the home to health communication materials.
- The NHEICC has a staff member for the position of librarian.
- The NHEICC has a system for capturing and sharing health information that is in the newspapers.
- NHEICC staff share information and knowledge during formal meetings as well as informal meetings, SMS and email, and post.
- NHEICC leadership believes that Nepal has a contribution to make to the global stage and seeks a forum that allows them to hear and gain expertise as well as share with other countries.

Barriers

- Knowledge management is a new concept and is not fully understood by staff.
- Knowledge management can be time consuming and there are limited staff to be able to contribute to the process.

Current Recommendations

- Expand the role of librarian to become focused on developing and managing a knowledge management system.
- Utilize the existing online website and expand it into a knowledge management hub that is user-friendly to all partners and the NHEICC staff.
- Utilize existing tools such as the Health Communication Springboard to link to other regions and countries.

- Develop a hub or system for knowledge management that allows NHEICC to capture and document SBCC interventions in Nepal.

Conclusions and Recommendations

As stated above, the vision of the NHEICC is to work within an environment where the role of social and behavior change communication is recognized and elevated within the Ministry of Health and Population, as well as among other government ministries and departments. In order to reach this vision, the NHEICC must become its own advocate, as well as recognized by others as a center that is knowledgeable, efficient and able to produce quality results and impact. In order to do this, NHEICC must be committed to quality programming, providing evidence of impact, and taking a truly leadership role through effective collaboration and coordination.

Based on the findings of the capacity assessment, the following key actions are recommended:

- Short term: provide SBCC training for NHEICC staff to strengthen their health communication strategy development skills;
- Medium term: work with the NHEICC to improve knowledge management capacity and facilities including resource center and website development; and,
- Long term: work with the NHEICC to position themselves to be able to advocate to the Ministry of Health and Population to ensure that health promotion is budgeted.

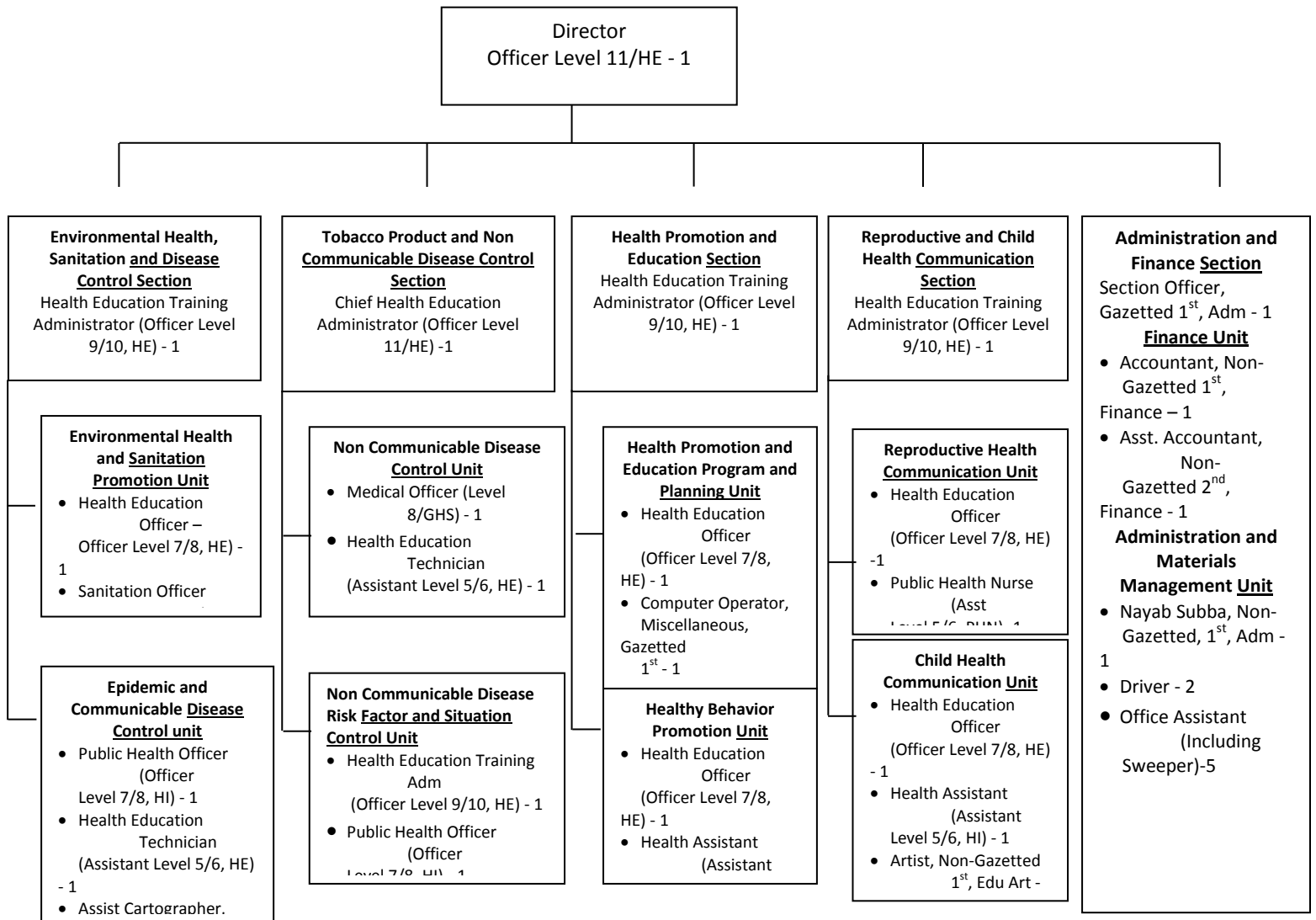
Annex I: Organogram

Government of Nepal

Ministry of Health

National Health Education, Information & Communication Centre

Organizational Structure



Summary

Position	Level	Group	Number	Position	Level	Group	Number
Director	11	HE	1	Finance Officer	Non-Gazetted	Finance	1
Chief Health Education Administrator	11	HE	1	Artist	Non-Gazetted	Art	1
Health Education Training Administrator	9/10	HE	4	Assistant Cartographer	Non-Gazetted	Miscellaneous	1
Health Education Officer	7/8	HE	5	Computer Operator	Non-Gazetted	Miscellaneous	1
Public Health Officer	7/8	HI	2	Na.Su.	Non-Gazetted	Administration	1
Medical Officer	8	GHS	1	Na.Su. (Typist)	Non-Gazetted	Administration	0
Sanitation Officer	Gazette 3 rd	Civil, Sanitation	1	Accountant	Non-Gazetted	Finance	1
Section Officer	Gazette 3 rd	Administration	1	Kharidar	Non-Gazetted	Administration	0
Health Assistant	5/6	Health Inspection	2	Driver		Administration	2
Public Health Nurse	5/6	PHN	1	Office Assistant		Administration	5
Health Education Technician	5/6	HE	2				
Total							34



Social and Behavior Change Communication Analysis Tool

DEFINITIONS:

Communication Strategy- A careful plan or method; the art of devising or employing plans toward a goal. In the context of SBCC, a “strategy” is the health communication strategy that includes subsections describing the situation, the audience, behavior change objectives, the strategic approach, key message points, channels, management and evaluation plans.

Concept Testing- The use of quantitative or qualitative methods to test new or hypothetical products, materials or services before they are launched. Typically a number of concepts are tested to identify the strongest candidate.

Formative Research- The basis for developing effective strategies, including communication channels, for influencing behavior change. It helps researchers identify and understand the characteristics - interests, behaviors and needs - of target populations that influence their decisions and actions. Formative research is integral in developing programs as well as improving existing and ongoing programs.

Framework- Guides the strategic design process or implementation of a program.

Gender Equality- Equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.

Gender Equity- Fairness and justice in the distribution of benefits and responsibilities between women and men.

Pre-Testing- The use of quantitative or qualitative methods to test materials in order to be sure the messages, materials, and tools are culturally appropriate, gender-sensitive, and free from negative stereotypes of the affected individuals and groups.

Social and Behavior Change Communication- Systematic process to analyze a problem in order to define key barriers and motivators to change, and design and implement a comprehensive set of interventions to support and encourage positive behaviors. Communication goes beyond the delivery of a simple message or slogan to encompass the full range of ways in which people individually and collectively convey meaning. Other similar terms used in the past are: Health Communication (HC), Health Promotion, Information Education & Communication (IEC), and Behavior Change Communication (BCC).

Theory- Guides the design of interventions and how to analyze the individuals and groups the program wants to reach.

Strategic Approach- Describes the overarching direction that guides the choice of messages, channels, tools, management components, and indicators to achieve desired goals.

Strategic Communication- A process based on a combination of data, ideas and theories integrated by a visionary design to achieve verifiable objectives by affecting the most likely sources and barriers to behavior change, with the active participation of stakeholders and beneficiaries.

1.0 Social and Behavior Change

NOTE: The use of the word intervention can refer to campaigns, programs and/or projects

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.1 Situation Analysis When conducting a situation analysis, which steps does NHEICC use?	1. Conduct a baseline and/or formative research to establish knowledge, attitudes and practices of target audience. 2. Conduct a review of relevant studies. 3. Assess existing policies and programs. 4. Learn about active and available communication channels. 5. Identify partners and allies. 6. Assess organizational capacities. 7. Be sensitive to possible gender differences and make sure all viewpoints are represented 8. Summarize the understanding of the problem into a problem statement.	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them.	We use 4-6 of the key steps and can clearly articulate them.	We use 6-8 of the key steps and can clearly articulate them.	2, 4, 4, 4

Evidence (when providing evidence, please list the number associated with the key steps with examples of each):

Evidence:

- IEC/BCC Formative Research 2006
- IEC/BCC Formative Research 2012
- Health Communication Policy
- DHS
- HMIS
- NHEICC has done formative and desk review research
- Identify the most popular channels using the DHS, 2006 and 2012 research
- Research helps to identify based on channels and language

Gaps:

- The research does not really address the social aspects/social norms
- Partners are identified by not “systematically”

Action: N/A

Priority Area: 4

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.2 SBCC Theory When designing an SBCC intervention, how does NHEICC apply a behavior change model/theory and theoretical framework?	N/A	We do not use theory to guide our interventions.	We use a theory to guide our intervention design but it is not a behavior change theory.	We use a few theoretical constructs from behavior change theories to guide our intervention design.	We use a behavior change theory or theories to guide our intervention design.	1, 4, 4, 4

Evidence (when providing evidence, please include the SBCC theory(s) your organization has used with examples of each):

Evidence:

- Trained staff on SBCC
- P-Process (SBCC Model)
- KAIPA Model (Knowledge, Attitude, Interest, Practice, Advocacy)

Gaps:

- Theory gaps – knowledge and use of models but maybe not so much theory
- Senior staff are more aware. Entry-level and mid-level could use more training
- Training is usually through partners/projects and not consistent or sustainable

Action: N/A

Priority Area: N/a

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.3 SBCC Strategy Design When designing an SBCC strategy, which key elements does NHEICC include?	1. Communication objectives 2. Audience segmentation 3. Program approaches and positioning 4. Communication channels 5. Structural and communication interventions 6. Implementation plan and timeline 7. Monitoring and evaluation plan 8. Dissemination plan	We do not use any of the key elements.	We use 2-4 of the key elements but cannot clearly articulate them.	We use 5-6 of the key elements and can clearly articulate them.	We use 7-8 of the key elements and can clearly articulate them.	4, 4, 4, 4

Evidence (when providing evidence, please list the number associated with the key elements with examples of each):

Evidence:

- National Health Communication Policy, 2012
- National Communication Strategy for Adolescent Sexual and Reproductive Health Nepal, 2012 – 2016
- National Communication Strategy for Maternal, Newborn and Child Health, 2012 – 2016
- Most staff follow the strategies, especially during planning
- Draft family planning strategy. NCD strategy in process
- A process is followed
- The strategy is designed and technical approves. There is a technical committee review process that also includes external partners. Health Promotion linked to Technical.
- Activities are set based on target groups and timelines
- Technical working groups are functional
- Activities and budget are reflected in “red book”
- Solid foundation to strengthen coordination between divisions and external partners

Gaps:

- Finalize FP strategy
- Finalize NCD strategy

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.4 Design Process What process does NHEICC use when designing an SBCC strategy?	N/A	We do not have a formal SBCC Strategy document.	The SBCC Strategy is designed based on internal/institutional understanding of local priorities.	The SBCC Strategy is designed with some of the key stakeholders based on informal conversations and meetings.	The SBCC Strategy is designed together with a group of program partners, decision-makers, audience members, and technical experts. The entire team comes together at crucial points in the planning and implementation process.	1, 4, 4, 4

Evidence (please provide examples):

Evidence:

- NHEICC has IEC/BCC Technical Committees. In the committee meeting the representatives of program partners, decision makers, audience and technical experts participate
- Strategies
- Minutes of meetings – tracking of information
- Workshop reporting
- Go through a process – Program division has idea (ex. Child Health), Technical committee and external partners meet, messages and content developed, technical review, pre-test
- IEC/BCC Technical Committee includes NHEICC staff, members from program division and partner agencies
- Conduct meetings/workshop involving government agencies, related stakeholders, target group and line ministries

Gaps:

- No integrated communication strategy – only Health Communication Policy

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.5 Gender and Planning When designing an SBCC Strategy, how does NHEICC include gender?	N/A	We do not include gender in the SBCC Strategy.	We agree that gender should be included but most people are not clear what that means.	We include gender in the SBCC Strategy but it does not, in reality, guide activities.	We include gender the SBCC Strategy design. Gender equity is the underlying approach and is reflected throughout the communication plan.	1, 4, 4, 4
Evidence (please provide examples): Evidence: <ul style="list-style-type: none"> • NHSP II • National Health Communication Policy and Communication Strategy focus on gender • Most health programs under MoHP focuses on women and children • Separate section for GESI • Specific guidelines from the Government of Nepal • Determined depending on the need and objective of the program • Family planning looks at distadvantaged groups Gaps: <ul style="list-style-type: none"> • Address language but no separate program for marginalized and disadvantaged groups (except under HIV) • Programs touch on gender issues but do not look to address the social norms around gender dynamics Action: N/A Priority Area: N/A						

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.6 Communication Channels by Audience When designing an intervention, how does NHEICC identify communication channels?	N/A	We do not identify channels by audience.	We identify channels for one audience based on what we think the audience would utilize.	We identify channels per target audience based on what we think the audiences would utilize.	We identify appropriate channels per target audience based on media habits as validated by data.	4, 4, 4, 4

Evidence (please provide examples):

Evidence:

- NHEICC use Nepal Demographic and Health Survey and ICC/BCC formative research data to identify the appropriate communication channels in the designing of interventions.
- Formative research conducted in 2006 and 2012 (done periodically – every 5 years)
- Channel survey through formative research
- DHS
- We use FM, Radio, TV, journals and newspapers for communication
- IPC and orientation program conducted

Gaps:

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.7 Communication Channels and Coordination When designing an intervention, how does NHEICC use multiple channels?	N/A	We do not use more than one channel for communication.	We use more than one channel - mass media, community mobilization, ICT or interpersonal communication- but they work individually and are not coordinated.	We use more than one channel - mass media, community mobilization, ICT or interpersonal communication- in order to support an intervention but they are not always coordinated.	We achieve scale through coordination of channels by using mass media tied to community mobilization, ICT and interpersonal communication among multiple audiences.	4, 4, 3, 3
Evidence (when providing the evidence, please list the channels NHEICC uses with examples of each): <p>Evidence:</p> <ul style="list-style-type: none"> • Advocacy at different levels • Weekly radio program, advertisement, including all types of communication media • Use of mass media, FM, radio, TV, community mobilization, street drama, IPC, print, messages through mobile phones • Public health programs on radio • TV Programs (Jeevanchalira, Thara Vaye Pagisaree) • Website • Different campaigns <p>Gaps:</p> <ul style="list-style-type: none"> • Sometimes there is a lack of communication and coordination between the media agency and the local radio programs • Review of monitoring system of main media agency • Although there is forward planning, sometimes the timeslots are not available • There is no external monitoring agency <p>Action: N/A</p> <p>Priority Area: N/A</p>						

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.8 Program or Campaign Budget When designing an intervention, how does NHEICC develop a budget?	N/A	We do not develop a budget.	We do not develop a budget prior to the start of the intervention but keep track of costs as goes along.	We develop a budget based on assumed costs but do not always keep track of costs along the way.	We develop a realistic budget based on previous experience and periodically adjust it based on actual costs.	4, 4, 4, 4
Evidence (please provide examples): Evidence: <ul style="list-style-type: none"> • Priorities set • Budget discussion – budget set based on the decisions made during the discussion • Expenditure based on realized (?) budget • Programs are identified on the basis of need, policy and strategies • Priorities are set and the budget is allocated on the basis of unit cost and target • Design incentives allocated budget is realistic based Gaps: <ul style="list-style-type: none"> • Budget is not sufficient • Policy states 2% budget for NHEICC but it falls short • Decrease in budget from 22 to 17 Action: <ul style="list-style-type: none"> • Need some level of advocacy to be sure NHEICC is getting the full budget amount Priority Area: N/A						

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
<p>1.9 Product Design When <u>designing</u> communication products/ materials, which key steps does NHEICC use?</p> <p>OR When <u>revising</u> existing communication products/ materials, which key steps does NHEICC use?</p>	<ol style="list-style-type: none"> 1. Conduct inventory of existing materials. 2. Host a participatory process that facilitates agreement on design or revisions. 3. Develop creative briefs. 4. Create draft concepts and materials for audience pretesting. 5. Test concepts and materials with intended audience and key decision-makers. 6. Share results of pretest with the creative team and stakeholders. 7. Revise materials based on feedback. 8. Re-test materials to make sure revisions resolve key issues. 	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them	We use 5-6 of the key steps and can clearly articulate them.	We use 7-8 of the key steps and can clearly articulate them.	4, 4, 4, 4

Evidence (when providing evidence, please list the number associated with the key steps with examples of each):

Evidence:

- Documented in store
- Meeting with related sections to identify topic
- Brief prepared by concerned sections
- Content developed and drafted and shared for review
- Shared with IEC/BCC technical committee for finalization and approval
- Pre-testing of materials in field with target audience before finalized
- Revisions of materials based on feedback
- Final reviewed by technical committee

Gaps:

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.10 Product/ Material Design and Gender When designing SBCC interventions and products/ materials, how does NHEICC include gender?	N/A	We do not include or consider the impact the interventions and products/ materials may have on gender issues.	We include or consider one gender when developing interventions and products/ materials so not to reinforce gender stereotypes.	We include or consider the different needs of men and women when developing interventions and products/ materials, and design them accordingly.	We include or consider the different needs of men and women when developing interventions and products/ materials in order to change harmful gender norms specific to country context.	2, 4, 3, 4

Evidence (please provide examples):

Evidence:

- Brochure on Health Effects 2. Gender based violence
- Safe Motherhood radio and TV program
- Gender friend IEC/BCC materials
- Gender mainstreaming
- National Health Policy, 1991
- National Health Communication Policy, 2012
- MNCH Communication Strategy, 2012
- ASRH Communication Strategy, 2012

Gaps:

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.11 Intervention Planning and Implementation How are SBCC interventions planned and implemented within NHEICC?	N/A	We do not have an implementation plan. Most organizational activities are decided on short notice or reactive to external demands.	We develop a rough implementation plan for some intervention areas. The plans are developed to meet funders' requirements.	We develop an implementation plan for each intervention area. The individual plans do not always link to the SBCC Strategy.	We develop an implementation plan for all intervention areas. The plan is reviewed and adjusted on a routine basis. The individual plans link to a larger strategic communication plan and opportunities are identified to link.	3, 3, 4, 4

Evidence (please provide examples):

Evidence:

- Sections are responsible for making implementation plan before approval of program
- Approved annual programs on a quarterly basis
- Annual work plan and budget broken down by quarters

Gaps:

- Slow release of district budget
- Not a lot of flexibility in line items in the budget, especially for district

Action: N/A

Priority Area: N/A

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.12 Partner Mobilization and Coordination When implementing your interventions, which steps does NHEICC follow when working with partner organizations?	<ol style="list-style-type: none"> 1. Make sure each partner understands their role. 2. Identify a program lead whose responsibility is to facilitate the process. 3. Identify partner needs and conduct training as necessary. 4. Keep partners updated. 5. Share credit for good work. 6. Monitor activities. 7. Prepare for further evaluation activities. 	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them.	We use 4-5 of the key steps and can clearly articulate them.	We use 5-6 of the key steps and can clearly articulate them.	4, 3, 4, 4

Evidence (when providing evidence, please list the number associated with the key steps with examples of each):

Evidence:

- Meeting and minutes
- MOU
- Action Plans
- Example: Safe Abortion- through meeting with the partner organization we identify the problem area. Action plan is prepared. Program implemented. Monitoring. Way forward developed.

Gaps:

Action: N/A

Priority Area: 2

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.13 Training Needs When designing an SBCC Strategy, how does NHEICC identify necessary training needs of self and partners?	N/A	We assume our staff and partners are prepared and able to implement the plan.	We identify what the training needs are to implement the communication plan but do not provide a clear plan for how these needs will be met.	We identify what the training needs will be to implement the plan and develop a plan on how these needs will be met.	We identify what the training needs will be to implement the plan and develop a plan on how these needs will be met. We follow-up to make sure the necessary training takes place and staff and partners have the capacity to implement the strategy.	3, 3, 1, 4

Evidence (please provide examples):

Evidence:

- Based on health issues of present day
- IEC/BCC review meetings for focal persons – DHO/PHO
- Progress more than 90%
- Success of the program conducted

Gaps:

- SBCC training but a gap in how to apply it

Action: N/A

Priority Area: X

SBCC Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.14 Training If your organization trains others, which key elements does your organization use?	<ol style="list-style-type: none"> 1. Establish training session objectives that are SMART. 2. Include relevant stakeholders. 3. Use a participatory process. 4. Use adult learning methodologies. 5. Evaluate the training (for example, using Kirpatrick's four levels of evaluation- reaction, learning, behavior and results). 	We do not use any of the key elements	We use 2-3 of the key elements but cannot clearly articulate them	We use 3-4 of the key elements and can clearly articulate them.	We use 4-5 of the key elements and can clearly articulate them.	2, X, 4, 4

Evidence (when providing evidence, please list the number associated with the key elements with examples of each):

Evidence:

- Planning session, preparation before orientation, training.
- It should be approved by director before implementation.
- MPOWER training on tobacco control (M- monitoring, P- protect, O- offer quit, W- warn, E- enforcement, R- raise tax)

Gaps:

Action: N/A

Priority Area: N/A

SBCC Component	Key Elements or Steps	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.15 Program Data Review and Programmatic Decisions How does NHEICC make decisions about ongoing interventions?	N/A	We do not review intervention data.	We review intervention data when asked or if something goes wrong.	We have a system in place to review intervention data regularly at set times but do not use it to adjust the interventions.	We review intervention data regularly at set times for monitoring purposes and make programmatic decisions in response.	3, 2, 4, 4
Evidence (please provide examples): Evidence: <ul style="list-style-type: none"> • Quarterly reporting to MoHP • Review meetings • Review meetings with Region • Monthly progress report are collected from district and central • Annual reports • Supervision and monitoring with the help of tools that have been developed • Information collected is used to inform programs Gaps: Action: N/A Priority Area: N/A						

SBCC Component	Key Elements or Steps	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.16 Monitoring and Evaluation Plan How does NHEICC monitor and evaluate interventions?	N/A	We do not have a monitoring and evaluation plan.	We have some indicators but no clear monitoring and evaluation plan to determine the success of interventions.	We develop a monitoring and evaluation plan for each intervention during strategy design. Indicators are developed based on what the funder wants to know. Once developed, we do not review or adjust the plan.	We develop an implementation plan for all interventions during strategy design. Indicators are developed and clear and the plan is reviewed and adjusted on a routine basis. We use the lessons learned from the monitoring activities to make mid-course adjustments.	2, 2, 4, 4
Evidence (please provide examples): Evidence: <ul style="list-style-type: none"> • Annual M&E Plan is in place • Annual work plan • Supervision checklist developed. Supervision and monitoring at Central, RHD, RHTC, DPHO/DHO) - Relevant feedback is incorporated after sharing • Monthly reports Gaps: Action: N/A Priority Area: 1						

SBCC Component	Key Elements or Steps	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.17 Quality control When implementing interventions, how does NHEICC maintain quality?	N/A	We count the numbers but have no system to monitor the quality of services.	We acknowledge the importance of high quality services. We are considering activities that will help staff regularly assess and improve quality.	We have undertaken activities to assess and improve the quality of services. A few interested staff members have taken responsibility for conducting these activities.	We have an established system for assessing and improving the quality of services. All staff are trained to regularly use this system.	2, 4, 4, X

Evidence (please provide examples):

Evidence:

- Meeting regarding good service delivery before implementation and materials review
- Technical committee on different programs – meetings as per need
- Research has been conducted to evaluate the programs implemented
- Periodic formative research
- Supervision and monitoring – monitoring checklist
- Field reports based on checklist submitted to central
- Monthly and quarterly reporting from regions and districts
- Use of expertise

Gaps:

Action: N/A

Priority Area: N/A

SBCC Component	Key Elements or Steps	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.18 Program Evaluation How does NHEICC use or plan to use quantitative and qualitative analysis?	N/A	We only evaluate programs or campaigns for which we receive donor funding and that require evaluation.	We collect data to establish a baseline and then periodically compare results to this baseline but are unable to translate this to illustrate results.	We collect data to establish a baseline and then periodically compare results to this baseline to determine progress towards desired result.	We collect data to establish a baseline and then periodically compare results to this baseline to determine progress towards desired result. Information and lessons learned are disseminated and used to influence future programming both internally and with other stakeholders.	3, 3, 4, 4

Evidence (please provide examples):

Evidence:

- Baseline research on NCD and others
- DoHS annual report has a separate section for NHEICC
- Public Opinion poll and compliance survey (conducted in 2010, 2012 and now in process)

Gaps:

Action:

- Explore other data sources, such as service statistics

Priority Area: 2

SBCC Component	Key Elements or Steps	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
1.19 Collaboration on Research and Evaluation Does NHEICC collaborate or work with other organizations, departments or projects to do evaluation studies?	N/A	We do not collaborate with other groups on research and evaluation.	We rarely collaborate with other groups or academic institutions on research and evaluation.	We sometimes collaborate with other groups on research and evaluation.	We frequently collaborate with other organizations and academic institutions on research and evaluation.	2, 4, 3, 3

Evidence (please provide examples):

Evidence:

- Research on smoking and other risk behaviors (Solid Nepal, Public Private Partnership)
- NDHS report survey with collaboration with population section of MoHP
- Public Opinion Poll and Compliance Survey was conducted by NHEICC in collaboration with The Union

Gaps:

Action:

- Identify ways NHEICC can access other project and country level evaluation

Priority Area: N/A

2.0 Knowledge Management, Coordination and Communication

NOTE: The use of the word intervention can refer to campaigns, programs and/or projects.

KM Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
2.1 Knowledge Exchange How does NHEICC share information, resources, knowledge and lessons learned among programs and staff at the national and district level?	N/A	We do not have a mechanism for knowledge exchange, nor is it a priority at this time.	We consider knowledge sharing and managing important. However it is mostly done informally and interpersonally rather than systematic.	We have some structured, formal mechanisms for internal knowledge exchange (After Action Reviews, training, workshops, presentations, meetings, mentoring etc) used by some staff. However many staff do not take advantages of these mechanisms and tool.	We use structured, formal mechanisms for internal and external knowledge exchange (After Action Reviews, training, workshops, seminars, presentations, meetings, mentoring, website, online learning etc). Knowledge exchange mechanisms are utilized by staff and time is set aside to share and learn.	3, 3, 3, X

Evidence (please provide examples):

Evidence:

- NHEICC conducts review meeting at central level as well as regional level
- NHEICC conducts SBCC/BCC orientation at regional and district level
- Trainings and workshops at district level
- Monthly regional meetings
- Quarterly meetings at central level
- Informal sharing
- Website of NHEICC

Gaps:

- Meetings are the only source to get the information. There is no other system for exchange and sharing or resources or lessons learned

Action: N/A

Priority Area: N/A

KM Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
2.2 Knowledge Management (KM) How does NHEICC capture knowledge resources, and lessons learned among staff and projects at the national and district level?	N/A	We do not have a knowledge management system.	We recognize the importance of a KM system but we don't have consistent approaches across the various parts of our organization.	We have a formal knowledge management repository and system that is used to capture and document knowledge gained from programme implementation and learning. However, the KM system is not widely known about or well utilized.	We have a formal knowledge management repository and system that is used to capture, document and disseminate knowledge gained from programme implementation and learning. The KM system is widely known about and often used to inform programme design and for organisational learning. Knowledge gained benefits the organization.	2, 2, 3, 3

Evidence (please provide examples):

Evidence:

- Every year department of Health Services organizes regional and national review meeting
- NHEICC organizes IEC/BCC regional level meeting and orientation
- Experience people are used for the related work
- Staff meetings used for capturing information
- Regional and district level orientation
- Workshops
- Community level program

Gaps:

- No documentation

- Limited organizational memory

Action:

- See other knowledge management related components (2.1, 2.3, 2.4, 2.5)

Priority Area: 1

KM Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
2.3 Coordination: Internal How does NHEICC work with other internal staff or programs at the national and district level?	N/A	There is poor internal coordination – separate projects and technical programmes function in parallel without consultation.	There is some internal coordination between various parts of our organization through periodic meetings but this depends mostly on personal relationships and individual initiative.	We strongly encourage internal coordination between various parts of the organization through staff meetings, electronic media and or newsletters. We have reduced overlap, misunderstandings and duplications as a result.	We are well coordinated internally through a variety of means. We are aligned around our strategic plan, using common frameworks and speaking with one voice to external stakeholders.	2, 3, 3, 3

Evidence (please provide examples):

Evidence:

- Regular staff meetings
- Information is shared through Email
- District to Central communication – Email or faxing of reports and information
- Use of SMS to provide information to district level
- Pilot use of Facebook for sharing of reports but this did not work
- District reports are entered into a database that can be accessed by staff

Gaps:

- Staff are not required to share with other sections
- There is an emphasis on meetings as the sole mechanism for sharing information
- No Intra-net or shared drive

- File stored on personal computers

Action:

- Define our common goal/interest/needs for SBCC with other sections
- Design a strategy and plan for internal coordination based on those needs

Priority Area: 1

KM Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
2.4 Coordination: External How does NHEICC work with other external staff or programs at the national and district level?	N/A	We mostly work on our own. We don't know who else is doing similar, complementary or overlapping work in our geographical area(s).	We are aware of other organizations doing similar, complementary or overlapping work in our geographical area(s). We occasionally meet with some of them to discuss collaboration of some kind.	We are quite familiar with other organizations that are doing similar, complementary or overlapping work in our geographical area(s). We consult with each other to learn and serve our clients better.	We consult frequently with other organizations that are doing similar, complementary or overlapping work in our geographical area(s) in order to look for synergies, fill gaps and avoid duplication. We are a member of one or more networks.	3, 3, 3, 4

Evidence (please provide examples):

Evidence:

- Meetings (Technical Working Group)
- Consultative meetings and sharing of minutes
- Health Communication Policy
- Coordination meetings with external agencies
- Meetings are schedule with partners and TWG according to need
- There is an easy process to engage NHEICC – Come with letter, Assigned to section chief, Meeting between partner and NHEICC
-

Gaps:

- How do we “open the door” to external partners
- Where and who are our partners and what are they doing?

Action:

- Develop a plan for external partner engagement – How do we open our door and facilitate coordination
- Partner Mapping

Priority Area: N/A

KM Component	Key Steps or Elements	Stages of Development				Current Stage
		Stage 1	Stage 2	Stage 3	Stage 4	
2.5 External Communication and Public Relations How does NHEICC identify and disseminate information to key external stakeholders?	N/A	We have no organisational strategy regarding external communications or public relations.	Our communications with external audiences are ad hoc, triggered by events and often unplanned or poorly planned. There is no formal strategy that key staff and Board have agreed on.	We have a communication and/or public relations strategy that has been formalized/ documented but is not comprehensive or widely known by staff members. Some efforts have been made to identify and communicate key messages however there are often deviations from these.	Organization has an external communication and/or public relations strategy that has been formalized/ documented and is comprehensive and known by most staff. The organization has performed a stakeholder analysis and identified priority stakeholders at local levels and identified key messages, which are consistently communicated.	3, 4, 4, 3

Evidence (please provide examples):**Evidence:**

- Policy Document
- Press Conferences
- Dissemination Workshops

- Publications
- Stakeholder meetings
- Information is collected and shared

Gaps:

- How can NHEICC be the center of knowledge exchange for others?
- How can NHEICC be the communication hub for Nepal?

Action: N/A

Priority Area: N/A

Annex III: Key Informant Interview Guide

Name of Interviewee:

Position:

Number:

Years at HEU:

Years experience in SBCC:

Past Position:

QUESTIONS

Introduction

The NHEICC has years of experience and expertise in Social and Behavior Change Communication. I would like to start by asking you a few questions.

1. According to NHEICC experience, briefly tell me what is/was the best SBCC campaigns in the country in terms of technical accuracy and creative execution?
2. Based on feedback you have received, what are the positive features in this SBCC campaigns? What are the negative ones?
3. Where does the NHEICC sit within the MoHP? What is the structure of NHEICC at the central, regional and district levels?
 - *From their perspective, does NHEICC have adequate staff with the right expertise?*
 - *Are the staff trained in SBCC? What were the last two SBCC trainings that any staff member received?*
 - *Please explain the role and expertise of the National and Regional Training Centres?*
4. What are the technical factors that help NHEICC to do their work in health promotion and communication? What are the technical factors that make their work difficult?

Probe: Find out what the external factors are.

Probe: Find out what the internal factors are.

5. What could current leadership members do more of?
6. What should they do less of?
7. How clear is the strategic direction of the organization?
8. Where is there room for improvement with the leadership of NHEICC?
9. What are the respective roles, functions and deliverables of the following bodies:
 - Child Health, Family Health, and other Divisions under MoHP?

- NHIECC
- National Health Training Center
- Regional Level
- District Level
- Sub-District Level

10. What should coordination ideally look like between (this should be a diagram):

- NHIECC and the other Divisions under MoHP?
- NHIECC and the National Health Training Center?
- NHIECC and the Regional Level
- NHIECC central staff and the District Level?
- NHIECC and the sub-District Level?

11. What are the current challenges related to coordination across these bodies?

12. What systems are in place to address these coordination challenges?

13. Which systems need to be strengthened or added to support improved coordination across these bodies?

14. What is getting in the way of these bodies coordinating?

15. How important is coordination to you?

16. What are the possible outcomes that could be achieved through good coordination?

17. Describe the status of the following systems:

- Planning
- Human Resource Management
- Monitoring and Evaluation
- Information Management: Data Collection
- Information Management: Use of Information
- Quality Assurance
- Financial Management
- Revenue Generation
- Supply Management

18. Does NHIECC have a system in place to facilitate the generation, learning, sharing, and use of relevant knowledge by staff within the organization?

19. Does NHIECC have a repository and system to capture, document, and disseminate knowledge?

20. How does NHIECC view and support learning for program improvement, organizational learning, and sharing with stakeholders?

Annex IV: Analysis of Summary Recommendations from Formative Research on Information, Education and Communication Programme in Health Sector of Nepal (2012) and Assessment of Technical and Management Capacity of the NHEICC (2007)

Although the 2012 report provides **10 key recommendations**, many of which are in line with the recommendations made during the 2007 technical assessment of NHEICC, there is little evidence to support these recommendations. The report presents the findings from a cross-sectional qualitative and quantitative formative study and included individual interviews, key informant interviews, and 50 focus group discussions. The research is meant to be a follow-on to the NHEICC formative study conducted in 2006 yet there is not comparison between the two studies, no points of, and behavioral indicators were not measured.

Summary Recommendations from Formative Research on Information, Education and Communication Programme in Health Sector of Nepal (2012)

1. Develop IEC/BCC materials and programmes in emerging areas of health such as NCDs, WASH, climate change and occupational health in addition to re-emerging diseases and conventional health problems such as diarrhoea, uterine prolapse, vector-borne diseases etc.
2. **IEC/BCC materials (posters, pamphlets, flip chart) need to be updated at the central level, made adequately available at the health facility levels and locally re-produced considering the sociocultural context and need, and be disseminated in the rural areas. Proper distribution and use of the available materials is equally important.**
3. IEC/BCC activities seem mostly concentrated in the district headquarters and the peripheral urban areas. Therefore, there is a **need to focus more on rural areas. For this district specific bottom up planning is recommended.**
4. Explore ways to **make best use of innovative methods** such as use of cable television and mobile phones for dissemination of health education messages.
5. **D/PHOs need to explore opportunities for securing technical support from local development partners, local bodies and other partners in implementing IEC/BCC activities at local levels.** There is a **need to source in more resources for BCC activities through public private partnership in collaboration with private institutions and civil society.** Attempts should also be made to seek **more support from NHEICC in getting the adequate IEC/BCC resources for wider dissemination and use at the district and village levels.** Areas of such collaboration may include hand washing, climate change, uterine prolapse and disease prevention, among others.
6. **Build on capacity of the D/PHO team, health workers, FCHVs and journalists in the districts for designing and implementing context-specific IEC/BCC programme activities locally. Capacity building of DPHO team to assess needs and priorities for IEC and BCC resources** in the local context and in designing BCC programmes and materials locally is never the less important.
7. IEC/BCC materials should target adolescents and youths - considering local context and culture. There are more needs to educate rural populations who lack access to health information and communication in the remote areas from all ecological regions.
8. **More IEC/BCC campaigns are needed to raise awareness on health concerns and problems in rural areas.** Such campaigns or activities should target school children and teachers to enhance their participation in responding to local health problems or concerns. Emphasis should be laid

- on interpersonal communication, pictorial materials and dramatic techniques in the rural areas.
9. **Implementation of IEC/BCC activities can be improved by; a) initiating the design, development and dissemination of IEC/BCC materials based on local needs, audience segmentation, context and culture ensuring provision of budget for local planning in order to address language and cultural sensitivity.**
 10. **Strengthen monitoring and supportive supervision while implementing the IEC/BCC programmes.** D/PHOs should monitor the IEC/BCC activities to ensure the quality and consistency of the messages based on district needs. There is a pressing need of strengthening the monitoring and supervision system in particular at the district level.

Summary Table for Assessment of Technical and Management Capacity of the NHEICC (2007)

	Constraint	Recommendation	Status
NHEICC's Leadership			
Compliance	Limited to no authority over programs/divisions and outside organizations. No accountability.	Carry out proactive role of intense public relations. Define a systematic plan of coordination meetings to integrate NHEICC into their strategic BCC/IEC planning and implementation.	
Personnel	Frequent changes in leadership.	Advocate for long terms in leadership. Careful recruitment of future NHEICC director(s).	
Personnel	Staff do not feel they have sufficient BCC/IEC training or experience.		
Personnel	Duplication of functions.	Revise function of duplicate positions.	
Policy Advocacy			
Policy	No explicit Health	Health Communication Policy to be proposed to	Health Communication

	Constraint	Recommendation	Status
	Communication Policy	MoHP.	Policy developed in 2012
Personnel		Advocate for HET post or substitution of HETs by HAs.	
Personnel		Advocate to fill vacant position of RHEO at all Regions (finalize basic qualification criteria).	
Personnel		Advocate for longer terms for technical staff.	
Coordination/Support to Divisions/Programs/Centers			
Central	<p>Programs function as vertical programs with strong financial support, mostly for international and bi-lateral donors. Leads to programs operating autonomous.</p> <p>Specifically, NHTC and NCASC.</p>	<p>National BCC/IEC coordination committee should be proactive to coordinate with non-government stakeholders on BCC/IEC interventions.</p> <p>Follow-up with NCASC on plan to coordinate with NHEICC.</p>	
Central	Lack of Coordination with NHEICC leads to duplication of materials.	BCC/IEC materials should be reviewed by one of the five technical committees.	
Regional	Not all Regions have a RHEO – no point of contact.	<p>Advocate to fill RHEO positions.</p> <p>Two HEO officers assigned at NHEICC to be contact persons for Region and District level should develop a coordination plan.</p>	

	Constraint	Recommendation	Status
District	HET's role in reporting and giving feedback on BCC/IEC has not been as active as needed to make management decisions.	Feedback reporting system to NHEICC from district should be strengthened – HETs at district level should send to NHEICC a copy of the integrated report, complemented with his own report on BCC/IEC activities.	
District	Feedback reporting system to NHEICC from district is not constant and regular.		
District	Once budgets approved and sent to district, follow-up from the Center is inadequate.		
Other Sectors	No coordination mechanism with other sectors of government (Education, Agriculture, etc.)	National BCC/IEC Coordination Committee should amplify coordination with other sectors. RHEO should coordinate with NGOs, CBOs, and private sector through timely invitations to participate in specific BCC/IEC activities.	
Human Resources/Personnel			
Mobility of Personnel	Transfer of staff every two years – makes training difficult. New staff are usually un-experienced and unskilled in BCC/IEC.	Advocate for longer terms for technical staff. Cost out what frequent change of personnel is equivalent in re-investment of training new staff.	
Present Expertise	New staff has been brought onboard – some do not have BCC/IEC training needed		

	Constraint	Recommendation	Status
	to perform job. Limited experience in behavioral perspective rather curative and preventive.		
Position Eliminated	Health Educator Technician in charge of district BCC/IEC will not be replaced. Position abolished.	Advocate to substitute HET with HA. HAs to receive rapid BCC/IEC training.	
Vacant Positions	HEO vacancy at Regional level.	Fill RHEO positions.	
Gender	Evident gender imbalance in technical staff.		
Training in BCC/IEC Interventions			
More Training Needed	More than half of NHEICC staff at central and district level expressed they needed further BCC/IEC training.	<p>Intensive training for new personnel to bring up to date.</p> <p>Select experienced staff should have a refresher course on BCC and strategic planning.</p> <p>NHEICC should coordinate with JHU to take advantage of BCC/IEC overview training.</p>	
	HETs and health service providers have not received any training in methods and process of IEC activities in last 5 years.		

	Constraint	Recommendation	Status
NHTCs Role	NHTC has not developed a training package in BCC/IE to be included in their regular trainings.	NHEICC should appoint contact person to engage with NHTC to orient on training needs.	
	NHTC trainers have not been trained to become Master Trainers for BCC/IEC training.	NHEICC should coordinate with NHTC to incorporate BCC/IEC so that NHTC becomes knowledgeable to become trainers. Develop BCC/IEC package with NHTC to prepare Master Trainers.	
	NHTC has not been approached to determine how BCC/IEC trainings could be integrated in NHTC's regular training program.		
NHEICC's Methodological Approach			
BCC Perspective	Approach is still heavily anchored in IEC rather than behavior change and more holistic approach.	There needs to be a shift from IEC to BCC.	
Methodological Diversity	Mixed use of methodological approaches to health communication.	Personnel should be updated in BCC at central and district level.	
Formative Research	Not a regular step in methodology. Capacity within NHEICC is limited in this area.	NHEICC should use external partner, organization or program evaluations to plan future communication strategies.	

	Constraint	Recommendation	Status
Technical Projection	Technical expertise suffers with frequent transfer of staff.		
Cultural Aspects	Limited attention paid to different socio-cultural aspects when preparing BCC/IEC materials.		
Production of BCC/IEC Materials			
Bidding Process/Quality Control	Bidding process is slow. Awards of contracts given to lowest bidder – often with limited quality control.	Bidding process should be restructured to emphasize quality first and then cost.	
Quality Control	Lack of mechanism to exercise quality control before materials are finished and delivered.	NHEICC person associated with the design should be in close contact and monitor production process.	
Budget for District Level	District level budgets (given by Central level) are not sufficient for local production.		
Quality Control – District Level	No quality control mechanism developed at district level.		
Production of Materials and Facilities	No full production facility within NHEICC.	Mixed recommendation. NHEICC staff feel there should be on-site production facilities. External organizations do not agree.	
		Conference/Training room should be established in new building with appropriate audio-visual	

	Constraint	Recommendation	Status
		equipment.	
		Present resource center should transfer to an Educational Center where resources are cataloged.	
Distribution System of BCC/IEC Products			
Central	Challenge coordinating distribution of materials with Logistics Management Division's distribution plan.	NHEICC distribution plan should be developed in coordination with LMD. Assign point person to be in contact with LMD in order to send materials during supply distribution.	
Central	Lack of systematic distribution plan in order to identify gaps and fill in with alternate solutions.		
District/Community	Transport from district to health posts and community are not readily available, reliable or stable.	Encourage districts to use alternative transportation facilities.	
District/Community	Materials are stuck at district office because of transport (lack of budget), lack of vision for what materials are good for, how to use them, and importance in implementing strategy. Also, lack of support to HET to help him/her distribute	District should budget transport and inform Central level to help in annual budget requests. Districts to design a distribution models for "pilot". Scale-up best model to other districts.	

	Constraint	Recommendation	Status
	materials.		
Support/Implementation of BCC/IEC Interventions at Community Level			
Community Personnel	Limited trained and able personnel at community level.		
	Lack budget or transportation	Districts should develop an implementation plan using the guidelines prepared by the Center with desired budget and send it to NHEICC.	
	HW overburden with curative care of direct client interaction – little time to carry out BCC/IEC interventions.		
	Health personnel and community level volunteers are not trained on use of materials developed.	Audiovisual support should be given to the CV (JHU example) that guides the CV in the information learning process. Distance education for CV through radio.	
Language/Accessibility	Language barriers prevent HW and CV to appropriately use BCC/IEC materials with the women coming for services.	In districts with good production facilities, BCC/IEC materials should be produced locally. Locally produce materials should be sent back to Central level.	
Amplify Coverage		Amplify coverage through	

	Constraint	Recommendation	Status
		the use of radio.	
Amplify Coverage	Sustainability of programming at community level.		
Amplify Coverage		Linking demand generation with services.	
Amplify Coverage		Additional support should be given to local folk media, street drama, murals, etc.	
Community Mobilization		Integrate as many community partners, such as women's groups, local NGOs/CBOs to maximize BCC/IEC coverage.	
Community Mobilization		Make alliances with local government and community organizations for social health mobilization activities to increase ownership.	
Monitoring of BCC/IEC Interventions			
Limitations of the Monitoring System	Current monitory and supervision matrix does not cover all the BCC/IEC activities carried out at health post, sub-health post level and community level.	<p>NHEICC should revise the existing BCC/IEC indicators to be able to routinely track and monitor activities.</p> <p>Provide better and more appropriate indicators to HMIS.</p> <p>NHEICC should develop a complementary monitoring matrix of BCC/IEC activities to be used by personnel</p>	

	Constraint	Recommendation	Status
		from NHEICC, regional HEO or the HETs. Should not duplicate HMIS.	
Limitations of the Monitoring System	Supervisory staff are not trained to look carefully at the BCC/IEC activity indicators.		
Limitations of the Monitoring System	No specific monitoring guidelines for BCC/IEC activities produced by NHEICC.		
Limitations of the Monitoring System	Supervisory visits are few due to insufficient transport and budget. Some districts pose a security risk.	Increase the number and frequency of monitoring visits to provide support, guidance and encouragement. Consider budgeting an alternate means of transport like a motorbike for HETs.	
Reporting		RHEO and HET should report to NHEICC the results of all monitoring visits on a regular basis.	
Evaluation of BCC/IEC Interventions			
No Provisions for Evaluation	Lack of technical expertise to carry out sound technical evaluation or oversee and evaluation by an independent provider.	Output/Impact evaluations should be done by an independent organization after a <u>major</u> BCC/IEC intervention. Evaluations should be planned well in advance to	

	Constraint	Recommendation	Status
		allow for procurement process, including funding, and actual evaluation.	
	No unit or budget to conduct this level of evaluation.		
Financial Resources			
Finance Rules and Regulations	No flexibility in use of funds in other lines items allocated in the “red book”. Unable to respond to items that may arise later.		
Follow-Up	Disbursement of budget is slow (2-3 months after budget is approved). Additional delay to district as letters are dispersed.	Follow-up by persons in charge of the disbursement process at NHEICC to get documentation ready to obtain signed authorization letter from the Dir. General of the Department of Health Services.	
Plan Well		Plan well with the least amount of BCC/IEC activities to be done in the first trimester of the year at the district letter to allow for arrival of letter.	
Funding Partners		Submit negotiated program components to funding partners (UNFPA, USAID, DFID, WHO) so they can place these requests in their own country plans and budgets.	