# Breakthrough ACTION Nepal

## Social and Behavior Change Capacity Self-Assessment Report, 2019

**Submitted by:**      Johns Hopkins Center for Communication Programs
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**In collaboration with:**      Government of Nepal
Ministry of Health and Population
National Health Education Information Communication Center
Family Welfare Division

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# Acronyms

| | |
|---|---|
| CBO | Community-Based Organization |
| FCHV | Female Community Health Volunteer |
| GESI | Gender and Equity Social Inclusion |
| GON | Government of Nepal |
| HD | Health Directorate |
| HFOMC | Health Facility Operation and Management Committee |
| HMIS | Health Management Information System |
| INGO | International Nongovernmental Organization |
| M&E | Monitoring and Evaluation |
| MOSD | Ministry of Social Development |
| NGO | Nongovernmental Organization |
| NHEICC | National Health Education, Information, and Communication Centre |
| SBC | Social and Behavior Change |
| SMS | Short Message Service |
| USAID | United States Agency for International Development |

# Acknowledgements

The Breakthrough ACTION Nepal team graciously thanks the many stakeholders from the Karnali Province Ministry of Social Development and Health Directorate and from Barahatal rural municipality, Panchapuri urban municipality, Guthichaur rural municipality, and Chandannath urban municipality who contributed their time and energy to participate in the social and behavior change capacity self-assessment workshops.

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# Executive Summary

Breakthrough ACTION Nepal's social and behavior change (SBC) system-strengthening project (2018–2020) supports the institutional and technical capacity of the Government of Nepal (GON) to design, implement, evaluate, and coordinate SBC programs within its newly federalized landscape. The project aims to strengthen the SBC system in Nepal so that stakeholders can address the health needs of local households and communities and ultimately improve outcomes across family planning, nutrition, and maternal, newborn, child, and adolescent health.

At the outset of the project, Breakthrough ACTION Nepal, in collaboration with the National Health Education, Information, and Communication Center, facilitated a series of baseline capacity self-assessments at the federal, provincial, and municipal levels to gauge capacity in seven domains, including SBC design, implementation, evaluation, and coordination. The process included group and individual self-assessments at all three levels of government—federal, provincial, and palika/municipality—as well as in-depth interviews with government and nongovernment key informants.

Findings from baseline assessments helped to identify key gaps in SBC capacity, including a lack of understanding about SBC, lack of evidence-based SBC program design and planning, and inadequate coordination among stakeholders.

To address these gaps, Breakthrough ACTION Nepal designed activities to strengthen the country's SBC systems for health around needs and opportunities at the municipal level. Specifically, the project focused on four municipalities within Karnali Province (one rural and one urban each from Surkhet and Jumla districts) and how to link them to relevant counterparts at the provincial and federal levels. Support was also provided to the federal and provincial levels to strengthen their capacity to support rural/urban municipalities. Field implementation took place over ten months. Learnings from these systems-strengthening activities were documented and compiled into the SBC palika package, "Social and Behavior Change Capacity Strengthening Support Material for the Local Level"—a step-by-step guide for rural/urban municipalities on how to incorporate SBC for health into annual plans and conduct evidence-based planning, advocacy, implementation, and monitoring and evaluation of SBC programs.

The project examined changes in SBC capacity over time at the individual, organization, and system levels by using three approaches—an endline SBC capacity self-assessment, a most significant change exercise, and outcome harvesting. The endline self-assessments were conducted in focal municipalities and at the provincial level in July and August 2019. These assessments followed a similar process to the baseline assessments.

The major findings identified in the 2019 endline assessments were that local stakeholders, especially at the local municipalities, now had:

- Developed better understanding of SBC.

- Started evidence-based design and planning with the use of local-level quantitative and qualitative evidence to identify key issues in health.
- Started incorporating SBC activities into health programs during the municipal-level seven-step annual planning process and allocation of budget for such activities.
- Increased focus and understanding of the importance of identifying a target audience to plan activities.
- Gained the involvement of municipal-level elected members for implementing SBC activities in the community.

Major areas identified for further improvement are as follows:
- Development of a work plan with monitoring plan and budget, followed by implementation
- Implementation of health policy developed in 2076 Bikram Sambat (B.S.) Nepali calendar
- Coordination and collaboration among stakeholders and partners

The endline capacity self-assessment allowed the team to compare changes in SBC capacity scores across a set of key domains, from baseline to endline.[1] The aggregated SBC capacity assessment scores at the GON local, provincial, and federal levels reflected the changes that took place over the life of the project. During this time period, the aggregated SBC capacity assessment scores at the local and provincial levels improved[2]: 10.69 (baseline) to 14.05 (endline) and 13.63 (baseline) to 14.87 (endline), respectively.[3] Scores on SBC coordination at the local level also improved from baseline to endline (2.25 at baseline to 2.92 at endline) and held steady at the province level (3.17 at baseline and endline).

Table 1 shows the aggregate score (1, lowest; 4, highest) for expertise/capacity in each domain of the SBC capacity self-assessment at the federal, provincial, and municipality levels (see Appendix 1: SBC Capacity Self-Assessment Scores [2019]). The table shows the change in scores for each of the seven domains. These scores were determined based on a collaborative and participatory discussion among participants.

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[1] The SBC capacity components covered: (1) program management; (2) SBC technical capacity; (3) mobile technology and social media utilization; (4) advocacy, networking, alliance building, knowledge management, coordination, and collaboration; (5) communications; and (6) monitoring and evaluation.
[2] Scoring was based on an adapted SBC assessment tool developed for this project: https://www.thecompassforsbc.org/project-examples/sbc-assessment-tool-nepal
[3] The endline capacity assessment was not conducted at the federal level because staff were reduced and were not available.

*Table 1: Aggregate Scores of Social and Behavior Change Capacity Assessment—Baseline (2018) and Endline (2019)*

| Domains | Aggregated score (range 1–4) based on consensus score | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| | Federal level | | Provincial level | | Local level | |
| | Baseline | Endline[4] | Baseline | Endline | Baseline | Endline |
| Program management | 2.50 | NA | 3.00 | 3.00 | 2.75 | 3.13 |
| Social and behavior change | 2.90 | NA | 2.50 | 3.10 | 1.65 | 2.65 |
| Mobile technology | 2.25 | NA | 0.25 | 1.00 | 0.56 | 1.56 |
| Social and user-generated media | 2.00 | NA | 2.00 | 1.60 | 1.05 | 1.55 |
| Knowledge management, coordination, and collaboration | 3.17 | NA | 3.17 | 3.17 | 2.25 | 2.92 |
| Monitoring and evaluation | 2.43 | NA | 2.71 | 3.00 | 2.43 | 2.25 |
| Total aggregated for reporting (does not include advocacy domain, which was not conducted at baseline at the federal level) | **15.25** | NA | **13.63** | **14.87** | **10.69** | **14.05** |
| Advocacy | NA | NA | 2.10 | 1.90 | 1.08 | 1.90 |
| Total (including advocacy domain) | **15.25** | NA | **15.73** | **16.77** | **11.77** | **15.95** |

Overall, results from the self-assessments as well as the most significant change and outcome harvesting exercises indicate that SBC capacity was strengthened at the local and provincial levels. The self-assessments were a very powerful tool for change because they helped government staff realize their strengths and weaknesses in conversation with their colleagues.

Breakthrough ACTION Nepal strongly recommends conducting these kinds of self-assessments at the beginning of any capacity-strengthening project. Self-assessment exercises are critical to identifying the actual gaps and discussing possible appropriate solutions. These exercises involve stakeholders from the beginning, help with self-reflection, and ensure local ownership of the capacity-strengthening process.

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[4] The endline capacity assessment was not conducted at the federal level because staff had been cut back and were not available.

# Background

The Breakthrough ACTION Nepal social and behavior change (SBC) system-strengthening project was a 27-month USAID-funded field support program with the overall objective of strengthening the institutional and technical capacity of the Government of Nepal (GON) to design, implement, evaluate, and coordinate effective SBC programs for health related to family planning, reproductive health, and maternal, newborn, child, and adolescent health and nutrition in the new federal structure. The project succeeded in developing a model for integrating SBC into the federal system, which has been adopted by the Nepal government and disseminated nationally.

Breakthrough ACTION Nepal worked with key federal government counterparts including the National Health Education, Information, and Communication Center (NHEICC), the family welfare division, and four municipalities in Karnali Province to develop and test a program implementation model for SBC for health that is suitable for the new federal system.

Prior to reaching this point, Breakthrough ACTION, in conjunction with NHEICC, facilitated a series of baseline SBC capacity assessments with implementers (i.e., health coordinators and health facility staff) and decision makers at the federal, provincial, and municipal levels. Insights from these assessments helped to identify gaps in SBC capacity across government and were used to inform the design of program interventions and activities over the course of the two-year project.

The baseline assessments were a critical first step to understanding the SBC situation in Nepal, which at the time was experiencing significant changes to the structure of its health system. For example, the province health directorate (HD) within the Ministry of Social Development (MOSD) was formed without clear roles and responsibilities for SBC. At the same time, municipalities expected the province to provide them with technical support in SBC and other health areas. This situation resulted in confusion and uncertainty about the linkages and lines of authority between the federal, provincial, and municipal levels. (See Tables 2 and 3 to understand the change in the health promotion structure between 2018 and 2019; see Appendix 2 for the Karnali health system structure chart.)

Breakthrough ACTION worked with stakeholders at all levels to identify and clarify roles within the SBC for health system, which helped to establish the foundation for the project's work and provided a footing on which the government could begin to meaningfully engage in SBC. For example, it was revealed that both MOSD and the provincial HD have roles in SBC program implementation. Specifically, MOSD focuses on policy support while the HD role is to provide technical support to municipalities for evidence-based program planning, implementation, and monitoring. The district health office has been integrated as part of the HD because its health office extension does not exist in the federal structure.

Breakthrough ACTION implemented a series of interventions and activities to address gaps identified in the baseline assessment, specifically around increasing the understanding of SBC and improving implementation of evidence-based planning, coordination and collaboration, and monitoring and evaluation (M&E). Breakthrough ACTION Nepal focused on strengthening stakeholders' capacity in these areas. Based on assessment results and discussions with stakeholders, interventions for other identified gaps were not considered a priority. Most project activities were performed collaboratively with stakeholders through a learning-by-doing approach—a way to build or strengthen SBC capacity by collaboratively implementing projects with a partner or doing tasks with them to increase their knowledge and skills. Such an approach often allows the intended audience to

put into practice theoretical learnings gained during workshops and deep-dive sessions on key SBC topics.

Finally, the project conducted endline assessments at the provincial and municipal levels but could not do so at the federal level due to shortages in staff—many of whom were transferred to other departments within the Ministry of Health and Population as part of the government's overhaul and restructuring under federalization.

This report details findings from the endline assessments and highlights the journeys—both the successes and challenges—of the project's focal municipalities and the province and how they have begun to address key organizational gaps in SBC skills and competencies. While it is premature to identify long-term gains as result of Breakthrough ACTION's initiatives, considerable achievements were made during the project's ten-month implementation period in laying the groundwork for a robust SBC for health system in the future.

Table 2 : *Federal, Provincial, and Municipal Health Promotion Structure (2018) at Baseline Self-Assessment*

| NHEICC | Provincial | Local (rural/urban municipalities) |
|---|---|---|
| • 16 federal-level health promotion staff | • Ministry of Social Development <br>   o Public health section <br> • Provincial HD <br> • Health promotion and training section | • Social development unit <br>   o Health section <br>     ▪ Health coordinator/s in urban municipality <br>     ▪ Focal person responsible for health and women's and children's issues in rural municipality |

Table 3: *Federal, Province, Municipal Health Promotion Structure (2019) at Endline Self-Assessment*

| NHEICC | Provincial | Local (rural/urban municipalities) |
|---|---|---|
| • Five federal-level health promotion staff | • Ministry of Social Development <br>   • Health/service division <br> • HD <br>     o Provincial Health office (located in the districts) <br> • Human resource development center (in Karnali only)/training center in all other provinces | • Social development section Social development coordinator (nominated from among the municipality ward chairs) health section <br>   • Health section chief <br><br> Ward level <br> • Health facility in-charge |

## Objectives

- Identify changes in SBC capacity at the provincial and municipal levels of government.
- Identify further opportunities to improve SBC capacity at the provincial and municipal levels.

## Methodology

The endline capacity assessment was conducted in Breakthrough ACTION's four focal municipalities (one rural and one urban each in Surkhet and Jumla districts) and Karnali Province during July and August 2019. The endline self-assessments followed a process similar to that of the baseline self-assessment, in which participants in a facilitated workshop reviewed and rated their organization's skillsets in seven programmatic domains (e.g., program management, SBC, mobile technology, social and user-generated media, knowledge management/coordination and collaboration, M&E, and advocacy).

The SBC capacity self-assessment tool (see Appendix 3: SBC Capacity Assessment Tool) was employed to facilitate a robust, rigorous, and participatory assessment of SBC at both baseline and endline.[5]

***Workshop***

Small group discussion

Similar to the baseline self-assessment process, participants were divided into small groups. Each group was asked to rate items on a scale of 1–4 and to score themselves as a team. Each group was given a copy of the capacity assessment tool and a score sheet to document scores and evidence of capacity.

Thirty-five (35) capacity skillsets within seven domains were used during the baseline and endline assessments. To help groups assess themselves using evidence, group discussions focused on documentation, such as work plans, reports, guidelines, checklists, meeting minutes, and communication materials.



On the second day, the groups continued in plenary to review their scoring and to identify the skills that were improved. The groups then prioritized the skills that still needed improvement for initiation of SBC for health in the municipality and the province. The scores from both the baseline and endline were shared with participants and a discussion was held to identify the reasons behind the change.

*Ward chairs, executive members and deputy health coordinators review their SBC skills during endline capacity self-assessment at Chandannath, Jumla, on August 14, 2019*

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[5] The SBC capacity assessment approach was developed under the Health Communication Capacity Collaborative Project, led by Johns Hopkins University Center for Communication Programs, and is informed by an understanding of SBC capacity at the individual, organizational, and system level. An important component of designing effective capacity-strengthening activities is a robust, rigorous, and participatory examination of an organization's capacity (in this case, that of NHEICC, operational management, and local-level partners). This tool has been through several global program cycles since 2003. The latest version is being implemented in several Breakthrough ACTION countries, including Nepal.

Results of the self-assessments and discussions by the local municipality are described in the next section. The condensed scores are outlined in Appendix 1: SBC Capacity Self-Assessment Scores (2019).

***Key Informant Interviews***

The 2019 endline capacity assessment did not conduct interviews with key informants. Information collected during a separate most significant change evaluation (see Appendix 4: Most Significant Change Report) helped to explore in more depth topics covered in the workshop as well as to uncover and address topics that did not emerge during the workshop.

## Participants

Participants were decision makers and relevant government staff with SBC oversight, administrative management, and responsibilities at the provincial and municipal levels (see Appendix 5: Participant Lists). Most of the participants were the same as those involved in the baseline assessment.

- Participants from the province-level assessment worked in the health unit of MOSD and the HD.
- Participants from the municipal level were mayors and deputy mayors; chairpersons and deputy chairpersons; executive committee members, including representatives for women and marginalized groups such as *Dalit* and *Janajati*; and ward chairpersons (who also serve as presidents of health facility operation and management committees [HFOMCs]), health post in-charges, storekeepers, accountants, and chief administrative officers.

The table below shows the number of participants from the provincial- and local-level assessment workshops.

*Table 4: List of Participants in Provincial and Local Capacity Assessment Workshops*

| Venue | Organization | No. of participants (Baseline) | No. of participants (Endline) |
|---|---|---|---|
| Province | Karnali | 22 | 27 |
| Surkhet District | Panchapuri urban municipality | 39 | 33 |
| | Barahatal rural municipality | 27 | 32 |
| Jumla District | Chandannath urban municipality | 31 | 27 |
| | Guthichaur rural municipality | 32 | 27 |
| | **Total** | **151** | **146** |

## Breakthrough ACTION Interventions

Breakthrough ACTION Nepal designed and implemented the following capacity-strengthening activities based on the gaps identified from the baseline SBC capacity self-assessment exercises (see Appendix 6: 2018 Social and Behavior Change Capacity Assessment Report) at the provincial and

municipal levels. The impacts of these activities, which were implemented over a ten-month period, are outlined in the results section below.

- Held role clarification discussions with municipality, province, and federal government stakeholders working in SBC for health.
- Conducted capacity-strengthening activities with stakeholders for municipalities and provinces on how to design, implement, and evaluate SBC for health activities.
- Facilitated exercise for municipalities and province health teams on how to develop municipal-level SBC action plans.
- Facilitated SBC M&E capacity-strengthening exercises such as joint monitoring visits and SBC M&E.
- Conducted learning exchanges with SBC stakeholders at the local, provincial, and federal levels to discuss learnings, challenges, and next steps to address and sustain strengthened SBC capacity.
- Provided technical support to design SBC strategies and policies. Specifically, Breakthrough ACTION worked with province teams to draft SBC health promotion strategies for Karnali and Far West provinces. The team also supported two municipalities in including SBC for health in their policies.
- Documented learnings from local-level system-strengthening activities and compiled them as content for the SBC palika package. The SBC palika package is a guide to the health section of rural/urban municipalities to strengthen the SBC system for evidence-based planning, advocacy for SBC, implementation, and M&E of SBC programs at the municipality level.
- Supported municipality teams to field test the SBC palika package.

# Overall Endline Capacity Self-Assessment Results Improvement and Gaps Identified at the Local Level

During the endline assessment, participants scored themselves on each capacity indicator, and then revisited their scores. They compared the baseline and endline scores for each indicator to analyze their progress. Breakthrough ACTION facilitated a discussion on the scores, which showed improvement, remained the same, or decreased.

Major changes identified from baseline to endline at the palika level are as follows:
- Better understanding of SBC
- Initiation of evidence-based design and planning to identify key issues in health
- Steps taken to incorporate SBC activities in health programs during municipality-level seven-step annual planning process and allocation of budget for such activities
- Increased focus and understanding of the importance of identifying a target audience to plan activities

- Involvement of municipality-level elected members during the implementation of SBC activities in the community
- Improved M&E (using monitoring checklist, monitoring report writing, incorporating feedback, etc.)

The major areas identified for further improvement are as follows:
- Development of a work plan with monitoring plan and budget, followed by implementation
- Implementation of health policy that was developed this year
- Coordination and collaboration with stakeholders and partners

Table 5 shows the aggregate score (from 1 as lowest to 4 as highest) for expertise/capacity in each domain of the SBC capacity self-assessment at the federal, provincial, and municipality levels (see Appendix 1: SBC Capacity Self-Assessment Scores (2019). The table shows the change in score in the different domains. These scores were decided by participants based on criteria. Unfortunately, the project was unable to conduct an endline assessment at the federal level.

| Table 5: Aggregate Scores of SBC Capacity Assessment—Baseline (2018) and Endline (2019) **Domains** | Aggregated score (range 1–4) based on consensus score | | | | | |
|---|---|---|---|---|---|---|
| | **Federal level** | | **Provincial level** | | **Local level** | |
| | **Baseline** | **Endline**[6] | **Baseline** | **Endline** | **Baseline** | **Endline** |
| Program management | 2.50 | NA | 3.00 | 3.00 | 2.75 | 3.13 |
| Social and behavior change | 2.90 | NA | 2.50 | 3.10 | 1.65 | 2.65 |
| Mobile technology | 2.25 | NA | 0.25 | 1.00 | 0.56 | 1.56 |
| Social and user-generated media | 2.00 | NA | 2.00 | 1.60 | 1.05 | 1.55 |
| Knowledge management, coordination, and collaboration | 3.17 | NA | 3.17 | 3.17 | 2.25 | 2.92 |
| Monitoring and evaluation | 2.43 | NA | 2.71 | 3.00 | 2.43 | 2.25 |
| Total aggregated for reporting (does not include advocacy domain, as this was not conducted at baseline at the federal level) | **15.25** | NA | **13.63** | **14.87** | **10.69** | **14.05** |
| Advocacy | NA | NA | 2.10 | 1.90 | 1.08 | 1.90 |
| Total (including advocacy domain) | **15.25** | NA | **15.73** | **16.77** | **11.77** | **15.95** |

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[6] The endline capacity assessment was not conducted at the federal level because staff had been cut back and were not available.

# Detailed Results by Capacity Skill Set

This section outlines learnings from the endline capacity self-assessment and provides insights into areas where changes in SBC capacity have begun at the province and municipality levels. It also highlights technical areas in need of improvement. It is organized according to the seven programmatic domains and defines each of the 35 subcategories or capacity skill sets. While the assessment is exhaustive, Breakthrough ACTION prioritized and focused on certain issues deemed to be the basic building blocks on which SBC system strengthening could be extended. The interest expressed by local stakeholders, the self-assessment results, and the limited timeframe available to the project also drove this prioritization. Because of the time it took to conduct formative research and endline assessments, Breakthrough ACTION only had ten months left to implement activities. The majority of the implementation period was used to transfer basic SBC skills and co-design learning-by-doing activities with focal municipalities. Throughout the text of this report, there are multiple references to "learning-by-doing intervention" and "capacity-strengthening exercise." Learning-by-doing refers to multiple activities performed in collaboration with Breakthrough ACTION and municipalities. This collaboration allowed for transfer and increase in knowledge and skills. The capacity-strengthening exercise was a one-time five-day SBC capacity training implemented at the both the province and municipality levels. The trainings used the P-Process[7] to introduce participants to strategically and effectively planning, implementing, and monitoring and evaluating SBC programs.

## Program Management (Indicators 1.1–1.2)

**1.1 Program Design (Definition: participants' knowledge of and ability to conduct evidence-based research, evaluation, and/or needs assessment to inform program design, development, and improvement)**

**Findings**

At baseline, there were no strategically designed SBC activities, and a clear understanding of SBC was lacking. Evidence-based SBC program design and planning were not employed at the municipality or provincial level. Municipalities, for example, would develop annual work plans without analyzing local data or evidence and submit budget proposals accordingly. In addition, health service centers would collect data but never analyze the information for internal use.

The endline assessment showed that health sections at the municipality level had begun reviewing and analyzing data compiled from health service centers and had discussed progress shared by health service centers during monthly meetings. Stakeholders in the project's focal municipalities and the province are more prepared to implement evidence-based decision making during the annual seven-step planning process. To prepare for the upcoming fiscal year planning, data from the health facilities were collected and analyzed. Municipality health section personnel also interacted with community members to identify and prioritize health issues and social behaviors.

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[7] Developed by Johns Hopkins Center for Communications Program, the P-Process is a step-by-step approach to strategic communication, starting with analysis and including design, development, implementation, and evaluation.

At the time of the endline assessment, Guthichaur rural municipality included health promotion activities in its annual policy and program. Barahatal rural municipality included SBC in its health strategy 2076. Chandannath developed a health policy and programming for the year but not all the participants knew about it. Panchapuri had yet to draft its policy but was planning to do so.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION supported health coordinators at the municipal level to activate monthly health staff meetings. These meetings were used to promote learning and sharing evidence among health coordinators. In addition, Breakthroughs ACTION supported municipalities to coordinate with the province and seek technical assistance to review and analyze Health Management Information System (HMIS) data. Health coordinators were coached on how to enter and review HMIS data based on their area's health indicators. Breakthrough ACTION also introduced qualitative information collection techniques by inviting health coordinators to reach out to community members in their areas and coaching health coordinators on how to formulate and ask questions to enable better understanding of the community's needs and use of that information to plan for SBC programs. Further, Breakthrough ACTION guided health coordinators on how to summarize information gathered in a simple way so they could make informed decisions when planning.

### 1.2 Program Action/Work Plan and Budget (Definition: participatory project-planning culture with a complete, costed work plan that is implemented and monitored)

**Findings**

At baseline, SBC activities were not included in health programs during the GON seven-step annual planning process.

By endline, all health service centers followed the seven-step planning process and presented their prioritized SBC activities at cluster-level meetings.

- Barahatal ward chairs cited the lack of knowledge among community members in raising social issues during cluster-level meetings as a challenge; instead, community members often asked for infrastructure development and construction (e.g., drinking water, road improvements, bridges). Likewise, HFOMC does not suggest community issues. Many rural/urban executive committee members were still unaware of the seven-step planning process. The health facility



*Participants from Barahatal Rural Municipality and Panchapuri Municipality during the endline capacity self-assessment on 26-27 and 28-29 July 2019, respectively.*

in-charges developed SBC activities for health and shared them with HFOMC in regular

meetings. They developed activities for the upcoming fiscal year based on services provided by the health facilities and some of the needs of the community. They felt that, even then, the plan was not entirely based on community needs.

- In Panchapuri, the wards received their budget ceiling from the municipality close to the deadline for the cluster-level meeting. Due to this delay, they were unable to invite health facilities to the meeting even though they had planned to follow a thorough consultative process.

- Chandannath municipality health sections consulted with the health facility in-charge, HFOMC, and female community health volunteers (FCHVs) as part of their preparations for the annual planning process. This year (BS 2076/77), the health section also took part in cluster-level meetings to incorporate SBC for health activities in their budget. However, the municipality did not consult with respective social development sections for annual planning and did not formally invite them to participate in cluster-level meetings. Wards also did not receive a budget celling from the municipality, so the program activities and budget submitted by some wards were still waiting for approval from the municipality council when the endline assessment was being implemented.

- Guthichaur conducted a community gathering to identify relevant needs for planning, but the rural municipality council did not approve activities submitted from the community in some wards. Even though the rural municipality could not allocate a budget specifically for SBC activities during annual planning, it planned to set aside some funds for SBC. For the first time ever, all municipalities allocated a budget for SBC this fiscal year. At the time of this assessment, they were in the process of developing a detailed work plan, per the approved budget, for program implementation.

At the time of baseline, the province reviewed the HMIS, National Demographic Health Survey, and its previous year's annual report to inform the annual planning process. The province also planned activities on an ad hoc basis and according to any health issue being covered in the media.

At the time of the endline, the province made brief activity plans that were designed hastily. While their progress was not significant and required more technical support, Breakthrough ACTION activities helped to raise the awareness of participants of the assessment about the importance of using evidence when planning. The province held a coordination meeting with the health office, hospital and hospital management committee, and other concerned partners for annual planning. Some participants of the assessment mentioned they were not aware and/or involved in the planning process. Some staff even expressed that the planning section chief and office chief were the primary decision-makers of all the activities.

At the time of the endline assessment, MOSD estimated it would receive more funding this year, approximately NPR 7,500,000 (US$65,000) for health promotion purposes. MOSD is planning to use the funding on health promotion activities related to noncommunicable diseases and migrant labor health issues.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION conducted capacity-strengthening exercise for staff at rural/urban municipalities and at the province level to develop evidence-based SBC programs for health following the P-Process, which includes analyzing data (both quantitative and qualitative), prioritizing health issues, identifying the intended audience, developing activities/interventions, and M&E.

## SBC (Indicators 2.1–2.10)

**2.1 SBC Situation Analysis (Definition: the ability of government stakeholders to use and clearly articulate knowledge of the following key steps: [1] conduct baseline and/or formative research to establish knowledge, attitudes, and practices of target audience; [2] review relevant studies; [3] assess existing policies and programs; [4] review 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; and [8] formulate problem statement)**

**Findings**

The baseline assessment identified that SBC was not a priority at the local level. Situation analyses were typically not conducted, and collected data were not analyzed or used. Instead, municipalities would randomly plan and submit program proposals.

At the endline, participants showed an increase in understanding SBC. Municipalities allocated a budget specifically for SBC for the next fiscal year and prioritized health issues as part of their annual planning.

All participants were able to define various components of a situation analysis and started to think strategically for programming.

This year, health facility staff reviewed data and conducted community interactions on prioritized health issues to collect qualitative data. They shared that their challenge was not being able to reach all of the relevant communities for a situation analysis. However, they developed plans based on available data (quantitative and qualitative) analysis and submitted their plans during cluster-level meetings.

When planning programs for each municipality, Barahatal organized a coordination meeting with all partners working in the same municipality. Panchapuri reviewed its budget and annual health policy to inform their planning. Guthichaur interacted with partners working within the municipality, and Chandannath reviewed HMIS data and conducted a household survey to gather information about immunization and pregnant women.

The province rarely involved partners during situation analysis activities but included SBC activities in its annual planning. The endline showed that it followed federal-level health strategy in 2076 while planning for SBC.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION held a five-day workshop to sensitize and involve the health staff and executive members of municipalities in developing an evidence-based action plan on SBC for health.

This work included reviewing evidence-based strategies and planning activities for implementation and monitoring. Each municipality then implemented the work plan it developed with technical support from Breakthrough ACTION as a learning-by-doing exercise.

**2.2 SBC theory (Definition: use of SBC theories such as the socioecological model, theory of change, health belief model, and stages of change, to guide intervention design. These theories address the individual, family, community, and other target audiences.)**

**Findings**

Baseline findings indicated that municipality- and province-level officials had little to no awareness of SBC theories or models.

At the endline, there was some use of theories by the municipalities. Participants from Barahatal and Panchapuri shared that they would like to focus on the individual, family, and community levels as part of their planning, but many of them could not name the model they were using.

Some participants from Panchapuri stated that they used the P-Process to identify the target audience before developing SBC for health activities.

Participants in Chandannath reported focusing on a target audience, but they were not aware of a theory.

Participants from Guthichaur could not state which behavior change model they were using, but said that they were following their health policy for the year BS 2075.

One of the province-level participants said he used the health belief model, but could not explain how they were using it.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION used orientation and capacity-strengthening exercises, which intrinsically included theories and models. Discussion that focused on intended audiences and a socioecological model was a key agenda item in local-level monthly meetings.

**2.3 Strategy Design (Definition: the use and articulation of the following key elements within strategy design: [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] M&E plan, and [8] dissemination plan)**

**Findings**

At baseline, municipalities reported not practicing any SBC strategic design process.

At the endline, municipalities had developed or planned to develop details of a strategic SBC program based on their approved budget and evidence.

In Panchapuri, a budget for SBC for health activities was allocated, but a detailed plan had not yet been developed. At the time of the endline assessment, the province was in the process of designing a work plan based on the P-Process. Guthichaur's municipality plan mentioned individual behavior

but it did not use an SBC strategy during planning. During the year, the municipality identified local FM radio as the ideal communication channel to reach the segmented audience. Its plan followed the key elements of a strategic SBC design. Chandannath used a few elements of an SBC strategic design process.

The province is in the process of developing an SBC strategy based on the federal level's health promotion strategy.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION conducted orientation and capacity-strengthening exercises to introduce stakeholders to the key elements of strategic design for SBC. It also provided ongoing technical assistance through learning-by-doing exercises.

**2.4 <u>Product Design</u> (Definition: use of and the ability to articulate the following key steps in product design: [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, and [8] retest materials to make sure revisions resolve key issues)**

**Findings**

During the baseline assessment, most local municipalities noted they had not produced materials on their own but used materials received from the federal level. Any materials produced locally were not pretested.

During the endline**,** participants discussed some movement toward a systematic product design process. In Surkhet, Barahatal used materials sent from the federal level and the province, and it maintained a record of materials received and distributed. Panchapuri developed a radio message on institutional delivery without following the development process of the materials. However, when designing other SBC activities such as street dramas, it followed the process. Panchapuri also received brochures on noncommunicable diseases from the federal level, which it distributed to municipalities, without adaptations. Some participants understood they now have the authority to develop their own materials and do not have to depend on materials or approval from the federal level.

At the endline, some improvements were identified in Jumla. Guthichaur and Chandannath developed materials for the first time and followed the materials development process. Over the year, they produced invitation cards, a hoarding board (billboard), and radio messages in a participatory way. They also field-tested messages and materials.

The province used materials developed at the federal level but revised the language and illustrations. The



*Invitation card for pregnant women in institutional delivery developed as part of learning-by-doing intervention*

materials received by the municipalities from the province were the same that were sent from the federal level. It only replaced the logo. For example, in BS 2076/77 the province used a "Mero Barsha" hoarding board developed at the federal level but adapted it to include a local picture and the province logo. The province primarily developed radio messages, but it did not use a participatory process and did not conduct field tests with the target audience. It cited a lack of human resources as a barrier. While developing materials for the "Hamro Swasthya" health campaign, the province reviewed draft materials received from local designers and shared them with the ministry and HD for their feedback. It did not use creative briefs, but mentioned in a memo what the material should look like and the messages that should be included.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION introduced the materials development process and guided stakeholders through regular follow-up during the project period.



*Provincial material design workshop: Chandra Acharya from MOSD and beneficiaries role play for video on institutional delivery, Surkhet on 21–22 January 2020.*

### 2.5 Gender Equity and Social Inclusion (GESI)
**(Definition: how the strategies and plans include or consider GESI and the different needs of men and women when developing interventions and products/materials)**

**Findings**

At baseline, the participants said that they were sensitive to GESI, but had not considered these issues because they did not develop their own materials for local use.

At the endline, all municipalities considered GESI when conducting community activities (e.g., selecting an appropriate community, including minority groups). Panchapuri, Guthichaur, and Chandannath further considered GESI while developing street dramas and/or radio messages (e.g., male and female community actors and appropriate messaging of each community actor, field testing of messaging and materials, venue for the drama).

The province had not developed any SBC plan/activity or material on its own so there was no evidence of GESI.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION used orientation and capacity-strengthening exercise to introduce stakeholders to the key elements of GESI and build their capacity on them. Participants were asked to apply these elements in their program planning as part of learning-by-doing exercises. Unfortunately, the project did not have enough time to support implementation. Its main priority was to transfer basic SBC skills and to co-design SBC activities with focal municipalities.

### 2.6 Intervention Planning and Implementation (Definition: This segment covers how SBC interventions are planned and implemented.)

**Findings**

At baseline, local municipalities followed health activity SBC plans sent from the federal level. They did not plan according to local needs and did not prepare a local SBC work plan.



By the endline, the municipality health sections had developed detailed work plans before the annual planning process began. As a result, the plans and estimated budgets for health activities were shared during cluster-level meetings. This meant that budget breakdown for these activities was based on reference with previous year's budget. At the province level, however, SBC was not specifically mentioned in the annual plan even though the number of health education programs had increased over previous years.
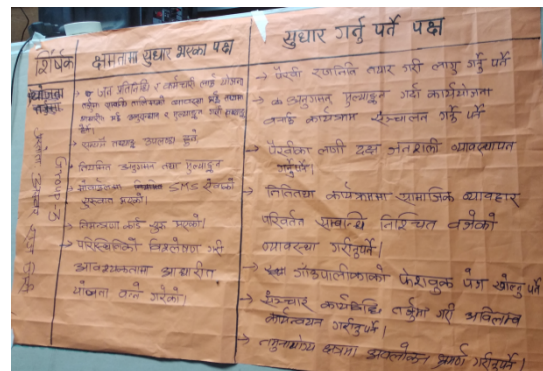
*Guthichour Rural Municipality prepared the SBC Capacity improved and to be improved area during the Endline CS Assessment group work, 12 Aug*

**Related Breakthrough ACTION Interventions**

To address this gap, Breakthrough ACTION facilitated a five-day capacity-strengthening exercise to introduce how to plan and implement SBC interventions. Plans drafted during this exercise were supported with on-site coaching and mentoring throughout the project period.

**2.7 Partner Mobilization and Coordination (Definition: This segment covered participants' use and knowledge of the following key steps when working with partner organizations: [1] ensure each partner understands their role, [2] identify a program lead who is responsible for facilitating the process, [3] identify partner needs and conduct trainings as necessary [4] keep partners updated, [5] share credit for good work, [6] monitor activities, and [7] prepare for future evaluation activities.)**

**Findings**

At baseline, all organizations working in the local area directly coordinated only with the municipality office for program implementation, and the municipalities' role was relegated to only enrolling with projects and receiving progress reports. The municipality was not aware of its own coordinating role to facilitate all partners.

At the endline, the coordination function had improved. The municipalities realized they were responsible for developing coordination committees as outlined in local government operation law 2074. It was clarified that the mandate was for the rural municipality deputy chair to form the coordination committees. Barahatal municipality social development section processed and extended authorization for a partner to work within the municipality after reviewing the partner's progress report.

In Guthichaur, the chief administrative officer managed coordination with various partners and updated the rural municipality council—which is responsible for overall planning, implementation, and monitoring—on the status of these relationships. Only a few participants at the endline self-assessment workshop were not aware of the deputy chair's role to coordinate partnerships. Instead,

now they were inviting partners for interaction, asking for budget ceilings, and following their progress to avoid duplication in programming.

Chandannath had formed a coordination committee under the chairpersonship of deputy mayor, an appointment that was not common knowledge among the municipality social development section personnel who had their own parallel coordination mechanism. Challenges remain in the functionality of coordination committees. The endline assessment participants shared that the mayor was still coordinating with partners. The focal person of the concerned units (e.g., the health unit, education unit) under the social development section was also coordinating directly with other local partners.

In Panchapuri, a coordination committee was not formed as mandated. As a result, the mayor took the lead to manage coordination. Participants, including the deputy mayor, were not aware that their role involved actively managing and coordinating partners. As a result, partners were not mobilized effectively.

By the endline, province-level health coordination committee meetings were taking place each month and started to include partners in province-level programming. The province mobilizes its partners based on province-level technical and coordination needs. Guidelines were developed outlining the roles and responsibilities of the coordination committee members though most of the endline assessment participants were not aware of these guidelines.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION conducted a landscape analysis workshop with SBC partners and stakeholders at the province and local levels. The goal of the analysis was to identify links among partners and the role each of those partners play in supporting or implementing SBC for health. Breakthrough ACTION Nepal helped assess the status of involvement of all partners and stakeholders in designing programs, their implementation and M&E. This exercise convinced rural and urban municipalities stakeholders of the importance of coordination and partnership. At the local level, SBC activities were found to be implemented by mobilizing local-level partners and community groups to conduct awareness activities (street dramas, deuda songs, and community-level interactions).

**Topline findings for landscape analysis:**

These maps expose gaps that could be addressed through capacity-strengthening activities designed to foster collaboration across actors within the SBC for health system.

Some actors were considered as having significant influence yet simultaneously limited connections, such as FCHVs or other local-level actors (e.g., locally elected representatives, community-based organizations [CBOs], local health institutions) in local SBC for health. Simultaneously, FCHVs were considered across all four maps at the local level to have significant influence and to have linkages to both government and nongovernment actors regarding how data are used in SBC programs. The landscape analysis revealed that FCHVs played important mediating roles between certain government actors and health mothers groups related to data use. The FCHVs can be a priority group for fostering connections and support.

The landscape analysis revealed a lack of collaboration, common goals, or information sharing related to how local-level SBC for health took place among:
- Government actors and local-level community organizations or community leaders
- NHEICC and other governmental actors at the central, provincial, or local levels
- International nongovernmental organizations (INGOs) and nongovernmental organizations (NGOs)

At the same time, participants in multiple workshops indicated that minimal linkages existed between actors of the same type (e.g., between INGOs or between NGOs which may suggest that minimal coordination was occurring at the local level regarding how data were being used.

Technical assistance was received primarily by government actors, with only a few actors working at the local level to provide technical assistance to CBOs or social actors on local-level SBC for health. Technical assistance related to the use of data on health for SBC programs was also typically focused on government actors such as the district health office or the HPs, with less attention to partner organizations or to other more local government actors (e.g., at the ward level).

Overwhelming differences in maps depicting how local-level SBC programs take place or how data are used for SBC programs across central, provincial, and local levels demonstrated different understandings of how SBC activities are planned for, designed, and implemented in Nepal.

Coordination of actors, including identification of agreed upon roles and responsibilities, could start to identify similarities across maps to strengthen the system, fill gaps, and reduce inefficiencies.

**2.8 SBC Training Needs (Definition: identifying necessary training needs of self and partners when implementing an SBC Strategy)**

**Findings**

Both baseline and endline results indicated that all health training is being planned and directed by the federal-level National Health Training Center.

In Barahatal, the need for health staff capacity strengthening had been mentioned this fiscal year planning. The municipality recognized the need for capacity for implementing SBC activities, but it did not have the required human and financial resources. Barahatal compiled the training received by the health staff. Chandannath and Guthichaur did not have any specific local plan and budget for training, and they did not receive any federal funding or guidelines to conduct trainings.

The province primarily received training programs from the center. In BS 2076/77, it allocated a budget for the training needs assessment and planned to use the same budget if SBC training needs were identified.

**Related Breakthrough ACTION Interventions**

The SBC capacity self-assessment revealed a need to identify training gaps. The five-day SBC capacity-strengthening exercise was a response to the identified training needs. Breakthrough ACTION further supported the health sections by mapping their staff's training status and gaps to facilitate planning in the upcoming fiscal year.

**2.9 Advocacy (Definition: the use or plan to use advocacy in interventions)**

**Findings**

At baseline, municipalities were not aware of advocacy or whether they were doing advocacy. By the endline, they understood the importance of advocacy and had allocated a budget to address the need for advocacy. By the endline, Barahatal's wards 4 and 8 had allocated a budget for advocacy, although they still had not developed a model, agenda, or strategy. They did not have a specific plan but were thinking of doing advocacy based on immediate need. Ward 2 of Panchapuri also allocated a budget for advocacy. Panchapuri said that it advocated against child marriage, violence, and *chaupadi* (the practice of banishing girls and women during menstruation), but did not include it in its annual plan. The municipality executive committee used to organize such advocacy activities based on perceived—not evidence-based—needs. Chandannath and Guthichaur did not have any plan to conduct advocacy.

The province referred to the National Health Promotion Strategy 2075 as an advocacy guideline. It was also developing a province-level SBC strategy and plan to include advocacy.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION Nepal demonstrated the advocacy process during the learning-by-doing intervention.

**2.10 <u>SBC Trends</u> (Definition: whether the planners looked at new and/or emerging trends in behavioral science such as design thinking, human-centered design, and/or behavioral economics)**

**Findings**

At baseline, participants were not aware of any of the latest SBC trends in behavioral science, such as human-centered design or behavioral economics.

In the endline, a few participants from Barahatal and many from Panchapuri, Guthichaur, and Chandannath spoke about target audience–focused design but did not say anything specific about human-centered design.

The province was not checking for new trends or following human-centered design.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION organized learning exchanges in which different trends in behavioral science were discussed.

# Mobile Technology (Indicators 3.1–3.4)

At baseline, local municipalities were still not using mobile technology for health promotion purposes. As the project was focused more on providing basic skills for implementing SBC activities, only basic support was provided pertaining to the possible future use of mobile technology as a medium.

**3.1 <u>Mobile Voice and Text Messaging</u> (Definition: use of multiple mobile voice technology and text messaging through an integrated approach with existing intervention activities)**

**Findings**

At baseline, the local municipalities were using mobile technology for personal purposes but not for health promotion purposes.

By the endline assessment, local municipalities recognized the importance of using mobile technology to share health promotion messages with their target audience and were committed to using mobile apps to share these messages. Barahatal stated that it was compiling a list of pregnant women's names and mobile numbers. In ward 9, the health post used mobile technology to follow up with pregnant women for their antenatal care and provided 100 rupees per month to each FCHV from their internal resources to do so. However, not all participants knew about this initiative. In Panchapuri, health service providers were planning to follow up with pregnant women with short message service (SMS) messages but had not started doing so.

Guthichaur compiled a list of pregnant women's contact numbers and sent them related text messages based on each woman's trimester. The health section was providing relevant messages by assigning the municipality's information technology officer to disseminate these messages. The Guthichour municipality health section had not yet tested the effectiveness of this initiative. Chandannath also collected information about pregnant women in the community but had not used it for messaging.

The province considered using mobile voice or messaging but had not yet implemented it because it did not have a policy, technology, or a technician in place.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION included guidelines on using multiple channels and mobile technology. This was done for the effective implementation of activities planned during the five-day SBC for health capacity-strengthening exercise as well as for a message design workshop organized to discuss and design mobile phone applicable push messages for pregnant women. Further technical support was provided as part of learning-by-doing activities related to integrating the use of mobile phones in SBC.

**3.2 Message Development Process (Definition: This segment covers the use of key elements: [1] identify and conduct relevant formative research, [2] develop a creative brief to inform message development, [3] engage a creative agency to craft and produce messages, [4] pretest messages with intended audiences, [5] consider channel in length of message, [6] maintain consistency with larger communication program, [7] ensure accuracy of messages, [8] ensure credibility of messages, and [9] include local languages and language options when possible.)**

**Findings**
At the baseline, messages were not developed in any of the local municipalities.

By endline, Guthichaur had drafted mobile-related messages for SMS during a materials design workshop conducted for the primary project audience. The messages designed were pretested for language clarity and message comprehension.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION supported Guthichaur and Chandannath municipalities in organizing a one-day workshop on how to develop messages for different media including mobile technology.



*Pretesting materials with beneficiaries during material design workshop at Guthichour, Jumla on 30 April 2019.*

**3.3 Mobile Technology Tools (Definition: key elements when identifying technology and tools for mobile behavior change communication [1] identify**

what type of information is most relevant, [2] determine the format best for the program, [3] consider the capacity of the format, [4] consider the implications of the format, [5] identify the most appropriate approach, [6] determine the "effective frequency" needed to reach the program goal, [7] employ multiple channels of communication, [8] determine the most useful platform and application, and [9] understand the organizational capacity in relationship to the tools and technology)

**Findings**
At the baseline, mobile technology tools were not used.

By the endline, Guthichaur had consulted with pregnant women about the best means for message reach; the women stated that they preferred messages sent to their mobile phones. Guthichaur accepted their feedback and began using mobile messages to disseminate messages. The other municipalities were not yet using these tools but there was intention to do so, as evidenced by 3.1 and 3.2.

**Related Breakthrough ACTION Interventions**

The project supported Guthichaur and Chandannath municipalities by developing a survey to collect information about mobile use in order to determine if mobile technology was the appropriate tool to reach the target audience.

**3.4 Monitoring and Mobile Technology (Definition: monitoring of mobile intervention)**

**Findings**
At the baseline, mobile technology was not used, so there was no monitoring.

By the endline, Guthichaur health section was checking pregnant women's mobile cell phones during their community visits to confirm the reach of their messages, but the section did not have set indicators to monitor.

The Barahatal health post began following up with pregnant women for antenatal care visits via mobile phone to determine whether the auxiliary nurse or health service provider had called her; however, they found that many pregnant women's mobile phones were switched off, or they had changed their numbers.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION emphasized the need to monitor all activities including the use of mobile technology during the capacity-building exercises and learning-by-doing activities. The project did not directly implement activities related to mobile monitoring but its work in this area was part of a larger push for the use and importance of using data to plan and support SBC programs. While mobile technology has proven to be a helpful tool in monitoring SBC programs, Breakthrough ACTION was more focused on strengthening stakeholder capacity in foundational SBC knowledge and skills given the limitations of its implementation timeline.

## Social Media (Indicators 4.1–4.5)

**4.1 <u>Multimedia, Web, and Social Media</u> (Definition: use of multimedia, web, or social media for use in interventions)**

**Findings**

At baseline, all four municipalities had webpages with municipalities' activities but had no health messages.

During the endline, a few health facilities of Barahatal (Lekhgaun, Pokharikada, and Hariharpur) had their own Facebook pages, but the communities were not aware of them. Guthichaur municipality and two of their health facilities (Depalgaun and Gajyangkot) had uploaded health messages to their webpage but people did not know about them. Chandannath had a webpage and access to Wi-Fi but had not disseminated any health messages through its website, while Facebook pages for Guthichaur, Depal, and Gajyangkot had health posts.

The province had an official Facebook page, but did not use it for SBC message dissemination. During outbreaks, the HD uploaded health messages to its webpage, but only health staff were checking this page; the general public was not aware of it.

**Related Breakthrough ACTION Interventions**

To address this gap, Breakthrough ACTION regularly motivated and provided guidelines for use of social media to disseminate health messages.

**4.2 <u>Social Media Strategy Design</u> (Definition: use of an integrated social and user-generated media strategy that is integrated into intervention goals as well as the communication strategy. The strategy is revisited on a continuous basis to ensure that the social and user-generated media is working.)**

**Findings**

At baseline, neither local municipalities nor the province had any guidelines or specific social media strategies.

At the endline, the municipalities started webpages (and some also had Facebook pages), but they did not have a social media strategy, even though disseminating information through social media is something they had all considered.

Guthichaur had planned to develop a communication strategy and include it in its program of 2076/2077 B.S. Chandannath had also planned to develop a communication strategy but did not follow through on the plans.

The province was in the process of developing an SBC strategy, in which it planned to incorporate social media usage. Until the endline, the province was referring to the health promotion strategy developed by NHEICC.

**Related Breakthrough ACTION Interventions**

At the province level, a series of strategy-development consultation meetings were organized for discussion of the content of the SBC strategy, at which time they recommended adding social media as part of their strategy.

**4.3 Social Media Message Development. (Definition: This segment includes the use of key elements: [1] identify or conduct relevant formative research, [2] develop a creative brief to inform message development, [3] engage a creative agency to craft and produce messages, [4] pretest messages with intended audiences, [5] consider channel in length of message, [6] maintain consistency with larger communication program, [7] ensure accuracy of messages, [8] ensure credibility of messages, [9] include local languages and language options where possible, and [10] identify a facilitator of content.)**

**Findings**

At the baseline, only two municipalities had official Facebook pages, but they did not include any SBC messages.

At the endline, the municipalities had yet to develop any message to the public on social media. They were just posting about their activities on the municipality webpages.

Any message posted on the province's Facebook page was developed from internal discussion among technical staff. The team did not include an SBC expert or technical person, and it did not identify the target audience or pretest the messages.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION supported the organization of a one-day materials design workshop for Guthichaur and Chandannath municipalities in which they developed messages for different media. Since social media messaging was not included as part of their planned activities, no specific support was provided for message development on social media.

**4.4 Meaningful End-User Engagement (Definition: engaging audiences on social and user-generated media)**

**Findings**

At baseline and endline, the municipalities posted their activity updates on their social media, but the community members were not aware of the posts.

**4.5 Monitoring, Evaluation, and Social Media**

**Findings**

At baseline and endline, the municipalities and the province had yet to monitor their social media sites.

**Related Breakthrough ACTION Interventions**

Since action plans developed during the capacity development exercise did not include social media mobilization, no specific intervention was conducted regarding monitoring.

## Knowledge Management, Coordination, and Communication (Indicators 5.1–5.7)

**5.1 <u>Knowledge Management</u> (Definition: systematically capturing, packaging, and sharing knowledge to foster learning and expand knowledge.)**

**Findings**

At baseline, the local municipalities and the province lacked any knowledge management system.

By the endline, some improvement had been identified. An information officer who was responsible for the documentation and information dissemination had been assigned in all four municipalities. In Chandannath and Guthichaur, the information officer had been given responsibility for knowledge management; in Guthichaur, the information officer was trying to compile information from all social development sections in addition to managing the existing information.

At the endline, MOSD was publishing an annual bulletin (Smarika) and an annual health report. Both MOSD and HD had their own respective information officer responsible for information dissemination only. Each section had its own documents but they were not compiled in a repository, so sections were planning an E-library for easy access.

**Related Breakthrough ACTION Intervention**

During the SBC capacity-strengthening exercise, a session on knowledge management was facilitated and the importance of the knowledge management process was discussed.

**5.2 <u>Coordination Platforms</u> (Definition: coordination platforms with different partners—a feedback mechanism between partners)**

At the baseline, municipalities were not aware of any coordination platforms, even though it was a requirement stated in the local government operation law 2074. These systems had crumbled under the transition to the federal system.

The endline assessments showed improvement in coordination between partners. Most of this improvement is evident in municipalities becoming aware of the need for coordination and ultimately forming a platform to facilitate smoother coordination on a frequent and regular basis.

In Barahatal, a coordination committee was formed, but not all participants were aware of the coordinating role of the municipality's deputy chair or of the coordination committee itself. Regular coordination meetings with partners were not taking place, but the partners were sharing progress with each other to acquire work permits. The municipality office had organized one coordination meeting with all partners working in the municipality for planning preparation for the fiscal year 2067/77.

In Panchapuri, regular coordination meetings were not taking place. The mayor was coordinating with partners and individuals separately, and if they needed any additional information, the mayor would send them to the relevant section.

In Guthichaur, participants were not aware of the coordination committee under the deputy chair or how the municipality was coordinating but had informal and formal meetings with different partners. In Chandannath, a coordination committee existed but was not functional. They knew the partners but did not have regular meetings or discussions.

The province met with partners and donors this year to discuss the program for the upcoming year, however, no other sharing took place between the partners.

**Related Breakthrough ACTION Intervention**



*Guthichour Rural Municipality mapping of who influences how data on health are used in SBC during net-mapping exercise.*

Breakthrough ACTION conducted a net-mapping exercise with INGOs, NGOs, and CBOs, working in the four rural/urban municipalities and Karnali province to assess coordination and dynamics among partners in the SBC for health system. Partners were engaged for learning and sharing (face-to-face) sessions at all levels and involved in the learning-by-doing intervention to foster further linkages. The net-map exercise was the basis for the situation analysis in this area. The project was able to support changes in capacity through consistent engagement (i.e., a presence on the ground) and by offering regular technical support to municipalities.

**5.3 External Coordination (Definition: work with external staff or programs at the national and district level)**

**Findings**

At the baseline, the municipalities did not have a coordination mechanism with the province or center. Usually, the province and chief of each municipality coordinated based on personal relationships as needed. This area requires continuing effort.

**Related Breakthrough ACTION Intervention**

Breakthrough ACTION conducted separate sessions. Discussions of the expected roles of different levels in the health system that support SBC for health took place during the SBC for health capacity-strengthening exercise. Each level listed roles to strengthen the SBC system for health for further discussion. The SBC roles were shared and discussed at the province and federal levels for finalization. The roles at each level were endorsed respectively.

**5.4 <u>Coordination Role</u> (Definition: having a documented coordination and facilitation mandate)**

**Findings**
At the baseline, participants were not clear about the coordination role, and coordination was conducted on an ad hoc basis.

Progress was made toward a documented coordination and facilitation mandate. The endline assessment identified that Barahatal had formed a coordination committee under the deputy chair, which was based on the mandate, but all the participants thought that responsibilities lay with the chair, as opposed to the deputy chair. In Panchapuri, the mayor lead coordination efforts. In Guthichaur, coordination was based on decisions made by the executive committee. Chandannath did not have a system in place to coordinate with concerned stakeholders.

The province was following what was outlined in the constitution for the role of coordination. This year, it held a general discussion at a coordination council (with the municipality chief and chief administrative officer). The coordination council, started last year, is the coordination mechanism of the province. It had started annual interaction with the municipality in which the health office and health coordinator were present.

**Related Breakthrough ACTION Intervention**

Breakthrough ACTION conducted a net-mapping exercise with INGOs, NGOs, and CBOs working in the four rural/urban municipalities within Karnali province. SBC roles and responsibilities discussions were held at all levels for clarity to strengthen coordination and to foster linkages as mentioned in 5.2.

**5.5 <u>Internal Communications</u> (Definition: whether there is a formal mechanism/structure for internal communications)**

**Findings**
At baseline, no all-section meetings were being held.

By the endline assessment, all municipalities were holding regular meetings each month with all section chiefs. The health section was also holding its regular monthly staff meeting and discussion, and it was documenting the decisions in meeting minutes.

**Related Breakthrough ACTION Intervention**

Breakthrough ACTION supported holding regular staff meetings through project coordinators as part of a learning-by-doing exercise.

**5.6 External Communications (Definition: existence of formal structure/mechanism for external communications)**

**Findings**

At the endline, as in the baseline, all municipalities had a website but also had an allocated information officer for external communications. Both the municipalities and the province were continuing to use letters, email, and phone for external communication. No change was found from baseline to endline.

**Related Breakthrough ACTION Interventions**

Through discussions regarding different workshops and meetings that featured learning-by-doing exercises, Breakthrough ACTION encouraged municipalities to recognize the need to allocate a person to serve as an information officer.

# Monitoring and Evaluation (Indicators 6.1–6.8)

**6.1.1 Monitoring and Evaluation Planning, budgeting (Definition: whether the plan includes the relevant operational results frameworks, such as an M&E strategy, M&E plan, and other key documents)**

**Findings**

At the baseline, a specific budget to monitor health activities at the local and provincial levels was lacking. The budget allocated for M&E was for monitoring all sectors (i.e., agriculture, education, and health). There were no monitoring tools. The province had allocated a budget for M&E, but it could not be used. Most of the monitoring visits were conducted at the end of the year.

Municipality health sections reported facing difficulties in logistical management, recording and reporting, and other technical support. They reported that there was no structure in place to provide support.

By the endline, Barahatal had developed an M&E plan and had allocated a budget, but the plan and budget were not tied to a fixed schedule. Panchapuri had an M&E committee under the chairpersonship of the deputy mayor, but the committee primarily focused on construction or infrastructure development work. Panchapuri using internal income and contingency costs. Guthichaur had five members on the M&E committee who primarily focused on construction or infrastructure development work; the municipality did not have an annual monitoring plan for all sections. Chandannath had developed M&E indicators, but not all participants were aware of it. The M&E committee was still more focused on construction or infrastructure development work, though it saw the need to expand health monitoring and all sectors.

Even at the endline, Karnali province did not have an annual monitoring plan since it still conducted monitoring on an ad hoc basis. The province was planning to develop an annual budget and plan in coordination with the MOSD and HD for the first time this fiscal year. On a quarterly basis, the province received a budget from MOSD for its expenditures, so the activities were also planned accordingly. It developed progress and program management reports on a quarterly basis, as requested by the MOSD. The province was following the supervision and monitoring guide sent from the federal level, but it did not measure results.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION organized a two-day workshop on M&E, during which participants developed local-level monitoring plans and a budget. Breakthrough ACTION supported their development of SBC monitoring checklists to follow the implementation of SBC activities at the local level. The project also conducted on-site coaching on District Health Information System (DHIS) data use and helped participants identify appropriate indicators for SBC programs. The project also instructed participants on how to review evidence and identify community-level issues by organizing community interaction activities.

**6.1.2 M&E-Guided Program Development and Implementation (Definition: whether the SBC program development and implementation are guided by evidence from an M&E system)**

**Findings**
Baseline activities found there was no M&E plan or evidence-based program development and implementation at the palika level.

By the endline, all four project palikas had developed evidence-based SBC programs to address institutional delivery for FY 2076/77. Outcomes from the learning-by-doing intervention were adopted to develop the SBC program for the FY 2076/77 with an associated M&E plan.

However, even by the endline assessment, the province was not following a planned schedule for monitoring. The province shared that it planned monitoring visits in such a way that all staff would get a chance to go into the field.

**Related Breakthrough ACTION Interventions**

To address gaps, Breakthrough ACTION organized two-day sessions on M&E during which the participants themselves developed learning-by-doing activities to increase institutional delivery. The health problem (low institutional delivery) was guided by an evidence-based approach. Participants looked at available evidence (DHIS indicators), prioritized the issues, and developed the learning-by-doing intervention, which they later implemented in their respective municipalities. The development and implementation process was supported and guided by a project team through ongoing technical mentoring.

### 6.1.3 Monitoring and Evaluation Planning (Routine Monitoring) (Definition: whether there is a plan for routine M&E of interventions)

**Findings**

At the baseline, no plans were in place to routinely monitor the implementation of health activities at the local level.

By the endline, municipalities had started to monitor non-infrastructure development activities (health, education, etc.).

However, the municipalities did not have a routine monitoring plan to measure the success of a program. Guthichaur did not follow a checklist when conducting monitoring so it was not effective, and the municipality did not have a sector-wide monitoring plan. A report would be written, but it would not be used for program improvement. Though municipal M&E plans exist, there was no feedback mechanism to share findings from the monitoring visits. Field visits were rarely used to improve the program.

The province had been making monitoring plans every year, but monitoring was not performed according to that plan. The monitoring budget was in a common basket fund for monitoring of all kinds of activities in the province, so all programs used it on an ad hoc basis. If this budget was separated by program activities, then it could be planned properly from the beginning and spent accordingly. After Breakthrough ACTION involved them in a capacity-building exercise, the province started preparing monitoring reports.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION organized a two-day session on M&E, in which the participants themselves developed a monitoring plan with specific indicators to gauge the implementation of SBC activities. With this, they developed a budget and checklists for the activities they had planned for their learning purpose. Each municipality experienced implementing and monitoring the work plan that was developed with technical support from Breakthrough ACTION. On-going support was provided to implement the developed SBC monitoring plan by using the monitoring checklist and tracking the implementation process at the local level.

### 6.2 Monitoring (Definition: whether the rural/urban municipalities and province had and implemented a process for monitoring implementation and were using monitoring information for internal and external program review)

**Findings**

At baseline, the municipalities and the province were not implementing a monitoring process or plan.

By the endline, some of the municipalities had made progress.

- Barahatal had formed an M&E and regulation committee; however, it had not started listing the recommendations from the monitoring for further program implementation.
- Panchapuri had started to write the feedback in the checklist, developed in coordination with Breakthrough ACTION, but it did not use this information for program improvement.
- Guthichaur still did not have a monitoring plan, but was conducting monitoring visits, which it felt were needed. The municipality had not started to use the feedback.
- Chandannath had started a monitoring committee, and the health section had organized monitoring visits, during which it used the monitoring checklist. During follow-up, the health facility was found to have improved based on the feedback provided during earlier monitoring visits.

At the endline, the province still did not have a formal review system in place. It had a policy and monitoring division, but the working environment was such that it could not work according to its roles and responsibilities. Even though there was a work plan with clear roles and responsibilities, province staff were not always able to follow the work plan due to external influences. They were not able to provide feedback in a regular and systematic way.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION organized field visits for the municipality executive members and health section staff in which they used checklists to monitor activities, and then prepared a report based on the checklists. For the first time, the participants realized the importance of a checklist and of using feedback for program improvement.

**6.3.1 <u>Data Utilization (Key Indicators)</u> (Definition: whether indicator data are used—[1] key indicators are linked to each strategic objective; [2] changes (or lack of changes) in key indicators are used to inform work plans; [3] indicator data are used to set benchmarks and targets; [ 4] indicator data are used to assess progress toward benchmarks and targets.)**

**Findings**
At baseline, it was found that health posts collected data from the community, which they sent to the municipal health section without analysis or use for local progress updates, program adjustments, or planning.

At endline, the municipalities were beginning to use data.
- Barahatal reported that it analyzed the data received from the health post in the municipality meeting for the upcoming fiscal year planning. Barahatal held a public audit hearing and conducted frequent discussions with relevant stakeholders before the annual planning meeting.
- Panchapuri reported that it held a semi-annual and annual review meeting with the mayor, deputy mayor, chief administrative officer, section chiefs of different sections, and a statistician; however, data were still not reviewed during the annual planning.
- Guthichaur had collected some data, but the information was not analyzed or used for the program development. Health facility visitors provided feedback in the visitor registry book, but this information was not referred to for program improvement.

- Chandannath had started using data for program development.

The province was using data for planning. This year it analyzed its annual report for planning. The analysis was done carefully because this year the province internalized its responsibility for planning as well as for implementation—compared with previous years when it relied on the plans received from the .

**Related Breakthrough ACTION Interventions**

During the two-day capacity-strengthening exercise on M&E, participants identified key health indicators as part of the learning-by-doing exercises and used those indicators to develop an M&E plan to track progress. Targets were set, and participants practiced collecting information related to their program indicators to gauge progress of their activities over time.

**6.3.2 Data Utilization (Coordinated Analysis) (Definition: whether the rural/urban municipalities and province engage partners and stakeholders to review data and analyze results)**

**Findings**

At baseline, health posts or province-based activities on process indicators were sent from the federal level.

The endline assessment showed the following progress toward coordinated data analysis.
- Panchapuri asked for reports from partners in writing, which they discussed with the mayor, deputy mayor, chief administrative officer, various section chiefs, and statisticians, but they did not document the discussion and decision/s that were made.
- Guthichaur organized a semi-annual review meeting, where they invited health specialists and journalists to review the information they had collected from the health facilities. The health specialists provided feedback, but Guthichaur was yet to use it.
- Chandannath started organizing monthly, semi-annual, and yearly review meetings with stakeholders. Even the ward had started organizing review meetings with all stakeholders.

The province organized a fiscal year review and planning workshop to which they invited all partners and the health office. The province formed a health advisory committee and developed a provincial health policy, which was in its final stage. For the development of the health policy, the province involved local-level officials, a legal professional, the secretary of the ministry, and other concerned stakeholders. It allocated a budget for quarterly, semi-annual, and yearly reviews.

**Related Breakthrough ACTION Interventions**

Breakthrough ACTION supported the review of health facility data at monthly review meetings at the local level by involving all health facility in-charges. Priority areas were identified for improvements for the upcoming period.

**6.4 <u>Program Evaluation</u>**

This segment covers whether the rural/urban municipalities and province evaluated the implementation and impact of its intervention.

**Findings**

The baseline assessment showed that program evaluation was not conducted at the local level.

By the endline, progress was made.

Guthichaur had started collecting health-related data but had not started proper analysis for its use. It previously had a program monitoring (monthly, quarterly, and annually) but focused only infrastructure development work only. The municipality still did not have an evaluation plan. This year, it proposed a budget for a household survey, which will serve as baseline data for different health indicators.

The province developed an HMIS report for Karnali province and an annual progress report, and held a review meeting, where it reviewed data from the previous year and compared the information with the current report to evaluate and use it for planning.

**Related Breakthrough ACTION Interventions**

A two-day capacity-strengthening exercise on M&E was organized which incorporated the evaluation concept within the sessions. The participants discussed their health M&E systems at the municipality level.

## Advocacy (Indicators 7.1–7.10)

This segment covers whether the rural/urban municipalities and province used or planned to use advocacy in interventions. It also assessed the use of advocacy models, advocacy strategy, advocacy materials, and activities in these interventions. Due to repetitive answers, this segment was collapsed.

**Findings**

The baseline assessment showed that anything the health service providers said to the clients was viewed as advocacy. There was no agenda, strategy, or model for advocacy. No staff were assigned advocacy responsibilities in the municipalities. The concerned section chief was usually the one responsible for any advocacy.

By the endline, progress had occurred. The rural municipality chief, deputy chief, and other executive members began to understand the value of SBC for their work and community, internalized the value, and became role models advocating the issues they had identified; however, advocacy planning continues to be ad hoc and based on the individual interests.



*President of Barahatal Rural Municipality Tej Bahadur Basnet facilitates women group's roles for institutional delivery.*

Elected officials had started to prioritize and discuss local health issues with the community. Barahatal and Chandannath were advocating various issues but were not following an advocacy plan. The executive member of each municipality had advocated on health issues in their respective communities.

In Barahatal, the municipality council had started deciding on advocacy based on the needs of the rural municipality. Barahatal was mobilizing the local journalists and had conducted press meetings and monitoring visits with the press.

Panchapuri was also developing a plan for advocacy based on the needs of the municipality. Panchapuri had continued to advocate against child marriage, *chaupadi*, and violence. Municipality leaders were coordinating with a local NGO, Awaj, for advocacy issues. The municipality also organized press meetings and other awareness programs.

Guthichaur had not started to engage in advocacy activities for behavior change, but it was raising awareness on harmful traditional beliefs (e.g., pregnant women should not see men when labor pain starts, are not allowed to cross the river). It had started planning advocacy activities following the strategy and policy of the Nepali government and Sustainable Development Goals to minimize poverty. It planned the strategy on an ad hoc basis. It used local FM radio broadcasting to air advocacy messages.

Similarly, Chandannath was developing advocacy strategy ad hoc. The mayor and deputy mayor or other executive member of the municipality participated in community-level activities (e.g., meetings with pregnant women) at which they advocated for institutional delivery.

The province did not have a separate strategy for advocacy but included it in the SBC strategy. The province was following a federal level communication strategy developed by NHEICC for advocacy. The province uses advocacy based on the objective of the program but does not follow a set agenda for this. It chose the agenda on ad hoc basis depending on staff meeting decisions, a previous report, or media coverage. Province-level advocacy was decided based on data, effectiveness, and understanding of the target audience. For example, for noncommunicable disease advocacy, the province organized a health check-up of elected officials to apprise them of the health issue so they would further advocate about it. The province developed an agenda for communication activities and prepared minutes from meetings. In the province, related staff conducted advocacy activities, which was not in their written responsibilities.

**Related Breakthrough ACTION Interventions**

The capacity-strengthening training and exercise organized by Breakthrough ACTION included advocacy as one of the steps of the planning process. A separate learning program was also organized in each municipality to discuss the seven-step planning process prescribed by GON, with importance of advocacy from the community level upwards to include the needed issues and allocate budget. Support was also provided through the project coordinators during the learning-by-doing intervention.

# Major Capacity Improvement and Gaps Identified at the Local Level

During the endline assessment, participants scored themselves on each capacity indicator and then revisited their scores from the baseline. They compared the baseline and endline scores for each indicator to analyze their progress. Breakthrough ACTION facilitated a discussion on the scores, which showed improvement, remained the same, or decreased.

Major changes identified from baseline to endline at the palika level are as follows:
- Better understanding of SBC
- Initiation of evidence-based design and planning to identify key issues in health
- Steps taken to incorporate SBC activities in health programs during municipality-level seven-step annual planning process and allocation of budget for such activities
- Increased focus and understanding of the importance of identifying a target audience to plan activities.
- Involvement of municipality-level elected members during the implementation of SBC activities in the community
- Improved monitoring and evaluation (using monitoring checklist, monitoring report writing, incorporating feedback, etc.)

Major areas identified for further improvement are as follows:
- Development of work plan with monitoring plan and budget and implement accordingly.
- Implementation of health policy that was developed this year.
- Coordination and collaboration with stakeholders and partners.

(See Appendix 7: Changes Identified by Participants and Additional Improvements Needed)

# Recommendation for Municipalities and Province-Level MOSD and HD

**Province (MOSD and HD):**
- All four municipalities have started evidence-based design and planning with the use of local-level quantitative and qualitative data, and target audience to plan activities. The province should provide technical support to the municipalities in data review and development of a detailed budgeted work plan. The province should also provide technical support in incorporating monitoring activities in the municipalities' work plans and ensure implementation accordingly.

- All municipalities need to follow the step-by-step process for effective SBC program implementation. As it may be time consuming, they might choose to skip some steps. Officials responsible for SBC technical support at the province level should provide the needed technical support for systematic implementation.

**Municipality-level social development section**
- Involve municipality-level elected members throughout the process, from preplanning to implementation of SBC activities in the community, for the advocacy and support of SBC.
- Support the health section in implementation of the local health policy, which was developed this year.
- All municipalities need to continue following the step-by-step process for effective SBC program implementation.
- Coordinate and collaborate with stakeholders and partners for the sustainability of SBC programs.

**Concerned partners**
- To ensure sustainability of SBC programs, all partners working in municipalities should have a plan for transferring skills to the health section so it can take the program further even after the program has ended.

# Appendix 1: SBC Capacity Self-Assessment Scores (2019)

| Domains | Aggregated Score Based on Consensus Score and Target | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Federal level | | | Province level | | | Local level | | |
| | Baseline | Target | Endline | Baseline | Target | Endline | Baseline | Target | Endline |
| Program management | 2.50 | 3.50 | NA | 3.00 | 3.50 | 3.00 | 2.75 | 3.00 | 3.10 |
| Social and behavior change | 2.90 | 3.50 | NA | 2.50 | 3.00 | 3.10 | 1.65 | 2.00 | 2.70 |
| Mobile technology | 2.25 | 3.00 | NA | 0.25 | 1.00 | 1.00 | 0.56 | 1.00 | 1.60 |
| Social and user-generated media | 2.00 | 3.00 | NA | 2.00 | 2.50 | 1.60 | 1.05 | 150 | 1.60 |
| Knowledge management, coordination, and collaboration | 3.17 | 3.50 | NA | 3.17 | 3.50 | 3.17 | 2.25 | 3.00 | 2.90 |
| Monitoring and evaluation | 2.43 | 3.00 | NA | 2.71 | 3.00 | 3.00 | 2.43 | 3.00 | 2.30 |
| Total aggregated for reporting (does not include advocacy domain, which was not conducted at baseline at the federal level). | 15.25 | 19.50 | NA | 13.63 | 16.50 | 14.87 | 10.69 | 13.50 | 14.05 |
| Advocacy | NA | NA | NA | 2.10 | 2.50 | 1.90 | 1.08 | 2.00 | 1.90 |
| Total (including advocacy domain) | 15.25 | | NA | 15.73 | 19.00 | 16.77 | 11.77 | 15.50 | 15.95 |

**Scoring scale:**
1 = Does not use any of the steps.
2 = Uses two to four of the key steps and can clearly articulate them.
3 = Uses five or six of the key steps and can clearly articulate them.
4 = Uses seven to nine of the key steps and can clearly articulate them.

# Appendix 2: Health System Structures

# Appendix 3: SBC Capacity Assessment Tool

# Appendix 4: Most Significant Change Report

# Appendix 5: Participant Lists

**Capacity Assessment Workshop, National Health Education Information Communication Center (NHEICC), Kathmandu, Nepal, July 25–26, 2018**

1. Mr. Sunil Raj Sharma, director
2. Dr. Radhika Thapaliya, chief health education administrator
3. Mr. Kunj Joshi, Sr., health education administrator
4. Dr. Bhakta Bahadur K.C., health education administrator
5. Dr. Shashi Kandel, medical officer
6. Ms. Sheela Shrestha, health education administrator
7. Mr. Lok Raj Pandey, health education administrator
8. Ms. Ava Shrestha, health education administrator
9. Ms. Anjana Khadka, public health nurse officer
10. Mr. Arjun Paudel, health education officer
11. Mr. Bharat Bahadur Kunwor, health education administrator
12. Mr. Anil K.C., public health officer
13. Mr. Chetnath Neupane, Nayab Subba

**Capacity Assessment Workshop, Barahatal, Surkhet, September 1–2, 2018**

| Serial No. | Name | Organization | Designation |
|---|---|---|---|
| 1 | Tej Bahadur Basnet | Barahatal Rural Municipality | Chairperson |
| 2 | Shova K. Sharma | Barahatal Rural Municipality | Vice chairperson |
| 3 | Yadab Prasad Sapkota | Barahatal Rural Municipality | Chief administration officer |
| 4 | Mohan Budha | Barahatal Rural Municipality | Account officer |
| 5 | Sumitra Acharya | Barahatal Rural Municipality | Social and women development in charge |
| 6 | Ramesh Pandeya | Barahatal Rural Municipality | Nayab Subba |
| 7 | Anand Chapai | Barahatal Rural Municipality | Nayab Subba |
| 8 | Kamala Chalise | Barahatal Rural Municipality | Vet Service Technician |

| 9 | Dipak Sijapati | Barahatal Rural Municipality | Junior technical assistant |
|---|---|---|---|
| 10 | Dan Bahadur Saud | Barahatal Rural Municipality | Information Technology officer |
| 11 | Bakhat Bdr. Shahi | Barahatal Rural Municipality | Nayab Subba |
| 12 | Gagan Dev Giri | Kunathari Health Post | Health post in-charge |
| 13 | Dilip Dhakal | Barahatal Rural Municipality | Kharidar |
| 14 | Deviram Subedi | Barahatal Rural Municipality | Kharidar |
| 15 | Chandra Subedi | Barahatal Rural Municipality | Officer |
| 16 | Raju Basnet | Barahatal Rural Municipality | Health coordinator |
| 17 | Tilak Bdr. Marsangi | Barahatal Rural Municipality | Ward chairperson |
| 18 | Mahendra Khatri | Barahatal Rural Municipality | Health coordinator |
| 19 | Dammar K. Rokaya | Barahatal Rural Municipality | Education supervisor |
| 20 | Ram Pd. Bhandari | Lekhgaun Health Facility | Health post in-charge |
| 21 | Yam Prasad Adhikari | Pokharikada Health Facility | Health post in-charge |
| 22 | Dipak KC | Taranga Health Facility | Health post in-charge |
| 23 | Kamala Pun Magar | Hariharpur Health Post | Health post in-charge |
| 24 | Maniraj Karki | Barahatal Rural Municipality | Ward chairperson |
| 25 | Tuladev Bharati | Barahatal Rural Municipality | Ward chairperson |
| 26 | Tilak Bdr. Marsangi | Barahatal Rural Municipality | Ward chairperson |
| 27 | Jhakkad Pulami | Barahatal Rural Municipality | Ward chairperson |
| 28 | Bhabana Basnet | Barahatal Rural Municipality | Executive member |
| 29 | Chitra Biswokarma | Barahatal Rural Municipality | Executive member |
| 30 | Disara Raji | Barahatal Rural Municipality | Executive member |
| 31 | Gyanu Shahi | Thari Community Health Unit | Auxiliary nurse midwife |
| 32 | Bhuwan Poudel | Chepang Community Health Unit | Assistant health worker |
| 33 | Dan Bahadur Saud | Barahatal Rural Municipality | IT officer |
| 34 | Ram Kumari Basnet | Pagma Community Health Unit | Assistant health worker |
| 35 | Padam Karki | Barahatal Rural Municipality | Nayab Subba |
| 36 | Tika Ram Sharma | Barahatal Rural Municipality | Civil engineer |

**Capacity-Assessment Workshop, Panchapuri, Surkhet, August 20–21, 2018**

| SN | Name | Organization | Designation |
|---|---|---|---|
| 1 | Upendra Bahadur Thapa | Panchapuri Municipality | Mayor |
| 2 | Mukti Devi Regmi Puri | Panchapuri Municipality | Vice-mayor |
| 3 | Ganga Dev Puri | Panchapuri Municipality | Health coordinator |
| 4 | Hasta Raj Giri | Panchapuri Municipality | Sub-health coordinator |
| 5 | Jagat Bahadur BC | Panchapuri Municipality-2 | Ward chairperson |
| 6 | Hom Prasad Ramjali | Panchapuri Municipality-5 | Ward chairperson |
| 7 | Ratna Bahadur Dhural | Panchapuri Municipality-3 | Ward chairperson |
| 8 | Kamal Bahadur Chhetri | Panchapuri Municipality-7 | Acting ward chairperson |
| 9 | Yubraj Bhandari | Panchapuri Municipality-1 | Assistant health worker |
| 10 | Chandra Ale Magar | Panchapuri Municipality-2 | Executive member |
| 11 | Rukmi Devkota | Panchapuri Municipality-6 | Executive member |
| 12 | Khagisara Rana | Latikanda Community Health Unit | Auxiliary nurse midwife |

| 13 | Khagisara Kandel | Panchapuri Municipality-4 | Executive member |
| 14 | Ganesh Shahi | Panchapuri Municipality-10 | Executive member |
| 15 | Bhadra Bahadur Thapa | Panchapuri Municipality | Nayab Subba |
| 16 | Sharmila Budhathoki | Panchapuri Municipality | Junior technical assistant |
| 17 | Parbati Koirala | Panchapuri Municipality | Assistant/women development supervisor |
| 18 | Nayan Singh BK | Panchapuri Municipality-10 | Acting ward chairperson |
| 19 | Bhage Kami | Panchapuri Municipality 11 | Executive member |
| 20 | Samindra Bahadur Raji | Panchapuri Municipality-10 | Executive member |
| 21 | Binod Kumar Khatri | Panchapuri Municipality | Junior technician |
| 22 | Gorkhe Kami | Panchapuri Municipality-4 | Executive member |
| 23 | Nabaraj Ghimire | Orban Education Section | Chief |
| 24 | Dron Raj Pathak | Palaite Resource Center | Resource person-education |
| 25 | Prem Bahadur Shahi | Panchapuri Municipality-4 | Ward chair person |
| 26 | Khadka Bahadur Thapa | Panchapuri Municipality-6 | Ward chair person |
| 27 | Rajendra Adhikari | Panchapuri Municipality-5 | Health assistant |
| 28 | Dilliram Sapkota | Salkot Public Health Centre | Senior assistant health worker |
| 29 | Bakhat Bahadur Khadka | Panchapuri Municipality | Chief administrative officer |
| 30 | Gagan Singh Pandey | Chhapre Health Post | Health assistant |
| 31 | Urmila Kumari Saud | Bachchhi Community Health Unit | Assistant health worker |
| 32 | Tulashi Lamichhane | Panchapuri Municipality | Executive member |
| 33 | Shanti Raj Kharal | Panchapuri Municipality 9 | Ward chair person |
| 34 | Dinesh Gautam | Bidhyapur Health Post | Senior assistant health worker |
| 35 | Bhakti Prasad Paudel | Panchapuri Municipality-8 | Ward chair person |
| 36 | Dhan Bahadur Thapa | Panchapuri Municipality-1 | Ward chair person |
| 37 | Saroj Kumar Misra | Tatapani Health Post | Health assistant |

**Capacity Assessment Workshop, Chandannath, Jumla, September 16–17, 2018**

| SN | Name | Organization | Designation |
|---|---|---|---|
| 1 | Kantika Sejuwal | Chandannath Municipality | Mayor |
| 2 | Shiv Raj Chaulagain | Chandannath Municipality | Chief administrative officer |
| 3 | Rajesh Prasad Pokhrel | Chandannath Municipality | Section officer |
| 4 | Angad Bahadur Shahi | District Health Office-Jumla | District health officer |
| 5 | Prithivinath Yogi | Chandannath Municipality | Health coordinator |
| 6 | Aaj Bahadur Rawal | Chandannath Municipality-6 | Ward chairperson |
| 7 | Mahendra Raj Acharya | Chandannath Municipality | Nayab Subba |
| 8 | Tilak Raj Dangi | Chandannath Municipality | Finance officer |
| 9 | Jaya Prakash Sharma | Chandannath Municipality | Store in charge |
| 10 | Jaya Prakash Kumai | Chandannath Municipality | Planning Section Nayab Subba |
| 11 | Prem Sunar | Chandannath Municipality | Executive member |
| 12 | Aamar Singh Sunar | Chandannath Municipality | Executive member |
| 13 | Mukti Acharya | Orban Health Clinic | Auxiliary nurse midwife |

| 14 | Ratna Thapa | Maternal and Child Health Clinic | Auxiliary nurse midwife |
| 15 | Chandrawoti Upadhya | Chandannath Municipality-9 | Executive member |
| 16 | Uma Upadhya | Chandannath Municipality-3 | Executive member |
| 17 | Binu Shahi | Chandannath Municipality-2 | Executive member |
| 18 | Bishnumaya Shahi | Chandannath Municipality-1 | Executive member |
| 19 | Narendra Dharala | Talium Health Post | Health post in-charge |
| 20 | Ekraj Prasai | System Strengthening for Better Health | Planning and budgeting consultant |
| 21 | Bimala Mahat | Kartikswami Health Post | Health post in-charge |
| 22 | Taradevi Sejuwal | Chandannath Municipality | Asst. health coordinator |
| 23 | Shree Bahadur Rawal | Mahat Health Post | Health post in-charge |
| 24 | Jaya Bahadur Rawal | Chandannath Municipality-1 | Ward chairperson |
| 25 | Nanda Bahadur Gurung | Chandannath Municipality-3 | Ward chairperson |
| 26 | Kali Bahadur Sarki | Chandannath Municipality-7 | Ward chairperson |
| 27 | Narbir Rawal | Chandannath Municipality-6 | Ward chairperson |
| 28 | Krishna Bahadur Budhathapa | Chandannath Municipality-2 | Acting ward chairperson |
| 29 | Naresh Kumar Shahi | District Health Office | Information, education, and communication focal person |
| 30 | Hemlal Thapa | Chandannath Municipality-8 | Acting ward chairperson |
| 31 | Santosh Bikram Shahi | Chandannath Municipality | Computer assistant |
| 32 | Min Bahadur Jaini | Chandannath Municipality-9 | Ward chairperson |
| 33 | Ishwori Neupane | Chandannath Municipality-10 | Ward chairperson |
| 34 | Ramkrishna Nepali | Chandannath Municipality | Office assessment |
| 35 | Nirmala Dangi | Chandannath Municipality | Kharidar |
| 36 | Kamal Bhandari | Chandannath Municipality | Nayab Subba |

**Capacity Assessment Workshop, Guthichaur, Jumla, September 10–11, 2018**

| SN | Name | Organization | Designation |
| --- | --- | --- | --- |
| 1 | Hari Bahadur Bhandari | Guthichaur Rural Municipality | Chairperson |
| 2 | Jaan Devi Yeidi | Guthichaur Rural Municipality | Vice-chairperson |
| 3 | Keshab Raj Sharma | Guthichaur Rural Municipality | Chief administrative officer |
| 4 | Prem Bahadur Budha | Guthichaur Rural Municipality- | Ward chairperson |
| 5 | Laxmi Prasad Adhikari | Guthichaur Rural Municipality | Social development section chief |
| 6 | Dhan Prasad Neupane | Depalgau Health Post | Health post in-charge |
| 7 | Sushma Shaha | Garjyangkot Health Post | Health post in-charge |
| 8 | Bhakta Bahadur Khatri | Manisaghu Health Post | Auxiliary nurse midwife |
| 9 | Jagga Prasad Jaishi | Guthichaur Rural Municipality-4 | Ward chairperson |
| 10 | Prithibi Bahadur Budha | Guthichaur Rural Municipality-2 | Ward chairperson |
| 11 | Harka Bahadur Sarki | Guthichaur Rural Municipality | Executive member |
| 12 | Makar Bahadur Mahat | Guthichaur Rural Municipality | Finance officer |
| 13 | Ram Prasad Jaishi | Guthichaur Rural Municipality | Nayab Subba |
| 14 | Ganesh Prasad Neupane | Guthichaur Rural Municipality | Ward secretary |
| 15 | Ganga Prasad Pandey | Guthichaur Rural Municipality | Nayab Subba |
| 16 | Gobichandra Pyakurel | Guthichaur Rural Municipality | Nayab Subba |
| 17 | Gokarna Prasad Upadhya | Guthichaur Rural Municipality | Nayab Subba |

| 18 | Bhagawoti Giri | Guthichaur Rural Municipality | Mahila Bikash Nirikshya |
|----|----------------|------------------------------|------------------------|
| 19 | Nar Bahadur Budha | Guthichaur Rural Municipality | Nayab Subba |
| 20 | Harish Chandra Giri | Guthichaur Rural Municipality | Nayab Subba |
| 21 | Shiva Laxmi Jaishi | Guthichaur Rural Municipality | Agriculture technician |
| 22 | Jagii Prasad Dhital | Guthichaur Rural Municipality | Computer operator |
| 23 | Tika Datta Neupane | Guthichaur Rural Municipality | Ward secretary |
| 24 | Janga Bahadur Khatri | Guthichaur Rural Municipality | Resource person |
| 25 | Parbati Budha | Guthichaur Rural Municipality | Executive member |
| 26 | Chan Devi Budha | Guthichaur Rural Municipality | Executive member |
| 27 | Dhanraj Devkota | Guthichaur Rural Municipality | Executive member |
| 28 | Balaram Nepali | Guthichaur Rural Municipality | Health coordinator |
| 29 | Ganesh Bahadur Aidi | Guthichaur Rural Municipality | Ward chairperson |
| 30 | Chandra Bahadur Nepali | Guthichaur Rural Municipality-5 | Ward chairperson |
| 31 | Dharma Raj Rawal | Guthichaur Rural Municipality | Store in-charge |
| 32 | Kabiraj Khatri | Guthichaur Rural Municipality | Executive member |
| 33 | Govinda Bahadur Mahat | Guthichaur Rural Municipality | Family planning officer |
| 34 | Lal Maya Damai | Guthichaur Rural Municipality | Executive member |
| 35 | Angad Bahadur Shahi | District Health Office | District health officer |
| 36 | Naresh Shahi | District Health Office | District technical lab assistant |

**Capacity Assessment Workshop, Karnali Province, Surkhet, August 28–29, 2018**

| SN | Name | Organization | Designation |
|----|------|--------------|-------------|
| 1 | Sushil Shahi | Ministry of Social Development | Health assistant |
| 2 | Dharma Raj Pathak | Health Directorate, Karnali Province | Senior assistant health worker |
| 3 | Tika Ram Jaisi | Health Directorate, Karnali Province | Public health inspector |
| 4 | Tulsi Prasad Adhikari | Health Directorate, Karnali Province | Public health officer |
| 5 | Mohammad Aphak Ahamad Khan | Health Directorate, Karnali Province | Account officer |
| 6 | Padam KC | Health Directorate, Karnali Province | Training officer |
| 7 | Kumar Prasad Upadhya | Ministry of Social Development | Account officer |
| 8 | Rajan Prasad Acharya | Ministry of Social Development | Nayab Subba |
| 9 | Gokarna Giri | Health Directorate, Karnali Province | Senior public health officer |
| 10 | Binod Acharya | Health Directorate, Karnali Province | Statistics officer |
| 11 | Naresh Babu | Ministry of Social Development | Family planning officer |
| 12 | Chetan Nidhi Wagle | Health Directorate, Karnali Province | Senior public health officer |
| 13 | Brish Bahadur Shahi | Ministry of Social Development | Public health administrator |
| 14 | Khagendra Gaire | Ministry of Social Development | Tuberculosis/leprosy officer |
| 15 | Man Kumari Gurung | Health Directorate, Karnali Province | Community nursing officer |
| 16 | OM Raj Acharya | Health Directorate, Karnali Province | Lab technician |

| 17 | Shyam Lal Acharya | Health Directorate, Karnali Province | Vector control officer |
|----|-------------------|--------------------------------------|------------------------|
| 18 | Pushpa Khatri | Ministry of Social Development | Nursing officer |
| 19 | Chakra Bahadur Khadka | Ministry of Social Development | IT officer |
| 20 | Nand Lal Dhakal | Health Directorate, Karnali Province | Nayab Subba |
| 21 | Bhala Ram Pangeni | Health Directorate, Karnali Province | Nayab Subba |
| 22 | Mani Ram Kharal | Ministry of Social Development | Section officer |
| 23 | Nod Narayan Chaudhary | Health Directorate, Karnali Province | Senior health and education officer |
| 24 | Sita Sapkota | Ministry of Social Development | Statistics assistant |

# Appendix 6: 2018 Social and Behavior Change Capacity Assessment Report

# Appendix 7: Changes Identified by Participants and Additional Improvements Needed

| Major changes identified by the participants | Areas for further improvement |
|---|---|
| **Chandannath urban municipality, Jumla**<br>• Analyze data and plan based on the need<br>• Coordinate with partners during planning<br>• Use checklist while monitoring<br>• Develop SBC materials for health<br>• Use mobile technology to send messages<br>• Regular health staff meeting | • Monitoring following the plan<br>• Development of message for social network<br>• Coordination and collaboration |
| **Guthichaur rural municipality, Jumla**<br>• Plan based on the situation analysis<br>• Focus on the target audience while planning<br>• Start monitoring health program<br>• Use Facebook page for message dissemination | • Development of detailed work plan with budget<br>• Development of monitoring and evaluation plan<br>• Knowledge management<br>• Advocacy plan<br>• Development of communication plan |
| **Barahatal rural municipality, Surkhet**<br>• Follow seven-step planning process<br>• Form rural municipality monitoring committee<br>• Focus on target audience<br>• Have information officer for knowledge management<br>• Conduct discussion among health facilities in-charge and executive committee members on health issues.<br>• Have elected members begin to disseminate health messages<br>• Activate monitoring committee, coordination committee | • Development of detailed work plan with budget<br>• Development and implementation of monitoring and evaluation plan<br>• Development of messages for mobile<br>• Development of materials |
| **Panchapuri urban municipality, Surkhet**<br>• Develop program based on target audience<br>• Gain more knowledge about monitoring and evaluation<br>• Plan for SBC health activities | • Knowledge management<br>• Development of advocacy strategy<br>• Development of information and communication strategy<br>• Make planning process more participatory |
| **Karnali Province**<br>• Gain understanding of SBC<br>• Develop annual implementation plan<br>• Start database planning<br>• Undertake advocacy for health education<br>• Develop SBC health activities | • Conduct advocacy for policy maker (secretary, department chief, directors) for SBC<br>• Acquire skills for advocacy<br>• Gain knowledge about other SBC models |

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