Breakthrough ACTION Nepal

2018 Social and Behavior Change Capacity Assessment Report

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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Acronym List

DHO	District Health Office
DPHO	District Public Health Office
FCHV	Female Community Health Volunteer
HD	Health Directorate
IEC	Information, Education, and Communication
M&E	Monitoring and Evaluation
MOHP	Ministry of Health and Population
NHEICC	National Health Education Information and Communication Centre
PMP	Project Managing Plans
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SMS	Short Message Service
TOR	Terms of Reference
USAID	United States Agency for International Development

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Executive Summary

Breakthrough ACTION Nepal is a two-year (2017–2019) project funded by the United States Agency for International Development (USAID) and led by the Johns Hopkins Center for Communication Programs in partnership with the National Health Education Information Communication Center (NHEICC) and Family Welfare Division (FWD) and in collaboration with USAID's Strengthening Systems for Better Health (SSBH) project and other partners. The overall objective of the project is to strengthen institutional and technical capacity of the Government of Nepal to design, implement, evaluate, and coordinate effective social and behavior change (SBC) programs.

Breakthrough ACTION 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, maternal, newborn, child, and adolescent health; and nutrition.

In 2018, Breakthrough ACTION Nepal, in collaboration with the National Health Education Information and Communication Centre (NHEICC) in Nepal, worked closely with government and civic representatives to organize and facilitate a series of systematic assessments to gauge capacity in SBC design, implementation, evaluation, and coordination.

These assessments were administered soon after a recent shift in Nepal's government from a centralized structure to a federal system with three equal levels (i.e., central, provincial, and local). Traditionally, SBC expertise in Nepal has been assigned to the central level, but the government reorganization granted provincial and local authorities decision-making power and financial resources to identify health programs, including SBC, based on the needs of their communities. However, the extent of SBC knowledge and experience in these areas is largely unknown, mostly because SBC programs were primarily developed and implemented at the central level.

The 2018 assessments employed a workshop-style format supplemented with key informant interviews conducted with internal and external stakeholders. The workshops were guided by the SBC Capacity Assessment Tool.[1] This tool involves a participatory process to assess the current status of programmatic SBC, identify gaps and feasible areas for improvement, and develop change implementation plans. Programmatic areas (also called domains) reviewed during the Nepal assessments include SBC, mobile technology, social and user-generated media, advocacy, monitoring, and evaluation. Elements of knowledge management, coordination, and communication were also integrated.

Breakthrough ACTION Nepal's work focus on activities at the central and provincial levels as well as four municipalities within the districts of Surkhet and Jumla of Karnali Province – one rural and one urban municipality from each district. Participants from the central level included 12 staff from NHEICC under

[1] The SBCC Assessment Tool was developed under the Health Communication Capacity Collaborative (2012–2017), which was implemented by the Johns Hopkins Center for Communication Programs.

the Ministry of Health and Population (MOHP) Health Promotion Unit. The provincial level workshop comprised of 22 people from Karnali province. At the local level, 129 (66 from Surkhet and 63 from Jumla) health workers, government authorities, and civic officials participated in the assessments.

The first assessment took place at the central level with NHEICC for which various SBC capacity assessments have been implemented in the past. NHEICC underwent a similar self-assessment process in 2007 and again in 2014. The 2018 assessment was, in part, meant to identify progress since 2014 and explore how NHEICC might respond to increasing changes to SBC across the health landscape, which previously had been managed and implemented solely by the government at the central level.

Overall, results from the 2018 assessment indicate a need for a robust plan and sustained capacity-strengthening efforts to reinforce the SBC system in Nepal. NHEICC has made improvements since 2014, but gaps remain. Major gaps identified in 2018 included program management (using evidence-based SBC program design and implementation), knowledge management, and monitoring and evaluation (M&E) to strengthen outcome tracking and guide program design and refinements. Advocacy, coordination, and strategy development also were identified as specific gaps at the local level.

Table 1 shows the aggregate score (from 1 or least to 4 or highest) for expertise/capacity in each domain of the SBC Capacity Assessment at the central, provincial, and local levels. (see Appendix 1: SBC Capacity Self-Assessment Scores (2018)).

Table 1: Aggregate Scores of SBC Capacity Assessment 2018

Domains	**Aggregated score (range 1–4) based on consensus score**		
	Federal-level	**Provincial-level**	**Local-level**
	Baseline	**Baseline**	**Baseline**
Program management	2.50	3.00	2.75
Social and behavior change	2.90	2.50	1.65
Mobile technology	2.25	0.25	0.56
Social and user-generated media	2.00	2.00	1.05
Knowledge management, coordination, and collaboration	3.17	3.17	2.25
Monitoring and evaluation	2.43	2.71	2.43
Advocacy		2.10	1.08

Discussions and results of these full-capacity assessments, as well as preliminary recommendations for next steps, will be refined and developed into a capacity-strengthening plan in collaboration with participants at the central, provincial and local levels.

Background

In 2015, Nepal adopted a new constitution. In 2017 and 2018, the country began implementing a federal structure through political elections. The new federal system includes legislative bodies at three levels: central, provincial, and local municipalities referred to as *nagarpalikas* (urban municipalities) and *gaupalikas* (rural municipalities). For health care, this means that local governments have the authority to make planning and budgeting decisions to address the unique needs of their communities. Previously, these decisions were managed at the central level.

Prior to the federal system, the NHEICC was primarily responsible for the planning, implementation, and M&E of health communication activities across the different centers, divisions, and programs within the MOHP. NHEICC had the mandate, under the *2012 National Health Communication Policy,* to coordinate and regulate SBC activities conducted by external organizations. In addition, the Center supported all three MOHP departments—Health Services, Ayurvedic, and Drug Administration—and comprised four health sections: (1) reproductive and child health, (2) environmental health, (3) tobacco and noncommunicable diseases, and (4) health promotion and education. NHEICC also liaised with focal persons at the regional and district offices to support local SBC activities.

The role of the NHEICC within the new federal system is not clearly defined; however, NHEICC leaders recognize that this is an opportunity for the Center to plan an exciting function within an evolving SBC for Health landscape.

It remains uncertain whether NHEICC will have focal persons at the provincial and local levels under the new structure, given its condensed role and resources. The unit is grappling with significant budget (from NPR 24 million in 2017 to NRP 12 million in 2018) and staff (from 33 to 16) reductions. Similarly, the Family Health Division and Child Health Division—key counterparts to NHEICC—were consolidated into the Family Welfare Division. Although the unit's 2012 National Health Communication Policy and other guidance are now outdated, they remain effective until revised or replaced with ones that align with the structural changes.

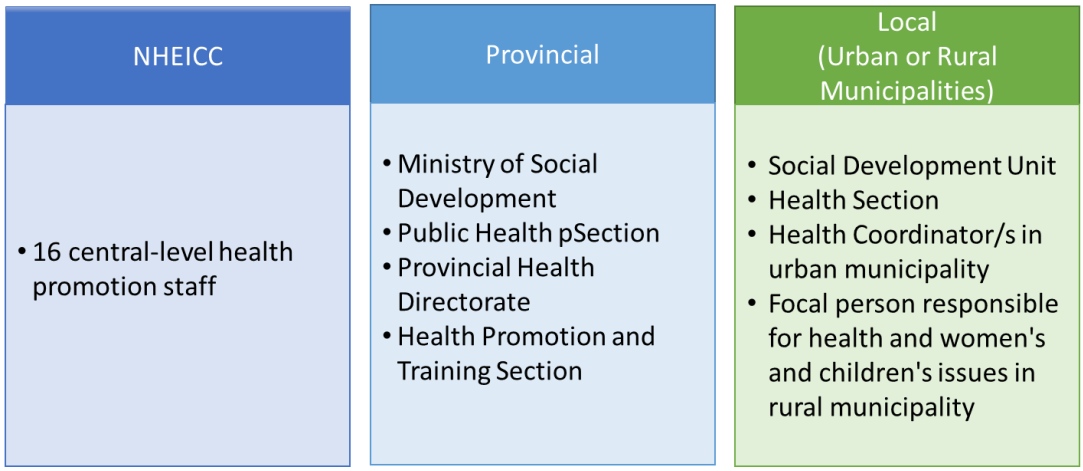
The Emerging SBC Health System

Central Level

According to NHEICC's senior staff, the Center's new mandate will likely center around coordination; M&E; design and management of national SBC guidelines, policies, and strategies; and development of standard messages and various templates (e.g., materials development, risk and emergency communication). The guidance and tools would be developed in close collaboration with provincial and local stakeholders, who would adapt them for local context and needs. This process will allow NHEICC to maintain some quality control over the accuracy and consistency of health-related information.

NHEICC will likely maintain responsibility for MOHP-related SBC programs at the central level. Health communication will be disseminated mostly via mass media and mobile technology. The production of print materials (e.g., brochures and posters), which comprise a large part of the center's previous workplans, will be transferred to the local level. The province and local municipalities will have separate health promotion structures and will be responsible for planning, implementing, and monitoring their SBC activities. NHEICC will not have any authority to directly track or monitor these activities, either at the provincial or local municipality levels. The structure for this work is in development, so an official organogram outlining this information is not yet available. Figure 1 depicts the tentative health promotion structures across the three levels of government.

Figure 1: Ministry of Health and Population Health Promotion Structures



In June 2018, local governing bodies submitted their annual action plans and budgets as usual; however, the structure to support these activities is in development. Vacancies remain at provincial and local levels, and a mass reorganization of MOHP centers and divisions is ongoing.

Provincial and Local Levels

The province and local municipalities are independent bodies, with no formal line of authority or linkages between them. The linkage between the local municipality and NHEICC also is unclear.

The health section of the municipality's Social Development Unit is responsible for all health activities across the municipality. Before the new federal system, the District Public Health Office (DPHO) was the authority on health-related issues and was responsible for data collection and commodities logistics management related to the ward-level (municipalities were created after the new federal structure came into place and comprises of different number of wards) health posts. Ward-level health staff now report to the municipality's health coordinator, and data are now collected and compiled by the municipality.

In the newly federalized health structure, health falls under the jurisdiction of the provincial Ministry of Social Development. The Health Directorate (HD) was launched in August 2018. It has nine health-

related sections, amongst which the Health Promotion and Training section and Public Health section are most relevant in the SBC system. Figure 2 illustrates the health system structure of the Ministry of Social Development.

Figure 2: Health System Structure of Provincial Ministry of Social Development in Karnali Province

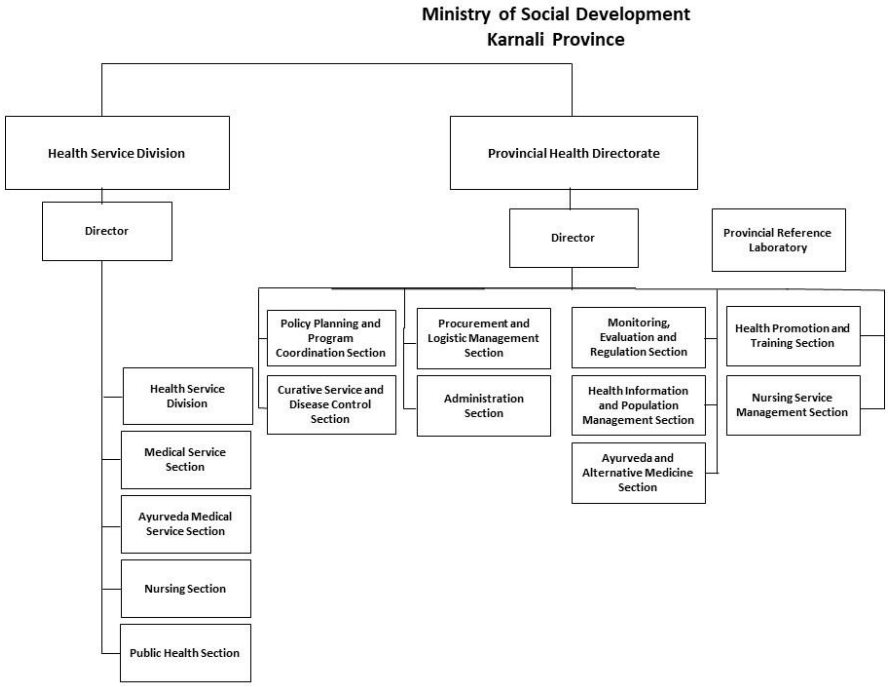
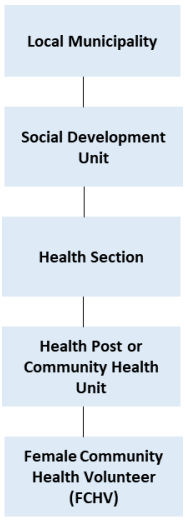


Figure 3: Health System Structure at the Local Municipality Level



The long-term existence of the DPHO is unclear. Across the country, 35 DPHOs were re-instated.[2] They are under provincial authority and support the municipalities. The District Health Offices (DHOs) have been revived under HD authority, with the intent of strengthening municipalities' health portfolio capacities over the next few years.

Overview of SBC Capacity Assessment Exercise

The SBC capacity assessment tool was used to facilitate a robust, rigorous, and participatory assessment of NHEICC- and SBC-related provincial and local municipality stakeholders to understand their current capacity to design, implement, monitor, and coordinate SBC in Nepal. Using the SBC Capacity Assessment Tool (see Appendix 2: SBC Capacity Assessment Tool),[3] along with in-depth interviews (see Appendix 3: Interview Guidelines for internal use and Appendix 4: Interview Guidelines for External Partners), an organization can review its programmatic sustainability in SBC and develop a concrete plan for improvements.

Objectives

- Review and discuss existing SBC capacity of the central, provincial, and local levels of government.
- Understand SBC needs and gaps at the central, provincial, and local levels of government.
- Develop a capacity-strengthening plan for central, provincial, and local officials based on identified needs and gaps in SBC.

Participants

Participants of this activity were NHEICC staff at the central level and relevant government staff with SBC oversight, administrative management, and responsibilities at the provincial and local municipality levels.

- Central-level SBC capacity assessment focused on NHEICC staff.

[2] In January 2019, MOHP decided to retain DHOs in all 77 districts, including those under provincial authority.

[3] 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.**

- Provincial-level assessment focused on the health unit of the Ministry of Social Development and the HD.
- Local-level assessment focused on the urban municipality's mayor and deputy mayor; the rural municipality's chairperson and deputy chairperson; executive committee members, including representatives for women and marginalized groups, such as *Dalit* and *Janajati*; the ward chairperson, who is also the president of the Health Facility Management and Operation Committee, health post in-charges, storekeepers, accountants, and the chief administrative officer.

Approach

The phases of the capacity assessment exercise included (1) stakeholder engagement, (2) preparation, (3) the workshop, (4) key informant interviews, and (5) follow-up at all three levels (central, province, and local).

1. ***Stakeholder engagement***: Breakthrough ACTION engaged NHEICC and conducted an orientation and met with key staff to discuss the overall project and shared SBC capacity assessment tool. Similarly, relevant government and civic stakeholders were engaged for the assessment at the provincial and local levels.
2. ***Preparation***: Breakthrough ACTION worked with NHEICC to adapt the existing SBC Capacity Assessment Tool to the Nepal context at all levels to ensure inclusion of relevant domains. Other USAID-funded and non-USAID-funded partners were consulted in the development of the assessment exercise to ensure synergies in activities and opportunities for collaboration.
3. ***Workshop***: The workshop was led by NHEICC and Breakthrough ACTION. Each workshop began with a brief explanation of the tool and process. An overview of the findings from previous assessments, if applicable, was shared during the assessments. Breakthrough ACTION provided technical support to NHEICC through an initial participatory workshop to assess SBC capacity at the central level. Prior to each workshop, participants from the intended audiences were asked to identify documents (e.g., SBC strategies, message harmonization guides, M&E plans) that would be useful during the workshop to verify the capacity level of the organization, as reported by participants. Where applicable and available, these documents were reviewed by Breakthrough ACTION staff to gain further insight into the participants' SBC capacity. Between 1 to 1.5 workshop days were dedicated to assessing capacity across a set of SBC domains. The SBC capacity assessment included organizational capacity in the following domains: SBC, including program management; advocacy, including advocacy networking and alliance building; coordination and collaboration; M&E; and knowledge management. These domains were drawn from the SBC Capacity Assessment Tool and included relevant domains from the 2014 Capacity Strengthening Planning Report (see Appendix 5: Summary Findings from the 2014 National Health Education Information Communication Center Self-Assessment). Participants at the assessment workshops were divided into groups and asked to rate their

organization or group's capacity for each domain. A short consensus-building exercise took place at the end of the workshop to give groups an opportunity to verify ratings and provide additional information that might support scores across the domains.

4. ***Key informant interviews*:** Interviews were conducted after the workshop at the Center with select staff from NHEICC and stakeholders with a history of working closely with NHEICC. Similar interviews were conducted with key persons at the provincial and local levels during SBC capacity assessment at these levels. The interviews helped to verify and enrich findings from the workshop as well as address topics not covered in the workshop.
5. ***Follow-up at all three levels (central, province, and local):*** Shared the findings at all levels. Based on the findings, designed capacity strengthening activities, e.g. capacity strengthening exercise on SBC for health.

Process

The workshop employed a participatory self-assessment process designed to reflect on and prioritize ways to improve the design, implementation, and evaluation of SBC programs.

Prior to conducting the federal-level assessment, Breakthrough ACTION met with NHEICC on several occasions to orient its leadership and staff to the assessment tool and process, as well as to identify someone within the organization to facilitate the assessment process. These were important steps, as NHEICC, with support from Breakthrough ACTION Nepal, implements the tool with SBC stakeholders at both the provincial and local levels.

The workshops were conducted in three parts:

1. **Preliminary Discussion about Self-Assessment**
    - Review of the assessment design approach
    - Visioning exercise
    - Review of capacity skillsets
2. **Small Group Discussion**
    - Self-assessment by organizations or units working together
    - Consensus building
3. **Action Planning for Implementation and Monitoring**
    - Prioritization of areas for capacity strengthening

SBC Capacity Assessment at the Central Level

On July 25–26, 2018, a 1.5-day capacity assessment workshop was conducted with 12 NHEICC staff (see Appendix 6: Participant List). As previously described, workshop participants discussed specific skillsets and indicators involved in the implementation and coordination of the SBC process. Consequently, NHEICC identified specific SBC strengths and areas for improvement. In particular, the team highlighted gains in its capacity to coordinate and collaborate with partners (i.e., international nongovernmental organizations) and identified a greater desire to learn more about formative research, program design, social and user-generated media, and M&E.

The first day began with a short presentation by NHEICC on the 2018 process and findings from the 2014 assessment (see **Error! Reference source not found.**).

Visioning Exercise

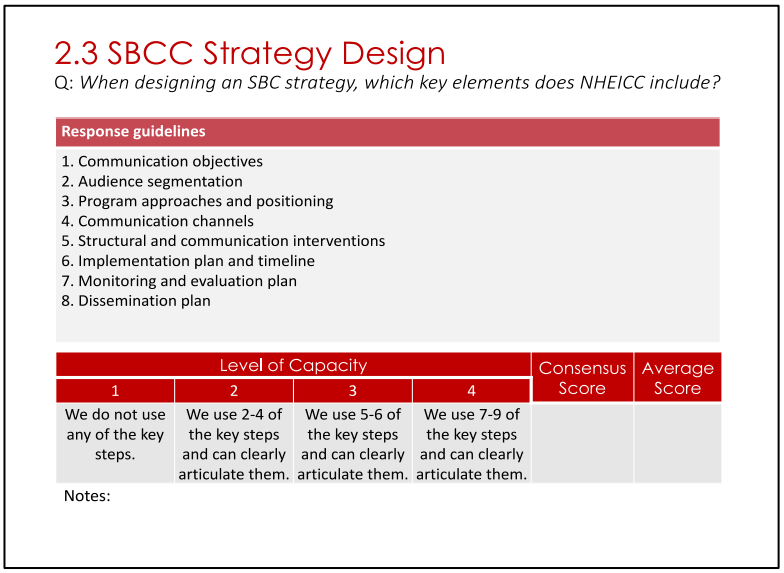
The opening presentation was followed by a visioning exercise. Participants were divided into three groups, and each group was asked to review the Center's 2014 vision statement and then visualize and think about how, if at all, that vision had changed. The groups then developed a vision statement, story, or illustration of what they hope to see from NHEICC in the next five years. The following statements show the 2014 vision statement and a synthesis of the group's statements for 2018:

2014 Vision Statement	2018 Vision Statement
To elevate the role of health communication within the MOHP and among other government ministries and departments and for others to see the role and importance of social and behavior change communication.	*To serve as a center of excellence and focal point for evidence-based health promotion with the capacity to lead, support, coordinate, and collaborate with stakeholders at all levels in support of a healthy and prosperous Nepal.*

NHEICC's focus seems to have shifted from one of advocacy in 2014 to leadership and the desire to demonstrate its capacity in SBC and coordination in 2018. The Center also is highly interested in evidence-based health promotion and looks to strengthen itself in this aspect. NHEICC leadership is enthusiastic and open to the change process. The Center's desire to be a focal point for SBC is echoed from the top down, with an eagerness to address gaps and areas for improvement.

Preliminary Discussion about the Self-Assessment

Breakthrough ACTION provided a brief presentation on SBC and its evolution, as well as the capacity assessment approach and skillsets (**Error! Reference source not found.**). Thirty-five capacity skillsets were identified, in collaboration with NHEICC, as relevant for this assessment.[4] These skillsets fall under the domains previously cited in the Approach section.



2.3 SBCC Strategy Design

Q: *When designing an SBC strategy, which key elements does NHEICC include?*

Response guidelines

1. Communication objectives
2. Audience segmentation
3. Program approaches and positioning
4. Communication channels
5. Structural and communication interventions
6. Implementation plan and timeline
7. Monitoring and evaluation plan
8. Dissemination plan

Level of Capacity				Consensus Score	Average Score
1	2	3	4		
We do not use any of the key steps.	We use 2-4 of the key steps and can clearly articulate them.	We use 5-6 of the key steps and can clearly articulate them.	We use 7-9 of the key steps and can clearly articulate them.		

Notes:

Figure 4: Example of Assessment Scoring Sheet

Small Group Discussion

Facilitated by one senior NHEICC staff member, each group was asked to rate each capacity indicator on a scale of 1–4 and then to score themselves as a unit. Figure 4 shows an example of the tool and scale measurements. Each sheet poses a question and provides response guidelines.

Each group received a copy of the SBC Capacity Assessment Tool and flip-chart paper to document scores and evidence of capacity. At the end of the day, each group was asked to identify one or two priority gaps or areas for improvement for each assessment section or domain, write them on a sticky note, and apply the notes to flip charts that were placed on the wall around the room. The criteria for judging each skill area is detailed in Appendix 2: SBC Capacity Assessment Tool.

To help groups assess themselves using evidence, each was asked to bring available documentation (e.g., workplans, reports, budgets, training plans, communication materials, procedural guidelines) to the workshop so it could be consulted, if needed. As part of the process, groups identified documentation linked to a skill area, and workshop facilitators verified this information.

[4] Relevant capacity skillsets were selected from two assessment tools developed under earlier global projects: the Management Sciences for Health PROGRESS_SBC and Johns Hopkins Center for Communication Programs SBC Assessment Tool. Both tools were developed under the Health Communication Capacity Collaborative Project. All aspects of capacity may not be relevant for NHEICC.

On the second day, the groups reconvened in plenary to review their scoring and identify a prioritized list of the skills they believed would be most important to develop in the shorter term and longer term, with support from Breakthrough ACTION Nepal. The next section discusses results of the self-assessment and discussions by NHEICC. **Error! Reference source not found.** outlines the condensed scores.

Assessment Results for the Central Level

References to sub-indicators within this section apply to those same indicators as outlined in the SBC Capacity Assessment Tool (see Appendix 2)

Program Management (Indicators 1.1–1.2)

1.1 Program Design

NHEICC indicated that they use some evidence, mainly the Nepal Demographic Health Survey, to inform program design, development, and improvement. However, lessons learned are not used to consistently improve strategies (see **Error! Reference source not found.** – 1.1). NHEICC recognized the need to use more evidence to inform programming and noted that the Nepal Demographic Health Survey is not sufficient, as it has few questions related to knowledge, attitudes, and behavior change. They are unable to conduct primary research due to a lack of resources and indicated that 2011 was the last time NHEICC conducted primary research. Research findings from external stakeholders are not accessed or used, as the NHEICC regards those findings as not representative of the general population.

1.2 Program Action/Workplan and Budget

NHEICC regularly develops its annual program action/workplan and budget. However, the process is not participatory and hence not reflective of the diverse, public-private partnerships in which the Center participates.

SBC (Indicators 2.1–2.10)

2.1 Situation Analysis

NHEICC typically assesses existing policies and programs, learns about active and available communication channels, identifies partners and allies, assesses organizational capacities, and accounts for possible gender differences and ensures all viewpoints are represented. However, as indicated in the program management domain, they have less experience conducting primary research, such as baseline/end line studies and reviewing relevant studies to inform development of problem statements.

2.2 SBC Theory

The team said they incorporate theories into their strategy and have staff who are trained and qualified on SBC theories/frameworks, but they could not indicate or articulate which ones were used.

2.3 Strategy Design Process

The team said they use all the elements of the strategy design process, except M&E, and they acknowledged that M&E is an area in which the unit requires robust capacity strengthening.

2.4 Product Design

NHEICC conducts inventory of existing materials and hosts participatory processes that facilitate agreement on designs and revisions. However, they do not develop creative briefs or undertake rigorous concept or pretesting activities. They said that they often are asked to design products for an urgent need (e.g., epidemics, directives from higher-level authority) and mostly do not have the time or resources to pretest materials with end users. Instead, internal staff conducts pretesting. The team recognized this as an area in which they could improve, and which requires capacity strengthening.

2.5 Gender Equity and Social Inclusion

NHEICC incorporates Gender Equity and Social Inclusion during product design. The different needs of men and women are included and considered when designing interventions, products, and materials to change harmful, country-specific gender norms. For example, they follow gender guidelines via Information, Education, and Communication (IEC) Kits developed by the MOHP, and gender experts within the MOHP participate in IEC technical committee meetings to review materials and products. They also indicated that they include female staff in the product and materials design process to address gender inequity.

2.6 Intervention Planning and Implementation

Monthly, quarterly, and annual plans and budgets are developed. However, they cannot always adhere to those plans due to circumstances out of their control (e.g., schedule changes precipitated by other units within the MOHP, delay of funds released by the MOHP).

2.7 Partner Mobilization and Coordination

The team said that they have improved over the years in their efforts to facilitate Partner Mobilization and Coordination. They currently hold regular meetings with partners and the MOHP, which ultimately approves the Center's workplan. However, gaps in this area remain. For example, the 2012 National Health Communication Policy supports a "one-door" system in which all behavior change activities (internal and external) are supposed to go through NHEICC for review and approval. However, this is not always the case. The team acknowledged that despite this mandate, the Center is not aware of all the organizations in Nepal working in SBC.

The team identified stakeholder mapping as an important process that needs to be undertaken by the NHEICC to improve its coordination efforts. A similar mapping exercise was highlighted as part of the recommendations from the 2014 assessment. There was no evidence that this was done.

2.8 SBC Training Needs

SBC Training Needs were identified among staff, although not via formal assessment, and the Center lacks a clear plan for addressing these needs. Most trainings within the MOHP are conducted by the National Health Training Center, which has not developed SBC training. Also, the NHEICC team did not know whether the National Health Training Center could develop or conduct such trainings. Many NHEICC staff participated in global SBC trainings (e.g., Leadership in Strategic Communication Workshop) facilitated by external partners or entities, but the Center does not have the mandate to conduct such trainings. The team reported that they hope to develop a staff training plan following the SBC capacity assessment.

2.9 Advocacy

The team reported that advocacy is a provision of the 2012 National Health Communication Policy and individual program strategies, though it is not used as part of a strategic communication process when planning interventions.

2.10 Social and Behavior Change Communication Trends

Some staff knew about the social and behavior change communication (SBCC) process but were less clear on the difference between SBC and SBCC. The team also acknowledged that they were unfamiliar with other SBC approaches, such as human-centered design and behavioral economics.

Mobile Technology (Indicators 3.1–3.4)

3.1 Mobile Voice and Text Messaging

Currently, NHEICC uses mobile technology, including short message service (SMS) and interactive voice response, as part of its SBC programs, mainly to support the dissemination of health messages. The use of mobile technology is sometimes included in the overarching strategy for a specific SBC activity; however, the Center does not have general guidelines on how to integrate mobile technology into programs. Despite these gaps, the team scored the Center well in this area.

The team was extremely excited about a recently established information technology (IT) hub, a large tower of equipment in a secured room on the ground floor of the NHEICC building. The hub has been in development for the past three years with support from UNICEF. It will allow NHEICC to send SMS and interactive voice response messages directly to the general public at a subsidized rate through an agreement with the Nepal Telecom Company. The hub is a source of pride for the Center, but the team

acknowledged that it is not fully operational. An IT consultant helped establish the hub, but the NHEICC does not yet have a full-time position to manage it.

3.2 Mobile Technology Message Development Process

Messages are sent via various tools and according to certain variables, such as length of message for each channel, which are considered during the message development process. However, a strategic process is not followed. This also is the case for identifying technology and tools for SBC programs. The team could not articulate a specific process for using mobile technology but highlighted the use of tools such as mobile applications. Mobile applications were recently developed for the Golden 1000 Days national campaign, which raises awareness around proper nutrition for pregnant women and children, and the *Khulduli* national campaign, which promotes sexual and reproductive rights of adolescents. The Center has a limited budget to promote these applications.

3.3 Mobile Technology Tools

Although NHEICC uses mobile technology, no monitoring tools are currently in use.

3.4 Monitoring Use of Mobile Technology

Software is being installed at NHEICC to monitor its use of mobile technology on a trial basis. Once this process is complete, the IT consultant will hand over the software and train staff on how to use it. As previously noted, the team acknowledged that monitoring (even of mobile technology) is not one of its strengths and welcomes technical assistance to improve in this area.

Social and User-Generated Media (Indicators 4.1–4.5)

4.1 Multimedia, Web and Social Media and 4.2 Social and User-Generated Strategy

NHEICC uses various social and user-generated media such as Facebook, SoundCloud®, YouTube, and a website to support SBC campaigns and promote activities sponsored by the Center. The use of social and user-generated media is part of its annual workplan, but it is not guided by a specific strategy. NHEICC does not yet have a robust social and user-generated media system in place, and the Center wants to improve and strengthen its capacity in this area.

4.3. Social and User-Generated Message Development

There is no process in place specifically for social and user-generated media.

4.4 Meaningful End-user Engagement

Despite its use of social media, the team noted these platforms are mainly used to push out information to but not engage meaningfully with users.

4.5 Monitoring and Evaluation of Social and User-generated Media

Vigorous or strategic M&E of social and user-generated media use is non-existent. According to the team, the only form of feedback tracked on social media are "likes" and "shares." They do not use it to evaluate programs.

Knowledge Management, Coordination, and Communications (Indicators 5.1–5.6)

5.1 Institutional Knowledge Management System

NHEICC's knowledge management system includes its website and a public library within the NHEICC building that houses various program documents and materials. There is no strategic process for capturing, packaging, and sharing knowledge with relevant staff. The Center's website stores campaign materials, reports, and policy documents. The library, in the aftermath of the 2015 earthquake, is unkempt and primarily used as a storage space. The team noted that it is hardly ever used by the public. Staff also does not always use these systems.

Until recently, NHEICC was responsible for maintaining an online Health Education Library Information System for medical professionals. This system, which is supported by the World Health Organization, provides medical doctors and personnel access to health journals and medical research. For years, NHEICC was responsible for training and orienting medical professionals on the system; however, funding for the Center's support ended last year.

5.2–5.4 Knowledge Management Coordination

NHEICC oversees the IEC Technical Committee for SBC materials (5.2). This committee is guided by terms of reference (TOR), and the process is documented through meeting minutes. However, there is no feedback mechanism in place. The team said that NHEICC is mandated by the MOHP to coordinate all SBC and health promotion in the country (5.3), as outlined in the 2012 Health Communication Policy (5.4), so its role is clear. However, they acknowledged the Center is not always aware of other organizations doing similar, complementary, or overlapping work in the country and suggested the need for stakeholder mapping. They recognized that similar review committees are needed at the local level and that central-level staff should coordinate with these committees whenever possible.

5.5–5.6 Internal and External Communication

The team rated the Center high in terms of its ability to communicate both internally and externally. Internally, NHEICC has various mechanisms (e.g., staff memos, meeting minutes, Facebook page, Viber group) for communicating with stakeholders. These mechanisms are known by all staff but are not always used. Similarly, the team noted other methods for external communication with stakeholders (e.g., notice boards, website, official letters, newspaper notices, TV and radio announcements), but they are not used consistently.

Monitoring and Evaluation (Indicators 6.1–6.4)

6.1 Intervention Monitoring

M&E is an area that everyone agreed is a major gap for the Center. It was noted that NHEICC has an M&E plan, but it is not adequately funded and does not include a results framework or clearly defined performance indicators to determine the success of interventions (see **Error! Reference source not found.** - 6.1.1–6.1.3). Instead, NHEICC mainly tracks process indicators, such as number of materials printed or number of times messages were aired.

6.2 Monitoring and Evaluation of Program Development and Implementation

NHEICC has internal and external monitoring systems in place (e.g., supervision checklists, Health Management Information System), but the information generated from these systems is not always used to inform program development and implementation. The team collectively indicated that NHEICC includes process indicators as part of its annual work plans; however, outcome indicators represent major gaps in its M&E program. While the NHEICC has annual targets, it does not have an efficient system for tracking whether targets are being met.

6.3 Data Utilization

Only quantitative data are collected. Qualitative data are not part of the data collection and analysis process. In terms of data utilization, the team agreed that indicators are not used to set benchmarks and targets for subsequent years, as the MOHP established those.

6.4 External Data Review and Use

The Center does not track outcome indicators internally. However, the team noted that it participates in joint annual review meetings with the MOHP and other stakeholders to review data and program results from external programs related to SBC (see **Error! Reference source not found.** - 6.3.2, 6.4).

Insights from Key Informant Interviews at the Central Level

External and internal stakeholders participated in key informant interviews. The following is a summary of the gaps, challenges, areas of concern, and potential solutions that stakeholders indicated should be considered when developing NHEICC's capacity-strengthening plan.

- ***Technical Capacity*** – Staff is trained on basic-level SBC but are not building on their knowledge and skills. Message design following the strategic design process is a challenge for the Center, as is the ability to integrate SBC into service delivery. Social media tools are highly underutilized, and materials are not youth-friendly or adapted for different audiences.
- ***Full Utilization of Staff*** – Staff seem to be mainly responsible for managing the procurement of services to develop health messages and materials. Results often are subpar, as the Center tends to select the vendor with the lowest-cost bid. The Center should consider taking a more active technical role in program and materials development as a way to influence the quality of deliverables and demonstrate its SBC capacity.
- ***Workplan Development*** – The Center's annual workplan is similar from year to year and does not necessarily reflect some areas (i.e., budgeting for supportive monitoring and supervision and local-level visits) that would help position it as a leader and focal point for SBC. In addition, the Center's work-planning process is somewhat ad-hoc and does not involve collaboration or participation from key stakeholders early in the process.
- ***Coordination*** – The Center cannot enforce its one-door policy. Many organizations do not submit materials and messages through the IEC Technical Committee for review or approval. In some cases, even MOHP divisions bypass this process. As the committee and one-door policy are likely to become less relevant under the new structure, the Center should strengthen its coordination by becoming more results-oriented and supporting local structures to coordinate and manage the influx of local programming and potential duplication of efforts. The Center also might recommend standard templates and messages, designed and produced in coordination with program divisions, that can be archived, consolidated, and distributed for use.
- ***Local-level Engagement*** – In the past, the Center reportedly developed materials and guidelines and sent them to the local level without follow-up, proper orientation, communication, or support. For the NHEICC to remain relevant, it must engage provincial and local leadership to develop relationships based on mutual respect, and it must promote its ability to build capacity in SBC. This must be done diplomatically to ensure guidance is not perceived as directive but supportive. Some of the Center's peers with the same skillsets will be relocated from the central to the local level. Thus, the Center may need to demonstrate that its staff are technically sound, with something unique to offer and an overall higher level of capacity in SBC.
- ***Leadership*** – The director and other members of senior leadership are constantly changing. As a result, there is not enough time to invest fully in the Center or to develop and execute its vision and overall strategy. There also is a lack of coordination with other division heads.
- ***High-level Advocacy*** – Despite widespread recognition that SBC is essential to improving health outcomes, many within the MOHP consider SBC as simply the dissemination of health information through mass media. NHEICC staff are frustrated about being called upon solely to produce print materials and coordinate communications with the press. The Center's workplan mainly consists of materials production, and it is difficult to demonstrate its capacity beyond this. There is a need to advocate for additional resources to engage locally. However, the

current focus on curative health without the understanding the need to invest in health promotion makes it difficult to advocate for additional financial and human resources. One way to do this is to bolster the Center's M&E function so that it shows the effectiveness and impact of SBC on service uptake and outcome indicators.

- ***Internal Relations*** – It is difficult to advocate for the Center when its perceived level of importance is low among decision-makers within the MOHP. Some people within the Ministry question the need for the Center, based on the prevailing notion that "communication" or "behavior change" can be done by anyone.

Major Gaps Identified at the Central Level

After rating themselves on each capacity indicator during the workshop, the participants revisited their ratings and discussed which ones to prioritize for capacity strengthening. They further divided these into short-term and long-term priorities. These priorities are based on NHEICC's needs and aspirations within the new system. Breakthrough ACTION will support NHEICC in strengthening these capacity needs by either working with NHEICC directly or linking them to other organizations that can provide the support needed.

The major gaps identified as needing capacity strengthening were as follows:

- Evidence-based program management, design, and implementation
- M&E system strengthening for outcome tracking to guide program design, refinements, and revisions
- SBC national strategy development
- SBC guidelines for local levels
- Standardized materials and messages for easy access and local use

Short-term priorities include the following:

- **Program Management** – Use formative research to inform program design (see **Error! Reference source not found.** - 1.1), which entails analyzing research gaps, developing the Center's capacity to generate data to inform programmatic decisions, and improving research capacity to strengthen NHEICC's ability to conduct situation analysis and better understand the needs of stakeholders (see **Error! Reference source not found.** - 2.1).
- **M&E** – Develop an M&E strategy and indicators with implementation timelines (see **Error! Reference source not found.** - 6.1.1), which entails strengthening the Center's capacity to develop a strategy (including a results framework, performance indicators, and implementation plan) early in the workplan year to allow for routine monitoring and adjustments and to inform future workplan cycles and SBC programs (see **Error!**

Reference source not found. - 6.1.3, 6.2, 6.3.1). The Center also expressed interest in M&E of data using mobile technology (see **Error! Reference source not found.** - 3.4).

- **SBC** – Develop a staff training plan including training of trainers, re-orientation, and updates on foundational SBC skills, emphasizing theory and pretesting. This plan would enhance the Center's ability to provide technical assistance to provincial and local-level representatives to develop and use creative briefs to guide product design and pretest with end-users rather than internal staff (see **Error! Reference source not found.** - 2.2, 2.5). It would also enhance NHEICC's capacity to monitor and support the work of other SBC partners in the country.
- **National Strategy** – NHEICC expressed a need to develop a national health promotion strategy as part of its goal to position itself as a leader in SBC. Various stakeholder organizations, such as GIZ and PSI, have offered to assist NHEICC with the development of this strategy, so this likely will be a collaborative effort. This strategy would ideally serve as a guiding document for operationalizing SBC across the country.
- **Social and User-generated Media** – A social media strategy is needed that includes strengthening capacity to move beyond just pushing out messages. The goal is to strategically engage the audience and to monitor and evaluate feedback to inform programming (see **Error! Reference source not found.** - 4.2, 4.4., 4.5).

Long-term priorities include the following:

- **Knowledge Management** – Orientation and training on knowledge management approaches and tools are needed. This will include developing a systematic process for coordinating with internal and external stakeholders; capturing and documenting reports, tools, and materials; and making this information accessible to internal and external stakeholders.
- **Coordination** – Coordination is needed to map the country's SBC stakeholders, including identifying SBC players at all levels and any relevant information about their work.
- **Advocacy** – Advocacy for appropriate HR and training should be done by NHEICC in coordination with National Health Training Centre. In the short term, NHEICC can conduct orientations. Advocacy with the MOHP should be done to identify the scope of SBC and health promotion.

Recommendations for the Central Level

Breakthrough ACTION Nepal developed preliminary recommendations based on the assessment results:

- Support implementation of SBC capacity assessment at the provincial and local levels to better understand how the Center might offer support and position itself as a national resource for SBC capacity strengthening.
- Support implementation of landscape analysis and mapping of SBC stakeholders at the provincial and local levels to learn more about organizations that are working and contributing to the SBC for Health system.
- Identify relevant individuals at the Center to receive mentoring, supportive supervision for program management, SBC design, M&E, social and user-generated media, and knowledge management and coordination. Identify key staff who will lead and manage the Center's efforts in priority areas.
- Skillsets for NHEICC should include the following:
    - Using theoretical frameworks and formative research to understand the needs of stakeholder groups and the strategic use of data for planning and M&E.
    - Improving use of systematic, SBC, evidence-based design processes, including field testing with end users for strategy, message, and materials development.
    - Improving communication and coordination with SBC stakeholders, both internal (MOHP) and external, at the central, provincial, and local levels for planning and implementation, including leadership and coordination of SBC-relevant M&E throughout the MOHP.
    - Developing a monitoring system that tracks behavioral indicators and output indicators to measure impacts, inform future programming, and advocate on behalf of SBC within the MOHP.
- Design a basic SBC planning and implementation guide for and in collaboration with provincial and local stakeholders.
- Convene training of trainers for individuals who will become resources at the Center and for SBC stakeholders at the provincial and local levels.

A final capacity strengthening plan will be developed in consultation with NHEICC leadership.

SBC Capacity Assessments at the Provincial and Local Levels

In the fall of 2018, Breakthrough ACTION Nepal, with support from NHEICC, conducted local-level SBC capacity assessment workshops at the provincial level and with four local municipalities. These assessments followed the same participatory process as the one completed at the central level. The table below shows the number of participants from the province and local level assessment workshops.

Table 2: List of Participants in Provincial and Local Capacity Assessment Workshops

Venue	Organization	# Participants
Province	Karnali	22
Surkhet	Panchapuri urban municipality	39
	Barahatal rural municipality	27
Jumla	Chandannath urban municipality	31
	Guthichour rural municipality	32

Initial selection of participants was a challenge, given there was no clear communication or SBC for Health units at the province or local level. The central-level assessment was easier, as there was a set organizational structure, NHEICC, which serves as the communication focal point for SBC for Health. This was not so at the provincial or local level at the time of the assessments.[5]

At the local level, the health coordinator is responsible for the overall health program, including SBC. While planning for the workshops, the team identified the following people, in three municipalities, as participants at the local level:

1. Ward president or chairperson of the Health Facility Operation and Management Committee
2. Health Post In-charges;
3. Five to seven executive members of the local municipality, mandated to be from an ethnic caste, Dalit, and women; and
4. Accountant and storekeeper of the municipality.

[5] As of December 2018, the Health Promotion and Training section in the HD and the Public Health section are staffed and designated as focal SBC sections.

During the first workshop, the groups learned to exclude certain section heads of the municipality office (e.g., agriculture, livestock, education), because their unique working modalities and systems did not match the health system, thus creating confusion during small group discussions. The chief guests for the workshops' formal opening sessions were the mayors of urban municipalities, the municipality chairperson in rural municipalities, and the HD director in the province.

The technical session was initiated with a game to sensitize the participants on the meaning of SBC and health system strengthening. This game was necessary, as the health sections of the local municipalities had not done anything on SBC for Health.

Visioning Exercise

In the visioning exercise, the workshop participants were divided into three groups and asked to think about their hopes and vision for their health section and SBC after five years. The groups then were asked to develop with a vision statement. The participants generally hoped to see themselves as local leads in SBC in the next five years, as shown in the following synthesis of group statements:

Karnali Province
For the development of healthy and prosperous Karnali province, in five years the province will be a lead in social behavior change for health with resources including capacitated human resources for quality health services.

Barahatal rural municipality, Surkhet	Panchapuri urban municipality, Surkhet
In the coming five years, Barahatal wil be a Gaun health section with capacitated human resources and the physical structure to serve on SBC for Health.	*Will be serving the community SBC for Health, being resourceful and equipped in five years.*

Chandannath urban municipality, Jumla	Guthichour rural municipality, Jumla
Will be capable health section with people-friendly, capacitated human resources, equipment, and counseling materials in five years.	*Will be a center with a health environment that is physically equipped, served by capable human resources, and able to change the community with quality SBC services in five years.*

All municipalities expected to strengthen their health section and to provide SBC leadership and expertise, along with human resources, a physical facility, and counselling tools for quality health services. The Surkhet provincial HD also wants to be the leader in the province for social behavior change.

Capacity Skillsets

The 35 capacity skillsets used at the central level were adopted for provincial and local assessments through close coordination and discussion with NHEICC and members of the Operational Management team, which includes the Family Welfare Division, NHEICC, USAID, and Breakthrough ACTION Nepal. A separate advocacy domain was included at the local level, given the strong need for SBC advocacy skills. In all, 43 skillsets were identified with the addition of new advocacy related skill sets at the local level.

Small Group Discussion

As with the federal level, 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 score sheet to document scores and evidence of capacity.

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 identify a prioritized list of the skills that they believed would be most important to develop for initiation of SBC in the local municipality and province. Results of the self-assessments and discussions by the local municipality are described in the next section. The condensed scores are outlined in **Error! Reference source not found.**.

Assessment Results for the Provincial and Local Municipalities Level

Program Management (Indicators 1.1–1.2)

1.1 Program Design

There are no strategically designed SBC activities, either at the local or provincial level. Local municipalities have a health section under the Social Development Unit and led by a health coordinator.[6] This section handles the overall management of health programs. The health coordinator also is responsible for SBC issues. Regular health activities, which have been conducted for many years, are seen as low priorities that are monotonous and unresponsive to local needs. These health activities receive no local budget allocation, and the health issues must rely on activities from the Center, which have conditional budgets. Local municipalities do not yet visualize the province providing them technical support.

The DHO no longer has the jurisdiction or the authority to lead the health facilities as they did before, as authority has shifted to the municipality. The municipality health coordinators share the same background and level as the health post in-charges and therefore cannot effectively lead the municipal health section in coordination with the health posts.

Province-level participants mentioned that they developed activities based on the Nepal Demographic Health Survey, Health Management Information System data, and their review meeting feedback. Some participants mentioned that they get activities from the Center, with similar budgets as the Center, for epidemic and non-epidemic issues. The activities received are not specific to local situations.

1.2 Program Action/Workplan and Budget

All local municipalities follow the seven-step planning process (below) to select community activities:

Step 1: Receive direction and financial handover outline from the Center and province.

Step 2: Calculate resources and total budget ceiling allocation.

Step 3: Select program from the cluster level.

Step 4: Prioritize ward-level planning.

[6] Local municipalities with populations less than 25,000 do not have a dedicated health coordinator.

Step 5: Integrate budget and program planning.

Step 6: Approve budget and program from rural and urban municipality executive meetings and submit to rural and urban municipality council meetings.

Step 7: Approve budget and program from rural and urban municipality council meetings.

Program selection is based on the ward-level assembly, in which each sector (including the health post) are called to bring their proposed program for discussion. The ward assembly selects the activities for the year and submits it to the ward council, which prioritizes the activities and related budget allocations. The proposed activities then are sent to the municipal council, which can make further changes to the activities. Activities also get priority based on the local leaders' interests, so activities can change even after selection by the municipal council and even if the municipal council decision is documented in council meeting minutes. Most proposed health activities are repeated every year, with changes only to the target numbers.

The Center guides the proposed and conducted health activities, as there is no formal localized planning for health. Resources allocated from the municipality are allocated only for hiring staff or for infrastructure development and maintenance of the health service center. The Health Post does not propose activities based on the data that they collect regularly using the Health Management Information System (HMIS) 9.3 format. The HMIS 9.3 format is based on information collected by the female community health volunteer (FCHV) and services provided by health facilities. The health post submits these data to the health section of the local municipality.

SBC (Indicators 2.1–2.10)

SBC is not a priority, even in the Center-directed health activities list that is sent to the local level. SBC is a new issue for local-level participants.

2.1 SBC situation analysis

Health service centers collect data, but they never analyze it for their own local use. The data are collected and sent onwards, previously to the DHO and now to the municipal health section. SBC situation analysis has not been done.

2.2 SBC theory

There is little or no awareness about any SBC theory or model at the local levels, which lack even basic knowledge on SBC for Health. SBC is erroneously defined as dialogue with the client during service delivery. The Surkhet participants are more aware of SBC due to the Suaahara project's work in their areas. The Surkhet participants mentioned Suaahara-initated activities, such as *posilo jaulo* (nutritious porridge) and *handwashing*, as examples of SBC.

2.3 Strategy Design

None practiced.

2.4 Product Design

Most local municipalities have not produced materials on their own. They instead use materials received from the Center. The materials published locally do not follow the standard SBC materials development procedure. The locally produced materials are not pre-tested.

Panchapuri urban municipality budgeted for materials production. Their IT unit (store, health section, and chief administrative officer) developed a pamphlet and hoarding board (billboards) on breastfeeding and antenatal care. They outsourced the work to a local vendor, who then changed the message and design. The urban municipality did the final review only. Chandannath municipality produced materials on adolescent health, family planning, and diarrhea but did not follow any SBC materials development process. They instead copied the message from the materials published by the Center, changed some illustrations, and replaced the logos. Barahatal municipality published a brochure on *chaupadi* (tradition where menstruating girls and women are kept in a separate space/hut during menstruation, and similarly after delivery) and cancer, using similar procedure as those described for the other municipalities.

At the province level, there is no awareness of the standard process for SBC materials development. For materials development, the technical team members, including the director, decide together on the subject and then outsource the publication of materials. They use the message that is sent from the Center. The province keeps records of all materials received from the Center for distribution and maintains the register.

2.5 Gender Equity and Social Inclusion

The participants said that they are sensitive to gender equity and social inclusion, but they have not considered these issues, because they do not develop materials on their own for their local use.

2.6 Intervention Planning and Implementation

All local municipalities follow health activity plans sent from the Center. The Center sends the conditional activities and budget allocations. The unconditional budget sent from the Center and the Ministry of Finance is flexible and can be planned according to local needs, although the funds are mostly used for physical construction or to purchase medicine. Funds are not used for any SBC activities.

2.7 Partner Mobilization and Coordination

All organizations working in the local area directly coordinate only with the municipality office for program implementation. The wards, local health facility, and other partners are unaware of each other's activities. Organizations do not go through the ward council and municipal council for program

implementation. The municipality also does not inform the local implementers at the ward level, so the community, including the health service center, is not comprehensively aware of projects and activities at the local level. There is no forum or platform for stakeholders to share with, coordinate with, and learn from each other. The Province organizes partner review meetings, during which the implementing partners share their progress. The province also holds Provincial Health Coordination Team meetings to discuss and share with all partners. They have joint plans for field site monitoring visits with partners.

2.8 SBC Training Needs

All SBC for Health trainings are planned and directed by the Center. The province organizes the trainings according to Center directives. The Province claimed to conduct need assessments to identify training needs and plans, but they provided no support or evidence of this claim. The province does not yet have separate SBC trainings. According to them, counseling training (they define counseling and interaction with clients as SBC) is included in the FCHV and immunization training package.

2.9 Advocacy

Please refer to section: 7 Advocacy.

2.10 SBC Trends Awareness

Participants were not aware of SBC trends.

Mobile Technology (Indicators 3.1–3.4)

3.1 Mobile Technology Use

Both the local municipalities and the province are committed to use mobile apps to share health promotion messages. Many service providers have received health-related SMS from the Center, such as on Breastfeeding Day, and were excited to receive these messages on their phone. Barahatal has developed mobile apps for the local municipality that provide updates of rural municipality activities.

3.2 Message Development

Messages are not developed in any of the local areas. The Province involves “expert” agencies (i.e., local FM radio stations, journalists, media) in their message development process. They do not field test or pre-test materials. Documented evidence could not be provided to support this statement that expert agencies were involved in strategic message development. SBC materials developed through a systematic technical process by the provincial HD or the health division of the Ministry of Social Development were not presented.

3.3 Mobile Technology Tools

No tools are used.

3.4 Mobile Technology Monitoring

There is no monitoring of mobile technology.

Social and User-Generated Media (Indicators 4.1–4.5)

4.1 Social and User-generated Media Use and Strategy (4.2)

The local municipalities use their websites to update their municipal activities. The Province also has a Facebook page. The Karnali province communication policy was recently approved by the Karnali province parliament and provides the guidelines for the province to follow.

4.2 Social Media Strategy

There are no guidelines or specific social media strategies.

4.3. Social and User-Generated Message Development

Panchapuri and Barahatal of Surkhet have official Facebook pages that are not regularly updated and do not include any SBC messages.

4.4 Meaningful End-user Engagement

They do not engage their local community meaningfully. The websites of Guthichour and Chandannath are not updated because of a lack of IT personnel.

4.5 Monitoring and Evaluation of Social and User-generated Media

This is not done.

Knowledge Management, Coordination and Communications (Indicators 5.1–5.6)

5.1 Knowledge Management System

There is no knowledge management system in the local municipalities or in the province. **The province** produces their annual report and monthly reports.

5.2–5.4 Knowledge Management Coordination

The local government operation law 2074 mentions the need for coordination among all stakeholders. In Chandannath, Jumla, Reproductive Health Coordination Committee, and Data Quality Assurance committees were active before federalization but currently do not exist. There are no coordination meetings held among stakeholders in Guthichour. There are no forums or platforms for coordination amongst concerned stakeholders. Panchapuri, Surkhet has allocated an information officer for

coordinating with their stakeholders. International/Non-Government Organizations submit their monthly and yearly reports to the health section in Guthichour, Panchapuri, and Barahatal.

The Province does not yet have any mechanism to coordinate with the health sections of its municipalities. The Provincial Health Coordination Team and other committees recently were formed. This team and Provincial Health Coordination committee conducts joint monitoring visits and have a feedback mechanism through which they document their findings.

5.5–5.6 Internal and External Communications

Internet, staff memos, letters, meeting minutes, and meeting photos are used in local municipalities to communicate within the organization and with stakeholders. The province has TOR with their concerned stakeholders for roles and responsibilities. Panchapuri holds monthly and annual meetings with its stakeholders. They have an information officer in the social development section responsible for overall information of the local municipality and is a spokesperson for the local municipality. Guthichour provides postpaid phone use to all staff for internal communication.

Monitoring and Evaluation (Indicators 6.1–6.4)

6.1 Intervention monitoring

There is no specific budget to monitor health activity. This budget is included in the budget for all sector monitoring (i.e. agriculture, education, health). The local municipalities have M&E plans, but they are not adequately funded and do not include a results framework or clearly defined direction for monitoring interventions (see **Error! Reference source not found.** - 6.1–6.4).

Panchapuri has a M&E committee for monitoring all activities implemented in the local municipality. Most monitoring visits are done at the end of the fiscal year, and reports are submitted only to the finance department for financial clearance. Monitoring visits are done mostly to get leaders into the field.

The province has allocated money for monitoring but cannot use it because of a lack of a clear plan. Most of the allocated funds are frozen every year, because they are not used.

6.2 M&E-guided Program Development and Implementation

Barahatal, Panchapuri, and Guthichour had a monitoring checklist. Though municipal M&E plans exist, there is no feedback mechanism to share findings from the monitoring visits. Field visits are never used to improve the program.

6.3 Data Utilization

In practice, the health posts collect data from the community and send it to the municipal health section without analyzing or using the data for local progress updates, program adjustments, or planning. They

collect the data and send it forward as a ritual (see **Error! Reference source not found.** - 6.5-6.7). The health post or province receives activity-related targets from the Center, which are used as process indicators.

6.4 External Data Review and Use

These activities are not done locally.

Advocacy (Indicators 7.1–7.10) (see Error! Reference source not found.)

In general, the municipalities and province define their health communication health as advocacy, including health staff communication with clients. An advocacy model, agenda, or strategy is not followed. Barahatal said that they advocate against child marriage, under-age marriage, open defecation, and *chaupadi*. Panchapuri said that they advocate for the establishment of a community health unit as per community needs at different locations in the municipality. Guthichour organizes public discussions on child marriage, under-age marriage, and the caste system, which they cited as an example of advocacy.

Key Informant Interviews Insights at the Local Level

To supplement the provincial and local municipality self-assessments, representatives from different organizations were identified to participate in the key informant interviews. At the local municipality, as the health coordinator is the only person responsible for the health activities of the local municipality, it was decided to interview one health post in-charge among the health posts, along with the municipal health coordinator. Those two positions represented the health personnel.

For external interviews, one ward chairperson or Health Facility Management and Operation Committee Chairperson was chosen from among the 10–12 wards, along with the chief administrative officer and a health-sector representative from a non-governmental organization.

The following summarizes the gaps, challenges, areas of concerns, and potential solutions that these stakeholders indicated could be considered when developing provincial and local SBC capacity-strengthening plans.

- ***Technical Capacity (Workplan Development)***

  There is no understanding of SBC. Any health staff interaction with clients is considered to be SBC. The budget and activities that the health section receives from the Center is not enough. The local municipality also contributes to the budget from their local source, but these

resources are allocated to staff hiring, boundary wall construction of the health facility, and other similar projects.

Health post staff and the health coordinator received no SBC-related training. In Surkhet, the FCHVs are mobilized for some behavior change activities, such as *posilo jaulo* and handwashing.

Health posts mobilize the FCHVs for health message dissemination, but it is unclear how many discussions focus on health issues during the mothers' group meetings.

Local municipalities should be strategic in designing health programs to avoid duplication of effort by the Center. For example, the Nepal provides Rs 2,800 to women who deliver at the health service center, and Panchapuri provides Rs 2,000. This additional money could be used for social behavior change interventions. Health posts are not supported by the health section of the local municipality. When they go to the DPHO for support, they are diverted to the health section.

- ***M&E***

  The local municipality budgets for monitoring and supervision but focuses on staff attendance. There is no discussion on health issues or problems. Before the federal system, the health staff had regular review meetings, but there is no longer a budget for these meetings. As per the new structure, the health section of the local municipality has a monitoring and guidance role, whereas the health facilities are implementers. An external evaluation of the program is important to improve the internal evaluation of health.

- ***Knowledge Management***

  The staff at all levels (health section, health facility, ward) realize the need for documenting all publications, minutes, and reports for their own records and for sharing with others. However, they cite lack of space as a reason for not having a knowledge management system. All information remains with the staff responsible for the task. If that person transfers, then the organization loses all the information that person had. Different International/Non-Government Organizations in these locations do not share information or data collected from interventions with the rural or urban health section or even with the wards where they operate. All local municipalities have their own webpages. Panchapuri of Surkhet and Guthichour of Jumla have Facebook pages, but they are not used for SBC.

- ***Staff***

  Staff have not received any SBC training in recent years. There is a possibility of staff transfer at any time. The local municipality's health section has limited staff with no SBC knowledge, so they cannot support health facilities on SBC.

- ***Coordination and Internal Relations (Local-level Engagement)***

Wards can support SBC for Health by mobilizing the community, because community members believe the wards more than they believe the government, but the wards do not coordinate with the municipality's health section for SBC requirements. The ward chairperson is the chair of Health Facility Management and Operation Committee, but no issues regarding health have been raised during management committee meetings. The municipality contacts the wards only to approve policy and laws.

There is no coordination mechanism between the health section and DHOs, but the health section submits health data to the DPHO. The Health Post sends data to the health section of the local municipality. Before the federal system was implemented, this information was sent to the DPHO.

There is no formal coordination among local municipalities of the same district. Local municipalities do not coordinate with stakeholders working in the area. Barahatal of Surkhet coordinates with one organization for water and sanitation, as they have allocated budget for a matching fund.

DHOs and the provincial HD role and structure remain unclear. There is a possibility of change in the health system organogram, whereas the DPHO and DHOs will be changed to health offices. If there is strong coordination between the local municipality health section and HD, both will benefit. The HD has technical expertise, and the local municipality has updated information from and direct linkages with the health post. However, HD has not coordinated with the health section.

There is no clear and specific policy direction for the roles of the central, province health directorate, local municipality, and health facilities regarding SBC.

- ***Leadership (High-Level Advocacy)***

  In this newly changed structure, health coordinators are responsible for the overall management of the health program of the local municipality. The health post in-charge is the health coordinator in the local municipality. The local municipality's mayor or deputy mayor are elected and thus focused on development work. They consider the health section an independent body, so they do not prioritize health programs in their budgeting. In the local municipality, elected members and the chief administration officer play vital roles in decision making, so they must understand SBC to give it priority at the local level.

  Council is held twice a year during winter and summer to endorse budget items and activities. During council, the ward asks health facilities for activities, but they focus on hiring staff and physical construction. For activities, health facilities simply continue the same activities that they have been doing for years. Local leaders expect that the health facilities will address local health issues by conducting activities related to them.

Major Gaps Identified at the Local Level

After rating themselves on each capacity indicator, the participants revisited their ratings and discussed priorities for SBC capacity strengthening. The major gaps identified from the assessments are as follows:

Province-level gaps

- M&E system
- SBC strategies and guidelines
- Standardized materials and messages

Local municipality gaps

- SBC strategy and implementation guideline
- SBC work plan (how to plan SBC activities)
- Production of local SBC messages and materials based on local need
- M&E system and plan
- Data use for planning
- Coordination mechanism among concern stakeholders
- Advocacy strategy for SBC

Short- and Long-term Priorities at the Local Level

Action Planning for Implementation and Monitoring

After rating themselves on each capacity indicator, the participants revisited their ratings and discussed which ones to prioritize for capacity strengthening. These priorities are based on the vision set by the local municipality and province during assessment of the new system.

Short-term priorities include:

- **Program management** – Enhance province capacity to monitor the work of the local municipality and other SBC partners in the province. A program supervision checklist could be the first step of support for the province. Build the coordination mechanism between the local municipality and the provincial HD for regular guidance on SBC program planning and implementation.

- **SBC** – Create a staff training plan, provincial facilitator development plan, and re-orientation and update on foundational SBC skills with an emphasis on theory and data scoping for SBC program planning.

Long-term priorities include:

- **SBC strategy** – Develop an SBC strategy for use at the local level for SBC initiation, including advocacy and social media use, because the local municipality must advocate for SBC as community access to mobile apps and internet increases.
- **M&E** – Develop an M&E strategy and indicators with an implementation timeline in line with central, province, and local indicators.
- **Knowledge management** – Provide orientation and training on knowledge management approaches and tools. Support developing a systematic process for coordinating with internal and external stakeholders; capturing and documenting reports, tools, and materials; and making this information accessible to internal and external stakeholders.

Recommendations for the Local and Provincial Levels

Next steps for provincial and local levels, with support from Breakthrough ACTION, may include the following:

Local municipality

- Provide orientation on SBC for Health at the local municipality to get support for SBC initiation at the local level. Orientation participants should be the health post in-charge, ward chairpersons, executive members of the local municipality, chief administrative officers, mayors, deputy mayors, and local municipality presidents and vice presidents.
- Help design basic SBC activities planning and implementation guide for and in coordination with provincial and local stakeholders.
- Skillsets for local-level strengthening should include the following:
    - Improved communication and coordination with SBC stakeholders within the local municipality and the provincial HD
    - Improved analysis of local data for evidence-based program planning
    - Improved ability to monitor and supervise the program based on the indicators
- Strengthen the SBC supervision and monitoring system at the local level to ensure evidence-based planning of SBC activities.

Province

- Work with HD Karnali to identify SBC priorities and analyze data sources to fill gaps in knowledge and inform SBC activities throughout the province on reproductive, maternal, newborn, child, and adolescent health and nutrition, prioritizing learning areas.
- Develop capacity-strengthening activities for the health facilitator at HD Karnali so that the local municipality understands the importance of SBC and supports local program planning.
- Standardize materials and messages related to family planning, adolescent health, nutrition, and maternal, newborn, and child health for easy access and timely dissemination to the local municipality.
- Improve communication and coordination with SBC stakeholders at the provincial and local levels for planning and implementation.
- Strengthen SBC at the province level to support evidence-based planning and M&E of SBC activities.

Appendix 1: SBC Capacity Self-Assessment Scores (2018)

Domains	Aggregated score (range 1–4) based on consensus score and target					
	Federal level		Provincial level		Local level	
	Baseline	Target	Baseline	Target	Baseline	Target
Program management	2.50	3.50	3.00	3.50	2.75	3.00
Social behavior change	2.90	3.50	2.50	3.00	1.65	2.00
Mobile technology	2.25	3.00	0.25	1.00	0.56	1.00
Social and user-generated media	2.00	3.00	2.00	2.50	1.05	1.50
Knowledge management, coordination, and collaboration	3.17	3.50	3.17	3.50	2.25	3.00
Monitoring and evaluation	2.43	3.00	2.71	3.00	2.43	3.00
Advocacy			2.10	2.50	1.08	2.00

Scoring scale:
1 = Does not use any of the steps
2 = Uses 2–4 of the key steps and can clearly articulate them
3 = Uses 5–6 of the key steps and can clearly articulate them
4 = Uses 7–9 of the key steps and can clearly articulate them

Appendix 2: SBC Capacity Assessment Tool

Domain: Program Management – 1.0													
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
1.1	**Program Design**	Is NHEICC's program design, development, and improvement informed by evidence based on research, evaluation, needs assessment, and/or monitoring?	NHEICC bases their program design, development, and improvement on evidence of client and/or community needs based on research, evaluation, needs assessment, and/or monitoring.	NHEICC does not use evidence-based research, evaluation, needs assessment, or monitoring reports to inform their program design, development, and improvement.	NHEICC relies on secondary, unverified sources to inform program design. Sources are not applicable to the client and/or community relevant to the program.	NHEICC engages in evidence-based research, evaluation and/or needs assessment to inform program design, development, and improvement. However, lessons are not used consistently to improve program strategies throughout the program implementation phase.	NHEICC engages in evidence-based research, evaluation and/or needs assessment to inform program design, development, and improvement. Lessons are continuously used to improve program strategies throughout the program implementation phase.	Program surveys, landscape assessment results, health needs research results.					0.0	
1.2	**Program Planning and Monitoring**	Does NHEICC develop, implement, and monitor a costed workplan that has been developed through a participatory workplanning process?	NHEICC has a participatory project workplanning culture, and a complete, costed workplan is being implemented and monitored.	NHEICC has no participatory workplanning process in place, nor does a costed workplan exist.	NHEICC performs project workplanning independently, and a draft budget and draft workplan are in place, however the budget and workplan are not fully aligned.	NHEICC has a participatory project workplanning culture, and complete budget and workplan. The costed workplan is in place, however it is not always used to guide activities.	NHEICC has a participatory project workplanning culture, and a complete, costed workplan is being implemented and monitored.	Meeting minutes, workplans, TORs.					0.0	
								Overall Scores:						

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
2.1	**Situation Analysis**	When conducting a situation analysis, which key steps does NHEICC use?	1. Conduct a baseline and/or formative research to establish knowledge, attitudes and practices of target audience 2. Conduct a review of relevant studies. 3. Assess existing policies and programs. 4. Learn about active and available communication channels. 5. Identify partners and allies. 6. Assess organizational capacities. 7. Be sensitive to possible gender differences and make sure all viewpoints are represented. 8. Summarize the understanding of the problem into a problem statement.	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them.	We use 4-6 of the key steps and can clearly articulate them.	We use 6-8 of the key steps and can clearly articulate them.	List the number associated with the key steps: Other: Baseline Evaluation Report; Secondary analysis report; Situational Analysis report						0.0	**Evidence:** IEC/BCC Formative Research 2006 IEC/BCC Formative Research 2012 Health Communication Policy Review and use of DHS data Review and use of HMIS data NHEICC has done formative and desk review research Popular communication channels identified by using the 2006 and DHS **Gaps:** Research does not really address social aspects or norms Partners are identified but not systematically

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
2.2	**SBC Theory**	When designing an SBC intervention, how does NHEICC apply a behavior change model/theory and theoretical framework?	N/A	We do not use theory to guide our interventions.	We use a theory to guide our intervention design, but it is not a behavior change theory.	We use a few theoretical constructs from behavior change theories to guide our intervention design.	We use behavior change theory or theories to guide our intervention design.	List the SBC theory (ies): Other: Communication Strategy; Workplans; Interviews with staff						0.0	**Evidence:** Staff trained on SBCC P-Process (SBCC Model) KAIPA Model (Knowledge, Attitude, Interest, Practice, Advocacy) **Gaps:** Knowledge and use of models but not so much theory Senior staff are more aware of theory. Entry and mid-level staff could use more training Training is usually through partners/projects and not consistent or sustainable
2.3	**SBC Strategy Design**	When designing an SBC strategy, which key elements does NHEICC include?	1. Communication objectives 2. Audience segmentation 3. Program approaches and positioning 4. Communication channels 5. Structural and communication interventions 6. Implementation plan and timeline 7. Monitoring and evaluation plan 8. Dissemination plan	We do not use any of the key elements.	We use 2-4 of the key elements but cannot clearly articulate them.	We use 5-6 of the key elements and can clearly articulate them.	We use 7-8 of the key elements and can clearly articulate them.	List the number associated with the key elements: Example Documents: Communication Strategy; M&E plan; Dissemination Plan; Workplan						0.0	**Capacity:** National Health Communication Policy, 2012 National Communication Strategy for Adolescent Sexual and - Reproductive Health Nepal (2012 – 2016) National Communication Strategy for Maternal, Newborn and Child Health (2012 – 2016) Most staff follow the strategies, especially during planning Draft family planning strategy NCD strategy in process Activities are set based on target groups and timelines Technical working

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
															groups are functional Activities and budget are reflected in "red book" Solid foundation to strengthen coordination between divisions and external partners **Gaps:** Finalize FP strategy Finalize NCD strategy
2.4	**Product Design**	When designing communication products/materials, which key steps does NHEICC use? OR When reviewing new communication products/materials, which key steps does NHEICC use?	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-	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them.	We use 5-6 of the key steps and can clearly articulate them.	We use 7-8 of the key steps and can clearly articulate them.	List the number associated with the key steps: Other: Communication Strategy; Pretest Reports; Example of Communication Products						0.0	

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
			makers. 6. Share results of pretest with the creative team and stakeholders. 7. Revise materials based on feedback. 8. Re-test materials to make sure revisions resolve key issues.												
2.5	**Product/Material Design and Gender and Social Inclusion**	When designing SBC interventions and products/materials, how does NHEICC include gender and social inclusion?	N/A	We do not include or consider the impact the interventions and products/materials may have on gender issues.	We include or consider gender when developing interventions and products/materials so not to reinforce gender stereotypes.	We include or consider the different needs of men and women when developing interventions and products/materials and design them accordingly.	We include or consider the different needs of men and women when developing interventions and products/materials in order to change harmful gender norms specific to country context.	Creative Brief; Communication Strategy						0.0	**Evidence:** Brochure on Health Effects 2. Gender based violence Safe Motherhood radio and TV program Gender friend IEC/BCC materials Gender mainstreaming National Health Policy, 1991 National Health Communication Policy, 2012 MNCH Communication Strategy, 2012 ASRH Communication Strategy, 2012 Evidence: Meet with related sections to identify topic Brief prepared by concerned sections Content developed and drafted and shared for review Content shared with IEC/BCC technical

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
															committee for finalization and approval Pre-test materials in field with target audience before finalized Revisions of materials based on feedback from pretesting Final review of content/materials by technical committee
2.6	**Intervention Planning and Implementation**	How are SBC interventions planned and implemented within NHEICC?	N/A	We do not have an implementation plan. Most organizational activities are decided on short notice or reactive to external demands.	We develop a rough implementation plan for some intervention areas. The plans are developed to meet funders' requirements.	We develop an implementation plan for each intervention area. The individual plans do not always link to the SBC strategy.	We develop an implementation plan for all intervention areas. The plan is reviewed and adjusted on a routine basis. The individual plans link to a larger strategic communication plan and opportunities are identified to a link.							0.0	**Evidence:** Sections are responsible for making implementation plan before approval of program Approved annual programs on a quarterly basis Annual work plan and budget broken down by quarters **Gaps:** Slow release of district budget Little flexibility in budget line items, especially for districts

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
2.7	**Partner Mobilization and Coordination**	When implementing your interventions, which step does NHEICC follow when working with partner organizations?	1. Make sure each partner understands their role. 2. Identify a program lead whose responsibility is to facilitate the process. 3. Identify partner needs and conduct trainings as necessary. 4. Keep partners updated. 5. Share credit for good work. 6. Monitor activities. 7. Prepare for future evaluation activities.	We do not use any of the key steps.	We use 2-4 of the key steps but cannot clearly articulate them.	We use 4-5 of the key steps but can clearly articulate them.	We use 5-7 of the key steps and can clearly articulate them.	List the number associated with the key steps: Other: Training reports; Progress reports						0.0	**Evidence:** Meeting minutes MOUs Joint Action Plans
2.8	**Training Needs**	When implementing an SBC Strategy, how does NHEICC identify necessary training needs of self and partners?	N/A	We assume our staff and partners are prepared and able to implement the plan.	We identify what the training needs are to implement the communication plan but do not provide a clear plan for how these needs will be met.	We identify what the training needs will be to implement the plan and develop a plan on how these needs will be met.	We identify what the training needs will be to implement the plan and develop a plan on how these needs will be met. We follow up to make sure the necessary training takes place and staff and partners have the capacity to implement the strategy.	Pretest reports; Survey reports						0.0	**Evidence:** Based on health issues of present day IEC/BCC review meetings for focal persons – DHO/PHO Progress more than 90% Success of the program conducted **Gaps:** Training is conducted but gaps in how to apply skills

Domain: Social and Behavior Change – 2.0															
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Individual Score**	**Consensus Score**	**Average Score**	**Notes (includes evidence of capacity/gaps/action identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**				
2.9	**Advocacy**	How does NHEICC use or plan to use advocacy in your interventions?	N/A	We do not use or do not plan to use advocacy as part of our interventions.	We plan to use advocacy as part of our interventions but are not currently using it.	We are currently using advocacy in our interventions, but it does not follow a strategic approach.	We are currently using advocacy in our interventions. Our advocacy efforts follow a strategic approach that works to change norms and links to a larger SBC effort.	Advocacy Strategy; Advocacy Action Plan; Workplan						0.0	
2.10	**SBC Trends**	When designing an SBC intervention, does NHEICC look at new and/or emerging trends in behavioral science such as Design Thinking, Human Centered Design, and/or Behavioral Economics?	N/A	We do not know about other behavioral approaches.	We know about new and emerging behavioral approaches but do not use them in our design or feel confident to apply them in our work.	We know about new and emerging behavioral approaches and use them when developing interventions and products/materials but are not sure we are applying them correctly.	We know about new and emerging behavioral approaches and are confident in using/applying them when developing interventions and products/materials.	List the approaches used as outlined in the key elements: Other: Training reports; Training plan						0.0	
								Overall Scores:							

Domain: Mobile Technology – 3.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
3.1	**Mobile Voice and Txt Messaging**	How does NHEICC use/plan to use mobile voice technology or text messaging in your interventions? Mobile voice technology may include: Phone calls, automated voice messages, integrated voice response and telephone hotlines Mobile text messaging includes: One-way push messaging, interactive messaging (iSMS), including use of short codes, opt-ins, etc.	1. Identify most accessible mobile technologies by audience (e.g. smart phone, feature phone, simple phone). 2. Determine number of phones/internet access per household (e.g. by gender distribution or age). 3. Conduct baseline research related to use of and access to related technologies and what may be purchased in-country.	We do not use or do not plan to use any mobile voice technology or text messaging.	We plan to use mobile voice technology or text messaging but are not currently using it.	We are currently using at least one form of mobile voice technology or text messaging.	We use multiple mobile voice technology and text messaging through an integrated approach with existing intervention activities.	List examples of voice technology and text messaging: Other: Communication Strategy; Media plan, MOU with local mobile network operator or data host						
If NHEICC does not use or plan to use mobile voice or text messaging, skip to the next section														

Domain: Mobile Technology – 3.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
3.2	**Mobile Technology Message Development**	When developing messages for mobile Behavior change communication (mBCC), which key elements does NHEICC use?	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. 9. Include local languages and language options where possible.	We do not use any key elements.	We use 2-3 key elements but cannot clearly articulate them.	We use 3-4 key elements and can clearly articulate them.	We use 4-5 key elements and can clearly articulate them.	List the number associated with key elements:						

Domain: Mobile Technology – 3.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
3.3	**Mobile Technology Tools**	When identifying technology and tools for mBCC, which key elements does NHEICC use?	1. Identify which type of information is most relevant. 2. Determine which format is best for the program. 3. Consider the capacity of the format. 4. Consider the implications of the format. 5. Identify which approach is most appropriate. 6. Determine the "effective frequency" needed to reach the program goal. 7. Employ multiple channels of communication. 8. Determine which platform and application will be most useful. 9. Understand the organizational capacity in relationship to the tools and technology.	We do not use any key elements.	We use 2-5 elements but cannot clearly articulate them.	We use 5-7 key elements and can clearly articulate them.	We use 7-9 key elements and can clearly articulate them.	List the number associated with the key elements:						

Domain: Mobile Technology – 3.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
	3.4	When implementing mBCC interventions, how does NHEICC monitor the intervention?	N/A	We do not monitor mBCC interventions.	We establish indicators and check them at the end of the intervention.	We establish indicators and check them at mid-term and at the end of the intervention.	We routinely monitor that ICTs are functioning properly, indicators reflect program objectives, and program is adjusted throughout to make sure objectives are met.	PMP; Workplan, Data collected from dashboard of mBCC intervention						
								Overall Scores:						

Domain: Social and User-Generated Media – 4.0														
We	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
4.1	**Multimedia, Web and Social Media**	How does NHEICC integrate the use of consumer multimedia?	Multimedia electronics may include: 1. Digital cameras 2. Voice recorders 3. Smart phones Web tools may include: 4. Website 5. Online databases 6. eLearning Social media tools may include: 7. Facebook 8. Twitter 9. LinkedIn 10. Google+ 11. Pinterest 12. YouTube/Vimeo/ DailyMotion/MetaCafe (Video-on-demand) 13. Yammer 14. Flickr/Picaso/Instagram Vine (photo and micro-video hosting and sharing) 15. Wikipedia/Quora (Knowledge sharing) 16. Slideshare/Prezi (online presentation sharing) 17. Sound Cloud (online audio sharing) 18. Non-US Based Social Media Network	We do not use nor do not plan to use multimedia tools.	We plan to use multimedia tools but are not currently using them.	We are currently using at least one multimedia tool, but they are not linked to the overall strategic communication plan.	We use one or more multimedia tools through an integrated approach with the overall strategic communication plan.	List the number associated with the multimedia tools:						
4.2	**Social and User Generated Strategy Design**	What type of strategic process does NHEICC use to guide social and user generated media?	N/A	We use social and user-generated media, but we do not have a strategy.	We use social and user-generated media and are in the process of creating a social and user-generated media strategy.	We have a social and user-generated strategy, but it is not well integrated into current intervention areas.	We have an integrated social and user-generated media strategy that is integrated into intervention goals as well as their communication strategy. The strategy is revisited on a continuous basis to ensure the social and user-generated media is working.							

Domain: Social and User-Generated Media – 4.0														
We	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**1**	**2**	**3**			
4.3	**Social and User Generated Message Development**	When developing messages for social and user generated media, which key elements does NHEICC use?	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. 10. Identify a facilitator of content.	We do not use key elements.	We use 2-4 key elements but cannot clearly articulate them.	We use 5-7 elements and can clearly articulate them.	We use 8-10 elements and can clearly articulate them.	List the number associated with the key elements:						
4.4	**Participant Engagement and Social Media**	How does NHEICC engage audiences on social and user generated media?	N/A	We do not engage audiences on social media rather we just push information out.	We push information both from internal and other social media sources (re-tweet, social share, etc.)	We both respond to relevant topic areas in the social media world as well as push out information from internal and other social media sources (re-tweet, social share, etc.).	We structure our content to respond to the trends and popular content on social media as well as push out content from both internal and other social media sources (re-tweet, social share, etc.) that is engaging to target audiences.							
4.5	**Monitoring and Evaluation and Social and User Generated Media**	How does NHEICC monitor and evaluate its social and user generated media presence?	N/A	We do not use analytics or other measurement tools to monitor its social media presence.	We use free or low-cost analytic tools and analyze further in spreadsheets (e.g. Google Analytics, Hootsuite, Facebook, Insights).	We use professional social media management/metric tools to collect data (e.g. Radian 6).	We use professional social media management/metrics tools to collect data and train staff on how to use and/or bring in expert consultants to assist.							
								Overall Scores:						

Domain: Knowledge Management, Coordination and Collaboration - 5.0														
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
5.1	**Knowledge Management**	Does NHEICC systematically capture, package, and share knowledge to foster learning and expand knowledge?	NHEICC has a process for capturing, packaging, and sharing knowledge. The process is used by the relevant staff, and NHEICC uses this information to improve the implementation processes of its projects/programs.	NHEICC has no systematic process for capturing, packaging, and sharing knowledge.	NHEICC has a process for capturing, packaging, and sharing knowledge, but it may be incomplete and lacks some programs or elements, for example, it does not elaborate on how knowledge is shared. The system is not used by the relevant staff.	NHEICC has a process for capturing, packaging, and sharing knowledge, but it is not always used by the relevant staff (employees do not always capture, package, and share knowledge using this process). NHEICC does not frequently assess this process nor does it use this information to improve the implementation process of its projects or programs.	NHEICC has a process for capturing, packaging, and sharing knowledge, that is always used by the relevant staff. NHEICC frequently assesses this process and also uses this information from this process to improve the implementation of its projects/programs.	Website, success stories, social media.					0.0	**Evidence:** NHEICC conducts review meeting at central level as well as regional level NHEICC conducts SBCC/BCC orientation at regional and district level Trainings and workshops at district level Monthly regional meetings Quarterly meetings at central level Informal sharing Website of NHEICC **Gaps:** Meetings are the only source to get the information. There is no other system for exchange and sharing or resources or lessons learned
5.2	**Coordination Platforms**	Are there coordination platforms with NHEICC and its different partners; is there a feedback mechanism between NHEICC and its partners?	NHEICC has coordination platforms with its partners. They plan and meet regularly and are guided by clear terms of reference (TOR). A follow-up mechanism for feedback on coordination issues exists.	No coordination platforms between NHEICC and its partners are established.	NHEICC has coordination platforms with its partners and a TOR is drafted but they do not have meetings.	NHEICC has coordination platforms with its partners and meetings are held regularly as per the TOR. However, there is no feedback mechanism in place.	NHEICC has coordination platforms with its partners and meetings are held regularly as per the TOR. Coordination challenges are identified regularly, and a mechanism is in place for feedback.	List of coordination platforms established; list of members/ participants in those platforms; draft or final TOR for the forums; agenda and minutes of meetings; reports of issues addressed or feedback; reports or minutes initiating or developing TOR; minutes of joint planning/action and technical working groups.					0.0	

Domain: Knowledge Management, Coordination and Collaboration - 5.0														
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
5.3	**External Coordination**	How does NHEICC work with external staff or programs at the national and district level?	N/A	NHEICC works on its own. NHEICC does not know who else is doing similar, complementary or overlapping work in its geographical area(s).	NHEICC is aware of other organizations doing similar, complementary or overlapping work in its geographical area(s). NHEICC occasionally meets with some of these organizations to discuss opportunities for collaboration.	NHEICC is familiar with other organizations that are doing similar, complementary or overlapping work in its geographical area(s). NHEICC consults with these organizations to learn about them and better support them.	NHEICC consults frequently with organizations that are doing similar, complementary or overlapping work in its geographical area(s) in order to look for synergies, fill gaps and avoid duplication of efforts.							
5.4	**Coordination Roles**	Does NHEICC have a documented coordination and facilitation mandate?	NHEICC exercises its mandated coordination and facilitation roles and interacts with other stakeholders to deliver services.	NHEICC does not have a documented coordination or facilitation role.	NHEICC's coordination and facilitation role is known but not documented.	NHEICC's coordination and facilitation role is clear and documented but it does not interact with other stakeholders to deliver services.	NHEICC has a clear documented coordination or facilitation role. It exercises this roles and interacts with other stakeholders to deliver services.	NHEICC's coordination mandate document; policy documents; report/ minutes of coordination meetings; strategic/operational plans showing activities in line with mandate; partner meetings attendance list.					0.0	

Domain: Knowledge Management, Coordination and Collaboration - 5.0														
N0.	**Sub-Domain**	**Key Question**	**Key Steps or Elements**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
5.5	**Internal Communications**	Does NHEICC have a formal mechanism/structure for internal communications?	NHEICC has a formal mechanism/ operational structure for facilitating internal communications between staff and management, as well as interdepartmental communications. It is known by all relevant staff and used. It includes things such as bulletin boards, intranet, and feedback mechanisms.	NHEICC does not have a formal mechanism/structure for internal communications.	NHEICC has informal and unstructured mechanism/structure for internal communications.	NHEICC has a formal mechanism/ infrastructure for facilitating internal communications with relevant stakeholders. It is known by all staff but is not always used.	NHEICC has an operational, formal mechanism/structure for facilitating internal communications between staff and management and between departments, including a feedback mechanism. It is known by all staff and is consistently used.	Newsletters; success stories; staff meeting minutes; intranet.					0.0	**Evidence:** Regular staff meetings Information is shared through Email District to Central communication – Email or faxing of reports and information Use of SMS to provide information to district level Pilot use of Facebook for sharing of reports but this did not work District reports are entered into a database that can be accessed by staff **Gaps:** Staff are not required to share with other sections There is an emphasis on meetings as the sole mechanism for sharing information No Intra-net or shared drive File stored on personal computers
5.6	**External Communications**	Does NHEICC have a formal structure/mechanism for external communications?	NHEICC has a formal mechanism/structure for facilitating external communications with relevant stakeholders. It is known by all staff and used. It includes audience analysis matrices, messaging, and website(s).	NHEICC does not have a formal mechanism/structure for external communications.	NHEICC either has informal and unstructured mechanisms for external communications or a formal external communications mechanism/structure that is not operational.	NHEICC has a formal mechanism/ structure for enhancing external communications with relevant stakeholders. It is known by all staff but is not always used.	NHEICC has an operational formal mechanism/structure for facilitating external communications with relevant stakeholders. It is known by all staff and is consistently used.	Websites; newsletters; other products clearly geared to external stakeholders.					0.0	**Evidence:** Meetings (Technical Working Group) Consultative meetings and sharing of minutes Health Communication Policy Coordination meetings with external agencies Meetings are schedule with partners and TWG according to need There is an easy process to engage NHEICC – Come with letter, Assigned to section chief, Meeting between partner and NHEICC

Domain: Knowledge Management, Coordination and Collaboration - 5.0														
N0.	Sub-Domain	Key Question	Key Steps or Elements	Stages of Development				Means of Verification	Group Scores			Consensus	Average Score	Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)
				Stage 1	Stage 2	Stage 3	Stage 4		A	B	C			
														Gaps: How do we "open the door" to external partners? We are a member of one or more networks. Where and who are our partners and what are they doing? **Action:** Develop a plan for external partner engagement – How do we open our door and facilitate coordination?
								Overall Scores:						

Domain: Monitoring and Evaluation - 6.0														
N0.	Sub-Domain	Key Question	Key Elements or Steps	Stages of Development				Means of Verification	Group Scores			Consensus	Average Score	Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)Notes
				Stage 1	Stage 2	Stage 3	Stage 4		A	B	C			
6.1.1	**Monitoring and Evaluation Planning**	Does NHEICC have the relevant operational results frameworks, such as an M&E strategy, M&E plan, and other key documents?	NHEICC has the relevant results frameworks available and are applied by the relevant staff to guide the planning and measurement of results (documents include quarterly or annual workplans, budgets, project Monitoring & Evaluation (M&E) plans, M&E strategy or framework, Project Managing Plans (PMPs). The M&E function in NHEICC is supported by staff with relevant competencies.	NHEICC does not have the relevant results frameworks, and lacks the plans necessary to guide its work.	NHEICC has the relevant results framework. An M&E strategy exists but it is incomplete (it lacks key elements).	NHEICC has the relevant results framework in place. It is only partially utilized to inform the measurement of results, using only some elements such as the M&E plan, workplan, or PMP.	NHEICC has the relevant results frameworks present and are applied by the relevant staff to guide the planning and measurement of results.	M&E strategic documents/framework; M&E progress reports on key result areas; PMP status reports; updated workplans status.					0.0	

Domain: Monitoring and Evaluation - 6.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)Notes**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
6.1.2	**Monitoring and Evaluation Planning (Budget)**	Does NHEICC have an annual M&E budget?	N/A	NHEICC does not have an annual M&E budget in place.	NHEICC has an annual M&E budget but it is not sufficient to meet all M&E needs. For example, the budget cannot meet all costs including supportive visits, documentation of lessons, evaluations, assessments, and other activities.	NHEICC has an annual M&E budget but it is not fully utilized to meet planned M&E activities.	NHEICC has an annual M&E budget, and utilizes it to implement planned M&E activities.	Annual M&E budget for project/organization/institution; finance report indicating M&E activities/budget; M&E workplan.					0.0	**Evidence:** Annual M&E Plan is in place Annual work plan Supervision checklist developed. Supervision and monitoring at Central, RHD, RHTC, DPHO/DHO) - Relevant feedback is incorporated after sharing Monthly reports Research on smoking and other risk behaviors (Solid Nepal, Public Private Partnership) NDHS report survey - collaboration with population section of MoHP Public Opinion Poll and Compliance Survey was conducted by NHEICC in collaboration with The Union
6.1.3	**Monitoring and Evaluation Planning (Routine Monitoring)**	How does NHEICC plan for routine monitoring and evaluation of interventions?	1. Refine intervention objectives 2. Identify key performance indicators 3. Identify where, when and by whom data will be collected	We do not have a monitoring and evaluation plan.	We have some indicators but no clear monitoring and evaluation plan to determine the success of interventions.	We develop a monitoring and evaluation plan for each intervention during strategy design. Indicators are developed based on what the funder wants to know. Once developed, NHEICC does not review or adjust the plan.	We develop an M&E plan for all interventions during strategy design. The plan specifies who collects data, when they collect data and where data comes from. Indicators are developed and clear and the plan is reviewed and adjusted on a routine basis. We use lessons learned from the monitoring activities to make	List the number associated with the key steps: Other: M&E Workplan; M&E Reports; Project Reports; log frame; indicator tracking table or dashboard					0.0	

Domain: Monitoring and Evaluation - 6.0														
N0.	Sub-Domain	Key Question	Key Elements or Steps	Stages of Development				Means of Verification	Group Scores			Consensus	Average Score	Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)Notes
				Stage 1	Stage 2	Stage 3	Stage 4		A	B	C			
							mid-course adjustments.							
6.2	**Monitoring**	Does NHEICC have and implement a process for monitoring implementation and using monitoring information for internal and external program review?	NHEICC tracks the implementation process and progress toward program objectives. NHEICC uses monitoring data to track and revise activities. NHEICC conducts external review of monitoring data to compare program progress against external standards.	NHEICC does not have a program monitoring mechanism in place or perform internal or external program reviews.	NHEICC does not have formal program monitoring mechanisms in place, but does perform occasional internal and external reviews.	NHEICC has internal and external monitoring mechanisms in place, but findings are not used to inform program development and implementation.	NHEICC has program monitoring mechanisms in place for both internal and external reviews, and findings are used to improve program development or implementation.							

Domain: Monitoring and Evaluation - 6.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)Notes**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
6.3.1	**Data Utilization (Key Indicators)**	How does NHEICC use indicator data?	1. Key indicators are linked to each strategic objective. 2. Changes (or lack of changes) in key indicators are used to inform workplans. 3. Indicator data is used to set benchmarks and targets. 4. Indicator data is used to assess progress toward benchmarks and targets.	NHEICC does not use indicator data to inform programmatic decisions.	NHEICC does one of these things with indicator data.	NHEICC does 2-3 of these things with indicator data.	NHEICC does all four of these things with indicator data.							
6.3.2	**Data Utilization (Coordinated Analysis)**	How does NHEICC engage with partners and stakeholders to review data and analyze results?	NHEICC analyzes data about key indicators together with stakeholders and partners	NHEICC does not review data and analyze results.	NHEICC reviews data and analyzes results based on internal/institutional understanding of the program.	NHEICC reviews data and analyzes results with some of the key stakeholders based on informal conversations and meetings.	NHEICC reviews data and analyzes results with a group of program partners, decision-makers, stakeholders, and technical experts. Stakeholders are involved at all levels.							

Domain: Monitoring and Evaluation - 6.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Consensus**	**Average Score**	**Notes (includes evidence of capacity/gaps/actions identified during 2014 assessment)Notes**
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
6.4	**Program Evaluation**	How does NHEICC plan to evaluate the implementation and impact of its intervention?	1. Refine intervention objectives. 2. Allocate resources to ensure evaluation data is collected as planned. 3. Synthesize data for intended audience and circulate findings.	We only evaluate programs or campaigns for which we receive donor funding and that require evaluation.	We collect some data (e.g. baseline or endline) but not enough to assess the implementation or impact of our interventions.	We collect baseline data and then periodically compare results to this baseline to determine process towards the desired result.	We collect comprehensive baseline data and then periodically compare results to this baseline to determine progress towards the desired result. Endline data is compared to the baseline. Information and lessons learned are disseminated and used to influence future programming both internally and with other stakeholders.	Evaluation reports, fact sheets, lessons learned documents					0.0	
								Overall Scores:						

Domain: Advocacy - 7.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Concensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
7.1	**Advocacy**	How does your organization use or plan to use advocacy in your interventions?	N/A	We do not use or do not plan to use advocacy as part of our interventions.	We plan to use advocacy as part of our interventions but are not currently using it.	We are currently using advocacy in our interventions but it does not follow a strategic approach.	We are currently using advocacy in our interventions. Our advocacy efforts follow a strategic approach that works to change norms and links to a larger SBC effort.	Advocacy Strategy; Advocacy Action Plan; Workplan					0.0	
If the organization agrees that answer to the question above (7.1) is stage 1 or 2, and your organization does not currently do advocacy, skip to the next module.														
7.2	**Advocacy Models**	How does your organization use models when designing an advocacy strategy?	N/A	We do not use a model when designing an advocacy strategy	We follow a loosely defined process when designing an advocacy strategy but it does not include a model.	We follow a loosely defined process that includes an advocacy model to guide our advocacy strategy.	We follow a process that includes an advocacy model. The model includes the key constructs the intervention needs to address.						0.0	
7.3	**Advocacy Agenda**	When engaging in advocacy efforts, how does our organization set the advocacy agenda?	N/A	We set our advocacy agenda based on donor demands or project mandates.	We set our advocacy agenda based on internal/own institutional understanding of local priorities.	We set our advocacy agenda based consensus with counterparts.	We set our advocacy agenda based on evidence and a thorough understanding of health communication policies, the current health status of the population and geographical variations. We have broad buy-in from counterparts and colleagues.	Research Reports; Situational Analysis Reports; Meeting Reports					0.0	
7.4	**Advocacy Strategy Design**	When engaging in advocacy efforts, how does your organization develop an advocacy strategy?	N/A	We do not have an advocacy strategy.	We develop a rough advocacy approach for some intervention areas, but most advocacy activities are decided on short notice or reactive to external demands.	We develop a formal strategy or approach for intervention area, but they are inconsistent in defining the elements of an advocacy strategy and not always linked to the larger advocacy plan.	We develop a formal strategy or approach for each intervention area. The individual plans link to a larger strategic advocacy plan and opportunities are identified to link. The formal advocacy strategy is shared with stakeholders as part of the coalition process and the plan is reviewed and						0.0	

Domain: Advocacy - 7.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Concensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
							adjusted on a routine basis.							
7.5	**Program Decisions**	When engaging in advocacy efforts, which key elements does your organization use when making decisions?	1. Establishes a broad goal that identifies what the organization wants to achieve over the long term. 2. Identifies measurable steps that can be accomplished within 12 months. 3. Establishes objectives that are SMART. 4. Identifies decision-makers who can take specific action towards objectives. 5. Identifies and builds the capacity of champions.	We do no use any key elements.	We use 2-3 key element but cannot clearly articulate them.	We use 3-4 key elements and can clearly articulate them.	We use 4-5 key elements and can clearly articulate them.	List the number associated with the key elements:					0.0	
7.6	**Advocacy Tools**	When implementing an advocacy approach or strategy, how does your organization use or develop policy briefs, case studies, or other documents?	N/A	We do not use or develop policy briefs, case studies or other documents.	We develop policy briefs, case studies, or other documents using data on hand.	We conduct a search for the best evidence to inform development of policy briefs, case studies or other documents.	We develop evidence-based policy briefs, case studies, or other documents and has a dissemination strategy for advocacy materials.						0.0	
7.7	**Strategic Choices**	When designing an advocacy approach or strategy, which key elements does your organization use to identify the audience and develop messages?	1. Identifies the intended audience (s). 2. Explores the audience's readiness on the issue. 3. Identifies the audience's core concerns. 4. Illustrates the theme that will guide messaging. 5. Identifies key points to make with each identified audience. 6. Identifies	We do not use any key elements.	We use 2-4 key elements but cannot clearly articulate them.	We use 4-5 key elements and can clearly articulate them.	We use 5-6 key elements and can clearly articulate them.	List the number associated with the key elements:					0.0	

Domain: Advocacy - 7.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Concensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
			messengers who will best connect with the audience.											
7.8	**Communication Activities**	When designing an advocacy strategy, which key elements does your organization use for implementing advocacy activities?	1. Develop a detailed activity plan with outputs and outcomes to monitor progress. 2. Develop a line item budget. 3. Develop, share and follow a management plan that includes partner roles and responsibilities that make sure all involved area aware of what is expected of them. 4. Prepare print or electronic materials highlighting key facts and information. 5. Brief champions or messengers (and film or record if appropriate.) 6. Identify proper channels and prepare tactics, such as events, media appearances, campaign, trainings, field visits, etc. 7. Mobilize press and prepare press releases. 8. Conduct follow-up with key stakeholders.	We do not use the key elements.	We use 2-4 key elements but cannot clearly articulate them.	We use 4-6 key elements and can clearly articulate them.	We use 6-8 key elements and can clearly articulate them.	List the number associated with the key elements:					0.0	

Domain: Advocacy - 7.0														
N0.	**Sub-Domain**	**Key Question**	**Key Elements or Steps**	**Stages of Development**				**Means of Verification**	**Group Scores**			**Concensus**	**Average Score**	Notes
				Stage 1	**Stage 2**	**Stage 3**	**Stage 4**		**A**	**B**	**C**			
7.9	**Measurement of Success**	When engaging in advocacy efforts, how does your organization measure and record outputs and outcomes of advocacy activities.	N/A	We do not record outputs and outcomes of advocacy activities.	We record outputs of advocacy activities.	We record both outputs and outcomes of advocacy activities but do not link them back to advocacy objectives.	We record both outputs and outcomes of advocacy activities and use them to adjust advocacy efforts based on set objectives. Successes and lessons learned are shared.						0.0	
7.10	**Relevant Staff**	Does the organization have a relevant staff with competencies in advocacy?	The organization has relevant staff with competencies in advocacy programming who are assigned advocacy roles and responsibilities.	The organization does not have advocacy staff or staff who are assigned advocacy responsibilities.	The organization has advocacy staff or staff who are assigned advocacy roles and responsibilities, but these staff do not have the relevant competencies.	The organization has advocacy staff or staff who are assigned advocacy responsibilities. These staff have the relevant competencies, and have clearly assigned responsibilities; however, they do not always perform their advocacy function as stated in their roles.	The organization has advocacy staff or staff who are assigned advocacy responsibilities. These staff have the relevant competencies, have clearly assigned responsibilities, and perform their advocacy functions as stated in their roles.	Staff profiles; organogram; Job Descriptions, training and mentorship reports; training manuals or guides developed by the organization staff.					0.0	
								Overall Scores:						

Appendix 3: Interview Guidelines for Internal Use

Key informant's professional title:
Organization:
Key informant interview number:
Years of experience in SBC:

QUESTIONS

Introduction

The NHEICC has years of experience and expertise in Social and Behavior Change (SBC). An assessment was done in 2014, and this interview process seeks to build on the initial assessment and gain insights into NHEICC's current and future directions (understanding that the system is still in a transitional phase). I would like to start by asking you a few questions.

Technical Capacity

1. According to your experience, briefly tell me what is/was the best SBC campaign in the country in terms of technical accuracy and creative execution?
    a. What are/were the positive features in this campaign?
    b. What are/were the negative features in this campaign?

Organizational Structure and Capacity

2. What are the mandate and role of the NHEICC under the federal system? Have they changed? If so, how? Are the existing policies (like the 2012 Communication Policy) and strategies still active?

3. How has the structure of the NHEICC changed at the federal, provincial, and local levels under the federal system? What structural changes are still forthcoming?

4. Does NHEICC have adequate staff with the right expertise?
    a. Are staff trained in SBC?
    b. What were the most recent SBC trainings that any staff member received since 2014? When did they complete these trainings?

5. What other trainings do you think the staff require in SBC to effectively serve NHEICC's new role under the Federal System?

6. What are the technical factors that help NHEICC to do their work in health promotion and communication? What are the technical factors that make their work difficult?
    c. Probe: Find out what the external factors are.

d. Probe: Find out what the internal factors are.

7. Moving forward under the federal system, what has changed in the following systems (as relevant to each key informant's professional roles):
    e. Planning
    f. Human Resource Management
    g. Quality Assurance
    h. Financial Management
    i. Revenue Generation
    j. Supply Management
    k. Monitoring and Evaluation
        i. Information Management: Data Collection
        ii. Information Management: Use of Data

Leadership

8. What could current leadership members (i.e., director/unit heads) do more? What should they do less?

9. Have the leaders of NHEICC undergone any leadership training? If so, please explain the type of training and level of staff that participated.

10. How clear is the strategic direction of the organization?

11. Where is there room for improvement with the leadership of NHEICC?

12. What is NHEICC's plan to ensure trained and highly skilled remain with the organization?

Coordination and Collaboration

13. Is coordination among SBC stakeholders important for NHEICC? If so, why?

14. How has NHEICC ensured there is coordination among SBC players within the health system at the federal level? What is working in the coordination and what is not?

15. What is NHEICC's role and responsibilities when it comes to SBC training, planning, budgeting, implementation, and monitoring at the provincial and local levels? How does the system of sending technical guidelines work or not work?

16. What is NHEICC's role as part of operational management? Why is this partnership/platform important?

17. What are the respective roles, functions, and deliverables of the following government bodies related to SBC:

    a. Child health, family health, and other divisions under MOHP in the federal system
    b. NHEICC
    c. National Health Training Center
    d. Province level
    e. District level

f. Local municipality level
g. Ward level

18. What should coordination ideally look like under the new federal system? What should be NHEICC's role in coordinating with other government bodies or levels? Probe: Elaborate on the following relationships if necessary:
    h. NHEICC and other divisions under MOHP?
    i. NHEICC and the National Health Training Center?
    j. NHEICC and the provincial Level?
    k. NHEICC and the district level?
    l. NHEICC and the local municipality level?
    m. NHEICC and the ward level?

19. What are the current challenges related to coordination across theses bodies? How have challenges to coordination changed or how will they change under the new Federal Health System?

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

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

Knowledge Management

22. Does NHEICC have a system in place to facilitate the generation, learning, sharing, and use of relevant knowledge by staff within the organization?
23. Does NHEICC have a repository and system to capture, document, and disseminate knowledge? Probe: Ask for examples.
24. How does NHEICC view and support learning for program improvement, organizational learning, and sharing with stakeholders?

Advocacy

25. How do you think the MOHP understands or values SBC?
26. How has NHEICC been able to advocate for SBC within the MOHP?
27. How has NHEICC been able to advocate for SBC at the local municipality level?
28. How responsive are local municipalities to NHEICC requests? What might the local municipality need from NHEICC to be successful in local SBC efforts?

Appendix 4: Interview Guidelines for External Partners

Name of Interviewee:
Organization:
Position:
Number of years working in this organization:

Years of experience in social and behavior change communication:
Years of experience working with the National Health Education Information and Communication Centre:

QUESTIONS

Introduction
The National Health Education Information and Communication Centre (NHEICC) has years of experience and expertise in social and behavior change (SBC). First, I would like to learn more about your organization. Then, I would like to ask you a few questions about your experiences working with NHEICC and your perspectives on NHEICC's role within the SBC for Health system.

SECTION 1: Learning more about external partner's organization

1. What is your organization's mandate in Nepal?

2. What type of work are you doing in SBC for the health system? Please share some examples of the work that your organization does.

3. In your experience, what are some of the current challenges related to coordination at the national level and across provinces and local municipalities?

SECTION 2: Experiences with NHEICC

4. How have you worked with NHEICC to date? What is/was your experience?

5. What do you think is the role of NHEICC as it relates to SBC in the federal system?

6. In your opinion, how clear is the strategic direction of NHEICC?

7. How best do you think NHEICC can support organizations like yours? (Probe: What type of support does your organization needs the most?)

8. What are some strengths of NHEICC? What are some areas in which they could improve?

9. How does NHEICC reach out to and network with stakeholders at the central, provincial, and local levels? (Probe: Ask about methods/platforms of communication and collaboration, frequency, two-way or one-way, what types of content is communicated, guidelines/action plans/technical assistance/training, etc.)

10. What is the role of NHEICC at the provincial and local municipality levels for SBC? Tell us how NHEICC has worked at the local level. (Probe: Can you share examples of successes and challenges?)

11. Does NHEICC have a system in place to facilitate the generation, learning, sharing, and use of relevant knowledge from other organizations implementing or supporting SBC? (Probe: Ask about existing repositories to capture, document, and disseminate knowledge.) Have you used this system? If so, what was your experience?

12. How does NHEICC support learning for program improvement and sharing these learnings with stakeholders?

Appendix 5: Summary Findings from the 2014 National Health Education Information Communication Center Self-Assessment*

The 2014 report was based on the information collected as part of a capacity assessment and planning exercise under the Nepal Health Communication Capacity Collaborative (NHEICC). Information was collected through a desk review of key NHEICC documents, a participatory assessment and planning process, and in-depth interviews with internal staff at the central level.

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

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

The findings were categorized under institutional capacity and technical capacity. Leadership, human resources, coordination and support, and financial resources fall under institutional capacity, whereas training in behavior change communication (BCC) and information, education, and communication (IEC) interventions, the methodological holistic approach, monitoring of BCC and IEC interventions, evaluation of BCC and IEC interventions, and knowledge management are under technical capacity.

The assessment identified a need to strengthen NHEICC's technical capacity for methodological and holistic BCC and IEC interventions. The interventions also should be better monitored as they are implemented. Technical training and knowledge management for these interventions also benefit NHEICC staff, both at the central and district levels. Institutionally, frequent leadership changes and weak linkages with program divisions, need for more human resources at the district level, insufficient financial resource allocation by the Ministry and need for better coordination with other divisions and with external stakeholders are seen as key gaps.

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

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

* The full report is available at https://www.thecompassforsbc.org/project-examples/capacity-strengthening-planning-report-national-health-education-information-and

Appendix 6: 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

S. 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	Na. Pa. Se. Pra.
9	Dipak Sijapati	Barahatal Rural Municipality	Junior Technical A
10	Dan Bahadur Saud	Barahatal Rural Municipality	IT 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 Chairperson
26	Khadka Bahadur Thapa	Panchapuri Municipality-6	Ward Chairperson
27	Rajendra Adhikari	Panchapuri Municipality-5	Health Assistant
28	Dilliram Sapkota	Salkot Public Health Centre	Sr. 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 Chairperson
34	Dinesh Gautam	Bidhyapur Health Post	Sr. Assistant Health Worker
35	Bhakti Prasad Paudel	Panchapuri Municipality-8	Ward Chairperson
36	Dhan Bahadur Thapa	Panchapuri Municipality-1	Ward Chairperson
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	DHO-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	SSBH	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	Act. Ward Chairperson
29	Naresh Kumar Shahi	District Health Office	IEC 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, Guthichour, Jumla, September 10–11. 2018

SN	Name	Organization	Designation
1	Hari Bahadur Bhandari	Guthichour Rural Municipality	Chairperson
2	Jaan Devi Yeidi	Guthichour Rural Municipality	Vice Chairperson
3	Keshab Raj Sharma	Guthichour Rural Municipality	Chief Administrative Officer
4	Prem Bahadur Budha	Guthichour Rural Municipality-	Ward Chairperson
5	Laxmi Prasad Adhikari	Guthichour 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	Guthichour Rural Municipality-4	Ward Chairperson
10	Prithibi Bahadur Budha	Guthichour Rural Municipality-2	Ward Chairperson
11	Harka Bahadur Sarki	Guthichour Rural Municipality	Executive Member
12	Makar Bahadur Mahat	Guthichour Rural Municipality	Finance Officer
13	Ram Prasad Jaishi	Guthichour Rural Municipality	Nayab Subba
14	Ganesh Prasad Neupane	Guthichour Rural Municipality	Ward Secretary
15	Ganga Prasad Pandey	Guthichour Rural Municipality	Nayab Subba
16	Gobichandra Pyakurel	Guthichour Rural Municipality	Nayab Subba
17	Gokarna Prasad Upadhya	Guthichour Rural Municipality	Nayab Subba
18	Bhagawoti Giri	Guthichour Rural Municipality	Women Development Inspector
19	Nar Bahadur Budha	Guthichour Rural Municipality	Nayab Subba
20	Harish Chandra Giri	Guthichour Rural Municipality	Nayab Subba
21	Shiva Laxmi Jaishi	Guthichour Rural Municipality	Agriculture Technician

22	Jagii Prasad Dhital	Guthichour Rural Municipality	Computer Operator
23	Tika Datta Neupane	Guthichour Rural Municipality	Ward Secretary
24	Janga Bahadur Khatri	Guthichour Rural Municipality	Resource Person
25	Parbati Budha	Guthichour Rural Municipality	Executive Member
26	Chan Devi Budha	Guthichour Rural Municipality	Executive Member
27	Dhanraj Devkota	Guthichour Rural Municipality	Executive Member
28	Balaram Nepali	Guthichour Rural Municipality	Health Coordinator
29	Ganesh Bahadur Aidi	Guthichour Rural Municipality	Ward Chairperson
30	Chandra Bahadur Nepali	Guthichour Rural Municipality-5	Ward Chairperson
31	Dharma Raj Rawal	Guthichour Rural Municipality	Store in Charge
32	Kabiraj Khatri	Guthichour Rural Municipality	Executive Member
33	Govinda Bahadur Mahat	Guthichour Rural Municipality	Family Planning Officer
34	Lal Maya Damai	Guthichour 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	HD, Karnali Province	Sr. Assistant Health Worker
3	Tika Ram Jaisi	HD, Karnali Province	Public Health Inspector
4	Tulsi Prasad Adhikari	HD, Karnali Province	Public Health Officer
5	Mohammad Aphak Ahamad Khan	HD, Karnali Province	Account Officer
6	Padam KC	HD, 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	HD, Karnali Province	Sr. Public Health Officer
10	Binod Acharya	HD, Karnali Province	Statistics Officer
11	Naresh Babu	Ministry of Social Development	Family Planning Officer
12	Chetan Nidhi Wagle	HD, Karnali Province	Sr. 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	HD, Karnali Province	Community Nursing Officer
16	OM Raj Acharya	HD, Karnali Province	Lab Technician
17	Shyam Lal Acharya	HD, 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	HD, Karnali Province	Nayab Subba
21	Bhala Ram Pangeni	HD, Karnali Province	Nayab Subba
22	Mani Ram Kharal	Ministry of Social Development	Section Officer
23	Nod Narayan Chaudhary	HD, Karnali Province	Sr. Health and Education Officer
24	Sita Sapkota	Ministry of Social Development	Statistics Assistant