

# BOTTLENECK ASSESSEMENT OF SOCIAL AND BEHAVIOUR CHANGE FOR FAMILY PLANNING



World Health  
Organization

Nepal



Government of Nepal  
Ministry of Health and Population  
Department of Health Services  
Family Welfare Division

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# Abbreviations and acronyms

<b>ANC</b>	Antenatal care
<b>BNA</b>	Bottleneck Assessment
<b>CDC</b>	Centre for disease control
<b>DMPA</b>	Depot medroxy progesterone acetate
<b>DoHS</b>	Department of Health Services
<b>FCHV</b>	Female community health volunteer
<b>FP</b>	Family planning
<b>FPAN</b>	Family planning association of Nepal
<b>FWD</b>	Family Welfare Division
<b>GoN</b>	Government of Nepal
<b>HMG</b>	Health mothers group
<b>HMIS</b>	Health management information system
<b>HTSP</b>	Healthy timing and spacing of pregnancy
<b>IUCD</b>	Intra uterine contraceptive device
<b>KII</b>	Key informant interview
<b>KPIs</b>	Key performance indicators
<b>LAM</b>	Lactational amenorrhea method
<b>LAPM</b>	Long acting and permanent methods
<b>LARC</b>	Long acting reversible contraceptive
<b>MCH</b>	Maternal and child health
<b>mCPR</b>	Modern contraceptive rate
<b>MNH</b>	Maternal and newborn health
<b>MoHP</b>	Ministry of Health and Population
<b>MSI</b>	Marie stopes international
<b>NDHS</b>	Nepal demographic health survey
<b>NGO</b>	Non government organization
<b>NHFA</b>	Nepal health facility survey
<b>PAFP</b>	Post abortion family planning
<b>PMTCT</b>	Prevention of mother to child transmission
<b>PNC</b>	Post natal care
<b>PPFP</b>	Post partum family planning

<b><i>RH</i></b>	Reproductive health
<b><i>RHCC</i></b>	Reproductive health coordination committee
<b><i>SARC</i></b>	Short acting reversible contraceptive
<b><i>SBC</i></b>	Social and behavior change
<b><i>SDG</i></b>	Sustainable development goal
<b><i>TWG</i></b>	Technical Working Group
<b><i>USAID</i></b>	United states agency for international development
<b><i>WHO</i></b>	World health organization

# Executive summary

## **Introduction/Background**

Social and Behavior Change (SBC) is a vital approach for addressing non-supply-related barriers in family planning, targeting cultural beliefs, gender norms, and misconceptions about contraceptive use. In Nepal, despite high awareness of contraceptive methods, usage remains low due to barriers such as limited access, cultural opposition, and inadequate counseling. The World Health Organization (WHO) Family Planning (FP) Accelerator Plus project aims to support countries like Nepal in scaling up evidence-based practices (EBPs) in family planning. This initiative focuses on overcoming obstacles to enhance voluntary family planning services and promote bodily autonomy and gender-responsive access to contraception, addressing the unmet need for family planning through targeted SBC interventions.

## **Methodological Approach**

The methodological approach for assessing bottlenecks in scaling up EBPs under the WHO FP Accelerator Plus project involved preparation, data collection, and a bottlenecks assessment workshop. Under the leadership of the Family Welfare Division (FWD), the project team worked with guidance from Family Planning Steering Committee (FP SC), forming a Technical Working Group (TWG) to adapt assessment tools to the local context. Data collection included desk reviews and key informant interviews, informed by TWG guidance to identify barriers in implementing EBPs. A workshop with key stakeholders then facilitated consensus on critical bottlenecks and actionable solutions, aligning interventions with national priorities.

## **Findings-based on core protocol**

### **Policy alignment**

The assessment revealed several key findings based on the core protocol, highlighting gaps and strengths in the current policy framework for scaling up evidence-based family planning practices (EBPs) in Nepal. Policy reviews showed partial alignment with recommended SBC principles, including rights-based programming, community engagement, and locally adapted messaging. While the policies emphasize community participation and provide broad guidance on utilizing mass media and community health workers, they lack comprehensive frameworks for evidence-based design, monitoring, and evaluation. Interviews with stakeholders reinforced this finding, underscoring the need for more tailored strategies and measurable indicators to assess SBC efforts in family planning effectively.

### **Case study**

The Health Communication Capacity Collaborative (HC3) project was taken as a case study for the SBC for FP. The HC3 project, implemented in Nepal from 2013 to 2017 by the Johns Hopkins Center for Communication Programs, aimed to strengthen the Ministry of Health's (MOH)

capacity to deliver Social and Behavior Change Communication (SBCC) interventions. Focused on improving reproductive health, the project employed a multi-level approach to build SBCC capacity at national, district, and community levels. Through targeted campaigns, training for health workers, and community engagement, the project achieved notable success in promoting family planning, especially among young people, migrants, and disadvantaged groups. The flagship campaign, *Parivar Niyojan Smart Bancha Jeewan* (Family Planning Makes a Smart Life), effectively boosted contraceptive use by around 10%, demonstrating the impact of a well-structured SBCC intervention.

### *Success Factors and Challenges*

The HC3 project's success was driven by strategic approaches like comprehensive capacity building, community involvement, and the use of multi-channel communication. Integrating SBCC into routine health services helped establish a resilient practitioner network, enhancing both sustainability and local ownership. However, the project faced challenges, including cultural resistance to family planning, budget and resource constraints, and difficulties in reaching remote populations. Key lessons included the importance of community engagement, adaptability to local contexts, continuous monitoring, and strong stakeholder coordination, all of which are essential for scaling up and sustaining effective SBCC initiatives.

## **KII Findings**

### **Key Bottlenecks and Analysis**

The assessment identified critical bottlenecks impacting the scale-up of SBC for family planning in Nepal. Financial constraints were significant, with minimal budget allocations—only 0.13% of the health budget assigned to SBC, and 0.017% specifically for family planning—indicating that SBC for FP is not prioritized by national, provincial, or local governments. Spending is heavily reliant on external funding, which limits sustainability and government oversight.

Community engagement also emerged as a bottleneck, with inadequate consultation of target audiences and limited mechanisms for feedback and evaluation. This has led to a disconnect between SBC messaging and community needs, as well as missed opportunities for culturally relevant interventions.

In terms of information, there are significant gaps in data collection and reporting standards. SBC for FP lacks standardized indicators and mechanisms to assess its impact, making it difficult to monitor progress or adapt strategies based on evidence. These bottlenecks underscore the need for improved funding, systematic data practices, and stronger community involvement to enhance SBC for family planning in Nepal.

### **Consensus workshop**

The consensus workshop for the Bottleneck Assessment (BNA) of Social and Behavior Change for Family Planning (SBC-FP) in Nepal involved key stakeholders from the Family Welfare

Division (FWD) and Technical Working Group (TWG), aiming to identify major challenges and develop actionable solutions. Participants were divided into three thematic groups—governance and financing, people and information, and medicines/technology and service delivery. Through structured discussions, root cause analyses, and a solution-planning session, participants prioritized bottlenecks and proposed "quick-win" solutions to enhance SBC-FP efforts, focusing on feasible, high-impact interventions.

Important Bottlenecks	Proposed solution
There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.	Institutionalized SBC for FP especially at the subnational level. (Structure, focal person, processes) <b>Identify and assign the focal person. This focal person is the same focal assigned for FP/RH.</b>
There is inadequate budget available at all levels for scale-up of SBC for FP.	<b>Develop expertise to perform CBA and use the evidence for policy analysis and advocacy with focus on local government.</b>
Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.	<b>Strengthen existing mechanism for coordination and collaboration for social inclusion in SBC for FP for public institutions (three tiers), private institutions and NGOs.</b>
Inadequate recording and reporting on SBC activities	Set indicators and targets Agreed standards forms and formats for recording and reporting for SBCC. EHRR Ensure Capacity building Monitoring on quality of data, RDQA
Inadequate community engagement on SBC for FP	Design program with community engagement on SBC as a core intervention. Programs and interventions should be tailored as per the need of community. Mobilization of community key influencers for behavior change and change in norms: mother group, FCHV, leaders
<b>Inadequate skilled human resource for SBC-FP (includes HR-capacity and service delivery-motivation)</b>	Advocacy from SBC-FP champions Develop LRP for SBC-FP for health workers Orientation / training and mentoring on SBC-FP

## Conclusion and Way Forward

The bottleneck assessment of SBC for Family Planning in Nepal has identified major challenges that hinder the effective scale-up of family planning practices, including weak leadership, limited community engagement, inadequate data management, and a shortage of skilled human resources. These issues have led to fragmented implementation, impeding the sustainability of SBC initiatives. Moving forward, a strategic and coordinated approach is required, focusing on strengthening governance, enhancing community participation, improving data systems, and building human resource capacity to ensure a more effective and sustainable scale-up of SBC for FP in Nepal.

**Key Actions for the Way Forward:**

- **Strengthen Leadership and Commitment:** Institutionalize SBC for FP within government structures, with dedicated focal persons for consistent oversight.
- **Improve Community Engagement:** Develop strategies involving local stakeholders and influencers to design culturally relevant SBC programs.
- **Enhance Data Management and Accountability:** Standardize indicators and reporting formats, and build capacity for reliable SBC data collection and use.
- **Develop Human Resource Capacity:** Implement a Learning Resource Package and provide ongoing training for health workers in SBC-FP.
- **Ensure Adequate Financing:** Advocate for increased budget allocations and use cost-benefit analyses to encourage investment in SBC-FP.
- **Promote Coordination and Collaboration:** Strengthen coordination among stakeholders, fostering a collaborative environment for effective SBC implementation.

# Background and Introduction

Social and Behaviour Change (SBC) encompasses a range of evidence-based strategies to influence individual behaviours and societal norms to improve health outcomes. In the context of family planning, SBC is particularly important as it addresses the non-supply-related barriers that hinder contraceptive use, such as cultural beliefs, gender norms, and misconceptions about contraceptive methods. By utilizing a combination of mass media, community engagement, and interpersonal communication, SBC interventions work to enhance knowledge, shift attitudes, and promote supportive environments for family planning. These efforts are essential for enabling individuals and couples to make informed decisions about their reproductive health, thereby contributing to the reduction of unintended pregnancies and the improvement of maternal and child health outcomes.

Despite high levels of awareness of modern contraceptive methods in Nepal, with 99.8 percent of women and men knowing at least one method, the actual use of these methods remains relatively low. The Nepal Demographic Health Survey (NDHS) 2022 reported that only 42.7 percent of married women and 32.7 percent of all women use modern contraception, with a significant unmet need for family planning at 20.8 percent. Although most family planning decisions are made jointly by spouses, several barriers prevent effective contraceptive use, including inadequate access to contraceptive methods, limited availability of long-acting reversible contraceptives (LARCs) at health facilities, perceived side effects, cultural and religious opposition, and lack of proper counseling services. While primary health care centers and community health volunteers provide short-acting contraceptives, LARCs are less accessible and mainly offered in a few hospitals and health centers with trained providers. To address these gaps, it is crucial to complement the supply-side interventions with demand-side strategies that consider individual beliefs, attitudes, and cultural contexts. Integrating SBC approaches can enhance family planning programs by targeting these factors, ultimately reducing the unmet need for contraception in Nepal.

In the 1940s and 1950s, global movements such as concerns over rapid population growth, the rise of the birth control movement, and advocacy from organizations like the International Planned Parenthood Federation (IPPF) and the United Nations highlighted the need for family planning as a critical component of public health and development. These efforts emphasized the importance of family planning for improving women's health, economic stability, and social development, influencing countries, including Nepal, to integrate family planning into their national health policies and programs.

Building on these global trends, family planning programs in Nepal began in the late 1950s amid concerns over rapid population growth both globally and within the country. Initially focused on population control and preventing the adverse impacts of large families, such as high maternal and infant mortality rates, these programs relied heavily on interpersonal approaches through volunteers and NGOs like the Family Planning Association of Nepal (FPAN). With the advent of radio in 1951 and television in 1985, Nepal began to use these mediums to gradually expand the reach of family planning information, enhancing public awareness and understanding of the benefits of family planning.

Later, many vertical programs were introduced in Nepal, such as community-based distribution initiatives and mass media campaigns, which actively promoted family planning materials and services. These efforts primarily adopted a top-down, linear approach, where information was disseminated to the public without involving the target audience in the design or decision-making processes. Family planning strategies were heavily influenced by a health-centric perspective that focused on delivering messages through a standardized approach, often relying on Female Community Health Volunteers (FCHVs) to disseminate information at the grassroots level.

While the reliance on FCHVs was significant in extending the reach of family planning programs, this method was also indicative of the broader top-down strategy. Such approaches were heavily influenced by donor priorities and global frameworks, rather than tailored to the specific needs and cultural contexts of the communities. Consequently, these linear strategies often lacked the flexibility to adapt to local nuances and failed to engage users in the design or implementation stages, limiting their effectiveness in driving sustainable behavior change at the community level.

The National Health Education, Information, and Communication Centre (NHEICC) was established in 1993 as the central agency responsible for health promotion, education, and communication in Nepal. It has served as the focal point for social and behavior change communication (SBCC) activities, employing strategies like advocacy, social mobilization, and behavior change campaigns to improve public health outcomes. NHEICC has played a crucial role in coordinating SBCC efforts across various health programs, utilizing multiple channels such as radio, television, and print media to disseminate health information and promote healthy behaviors throughout the country.

The debate on integrating human-centered design (HCD) into Social and Behavior Change (SBC) began gaining momentum globally in the early 2000s, as the focus shifted towards creating interventions that are more responsive to the needs and contexts of individuals and communities. By the 2010s, organizations like IDEO.org, USAID, and the Bill & Melinda Gates Foundation were actively incorporating HCD principles into SBC programs to enhance their effectiveness and sustainability. However, there are very few projects and work that has followed this.

It is in this context that the World Health Organization (WHO) began working on the Family Planning (FP) Accelerator Plus project to support countries like Nepal in scaling up and sustaining the implementation of evidence-based practices (EBPs) in family planning. This initiative focuses on overcoming bottlenecks that impede the national scale-up of EBPs, such as SBC programs, to enhance voluntary family planning services, promote bodily autonomy, and ensure gender-responsive access to contraception for all.

## Objective

The BNA aims to bring together data and insights from a range of sources to:

- Synthesize what is known about scaling up SBC for FP in the country, including implementation status, alignment of guidance with national and international standards, and the lessons learned from successful implementation.
- Understand the perspectives of key stakeholders (policy makers, programme managers, healthcare managers, service providers and civil society) on the various health systems factors inhibiting scale-up of the SBC for FP.
- Build consensus among key stakeholders on the most important bottlenecks to SBC for FP scale-up, and on the solutions that address the root causes inhibiting scale-up.

## Conceptual Framework

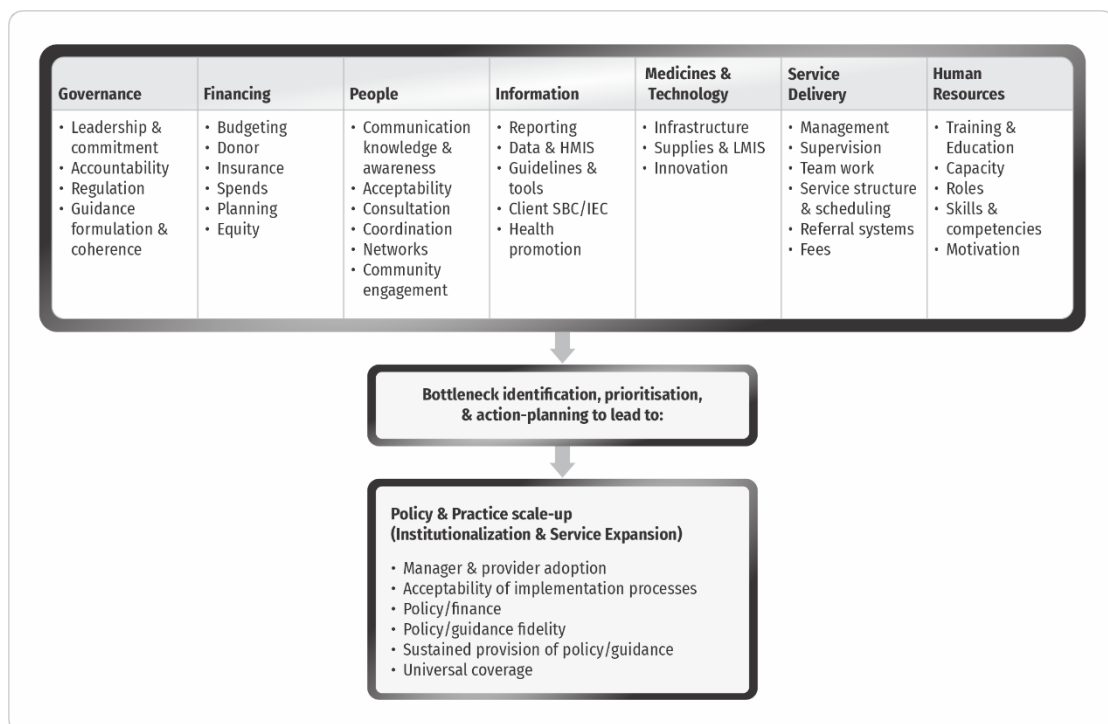


Figure 1: Conceptual framework for the assessment

### Methodological overview

The methodological process for the rapid assessment of bottlenecks inhibiting the scale-up of evidence-based family planning practices (EBPs) under the WHO FP Accelerator Plus project involved three key steps: preparation, data collection, and a bottlenecks assessment workshop.

During the preparation phase, the project team collaborated closely with the Family Welfare Division (FWD) and engaged in regular meetings with the Family Planning Steering Committee (FP SC) to secure alignment on objectives and priorities. Key decisions were made in FP SC meetings to establish a dedicated Technical Working Group (TWG), bringing together representatives from various sectors to ensure a comprehensive approach to the bottlenecks assessment. This TWG was instrumental in guiding the review and adaptation of assessment tools, ensuring they were tailored to the local context and aligned with national priorities.

The preparation phase also included preliminary facility visits to refine methodologies based on initial observations.

In the data collection phase, the team conducted a thorough desk review of national policies, guidelines, and case studies, and held key informant interviews to gather insights into existing challenges in implementing EBPs. Input from the TWG and insights from preliminary findings shaped the direction of these interviews, allowing for a targeted approach that addressed context-specific challenges in the scale-up of family planning services.

Finally, a bottlenecks assessment workshop was held, engaging key stakeholders and TWG members to review the findings, reach consensus on the most critical bottlenecks, and develop actionable solutions. This collaborative approach, facilitated through the TWG and informed by FP SC decisions, ensured that the identified solutions were both practical and aligned with national objectives, fostering a supportive environment for the effective scale-up of social and behavior change (SBC) initiatives for family planning.

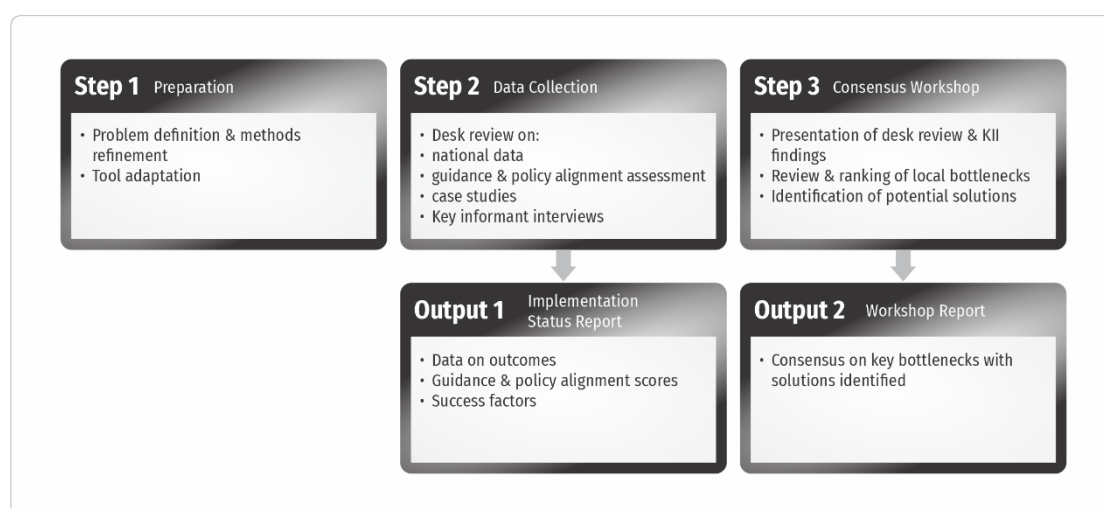


Figure 2: Step-by-step process that was followed during the assessment

### Findings based on core protocol

The core protocol for the rapid assessment of bottlenecks inhibiting the scale-up of evidence-based family planning practices (EBPs) under the WHO FP Accelerator Plus project was structured around three main steps: preparation, data collection, and a bottlenecks assessment workshop. During the preparation phase, the assessment team, led by a designated technical expert and in collaboration with the Family Welfare Division (FWD), refined the assessment tools and conducted preparatory facility visits to adapt the methodology to the local context. The Family Planning Technical Working Group (TWG) was actively involved, providing input on the tools to ensure alignment with national priorities. This step included applying for any necessary ethics exemptions and planning the logistics for the assessment, ensuring alignment with both WHO standards and national priorities.

The data collection phase involved a comprehensive desk review, which included assessing policy and guidance alignment, reviewing national data on family planning indicators, and analyzing relevant case studies to identify successful and challenging aspects of EBP

implementation. Key informant interviews (KIIs) were also conducted with a diverse group of stakeholders, including policymakers, healthcare managers, service providers, and civil society representatives, to gather qualitative insights on potential bottlenecks. Finally, the assessment culminated in a workshop where stakeholders reviewed the collected data, reached a consensus on the most significant bottlenecks, and developed actionable solutions to enhance the scale-up and sustainability of family planning practices across different levels of the health system.

Therefore, the findings below follow the core protocol with a few adaptations tailored to the Nepali context to address local challenges and needs better.

## Policy alignment (tabular format)

The review of policies and guidelines on SBC for FP focused on assessing the alignment of existing frameworks with recommended principles for effective SBC interventions. This process thoroughly examined various policy documents, strategies, and guidance materials related to FP and reproductive health (RH), health promotion, and specific SBC interventions, such as mass media, community engagement, and digital communication. The review also considered broader policies addressing social and gender norms that influence reproductive health behaviours, ensuring that all relevant policies incorporate behavioural and social behavioural change strategies. Additionally, recent SBC materials and media produced by the Ministry of Health and NGOs were evaluated to determine their adherence to evidence-based SBC principles, including rights-based programming, community participation, and context-specific adaptations. This assessment aimed to identify gaps or inconsistencies in the guidance provided to effectively promote family planning through SBC approaches.

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	FP/RH policy & guidance documents recommend scale-up of SBC interventions	None	The review showed a significant gap in the availability of comprehensive guidance documents specifically addressing SBC interventions for FP. While there are some overarching FP and reproductive health (RH) policies, few of these explicitly recommend or provide detailed strategies for the scale-up of SBC interventions tailored to FP. This lack of specific guidance results in a scenario where healthcare providers and program implementers lack clear, structured direction on how to incorporate SBC approaches effectively into their FP initiatives. The absence of such documents suggests that SBC for FP has not been adequately prioritized or integrated within the broader national health communication strategies, limiting the potential for systematic and evidence-based implementation of behavior change interventions. This gap points to the need for developing and disseminating dedicated SBC for FP guidelines that align with evidence-based principles, ensuring consistency and coherence in promoting family planning behaviors across different levels of the health system.	
2	FP/RH policy & guidance documents recommend use of community health workers for RMNCH health promotion, including FP	Full	The FP/RH policy and guidance documents place a significant emphasis on three primary communication strategies: advocacy, social mobilization, and behavior change communication. <b>Advocacy communication</b> is designed to create an enabling environment by influencing decision-makers to support FP initiatives, ensuring sustained political and financial commitment. <b>Social mobilization communication</b> aims to engage and empower communities, encouraging widespread participation and fostering a collective response to improve RMNCH and FP outcomes. <b>Behavior change communication (BCC)</b> focuses on altering individual and	National Communication Strategy for Maternal Newborn and Child Health 2012-16  Awaiting endorsement: National Social and Behaviour Change Strategy for

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
			community behaviors by providing targeted information, addressing misconceptions, and promoting positive attitudes towards FP. These strategies work synergistically to ensure that CHWs are effectively equipped to communicate health messages, drive community involvement, and foster sustainable behavior change, thus enhancing the overall impact of FP programs at the grassroots level.	Sexual and Reproductive Health and Rights  National Health Communication Policy (2012)
3	FP/RH policy & guidance documents recommend use of mass media to promote FP	Full	Strongly advocate using mass media to promote FP through an integrated approach to health communication. This approach involves leveraging a variety of communication channels—including radio, television, print, and digital media—to maximize reach and impact. Additionally, the documents emphasize <b>BCC</b> , which targets specific behaviors related to FP by providing tailored messages that are culturally and linguistically appropriate. This strategy is crucial for addressing the unique needs of diverse populations and ensuring that FP messages resonate with different cultural and linguistic groups. Furthermore, the integrated approach highlights the importance of <b>community mobilization and participation</b> , engaging communities as active participants in promoting FP, which enhances the effectiveness of mass media campaigns by reinforcing messages through trusted community networks and fostering a supportive environment for behavior change.	National Health Communication Policy (2012)  National Communication Strategy for Maternal Newborn and Child Health 2012-16
4	FP/RH policy & guidance documents recommend use of community engagement, including interpersonal communication and groups, to promote FP	Full	The FP/RH policy and guidance documents fully support the use of community engagement strategies, including interpersonal communication and group activities, to promote FP by implementing tailored demand generation and strategic behavioral change interventions. Interpersonal communication is highlighted as a major component, serving as a crucial prerequisite for effective community engagement. This approach involves direct, face-to-face interactions that are designed to foster trust and rapport within communities, making it more likely that individuals will adopt recommended FP behaviors. By focusing on these personalized communication methods, the policies aim to enhance the effectiveness of demand generation efforts and ensure that SBC interventions are both strategic and contextually relevant.	FP 2030  Adolescent Friendly Health Facility Guidelines:
5	FP/RH policy & guidance documents recommend use of digital health to promote FP	Partial	The FP/RH policy and guidance documents partially recommend using digital health to promote FP, emphasizing the importance of diverse communication methods. However, there is a notable lack of detailed information on which specific digital tools or platforms are most effective for different target audiences or contexts. This gap suggests a need for further research and guidance to determine the best digital communication channels and strategies to enhance the reach and impact of FP promotion efforts. As a result, while digital health is acknowledged as a valuable component of FP promotion, the documents fall short in providing comprehensive direction on optimizing its use within diverse settings.	National Health Communication Policy (2012)

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
6	FP/RH policy & guidance documents aim to address social and gender norms that may inhibit use of FP	Partial	Partially address social and gender norms that may inhibit the use of FP by emphasizing the importance of ensuring basic health services that include FP. This approach suggests that efforts should not be limited to the supply side—such as providing contraceptives and services—but should also focus on demand generation by educating and engaging communities. The policies highlight the right to education, information, and counseling, including FP, underscoring the need for comprehensive strategies that promote understanding and acceptance of FP while addressing cultural and social barriers. This dual focus aims to empower individuals, particularly women and marginalized groups, by ensuring they have access to both the resources and the knowledge necessary to make informed choices about FP, thereby challenging and changing restrictive social and gender norms.	Public Health Service Act 2018 and Regulations 2020  Safe Motherhood and Reproductive Health Rights Act, 2018
7	FP/RH policy & guidance documents aim to involve men and promote healthy couple communication	Partial	Partially promote the involvement of men and encourage healthy couple communication, particularly by ensuring that BCC interventions are tailored to the needs of newly married young people who may wish to delay their first pregnancy. These policies recognize that involving men and fostering open communication between partners are essential strategies for creating supportive environments where young couples can make informed decisions about FP. By specifically targeting newly married couples, the documents aim to address a critical window of opportunity to encourage the delay of the first pregnancy, which can lead to better health outcomes for women and provide couples with more control over their reproductive choices. However, the emphasis on men's involvement and couple communication is only partial, indicating a need for more robust, targeted approaches that fully integrate these aspects into broader FP promotion efforts.	National Family Planning Costed Implementation Plan 2015-2020
8	FP/RH policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs and self-efficacy of individual women and girls	Partial	Recognized the importance of strengthening the knowledge, attitudes, beliefs, and self-efficacy of women and girls, yet they do not provide comprehensive or specific guidance on how to achieve these goals across all relevant demographic groups. The documents broadly address the need for health communication and education but lack targeted strategies and clear, actionable steps specifically designed to empower women and girls in the context of FP and reproductive health. This gap in specificity and focus results in an incomplete approach, as the documents do not fully align with best practices for gender-responsive health communication. Additionally, there is evidence of a lack of coordinated and systematic interventions.	National Health Communication Policy (2012)  ASRH National Communication Strategy 2012-2016
9	FP/RH policy & guidance documents recommend community engagement, including working with	Partial	Partially recommend community engagement to promote FP, including working with community leaders, religious leaders, or other trusted opinion leaders. These documents highlight the importance of <b>community mobilization and participation</b> and emphasize cultural and linguistic appropriateness to ensure that health messages resonate with diverse populations. However,	National Health Communication Policy (2012)

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	community leaders, religious leaders, or other trusted opinion leaders, to promote FP		while the documents recognize these elements, their guidance is often broad and encompasses various health priorities rather than focusing specifically on FP. This general approach means that while there is some emphasis on engaging community stakeholders to support FP initiatives, the strategies are not detailed or sufficiently targeted towards FP-specific goals. The lack of specificity in addressing FP within the broader context of multiple health priorities dilutes the focus and impact of community engagement efforts, leading to a partial rating. The documents provide a foundation for involving community leaders and fostering participation, but they fall short of offering a comprehensive framework tailored explicitly to promoting FP through community-based approaches.	National Communication Strategy for Maternal Newborn and Child Health 2012-16  ASRH National Communication Strategy 2012-2016
10	FP/RH and SBC policy & guidance documents adhere to recommended and evidence-based principles for SBC (see Annex 1), including: - adherence to rights-based programming principles - community participation - adaptation to local context and target population - use of evidence-based structured design processes - monitoring, evaluation and learning of interventions	Partial	Partially adhere to the recommended and evidence-based principles for SBC. They emphasize the need to strengthen program design, implementation, and evaluation for SBC interventions, particularly those related to FP. This includes the development of a comprehensive FP communication strategy that aligns with rights-based programming principles, ensuring that all individuals have access to accurate and culturally sensitive FP information. The policies also highlight the importance of developing targeted IEC materials and media messages tailored to specific audiences, which supports the principle of adapting interventions to the local context and target populations.  Additionally, the documents advocate for building the capacity of partners involved in SBC, which is essential for fostering community participation and ensuring effective delivery of FP messages. However, while these elements are present, the adherence is only partial because the policies lack detailed guidance on using structured, evidence-based design processes for creating SBC interventions. Moreover, the documents provide limited information on the systematic monitoring, evaluation, and learning (MEL) of these interventions to measure their impact and effectiveness. This gap suggests a need for more robust frameworks and tools that fully integrate MEL practices into SBC program cycles, which would help ensure that interventions are continuously improved and aligned with evidence-based practices.	National Family Planning Costed Implemented Plan 2015-20 (Awaiting a new version of CIP that also focuses on SBCC)
11	FP/RH and SBC policy & guidance documents advise on effective approaches for SBC in family planning, along with	Partial	The FP/RH and SBC policy documents show partial adherence to recommended SBC principles, focusing on rights-based programming, community engagement, and locally adapted interventions. While they advocate for comprehensive FP communication strategies and targeted IEC materials, they lack detailed guidance on evidence-based design and systematic MEL	National Communication Strategy for Maternal Newborn and Child Health 2012-16

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	strength of evidence in the local context		processes. Although effective SBC approaches are advised, the documents would benefit from more robust, locally tailored evidence and updated frameworks for comprehensive SBC in FP.	<p>National Family Planning Costed Implemented Plan 2015-20 (Awaiting a new version of CIP that also focuses on SBCC)</p> <p>National Health Communication Policy (2012)</p> <p>National Communication Strategy for Maternal Newborn and Child Health 2012-16</p> <p>ASRH National Communication Strategy 2012-2016</p>
12	There are clear indicators for success for SBC in policy and guidance documents	No	The clarity of indicators for success in SBC policy and guidance documents is due to the limited number of documents that comprehensively define Monitoring and Evaluation (M&E) indicators. While some documents, like the National Communication Strategy for Maternal Newborn and Child Health 2012-16, mention the importance of M&E, they often lack specific, measurable indicators and clear definitions of desired achievements that could be considered benchmarks for success. This lack of detailed M&E frameworks makes it difficult to assess the effectiveness of SBC interventions and track progress toward achieving FP goals.	National Communication Strategy for Maternal Newborn and Child Health 2012-16

## Data review

Background: Current FP status	Module	Potential Data source	Suggested breakdown	Responses (Enter ND if no data available)				
				All WRA	Rural WRA	Urban WRA	<20 WRA	>=20 WRA
Modern contraceptive prevalence (% among women of reproductive age)	All	NDHS 2022	Rural/urban, <20/>=20	42.7	46.8	40.7	14.2	44.9
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	NDHS 2022	Rural/urban, <20/>=20	7.4	10.2	6	1.5	7.4
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	NDHS 2022	Rural/urban, <20/>=20	17	16.6	17.1	0.1	19.6
% of women with unmet need for FP	All	NDHS 2022	Rural/urban, <20/>=20	15.7	16.4	15.4	6.6	16.78
% of women knowing at least 3 modern methods	All	NDHS 2022	Rural/urban, <20/>=20	99.8	ND	ND	ND	ND
% of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP)	SBC	NDHS 2022	Rural/urban, <20/>=20	42.0	ND	ND	ND	ND
% of women intending to use FP in the future (or next 12 months)	SBC	NDHS 2022	Rural/urban, <20/>=20	68.6	ND	ND	ND	ND
% of women practicing covert FP use	SBC	NDHS 2022	Rural/urban, <20/>=20	ND	ND	ND	ND	ND
% of women not using FP due to health concerns or fears of side effects	SBC	NDHS 2022	Rural/urban, <20/>=20	13.7	ND	ND	ND	ND
% of female non-users intending to use FP in the future	SBC	NDHS 2022	Rural/urban, <20/>=20	68.6	ND	ND	ND	ND
% of women FP users making decisions about FP on their own or jointly with their husband	SBC	NDHS 2022	Rural/urban, <20/>=20	13.9 and jointly with their husband 76.8	ND	ND	ND	ND

Background: Current FP status	Module	Potential Data source	Suggested breakdown	Responses (Enter ND if no data available)				
				All WRA	Rural WRA	Urban WRA	<20 WRA	>=20 WRA
% of women FP non-users making decisions about FP on their own or jointly with their husband	SBC	NDHS 2022	Rural/urban, <20/>=20	12.8 and jointly with their husband 76.4	ND	ND	ND	ND
% of FP clients involved in decisions about their care during FP consultations	SBC	NDHS 2022	Rural/urban, <20/>=20	6.9	8.6	6.1	2.1	8.45
% of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone, online)	SBC	NDHS 2022	Rural/urban, <20/>=20					
% of women exposed to different media in the population (in past month or year)								
-TV	SBC	NDHS 2022	Rural/urban, <20/>=20	25.9	28.9	24.6	19.6	27.26
-radio								
- online/digital								
% of women with access to phones:								
- mobile phones	SBC	NDHS 2022	Rural/urban, <20/>=20	19	13.4	21.5	12.3	20.46
- smart phones								

## Case study

### Project description

The Health Communication Capacity Collaborative (HC3) project in Nepal, implemented from 2013 to 2017 by the Johns Hopkins Center for Communication Programs (CCP), aimed to strengthen the capacity of the Ministry of Health (MOH) and its partners to deliver effective SBCC interventions. The project's objective was to improve reproductive health outcomes among Nepali men and women by building local capacity for SBCC at the national, district, and community levels. Key activities included the development of targeted FP communication strategies, training for health workers, and community engagement initiatives to promote FP and reproductive health.

### Desired behaviour outcomes and achievements

The HC3 project in Nepal successfully achieved significant milestones in strengthening SBCC capacity to improve reproductive health outcomes. By implementing a comprehensive FP SBCC campaign, the project targeted young people, migrants, and disadvantaged groups, focusing on fostering informed decision-making regarding FP. The campaign, "Parivar Niyojan Smart Banacha Jeewan" (Family Planning Makes a Smart Life), was tailored to resonate with diverse audiences and effectively increased contraceptive use by approximately 10 percentage points. This achievement was supported by a systematic approach involving capacity-building workshops, training sessions, and mentoring for local SBCC practitioners, including FCHVs and peer facilitators.

At the community level, HC3 enhanced local engagement by leveraging interpersonal communication and strategic behavioral change interventions. Peer facilitators like Lalmati Rana were trained to conduct outreach activities and provide referrals, thus bridging gaps between the community and health facilities. This led to improved service delivery and quality of counseling at health facilities such as "Hamro Swasthya Kendra," where health workers received training to enhance interpersonal communication skills. The integration of SBCC into routine health services enabled the project to build a sustainable network of practitioners, fostering a resilient SBCC capacity that could withstand systemic challenges. Overall, the HC3 project made a substantial impact on promoting healthy FP practices, improving awareness, and fostering positive behavioral outcomes among young couples in Nepal.

### Success factors

The success factors of the HC3 project in Nepal were driven by several strategic approaches that significantly enhanced its impact:

- **Capacity strengthening at multiple levels:** The project focused on building SBCC capacity across all levels of the health system through training, mentoring, and collaborative implementation. This approach empowered local actors to deliver effective interventions, contributing to sustained improvements in SBCC practices.

- **Community engagement and participation:** Local peer facilitators, community health volunteers, and stakeholders played a crucial role in bridging gaps between communities and health services. They provided tailored FP information and referrals, fostering trust and acceptance among community members.
- **Integrated and evidence-based approach:** The SBCC Capacity Ecosystem model facilitated a resilient network of SBCC practitioners, ensuring sustainable and adaptable capacity-building efforts that avoided any single point of failure in the system.
- **Targeted campaigns and media use:** The "Family Planning Makes a Smart Life" campaign utilized diverse communication channels, such as television, radio, mobile phones, and social media, to effectively reach young people, migrants, and disadvantaged groups. Community-level activities promoted counseling services, enhancing the campaign's reach and effectiveness.
- **Collaborative partnerships:** The project's partnerships with the Ministry of Health, local health offices, and various public and private organizations enabled leveraging existing resources, expertise, and networks, which amplified the project's overall impact.
- **Continuous monitoring and adaptation:** Systematic processes of monitoring, evaluation, and adaptation allowed for the continuous refinement of SBCC strategies, ensuring they remained relevant and effective in changing local contexts.
- **Financing:** Dedicated funding from USAID provided the financial support necessary for the comprehensive implementation of project activities, ensuring sustainability and reach.
- **Service delivery and human resources:** The project focused on intervention design at health facilities, enhancing the skills of health professionals to provide quality FP services and counseling, which was crucial for integrating SBCC into routine health service delivery.

## Challenges

- **Capacity and resource limitations:** The project encountered challenges due to budgetary constraints and a lack of sufficient human resources within the Ministry of Health (MOH) and its partners, which hindered the full implementation of SBCC interventions.
- **Cultural and social barriers:** Overcoming deeply ingrained cultural norms and resistance to family planning and reproductive health initiatives among targeted groups required culturally sensitive and sustained engagement efforts.
- **Coordination and collaboration:** Ensuring effective integration and coordination among various stakeholders at multiple levels of the health system was complex, leading to logistical challenges and delays.
- **Reaching marginalized populations:** Engaging remote and disadvantaged populations with limited access to health services posed significant difficulties, requiring innovative approaches to outreach and service delivery.
- **Capacity building:** Strengthening the technical and institutional capacities of local institutions necessitated extensive training and resource allocation, which was time-consuming and resource-intensive.

- **Monitoring and evaluation:** Establishing a robust monitoring and evaluation framework was challenging due to the need for real-time data collection and feedback, which required adaptive management strategies and additional resources.
- **Sustainability and scalability:** Ensuring the long-term sustainability and scalability of SBCC interventions in resource-constrained settings was difficult, raising concerns about maintaining momentum and impact after the project's completion.
- **Cultural resistance:** Overcoming resistance to family planning and reproductive health practices among certain groups, due to deeply rooted cultural beliefs, required targeted communication strategies and community engagement.
- **Stakeholder coordination:** Achieving effective coordination among various stakeholders, including government agencies, NGOs, and community groups, was essential but challenging to maintain, requiring continuous effort to align goals and activities.

### Lessons learnt

- **Importance of capacity building:** Strengthening local capacity at multiple levels—national, district, and community—was crucial for delivering effective SBCC interventions. Ongoing training, mentoring, and collaborative implementation efforts are essential for building sustainable capacity.
- **Community engagement is key:** Actively involving local stakeholders, including peer facilitators and community health volunteers, is vital for successful SBCC campaigns. Engaging these community actors helps build trust and enhances the effectiveness of health communication strategies.
- **Adaptability to local contexts:** Tailoring SBCC campaigns to address the specific needs of diverse groups, such as young people, migrants, and disadvantaged communities, improves program effectiveness. Customizing messages and interventions to local cultural and linguistic contexts ensures better community acceptance and participation.
- **Integrated and multi-channel approach:** Utilizing multiple communication channels—mass media, digital platforms, and community outreach—maximizes reach and impact. Combining these channels ensures comprehensive coverage and reinforces key messages across different mediums.
- **Continuous monitoring and evaluation:** Regular monitoring and evaluation allow for real-time adjustments and improvements in SBCC strategies. Incorporating adaptive management strategies helps keep interventions relevant and effective in dynamic contexts.
- **Sustainability through distributed capacity:** Developing a distributed network of SBCC practitioners across the health system creates a resilient structure that sustains SBCC efforts beyond the project's lifespan. Building capacity within a diverse range of partners and stakeholders ensures continuity and reduces the risk of program disruption.
- **Overcoming cultural and social barriers:** Addressing deeply ingrained cultural norms and resistance requires sustained and culturally sensitive engagement. Building community trust through targeted communication strategies and local partnerships can effectively overcome these barriers.
- **Effective stakeholder coordination:** Ensuring smooth coordination among various stakeholders, including government agencies, NGOs, and community groups, is critical for



While these bottlenecks were at the national context, its further disaggregation show that there are more bottlenecks that are provincial specific as shown in Figure 4.

Province	Financing					Governance					Human Resources					Implementation	Information					Medicines & technology			People					Service delivery											
	Budgeting	Spending	Donors	Equity	Total	Leadership & commitment	Accountability	Regulation	Guidance formulation	Planning	Total	Training & education	Capacity	Roles	Skills & competencies	Motivation	Total	Implementation status	Reporting	Data & HMIS	Guidelines & tools	Client IEC	Health promotion	Total	Infrastructure	Supplies	Total	Consultation	Communication, knowledge & awareness	Acceptability	Coordination	Networks	Community engagement	Total	Management	Supervision	Teamwork & coordination	Service organisation & scheduling	Referral systems	Fees	Total
Koshi	3.50	3.67	1.00	2.89	3.24	2.88	2.78	2.44	2.88	2.86	2.77	2.67	2.44	2.11	1.89	2.36	2.56	1.00	1.00	1.00	2.56	2.33	2.78	2.78	2.89	2.83	1.23	2.86	2.33	2.78	2.43	2.50	2.69	2.56	2.56	1.80	2.44	2.11	1.30	2.15	
Madhesh	1.96	1.90	1.41	2.96	3.29	2.56	2.67	2.10	1.00	2.71	2.65	3.11	2.36	1.08	2.83	2.14	2.83	2.57	1.14	1.40	1.71	2.86	2.71	2.11	2.43	2.56	2.64	1.14	1.00	2.57	1.06	2.86	2.86	2.90	2.71	1.11	2.33	1.14	2.43	1.29	1.58
Total	3.18	3.19	2.83	2.76	2.99	2.75	2.67	2.42	1.75	2.70	2.66	2.87	2.56	1.59	2.25	2.08	2.47	2.56	3.13	3.24	2.96	2.56	2.40	2.36	2.48	2.88	2.68	1.64	2.83	2.48	2.78	2.59	2.71	2.74	2.88	2.83	2.05	2.56	2.26	1.41	2.14

Bottleneck indicators ■  
Average indicators ■  
Good indicators ■

Figure 4: Provincial disaggregated scores across the domains

## Key bottlenecks and its analysis

### Financing: Budgeting

- There is a lack of a costed implementation plan for the scale-up of SBC for FP.
- There is inadequate funding for SBC for FP in national budgets.
- SBC for FP is not a priority of provincial and local governments.

### Qualitative findings

- The allocation for Social and Behavior Change (SBC) remains minimal, with only 0.13% of the total health budget assigned by NHEICC, and an even smaller 0.017% specifically for family planning SBC. Combined central and provincial budgets allocate just 0.18% to SBC efforts.
- SBC budgeting is not a priority, and frankly, we haven't really thought about it from this perspective.

### Financing: Spending

- The earmarked budget is too low for the government and is heavily reliant on external funding.

### Qualitative findings

- Our biggest source of funding comes from partners who support us annually, and that largely dictates how we allocate and spend our resources.
- Most activities are run by NGOs and other partners. We attend when asked and review their work, but we don't get into the specifics of their spending and other details.

## **People: Consultation**

- Inadequate consultation with target audiences is a major pitfall of “expert bias” who, instead of facilitating, leads the process.
- FP promotion is not a priority mainly because policy makers and politicians now understand that FP activities are unnecessary because of the declining fertility rate and that promotion should focus “on having babies, not stopping them.”
- There are no mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meets the needs of clients and communities.

## **Qualitative findings**

- *I'm still surprised that we're even discussing family planning. Do you all think that's really necessary?*
- *We try to involve as many locals and stakeholders as possible when designing and pretesting messages, but it's clear there's room to make this process more systematic.*
- *I can't recall any time we were actually involved in designing the messages. We're simply asked to communicate them and reach out to the community.*

## **Information: Data and HMIS**

- SBC coverage and its proper assessment of knowledge or acceptance of FP are not a practice.
- Limited client surveys are done; those done by external agencies are not timely shared with the government. The surveys are many times supply-side-focused.
- There is no mechanism to regularly assess the KAP or perception.

## **Information: Reporting**

- There are no reporting standards and key performance indicators for monitoring of SBC for FP activities, including within health facilities, within community health programmes, and for national SBC activities and campaigns
- There is no agreed goal or target for SBC coverage.
- SBC approaches are not routinely monitored and evaluated, while allowing for design iteration and adaptive programming

## **Qualitative findings**

- *There aren't any proper indicators in place to measure SBC activities or their impact. Without these, it's hard to gauge what's working and what isn't.*
- *If we genuinely want to see the impact of our SBC efforts, we need to set agreed-upon goals and targets. It's essential for everyone to be aligned on what success looks like.*

# Consensus workshop

The consensus workshop for the Bottleneck Assessment (BNA) of Social and Behavior Change for Family Planning (SBC-FP) in Nepal was designed to identify and prioritize key challenges and develop actionable solutions for improving SBC initiatives. The process began with extensive preparation, including meetings with the Family Welfare Division (FWD) and Technical Working Group (TWG) members to review the BNA protocol and adapt the tools to the Nepalese context. Participants were divided into three groups focused on different thematic areas: governance and financing, people and information, and medicines/technology, service delivery, and human resources.

During the workshop, each group engaged in detailed discussions to rank the identified bottlenecks related to SBC-FP, considering factors such as the severity of the problem, its impact on program scalability and quality, and the urgency of resolving the bottleneck. The groups then performed a root cause analysis using a problem tree approach to identify underlying causes and potential solutions. This was followed by a session on solution planning, where participants prioritized high-impact and feasible interventions, particularly those that could be implemented quickly ("quick wins"). The workshop concluded with presentations of group findings, feedback collection from the broader group, and consensus-building on the final set of solutions to strengthen SBC-FP efforts in Nepal.

## Group ranking

During the group ranking exercise of the consensus workshop, participants were divided into three thematic groups focusing on governance and financing, people and information, and medicines/technology, service delivery, and human resources. Each group was tasked with ranking a set of bottlenecks related to SBC-FP using a predefined scale, considering criteria such as the severity of the bottleneck, its impact on program scalability, and the urgency of addressing it.

The participants discussed each bottleneck in detail, aiming to reach a consensus on their rankings. They considered questions such as the extent of the problem, its potential impact if addressed, and the urgency of resolving it. The exercise encouraged in-depth discussions and deliberations among group members, ensuring diverse perspectives were considered. Each group then presented their findings, highlighting the top five bottlenecks and their rationale for prioritization, fostering a collaborative environment for problem-solving and strategic planning.

<b>SBC Group 1: Governance &amp; Financing</b>		
<b>BNA Framework Theme</b>	<b>Categories</b>	<b>Bottleneck rank</b>
<b>Governance and financing</b>		
Governance	Leadership and commitment	1
Governance	Accountability	2
Governance	Planning	3
Financing	Budgeting	4
Financing	Equity	5
<b>Group 2: People and Information</b>		
<b>BNA Framework Theme</b>	<b>Categories</b>	<b>Bottleneck rank</b>
<b>People and information</b>		
Information	Reporting data/HMIS	1
People	Consultation	2
People	Coordination	3
People	Community Engagement	4
People	Communication, Knowledge and awareness	5
<b>Group 3: Medicine and technology, Service delivery and Human Resources</b>		
<b>BNA Framework Theme</b>	<b>Categories</b>	<b>Bottleneck rank</b>
<b>Medicine and technology, Service delivery and Human Resources</b>		
Human Resource	Training and education	1
Human Resource	Roles	2
Service delivery	Management	3
Service delivery	Supervision	4
Medicine and Technology	Supplies	5

## Root cause analysis using tree diagram

During the consensus workshop, three groups, each divided into two teams for PFP and SBC, were tasked with conducting root cause analyses on selected bottlenecks. Out of the 15 bottlenecks initially identified, each group focused on analyzing three specific bottlenecks, resulting in a 3-3-3 approach. Using the 'Problem Tree' method, participants identified the root causes for each bottleneck by asking the "5 Why's," allowing them to explore multiple underlying issues and potential solutions.

Major Bottlenecks Identified	Intermediate causes (5 Whys)	Problems (Main root causes)
There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.	<ul style="list-style-type: none"> <li>SBC for FP doesn't fall in the priority of leaders at all levels.</li> <li>Leaders at all levels don't understand the importance of SBC for FP.</li> <li>Insufficient evidence collected, packaged, and presented to leaders at all levels on the importance and effectiveness of SBC for FP.</li> <li>The government views SBC for FP as mainly the responsibility of the private sector and NGOs.</li> <li>SBC for FP has not been institutionalized, especially at sub-national levels.</li> </ul>	The government views SBC for FP as mainly the responsibility of the private sector and NGOs, assuming it will occur without significant effort. Hence, SBC for FP has not been institutionalised, especially at sub-national levels.
There is inadequate budget available at all levels for scale-up of SBC for FP.	<ul style="list-style-type: none"> <li>Budget allocation for SBC-focused FP programs is insufficient and unspecified at all levels. The National Health Communication Policy specifies that 2% of the health budget should go to SBCC, but only 0.18% has been allocated for the SBCC.</li> <li>Of the 0.18% of the total health budget allocated to SBCC, only 0.017% is designated for SBC for FP.</li> <li>Only 0.017% of total SBCC budget is designated for SBC for FP because we lack a robust cost-benefit analysis and sufficient evidence, so we haven't effectively presented our case to the Ministry of Finance.</li> <li>We have not performed a robust cost-benefit analysis and provided sufficient evidence because we lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis. (The first two issues are already addressed in two other bottlenecks.)</li> </ul>	We lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis.
Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.	<ul style="list-style-type: none"> <li>Adequate budget is not allocated for equitable SBC for intersectional groups, including adolescents, women from poor and/or rural contexts, WLHIV (women living with HIV), WLD (women living with disabilities), women from minority ethnic groups, and female sex workers. (This is linked with the 'Budgeting' bottleneck.)</li> <li>People in leadership and management positions have limited realization of the tailored needs of SBC for FP for intersectional groups of people.</li> <li>There is a lack of awareness and knowledge regarding the tailored needs of intersectional groups of people.</li> </ul>	Adequate budget is not allocated for equitable SBC for intersectional groups including adolescents, women from poor and/or rural contexts, WLHIC, WLD, women from minority ethnic group, female sex workers. <b>(Link with the 'Budgeting' in pointer 3)</b>

Major Bottlenecks Identified	Intermediate causes (5 Whys)	Problems (Main root causes)
	<ul style="list-style-type: none"> <li>Stakeholders have not been able to meaningfully coordinate and collaborate with leaders and managers within the health system to raise awareness about these needs. These stakeholders include agencies and groups working with intersectional groups.</li> <li>There is no existing mechanism (structures and processes are not defined) for coordination and collaboration to raise awareness about the needs of intersectional groups.</li> </ul>	<p>There is no existing mechanism (structures and processes are not defined) for the coordination and collaboration.</p>
<p>Inadequate recording and reporting on SBC activities</p>	<ul style="list-style-type: none"> <li>No agreed standards, forums, and formats for recording and reporting for SBCC.</li> <li>No indicators set for SBCC activities.</li> <li>Data use clarity issues, reliability, validity, and credibility problems.</li> <li>Discussion among decision-makers is not extensive and inclusive; no advocacy and capacity at the subnational level on planning and budgeting.</li> <li>Lack of regular engagement and coordination of different stakeholders; lack of regular capacity-building activities, and advocacy for related stakeholders; inadequate awareness of data validity and data use at the service provider level; no client feedback mechanism on monitoring and supervision to ensure credibility.</li> </ul>	<p>No Indicators set for SBCC activities</p>
<p>Inadequate community engagement on SBC for FP</p>	<ul style="list-style-type: none"> <li>No established strategy for designing SBC initiatives in collaboration with local stakeholders.</li> <li>Lack of familiarity with SBC for FP among the community and stakeholders.</li> <li>Lack of coordinated primary SBCC program in the context of federalization.</li> <li>More centralized SBC programs on FP in terms of TOR, HR, and resources.</li> <li>Lack of understanding among community people and related stakeholders regarding the needs of specific groups (religion, gender, geography, liability) and the impact/importance of SBC.</li> </ul>	<p>No established strategy for designing SBC initiatives in collaboration with local stakeholders</p>
<p><b>Inadequate skilled human resource for SBC-FP (includes HR-capacity and service delivery-motivation)</b></p>	<ul style="list-style-type: none"> <li>SBC-FP skill development is not a priority.</li> <li>There is a lack of evidence on SBC-FP HR competency status.</li> <li>Limited awareness about SBC-FP exists among authorities at all levels.</li> <li>No Learning Resource Package (LRP) for health workers in SBC-FP.</li> <li>The need for SBC-FP training is not felt at higher levels.</li> </ul>	<p>SBC-FP skill development not a priority  Limited awareness about SBC-FP (among authorities at all levels)  No LRP for health workers in SBC-FP</p>

## Solution grid

During the solution grid exercise for SBC for FP, participants focused on identifying "quick wins" – interventions that are both highly feasible and expected to have a significant impact. They evaluated solutions that could be swiftly implemented and would deliver immediate benefits to the SBC programs. This approach emphasized practical, actionable steps that required minimal resources but could significantly enhance the effectiveness and scalability of SBC initiatives for FP. The prioritization of these quick wins aimed to maximize resource use and achieve rapid progress in addressing the key bottlenecks identified in the earlier phases of the assessment.

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Primary Responsibility	Supporting agencies
There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.	The government views SBC for FP as mainly the responsibility of the private sector and NGOs, assuming it will occur without significant effort. Hence, SBC for FP has not been institutionalised, especially at sub-national levels.	Institutionalised SBC for FP especially at the subnational level. (Structure, focal person, processes) <b>Identify and assign the focal person. This focal person is the same focal assigned for FP/RH.</b>	NHEICC	FWD Provincial directorate Health Office Local government (Health Section)
There is inadequate budget available at all levels for scale-up of SBC for FP.	We lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis. (Former 2 are already addressed in 2 other bottlenecks.	<b>Develop expertise to perform CBA and use the evidence for policy analysis and advocacy with focus on local government.</b>	NHEICC	Donors/HDPs (capacity building), MOHP, NPC, MOF, Provincial Directorate planning section, Provincial planning commission, Local level
Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.	Adequate budget is not allocated for equitable SBC for intersectional groups including adolescents, women from poor and/or rural contexts, WLHIC, WLD, women from minority ethnic group, female sex workers. <b>(Link with the 'Budgeting' in pointer 3)</b> There is no existing mechanism (structures and processes are not defined) for the coordination and collaboration.	<b>Strengthen existing mechanism for coordination and collaboration for social inclusion in SBC for FP for public institutions (three tiers), private institutions and NGOs.</b>	NHEICC	FWD Provincial Directorate Local Level
Inadequate recording and reporting on SBC activities	No Indicators set for SBCC activities	Set indicators and targets Agreed standards forms and formats for recording and reporting for SBCC. EHRR	<b>FWD/MD</b>	Development agencies and subnational governments

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Primary Responsibility	Supporting agencies
		Ensure Capacity building Monitoring on quality of data, RDQA		
Inadequate community engagement on SBC for FP	No established strategy for designing SBC initiatives in collaboration with local stakeholders	Design program with community engagement on SBC as a core intervention. Programs and interventions should be tailored as per the need of community. Mobilization of community key influencers for behaviour change and change in norms: mother group, FCHV, leaders	<b>NHEICC</b>	<b>FWD and stakeholders</b>
<b>Inadequate skilled human resource for SBC-FP (includes HR-capacity and service delivery-motivation)</b>	SBC-FP skill development not a priority Limited awareness about SBC-FP (among authorities at all levels) No LRP for health workers in SBC-FP	Advocacy from SBC-FP champions Develop LRP for SBC-FP for health workers Orientation / training and mentoring on SBC-FP	<b>NHEICC, FWD, Provinces, local levels, NHTC, PHTC</b>	<b>Partners</b>

# Conclusion and way forward

The bottleneck assessment of SBC for Family Planning in Nepal has revealed several critical challenges that impede the effective scale-up of evidence-based practices. Key findings highlight a lack of strong leadership and commitment, inadequate community engagement, poor data management and accountability, and insufficiently skilled human resources. These gaps have led to fragmented implementation of SBC initiatives, hindering the broader adoption and sustainability of family planning practices across different levels of the health system. A strategic and coordinated approach is needed to overcome these challenges, focusing on enhancing governance structures, improving resource allocation, fostering community participation, and building robust data management systems. Addressing these areas will ensure a more effective and sustainable scale-up of SBC for FP in Nepal.

## Way Forward

- **Strengthen Leadership and Commitment:**
  - Institutionalize SBC for FP within government frameworks at all levels.
  - Assign dedicated focal persons for SBC-FP to ensure consistent support and oversight.
- **Improve Community Engagement:**
  - Develop and implement strategies that involve local stakeholders and community influencers in designing SBC initiatives.
  - Focus on tailored programs that address the specific needs and cultural contexts of diverse communities.
- **Enhance Data Management and Accountability:**
  - Establish standardized indicators and reporting formats for SBC activities.
  - Build capacity among service providers for data collection, management, and use to enhance the credibility and reliability of SBC data.
- **Develop Human Resource Capacity:**
  - Create and implement a Learning Resource Package (LRP) for health workers focused on SBC-FP.
  - Provide continuous training, mentoring, and support for health workers to strengthen their skills and knowledge in SBC-FP.
- **Ensure Adequate Financing:**
  - Advocate for increased budget allocation for SBC-FP at all government levels, including national, provincial, and local.
  - Conduct cost-benefit analyses to demonstrate the value and impact of SBC interventions, encouraging greater investment from government and donor agencies.

- **Promote Coordination and Collaboration:**
  - Strengthen mechanisms for coordination and collaboration among all stakeholders, including government, NGOs, and private sector partners.
  - Foster a collaborative environment to share resources, expertise, and best practices for implementing SBC initiatives effectively.

# Pictures





# Annex

## Annex 1: Members of technical working group

SN	Name	Designation	Affiliation	Contact
1	Dr Bibek Kumar Lal	Director	FWD	bibeklal@outlook.com
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6	Puspa Raj Joshi	Statistical Officer	FWD	pjoshiregmi@gmail.com
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8	Dirgha Raj Shrestha	FP Expert	HEADS	dirgharajshrestha@gmail.com
9	Dr Rajendra Bhadra	FP Expert	HEADS	rajendrabhadra@gmail.com
10	Dr Pooja Pradhan	National Professional Officer	WHO	ppradhan@who.int
11	Manish Gautam	Lead- SBC-FP	ANWESHAN	manish@anweshan.org
12	Madan Raj Bhatt	Lead – PFP	ANWESHAN	madan.bhatta@gmail.com
13	Pranav Rajbhandari	SBC Expert		pranabrb@jhu.edu
14	Dr Mahesh Puri	RH Research Expert	CREHPA	mahesh@crehpa.org.np
15	Dr Rajendra Gurung	FP Expert		gurung98@gmail.com

## Annex 2: Introduction and consent to participate in key informant survey

This questionnaire is part of a national ‘FP Bottlenecks Assessment’ being coordinated by the World Health Organization, investigating the scale-up of evidence-based practices in family planning. This questionnaire will ask about your opinions on a range of potential health systems ‘bottlenecks’ (or barriers or factors) that may be inhibiting scale-up of effective approaches for social and behaviour change in family planning (FP). You will be asked to rate your agreement out of 5 with a series of statements (from fully agree to fully disagree). You can also add comments about each statement if you wish. At the end, you can mention any potential barriers or challenges that have not been raised in the questionnaire.

You have been purposefully selected as a person with considerable knowledge on family planning programming in this country, on approaches to SBC. Your opinions will be greatly valuable for the Bottlenecks Assessment. A consensus-building workshop will be held with a range of different stakeholders to identify the most important bottlenecks, and to identify solutions to address them. Everything you write in this questionnaire or tell us in person will be anonymized. We will only ask questions about your work role. Please just let us know that you are not able to complete the questionnaire, and we will seek another informant. There will be no impact on your employment.

Agree to participate:

## Annex 3: Key informant Questionnaire for SBC

### Bottlenecks Assessment (BNA) KII Questionnaire – SBC

Section	Q #	Preliminary questions	Circle the correct response:	Any comments
Background	1	What type of organization do you work for (circle number that applies)?	1. Government 2. Professional association 3. NGO or civil society 4. Private (not for profit) 5. Private (for profit) 6. Other _____	
	2	What is your role in that organisation (circle number that applies)?	1. Policy 2. Programme management 3. Researcher/M&E 4. Clinician or health worker (community or facility, please specify) _____ 5. Other _____	
	3	At what level do you provide support to FP programmes (circle number that applies):	1. Federal 2. Provincial 3. District 4. Local 5. Community 6. Other _____	
	4	How long have you been working in or supporting FP programmes (circle number that applies):	1. <1 year 2. 1-3 years 3. 3-10 years 4. >10 years	

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Implementation status		1.	<b>SBC for family planning is adequately implemented and scaled-up nationally (federal, provincial and local levels)</b> <b>Consider these statements when rating:</b> <ul style="list-style-type: none"> <li>SBC for FP is well implemented and scaled across both the public and private/NGO health sector.</li> <li>SBC on FP is integrated into broader development programming including education, WASH, humanitarian, livelihoods, environment, etc.</li> <li>Mass media campaigns are implemented to address social and gender norms impacting reproductive health and to promote FP.</li> <li>Health facilities work to address social and gender norms impacting RH and promote FP in their catchment populations through various community engagement activities (e.g. community outreach, mobilization, home-based counselling, campaigns such as 'FP days', digital marketing and engagement (mobile, online), etc.)</li> <li>There is broad scale digital engagement on RH (via phones, apps, social media, web, etc.) to address social and gender norms impacting reproductive health and to promote FP.</li> <li>Health facilities actively try to inform, educate, and empower clients coming for FP about methods and their side effects before, during and after their visits.</li> <li>Health facilities actively try to inform, educate, and empower clients coming for</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<p>maternal &amp; child, nutrition, immunization, HIV or other linked health services about FP.</p> <ul style="list-style-type: none"> <li>Health facilities actively try to engage men in family planning, either via couples counselling or via other strategies to reach and educate men and adolescent boys.</li> </ul>		
Governance	Leadership & commitment	2.	<p><b>There is strong leadership and commitment to support scale-up of SBC for FP at all level.</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There is political support for SBC for FP at the national level</li> <li>SBC is included in national FP goals</li> <li>SBC for FP has champions advocating for the practice at the national level</li> <li>SBC for FP has champions advocating for the practice at the provincial and local level</li> <li>The MOHP sets out objectives, guidance and principles for SBC but allows provinces, districts and municipalities to determine locally relevant communication approaches</li> </ul>		
	Accountability	3.	<p><b>There is strong accountability for SBC for FP across institutions and among policy makers and programme managers</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) including provision of technical committees to enable effective SBC policy development and programming.</li> <li>A public officer has accountability* to deliver scale-up of SBC for FP at the national level (is someone responsible for ensuring scale-up of SBC in the MoHP or other public institution?)</li> <li>A public officer has accountability* to deliver scale-up of SBC for FP at the provincial and local level</li> <li>There is a provision of social audit at each level to ensure accountability.</li> </ul> <p><i>*Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up</i></p>		
	Regulation	4.	<p><b>There is strong regulation to ensure effective SBC for FP.</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There are no laws or policies that require partner consent to receive FP</li> <li>There are no laws or policies that restrict access for adolescents or unmarried women.</li> <li>There are no limitations to promoting contraception in the mass media</li> <li>The private/non-governmental sector is adequately regulated in its SBC activities</li> <li>There are laws that regulate misinformation.</li> </ul>		
	Guidance formulation	5.	<p><b>There is sufficient guidance (including policies, guidelines and tools) to support scale up of SBC for FP</b></p> <p><b>Consider these statements when rating:</b></p>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<ul style="list-style-type: none"> <li>• Policy &amp; practice guidance to support implementation of SBC for FP exists and is up to date.</li> <li>• Policy &amp; practice guidance to support implementation of SBC for FP is available to relevant district health teams and health facilities</li> <li>• Policy &amp; practice guidance on SBC is endorsed by the MoHP</li> <li>• International standards and guidance on SBC have been adapted to the federaland/or provincial/local context</li> <li>• SBC guidance exists that covers key principles including needs for formative research, pre-testing messaging, targeting of communication, communication channel selection, audience segmentation, coordination with existing community infrastructure, and community engagement.</li> <li>• SBC guidance advises structured design processes (including insight gathering, theory-based design, monitoring, iteration, redesign, dissemination, scale-up)</li> <li>• There is guidance to support the review of SBC materials/media and their alignment with national priorities</li> <li>• National SBC guidance allows for flexibility in implementation according to context</li> </ul>		
	Planning	6.	<p><b>There is a coherent national plan for SBC scale-up</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• The extent of SBC FP coverage or gaps have been mapped nationally</li> <li>• A strategic plan for expanding coverage of FP related SBC exists and has been effectively communicated and actions are included within annual operating plans.</li> <li>• Strategic plans for SBC FP delineate desired behaviour changes, determinants of behaviour change, audience, channels, costs, geography, M&amp;E and costing</li> <li>• Potential challenges to implementation are identified and addressed proactively</li> </ul>		
Financing	Budgeting	7.	<p><b>There is adequate budget available at all levels for scale-up of SBC for FP.</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• There is a costed implementation plan for scale-up of SBC for FP</li> <li>• SBC for FP has been included in the FP2020/30 CIP</li> <li>• SBC for FP has been included in the Global Financing Facility (GFF) Investment Case.</li> <li>• Adequate funds are allocated to SBC for FP in federal budgets</li> <li>• Adequate funds are allocated to SBC for FP in provincial and local level budgets</li> </ul>		
	Donors	8.	<p><b>Donors sufficiently contribute to financing scale-up of SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• Donor priorities are aligned with MOHP policies and priorities for SBC scale-up.</li> <li>• Donors commitments are sufficiently financed in budgets.</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Spending allocation	9.	<b>Government expenditure on SBC matches the allocated budget</b>		
	Equity	10.	<p><b>There are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high.</li> <li>Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts.</li> <li>Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethnic groups and female sex workers.</li> <li>Data are reviewed regularly to ensure equitable allocation of budget.</li> </ul>		
People	Communication, knowledge & awareness	11.	<p><b>There is a high level of knowledge and awareness of recommended SBC policies and practices:</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>There is effective national dissemination of relevant policies and guidance.</li> <li>Policymakers &amp; programme managers at the federal and provincial and local levels fully understand and know recommended principles and practices for SBC</li> <li>Health promotion/communication teams at various levels of the health system fully understand and know recommended approaches to SBC for FP</li> <li>There are effective communication channels in place to ensure that stakeholders remain engaged and informed about SBC activities and progress.</li> </ul>		
	Acceptability	12.	<p><b>There is acceptance of recommended SBC policies and practices by key stakeholders</b></p> <p><i>Consider these statements:</i></p> <ul style="list-style-type: none"> <li>Recommendations on SBC interventions and activities are supported by local evidence.</li> <li>Policymakers &amp; programme managers at national and provincial and local levels fully agree with the need to scale-up SBC for FP</li> <li>Senior healthcare managers fully agree with the need to scale up SBC for FP</li> <li>Health promotion and health communication managers see SBC for FP as relevant to their work</li> <li>Facility managers see SBC for FP as relevant to their work</li> </ul>		
	Consultation	13.	<p><b>Key stakeholders are adequately consulted about SBC recommended approaches, guidance and rollout</b></p> <p><i>Consider these statements:</i></p> <ul style="list-style-type: none"> <li>Stakeholders, including target audiences, have been adequately consulted during the creation of SBC practice guidance.</li> <li>Groups that may be opposed to FP promotion are sufficiently consulted (e.g.</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<p>for religious, cultural, anti-choice reasons, etc.)</p> <ul style="list-style-type: none"> <li>There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.</li> </ul>		
	Coordination	14.	<p><b>There is good coordination between different stakeholders to ensure effective scale-up of SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>National policies and budgeting are effectively transferred to provincial and local level policies</li> <li>The MOHP effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up SBC for FP</li> <li>There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoHP, donors, NGOs, UN, professional associations etc.)</li> <li>Technical working groups (TWGs) on SBC/FP exist to support coordination, resourcing, learning, etc.</li> <li>There are regular interagency meetings during the year that discuss and plan for SBC scale-up (with participation of MoHP, donors, NGOs, UN, professional associations etc.)</li> <li>The FP teams jointly plan with the health promotion/community health engagement teams in the MOHP for SBC scale-up</li> <li>The FP teams jointly plan with the Department of Education for SBC scale-up in SRH</li> <li>The FP and/or health promotion teams can coordinate demand generation/SBC efforts across different agencies, health teams, NGOs, and other civil society groups</li> <li>SBC coordinators/TWGs can quality-control SBC activities, for example using guidelines or checklists (including control for potential rights-violations)</li> <li>Health facilities work with civil society and NGOs to promote FP in the community, including to marginalized groups.</li> <li>Health promotion/communication experts regularly advise the MOHP and participate in planning meetings to scale up SBC.</li> <li>District health teams and facilities coordinate with schools or educational departments to support promotion of FP among adolescents</li> <li>Federal, Provincial or local level activities (e.g. campaigns, mass/digital media) are coordinated and non-duplicative.</li> </ul>		
	Networks	15.	<p><b>There are effective professional networks supporting scale-up of SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>The FP SC and SBC/IEC TWG prioritises and plans to support SBC scale up</li> <li>SBC is actively and regularly promoted through professional networks.</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<ul style="list-style-type: none"> <li>There are networks or communities of practice that support SBC scale-up (e.g. SBC/IEC TWGs) and help with coordination of efforts at all level.</li> <li>The country has learned from other similar country contexts on how to scale-up SBC</li> </ul>		
	Community engagement	16.	<p><b>There is adequate community engagement on SBC for FP</b></p> <p><b>Consider this statement:</b></p> <ul style="list-style-type: none"> <li>Engagement is tailored to address local social and gender norms that affect reproductive health decisions</li> <li>Health services and/or district health teams deliver community outreach on FP, including home-based SBC</li> <li>Facilities and district health teams work with trusted community or religious leaders to promote FP</li> <li>SBC initiatives are designed in collaboration with local communities</li> <li>SBC coordinators /health promotion teams work with religious leaders to promote FP in settings of religious resistance</li> <li>SBC coordinators/health promotion teams work with men and boys to promote male engagement in SRH</li> <li>SBC coordinators/health promotion teams make efforts to ensure that SBC activities are rights-based and non-coercive</li> <li>Health facilities offering FP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)</li> </ul>		
Information	Reporting	17.	<p><b>There is adequate reporting on SBC activities. Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There are agreed reporting standards and key performance indicators for monitoring of SBC for FP activities, including within health facilities, within community health programmes, and for national SBC activities and campaigns</li> <li>There is an agreed goal or target for SBC coverage.</li> <li>Data on SBC coverage, or information on different SBC initiatives (in both public and private/NGO sectors), is received and monitored at federal, provincial and local levels</li> <li>SBC approaches are routinely monitored and evaluated, while allowing for design iteration and adaptive programming</li> </ul>		
	Data & HMIS	18.	<p><b>There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities, and data is used regularly for performance management.</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Data trends on SBC coverage or outcomes on knowledge or acceptance of FP are shared with district health teams, facilities, and program managers to allow regular assessment and comparison of performance</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<ul style="list-style-type: none"> <li>HMIS (used by facilities or FCHVs) can capture referrals from community outreach/engagement efforts</li> <li>Client surveys capture data on how and why FP clients attended services and/or chose specific methods</li> <li>Data on SBC and its outcomes (knowledge, attitudes, practices, social norms, client perceptions of quality) is used regularly to assess and manage programming response</li> </ul>		
	Guidelines & tools	19.	<p><b>Updated guidance on SBC for FP is available and widely used.</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>Guidance on facility-based health communication on FP exists and is available at all service delivery points</li> <li>Health facilities are and community health programmes are equipped with guidance and tools to deliver community outreach for FP</li> </ul>		
	Client SBC/IEC	20.	<p><b>SBC/IEC materials exist to support SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>SBC/IEC materials/apps on FP provision exist for both health facilities and community outreach work, and are routinely distributed and available for use by providers with clients/for client takeaway</li> </ul>		
	Health promotion	21.	<p><b>Communication on FP is integrated with health promotion activities.</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>Successful behavioural interventions to promote social norm change and FP uptake (individuals or couples) via mass media are known and scaled</li> <li>Successful behavioural interpersonal interventions to promote social norm change and FP uptake (individuals or couples) are known and scaled.</li> <li>Successful behavioural interventions to promote social norm change and FP uptake (individual or couple) via community groups or other forms of community engagement are known and scaled</li> </ul>		
Medicines & technology	Infrastructure	22.	<p><b>There is adequate health infrastructure to deliver SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>Mass media and mobile phone technologies have sufficient market penetration/population coverage to be used as effective SBC tools</li> <li>Community health infrastructure exists and is used for health promotion</li> <li>There are effective linkages between community health and static health facilities</li> </ul>		
	Supplies	23.	<p><b>District health teams, health facilities and community health programmes have sufficient commodities, equipment, tools and other supplies required to deliver SBC for FP</b></p>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Health teams at each level and FCHVs are fully equipped with supplies and commodities needed</li> </ul>		
Service delivery	Management	24.	<p><b>There is effective health management to support SBC</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There is a designated manager in health facilities who is accountable for SBC activities in catchment populations</li> <li>Implementation of SBC is included in performance review processes of facility managers at each level.</li> <li>Quality improvement and program audit processes/system cover implementation of SBC including counselling, SBC/IEC materials and community outreach</li> <li>Clinical leaders advocate for and promote improved client and couple communication in their facilities</li> <li>The relevant healthcare and health promotion managers have sufficient capacity to manage the scale-up of SBC for FP on top of their other responsibilities</li> <li>Management tools and procedures exist to support managers address constraints with implementing SBC</li> <li>Managers regularly monitor trends in SBC activities and outcomes (knowledge, attitudes, social norms) to assess potential needs and gaps</li> <li>Health facility and health promotion/public health managers regularly conduct learning reviews on SBC to assess what is working well and what needs change/adaptation.</li> <li>Managers regularly conduct client journey mapping and/or client flow analysis to identify how to deliver education and counselling to clients attending for different services</li> </ul>		
	Supervision	25.	<p><b>There is adequate supervision to support SBC</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There are supervisors who are trained to advise on and quality-assure health promotion and SBC efforts for FP, including supervision of HWs and FCHVs activities</li> <li>FP providers are competency assessed in their counselling skills</li> </ul>		
	Team work & coordination	26.	<p><b>Community health teams and CHWs work in a coordinated way with health facilities</b></p>		
	Service organization & scheduling	27.	<p><b>The organization of services makes SBC feasible</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Health services have capacity to deliver SBC interventions to promote or educate on FP throughout the client journey (before, during and after service delivery)</li> <li>Community health services have capacity for effective SBC and demand generation activities in the communities they serve</li> <li>Health service operating hours are accessible for the whole community population in need of FP including adolescents</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Referral systems	28.	<b>There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities</b>		
	Fees	29.	<b>There are no fees for accessing FP services, or specific methods</b>		
Human Resources	Training & education	30.	<b>There is adequate training on SBC for FP</b> <i>Consider these statements when rating:</i> <ul style="list-style-type: none"> <li>• Training needs for HWs and FCHVs FP provision are regularly assessed</li> <li>• There is adequate training for district and/or facility-based health promotion teams on effective SBC approaches</li> </ul>		
	Capacity	31.	<b>Staff working on FP across the health system have capacity to deliver SBC for FP</b>  <i>Consider these statements:</i> <ul style="list-style-type: none"> <li>• Staff in national, provincial, district and local health teams working on FP have capacity in their roles to deliver SBC scale-up.</li> <li>• Health facility staff have relevant competencies to deliver counselling and other health education and communication on FP to clients</li> <li>• Staff turnover is low enough to allow institutionalisation of SBC approaches</li> </ul>		
	Roles	32.	<b>SBC is included in the relevant provider and manager job descriptions</b>  <i>Consider these statements:</i> <ul style="list-style-type: none"> <li>• SBC for FP is included in role descriptions of FP technical programme managers or focal persons at federal, provincial district and local levels.</li> <li>• HWs (e.g. ANM) and CHWs (FCHVs) have defined roles which include SBC for demand generation</li> <li>• There are assigned roles in health facilities and the district health team for health communication/education/promotion and SBC</li> <li>• Counselling skills are included in family planning provider job descriptions</li> </ul>		
	Skills & competencies	33.	<b>FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC</b> <ul style="list-style-type: none"> <li>• Staff working to support FP across the health system have relevant skills and competencies for SBC including in health communication and education, social and behaviour change, and community health.</li> </ul>		
	Motivation	34.	<b>Health workers involved in SBC have positive attitudes towards the policy</b> <i>Consider these statements when rating:</i> <ul style="list-style-type: none"> <li>• HWs and FCHVs are motivated to inform, educate, and counsel clients and their partners on FP</li> <li>• HWs and FCHVs are adequately remunerated or incentivised, and performance managed to deliver SBC for FP</li> <li>• Facility-based FP providers are motivated to inform, educate, and counsel clients and their partners on FP</li> <li>• Staff working in FP provision have positive attitude towards the community (non-judgemental, empathetic, respectful)</li> </ul>		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			<ul style="list-style-type: none"> <li>There is a supportive institutional culture that prioritises effective communication and community engagement.</li> </ul>		
		35.			
		36.	<p><b>Are there any other challenges, barriers, or 'bottlenecks' that are inhibiting effective scale-up of SBC for FP in this country that you would like to mention? Consider the different SBC interventions used for FP (mass media, community engagement, digital engagement) and different objectives of SBC (social norms change, healthy couple communication, and improved knowledge/attitudes/beliefs/self-efficacy).</b></p> <p><i>Enter response here:</i></p>		

## Annex 4: Checklist for SBC Case Study

Title of project or programme with short description (Select 2-3 case studies) (include the strategies and key populations included)	Where was the project or programme implemented? (States, regions, districts)	Who implemented it?	What behavioural outcomes were desired and what were the achievements?	What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework)	What were some of the challenges? (Review Bottlenecks Framework and SBC principles)	Any other relevant information including lessons learned?

## Annex 5: BNA Consensus Workshop Schedule

SN	Session Name	Session Aims	Timings	Facilitators
<b>August 9, 2024</b>				
1	Opening Session	Breakfast and registration	7-9 am	ANWESHAN
		<ul style="list-style-type: none"> <li>• Session chair – Director -FWD</li> <li>• Introductions</li> <li>• Welcome and objectives</li> </ul>	9-9:30am	FWD
		Key recommended evidence-based policies and practices on PPF and SBC-FP <ul style="list-style-type: none"> <li>• Global perspective</li> <li>• Country perspective</li> </ul>	9:30-10:30am	FWD/NHEICC/WHO
		<ul style="list-style-type: none"> <li>• Key findings from BNA – PPF</li> <li>• Key findings from BNA- SBC-FP</li> </ul>	10:30-11:30am	ANWESHAN
		<ul style="list-style-type: none"> <li>• Remarks from NHEICC</li> <li>• Remarks from FWD and closing of opening session</li> </ul>	11:30-11:45am	Keshab Raj Pandit Dr. Bibek Kumar Lal
		Tea break	11:45-12:00	All
<b>Technical Sessions</b>				
2	Data sharing and program updates	Breakout into two separate rooms (PPFP and SBC-FP) <ul style="list-style-type: none"> <li>• National data review</li> <li>• Policy alignment</li> <li>• Case studies</li> <li>• Key informant's survey findings</li> <li>• Workshop procedures</li> </ul>	12:00- 1:00pm	FWD WHO ANWESHAN
	Lunch		1:00-2:00pm	All
3	Group ranking of bottlenecks (Group work)	Breakout into two separate rooms (PPFP and SBC-FP) 3 sub-groups in each theme: <ul style="list-style-type: none"> <li>• Group 1: Governance and financing</li> <li>• Group 2: People and information</li> <li>• Group 3: Medicines/technology, service delivery &amp; human resources</li> </ul> <b>Major tasks</b> <ul style="list-style-type: none"> <li>• Review BNA ranking tool, discuss, and group rate important bottlenecks</li> <li>• Prioritise the potential bottlenecks inhibiting PPF scale-up</li> <li>• Come to consensus on the top 5 bottlenecks per group (altogether 15 bottlenecks)</li> </ul>	2:00- 3:30pm	GROUP FACILITATORS
	Tea break		3:30-3:45	
4	Group report back (Presentation)	<ul style="list-style-type: none"> <li>• Share the group work (group ranking of the key bottlenecks)</li> <li>• Highlight key five bottlenecks by each group (altogether 15 bottlenecks in each theme)</li> </ul>	3:45-5:00pm	PARTICIPANTS
<b>August 10, 2024</b>				
	Breakfast		7:-8:00	All
5	Root cause analysis of key bottlenecks	Breakout into two separate rooms (PPFP and SBC-FP) 3 sub-groups in each theme: <ul style="list-style-type: none"> <li>• Group 1: Governance and financing</li> <li>• Group 2: People and information</li> <li>• Group 3: Medicines/technology, service delivery &amp; human resources</li> </ul> <b>Key tasks</b> <ul style="list-style-type: none"> <li>• Identify the root causes of the key bottlenecks (9 bottlenecks – 3 from each group)</li> <li>• Develop a problem tree for each of their 3 bottlenecks (cause –effect relationship/5 whys)</li> </ul>	8:00-10:00	GROUP FACILITATORS
	Tea break		10-00-10:15am	
6	Solutions identification	3 groups: Group 1: Governance and financing Group 2: People and information	10:15am-12:15 pm	

		<p>Group 3: Medicines/technology, service delivery &amp; human resources</p> <p>Key tasks</p> <ul style="list-style-type: none"> <li>Identify intervention (solutions) based on the root cause analysis using solution grid (matrix)</li> <li>Prioritize <b>high impact</b> (among low, moderate and high impact solutions) and <b>highly feasible</b> (among very low, moderately and highly feasible) interventions (<b>Quick wins</b>)</li> </ul>		GROUP FACILITATORS
	Lunch		12:15-1:15	
7	Group presentation (report back)	<p>Key tasks</p> <ul style="list-style-type: none"> <li>Present the group work on root cause analyses and solutions planning</li> <li>Collect feedback</li> <li>Build consensus on the final solutions identified</li> </ul>	1:15-4:00	FACILITATORS AND PARTICIPANTS
8	Closing	<p>Wrap up the session</p> <ul style="list-style-type: none"> <li>Reflect on the major highlights of the workshop</li> <li>Collect commitment from the workshop participants</li> <li>Share the vote of thanks</li> <li>Close the session</li> </ul>	4-5pm	FWD

## Annex 6: Guidance Notes for Facilitators

### Session 1: Opening Session

Major contents	Notes for facilitators
Breakfast and registration	
<ul style="list-style-type: none"> <li>• Session chair – Director -FWD</li> <li>• Introductions</li> <li>• Welcome and objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitators to lead icebreaker to allow everyone to get to know each other.</li> <li>• Facilitators to welcome everyone in the workshop and present the objectives</li> </ul>
<ul style="list-style-type: none"> <li>• Global perspective on PFPF and SBC-FP</li> <li>• Country perspective on PFPF and SBC-FP</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitators will share the Key recommended evidence-based policies and practices (global and country) on PFPF and SBC-FP followed by key findings from the bottleneck assessment conducted in Nepal.</li> </ul>
<ul style="list-style-type: none"> <li>• Key findings from BNA – PFPF</li> <li>• Key findings from BNA- SBC-FP</li> </ul>	
<ul style="list-style-type: none"> <li>• Remarks from NHEICC</li> <li>• Remarks from FWD and closing of opening session</li> </ul>	<ul style="list-style-type: none"> <li>• Directors from FWD and NHEICC will share their opening remarks focusing on PFPF and SBC-FP</li> </ul>

### Session 2: Data Sharing and Program Updates

Major contents	Notes for facilitators
<b>Data sharing and program updates on PFPF and SBC-FP</b> <ul style="list-style-type: none"> <li>• National data review</li> <li>• Policy alignment</li> <li>• Case studies</li> <li>• Key informant's survey findings</li> <li>• Workshop procedures</li> </ul>	<ul style="list-style-type: none"> <li>• The facilitators will support to breakout the workshop participants into two separate rooms for PFPF and SBC-FP components.</li> <li>• The respective facilitator(s) will share the findings from the policy &amp; guideline alignment, national data review, case studies and detail of key informant's survey findings</li> </ul>

### Session 3: Bottleneck group ranking

Major contents	Notes for facilitators
<b>PFPF and SBC-FP bottleneck group ranking</b> <ul style="list-style-type: none"> <li>• Review respective BNA ranking tool, discuss, and group rate important bottlenecks</li> <li>• Prioritise the potential bottlenecks</li> <li>• Come to consensus on the top 5 bottlenecks per group (altogether 15 bottlenecks)</li> </ul>	<p>Split into 3 groups (~6-8) for each theme, ensuring a mix of participant types (policy/programme, clinical, NGOs) across the three groups:</p> <p>PFPF</p> <ul style="list-style-type: none"> <li>• <i>Group 1: Governance and financing</i></li> <li>• <i>Group 2: People and information</i></li> <li>• <i>Group 3: Medicines/technology, service delivery &amp; human resources</i></li> </ul> <p>SBC-FP</p> <ul style="list-style-type: none"> <li>• <i>Group 1: Governance and financing</i></li> <li>• <i>Group 2: People and information</i></li> <li>• <i>Group 3: Medicines/technology, service delivery &amp; human resources</i></li> </ul> <p>After the group formation, perform the following activities:</p> <ul style="list-style-type: none"> <li>• Choose one group leader and rapporteur</li> <li>• Make clear about the process of group discussion and anticipated outcomes with the facilitators.</li> <li>• Distribute hard copies (4-5 copies/group) of group ranking tool (thematic areas only)</li> <li>• Ask the questions by facilitators and request participants of the group rank the question/tool. Try to get consensus for the collective score.</li> <li>• Once process is completed, the facilitator will review and finalize the ranking in the master tool.</li> <li>• The team lead/rapporteur will present the final score with the larger group.</li> <li>• The feedback from the floor will be documented but will not be used for the ranking purpose.</li> </ul>

### Additional notes to the facilitators

- Facilitators to encourage group to read the potential bottlenecks at each level.
- Group participants to first group rank as follows
  - *Group 1: Governance and financing (1-9, 1 least important; 9 most important)*
  - *Group 2: People and information (1-11, 1 least important; 11 most important)*
  - *Group 3: Medicines/technology, service delivery & human resources (1-14, 1 least important; 14 most important)*
- If necessary, facilitators will read out the sub-categories under each theme and request for ranking.
- Facilitator to ask for 'voices of dissent' to set out their case for bottlenecks that are missing from the top 5 or which have been prioritised at a low level.
- Group to come to consensus through discussion on the final top 5 priority bottlenecks (based on the five highest bottleneck scores)

### Points to consider while group ranking the bottlenecks

- How big is the problem
- If it was addressed, would we see likely improvements in scale and quality of program?
- Is this a problem preventing nationwide scale-up of program?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

### Programmatic areas for ranking the bottlenecks

Group 1: Governance & Financing	Group 2: People & Information	Group 3: Medicines/technology, service delivery & HR
<p><b>Governance:</b></p> <ul style="list-style-type: none"> <li>• Leadership &amp; commitment</li> <li>• Accountability</li> <li>• Regulation</li> <li>• Guidance formulation &amp; coherence</li> <li>• Planning</li> </ul> <p><b>Financing</b></p> <ul style="list-style-type: none"> <li>• Budgeting</li> <li>• Donors</li> <li>• Spending</li> <li>• Equity</li> </ul>	<p><b>People:</b></p> <ul style="list-style-type: none"> <li>• Communication, knowledge &amp; awareness</li> <li>• Acceptability</li> <li>• Consultation</li> <li>• Coordination</li> <li>• Networks</li> <li>• Community engagement</li> </ul> <p><b>Information</b></p> <ul style="list-style-type: none"> <li>• Reporting</li> <li>• Data &amp; HMIS</li> <li>• Guidelines &amp; tools</li> <li>• Client SBC/IEC</li> <li>• Health promotion</li> </ul>	<p><b>Medicines &amp; technology:</b></p> <ul style="list-style-type: none"> <li>• Infrastructure</li> <li>• Supplies</li> <li>• Innovation</li> </ul> <p><b>Service delivery:</b></p> <ul style="list-style-type: none"> <li>• Management</li> <li>• Supervision</li> <li>• Team work</li> <li>• Service organization &amp; scheduling</li> <li>• Referral systems</li> <li>• Fees</li> </ul> <p><b>Human Resources:</b></p> <ul style="list-style-type: none"> <li>• Training &amp; education</li> <li>• Capacity</li> <li>• Roles</li> <li>• Skills &amp; competencies</li> <li>• Motivation</li> </ul>
<b>Total no. of potential bottlenecks: 9</b>	<b>Total no. of potential bottlenecks: 11</b>	<b>Total no. of potential bottlenecks: 14</b>

### Session 4: Group report back (Group ranking of bottlenecks)

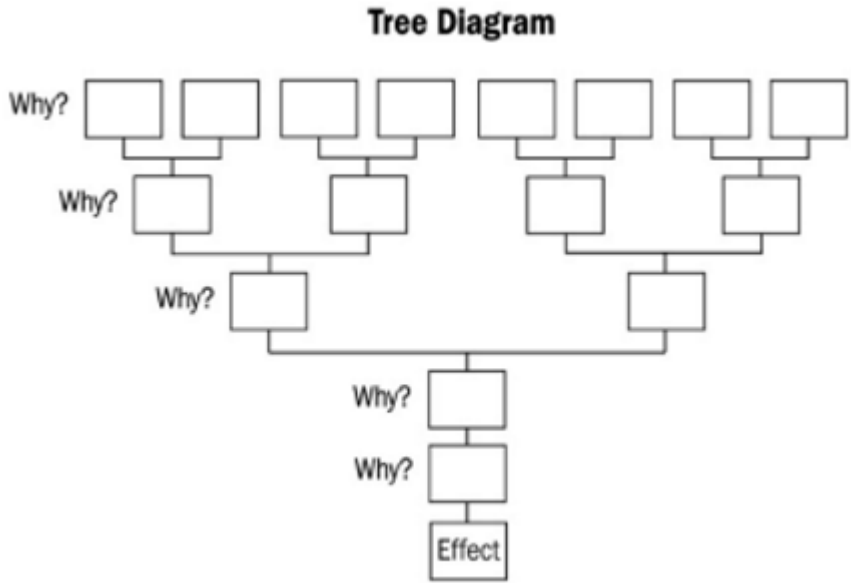
Major contents	Notes for facilitators
<p>Group report back (presentations)</p> <ul style="list-style-type: none"> <li>• Share the group work (group ranking of the key bottlenecks)</li> <li>• Highlight key five bottlenecks by each group (altogether 15 bottlenecks)</li> </ul>	<ul style="list-style-type: none"> <li>• Each group to report on its work, including the types of factors they discussed the bottleneck ranking, and the rationale for the most important bottlenecks chosen.</li> <li>• Ask the wider group to reflect on what they find surprising or interesting in the rankings.</li> <li>• Ask again for 'voices of dissent' for any important bottlenecks that have not been prioritised by other groups.</li> <li>• Ask each group if this bottleneck can actually be resolved with careful planning and resource-allocation?</li> <li>• Once that has been completed, the facilitators highlight or circle the <b>final 15 factors (bottlenecks)</b> for solutions planning.</li> <li>• Ask the group to any final voices of dissent.</li> </ul>

### Session 5: Root cause analysis

Major contents	Notes for facilitators
<ul style="list-style-type: none"> <li>• Develop a problem tree for each of their 5 bottlenecks (cause – effect relationship/5 whys)</li> <li>• Identify the root causes of the key bottlenecks (15 bottlenecks – 5 from each group)</li> </ul>	<ul style="list-style-type: none"> <li>• The same sub-groups will work on the root cause analysis and the group members will be kept the same as far as possible depending on dynamics/need.</li> <li>• Divide the <b>15 bottlenecks (5-5-5) among the respective groups.</b></li> <li>• Ask each group to develop a '<b>Problem tree</b>' for each of their 5 bottlenecks.</li> <li>• First write the <b>effect (i.e. the bottleneck)</b>, and then ask <b>The 5 Why has</b> to analyse the root cause of the bottleneck and some solutions.</li> </ul>

	<ul style="list-style-type: none"> <li>The participants will be requested to find the specific root causes and the steps of tree diagram may vary (may be less than 5) (please refer to tree diagram (fig 1) below while working on the root causes)</li> <li>Focus on the key whys so that we could focus on the important solutions.</li> </ul>
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**Figure 1: Root Cause Analysis, URC/USAID Assist Project**



**Example Root cause analysis**

If the group chose 'Accountability', the group might brainstorm as follows in one branch of the tree (but do all branches during the workshop!):

- Effect: There is no accountability for SBC in the MOPH (national and state)
- Question 1: Why is there no accountability for SBC in the MOPH?
- Answer 1: Because SBC falls between the cracks of the Family Planning Unit and the Health Promotion Team
- Question 2: Why does SBC fall between the cracks of the FP and Health Promotion units?
- Answer 2: Because nobody has it in their job description
- Question 3: Why does nobody have it in their job description?
- Answer 3: Because nobody in senior management realises that SBC isn't being addressed
- Question 4: Why does nobody in senior management realise that SBC isn't being addressed?
- Answer 4: Because SBC outcomes are not reported as KPIs for the family planning.
- Question 5: Why are FP social norms/behaviours/intentions not reported as a national FP KPIs?
- Answer 5: Because the relevant people don't know where the datapoints are and because the MOH is not required to report it to the UN/FP2030.

## Annex 7: List of facilitators and participants

	Group 1: Governance & Financing	Group 2: People & Information	Group 3: Medicines/technology, service delivery & HR	
1	Sheela Shrestha	Krishna Pandey	Ganesh Srivastav	Facilitator
2	Dr Rajendra Bhadra	Manish Gautam	Pranav Raj Rajbhandari	Co-facilitator
3	Dr. Khurshid Alam Hyder	Sujita Mishra	Santosh Paudel	
4	Ram Naresh Yadav	Deepa Bhattarai	Dr. Surakshya Thapa	
5	Hari Kala Thapa	Ravi Kumar Bhaskar	Dr Om Maharjan	
6	Upendra Khanal	Dr. Anju Deo	Kamal Subedi	
7	Roshani Adhikari	Binod Joshi	Indira Khawas	
8	Astha Subedi	Netra Bhatta		

Bottleneck analysis for Post-pregnancy Family Planning (Postpartum and postabortion and Social & Behavioral Changes for Family Planning 3-day residential workshop), 8-10 Aug 2024

List of Participants (BNA Workshop)				
S.N.	Province	Name	Organization	Designation
1	Bagmati	Dr. Bibek Kumar Lal	Family Welfare Division	Director
2	Bagmati	Ms. Sharmila Dahal Paudel	Family Welfare Division	Section Chief
3	Bagmati	Ms. Sheela Shrestha	National Health Education, Information and Communication Center	Sr. HEA
4	Bagmati	Ms. Amrita Pahadhi	Family Welfare Division	Sr. CNO
5	Bagmati	Mr. Puspa Raj Joshi	Family Welfare Division	Stat Officer
6	Bagmati	Mr. Binod Joshi	Family Welfare Division	M & E Officer
7	Bagmati	Mr. Krishna Raj Tiwari	Family Welfare Division	Stat Officer
8	Bagmati	Mr. Krishna Raj Pandey	Family Welfare Division	Stat Officer
9	Bagmati	Mr. Ganesh Srivastav	National Health Education, Information and Communication Center	SHEO
10	Bagmati	Mr. Bishnu Baskota	Family Welfare Division	
11	Bagmati	Dr. Rima Maharjan	Civil Hospital	Registrar
12	Bagmati	Dr. Jasmine Shrestha	Paropakar Maternity and Women's Hospital	Sr. Consultant
13	Bagmati	Dr. Saurav Sunar	Thankot Hospital	Medical Superintendent
14	Bagmati	Dr. Om Maharjan	FPAN	Medical
15	Bagmati	Mr. Dirgha Raj Shrestha	HEADS	MD
16	Bagmati	Dr. Rajendra Bhadra	HEADS	HSD
17	Bagmati	Ms. Haikali Thapa	DPHO, Hetauda	PHNO
18	Bagmati	Ms. Astha Subedi	Yuwa	APIUP
19	Bagmati	Ms. Roshani Adhikari	BYAN	EBM
20	Bagmati	Ms. Deepy Shah	SPN/MSI	CSO
21	Bagmati	Mr. Netra Bhatta	USAID	Sr. Program Specialist
22	Bagmati	Mr. Nava Raj Bhattarai	UNFPA	
23	Bagmati	Dr. Mahesh Puri	CREHPA	Co-Director
24	Bagmati	Mr. Pranav Raj Rajbhandari	JHUCCP	Senior SBC Advisor
25	Madhesh	Mr. Nilaramba Adhikari	Ministry of Health and Population	PHA
26	Madhesh	Mr. Ravi Kumar Bhaskar	Jeetpur Simara SMC, Bara	PHO
27	Madhesh	Mr. Ram Naresh Yadav	Health Office, Bara	CHO
28	Madhesh	Ms. Sujita Mishra	Jeetpur Simara Hospital, Bara	Nursing Supervisor
29	Koshi	Mr. Upendra Khanal	Ilam Municipality	PHI
30	Koshi	Mr. Kamal Subedi	FPAN, Ilam Jhapa	Branch Manager
31	Koshi	Ms. Bhagawati Ghimire	District Hospital, Ilam	HNI
32	Koshi	Ms. Indira Khawas	Ilam	FCHV
33	Koshi	Ms. Ranu Raut	FPAN, Sunsari	Act. Branch Manager/Service Provider
34	Koshi	Dr. Anju Deo	Koshi Hospital, Biratnagar	HOD Gyno/Obs
35	Koshi	Ms. Rambha Subba	Koshi Hospital, Biratnagar	Nursing Officer
36	Koshi	Ms. Talsa Adhikari	PHD, Dhankuta	Nursing Officer
37	Karnali	Ms. Dipa Bhattarai	Karnali	Sr. N/O
38	Gandaki	Mr. Santosh Paudel	Gandaki	F. P. Officer
39	Sudurpaschim	Ms. Shushila Timilsina	Seti Provincial Hospital	SHNI
40	Bagmati	Dr. Khurshid Alam Hyder	WHO	WHO

List of Participants (BNA Workshop)				
S.N.	Province	Name	Organization	Designation
41	Bagmati	Dr. Rita Kabra	WHO HQ	WHO HQ
42	Bagmati	Dr. Pooja Pradhan	WHO	WHO
43	Bagmati	Dr. Surakschha Thapa	WHO	WHO
44	Bagmati	Dr. Sameena Rajbhandari	WHO	WHO
45	Bagmati	Ms. Sarmistha Singh Shrestha	WHO	WHO
46	Bagmati	Mr. Manish Gautam	Anweshan	CMD
47	Bagmati	Mr. Madan Raj Bhatt	Anweshan	Team Lead/BNA
48	Bagmati	Ms. Sanju Maharjan	Anweshan	Program Manager
49	Bagmati	Ms. Sabitra Acharya	Anweshan	Finance Officer
50	Bagmati	Ms. Manisha Budhathoki	Anweshan	Research Officer

## Annex 8: SBC Bottlenecks Ranking Tool

### Three groups

1. SBC Workshop Group 1: Governance & Financing
2. SBC Workshop Group 2: People & Information
3. SBC Workshop Group 3: Medicines & Technology / Service Delivery / Human Resources

### SBC Workshop Group 1: Governance & Financing

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up SBC.

**\*9 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *9 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Governance	Leadership & commitment	<p><b>There is strong leadership and commitment to support scale-up of SBC for FP at all level.</b>  <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>• There is political support for SBC for FP at the national level</li> <li>• SBC is included in national FP goals</li> <li>• SBC for FP has champions advocating for the practice at the national level</li> <li>• SBC for FP has champions advocating for the practice at the provincial and local level</li> <li>• The MOHP sets out objectives, guidance and principles for SBC but allows provinces, districts and municipalities to determine locally relevant communication approaches</li> </ul>		
	Accountability	<p><b>There is strong accountability for SBC for FP across institutions and among policy makers and programme managers</b>  <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>• There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) including provision of technical committees to enable effective SBC policy development and programming.</li> <li>• A public officer has accountability* to deliver scale-up of SBC for FP at the national level (is someone responsible for ensuring scale-up of SBC in the MoHP or other public institution?)</li> <li>• A public officer has accountability* to deliver scale-up of SBC for FP at the provincial and local level</li> <li>• There is a provision of social audit at each level to ensure accountability.</li> </ul> <p><i>*Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up</i></p>		
	Regulation	<p><b>There is strong regulation to ensure effective SBC for FP.</b>  <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>• There are no laws or policies that require partner consent to receive FP</li> <li>• There are no laws or policies that restrict access for adolescents or unmarried women.</li> <li>• There are no limitations to promoting contraception in the mass media</li> </ul>		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *9 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		<ul style="list-style-type: none"> <li>The private/non-governmental sector is adequately regulated in its SBC activities</li> <li>There are laws that regulate misinformation.</li> </ul>		
	<b>Guidance formulation</b>	<p><b>There is sufficient guidance (including policies, guidelines and tools) to support scale up of SBC for FP</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Policy &amp; practice guidance to support implementation of SBC for FP exists and is up to date.</li> <li>Policy &amp; practice guidance to support implementation of SBC for FP is available to relevant district health teams and health facilities</li> <li>Policy &amp; practice guidance on SBC is endorsed by the MoHP</li> <li>International standards and guidance on SBC have been adapted to the federaland/or provincial/local context</li> <li>SBC guidance exists that covers key principles including needs for formative research, pre-testing messaging, targeting of communication, communication channel selection, audience segmentation, coordination with existing community infrastructure, and community engagement.</li> <li>SBC guidance advises structured design processes (including insight gathering, theory-based design, monitoring, iteration, redesign, dissemination, scale-up)</li> <li>There is guidance to support the review of SBC materials/media and their alignment with national priorities</li> <li>National SBC guidance allows for flexibility in implementation according to context</li> </ul>		
	<b>Planning</b>	<p><b>There is a coherent national plan for SBC scale-up</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>The extent of SBC FP coverage or gaps have been mapped nationally</li> <li>A strategic plan for expanding coverage of FP related SBC exists and has been effectively communicated and actions are included within annual operating plans.</li> <li>Strategic plans for SBC FP delineate desired behaviour changes, determinants of behaviour change, audience, channels, costs, geography, M&amp;E and costing</li> <li>Potential challenges to implementation are identified and addressed proactively</li> </ul>		
<b>Financing</b>	<b>Budgeting</b>	<p><b>There is adequate budget available at all levels for scale-up of SBC for FP.</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There is a costed implementation plan for scale-up of SBC for FP</li> <li>SBC for FP has been included in the FP2020/30 CIP</li> <li>SBC for FP has been included in the Global Financing Facility (GFF) Investment Case.</li> <li>Adequate funds are allocated to SBC for FP in federal budgets</li> <li>Adequate funds are allocated to SBC for FP in provincial and local level budgets</li> </ul>		
	<b>Donors</b>	<p><b>Donors sufficiently contribute to financing scale-up of SBC for FP</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Donor priorities are aligned with MOHP policies and priorities for SBC scale-up.</li> <li>Donors commitments are sufficiently financed in budgets.</li> </ul>		
	<b>Spending allocation</b>	<p><b>Government expenditure on SBC matches the allocated budget</b></p>		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *9 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	<b>Equity</b>	<p><b>There are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high.</li> <li>Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts.</li> <li>Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethnic groups and female sex workers.</li> <li>Data are reviewed regularly to ensure equitable allocation of budget.</li> </ul>		

### SBC Workshop Group 2: People & Information

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of SBC.

\*11 is the most important bottleneck, 1 is the least important

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
<b>People</b>	<b>Communication, knowledge &amp; awareness</b>	<p><b>There is a high level of knowledge and awareness of recommended SBC policies and practices:</b></p> <p><b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There is effective national dissemination of relevant policies and guidance.</li> <li>Policymakers &amp; programme managers at the national and state/regional levels fully understand and know recommended principles and practices for SBC</li> <li>Health promotion/communication teams at various levels of the health system fully understand and know recommended approaches to SBC for FP</li> <li>There are effective communication channels in place to ensure that stakeholders remain engaged and informed about SBC activities and progress.</li> </ul>		
	<b>Acceptability</b>	<p><b>There is acceptance of recommended SBC policies and practices by key stakeholders</b></p> <p><b>Consider these statements:</b></p> <ul style="list-style-type: none"> <li>Recommendations on SBC interventions and activities are supported by local evidence.</li> <li>Policymakers &amp; programme managers at national and regional/state levels fully agree with the need to scale-up SBC for FP</li> <li>Senior healthcare managers fully agree with the need to scale up SBC for FP</li> <li>Health promotion and health communication managers see SBC for FP as relevant to their work</li> <li>Facility managers see SBC for FP as relevant to their work</li> </ul>		
	<b>Consultation</b>	<p><b>Key stakeholders have been adequately consulted about SBC recommended approaches and guidance</b></p> <p><b>Consider these statements:</b></p> <ul style="list-style-type: none"> <li>Stakeholders, including target audiences, have been adequately consulted during the creation of SBC practice guidance.</li> <li>Groups with potential opposition to family planning promotion are sufficiently consulted (e.g. religious, cultural, anti-choice etc.)</li> <li>There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.</li> </ul>		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	<b>Coordination</b>	<p><b>There is good coordination between different stakeholders to ensure effective scale-up of SBC for FP</b>  <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>• National policies and budgeting are effectively transferred to state/regional policies</li> <li>• The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up SBC for FP</li> <li>• There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.)</li> <li>• There are regular interagency meetings during the year that discuss and plan for SBC scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.)</li> <li>• Technical working groups (TWGs) on SBC/FP exist to support coordination, resourcing, learning, etc.</li> <li>• The FP teams jointly plan with the health promotion/community health engagement teams in the MOPH for SBC scale-up</li> <li>• The FP teams jointly plan with the Department of Education for SBC scale-up in SRH</li> <li>• The FP and/or health promotion teams are able to coordinate demand generation/SBC efforts across different agencies, health teams, NGOs, and other civil society groups</li> <li>• SBC coordinators/TWGs are able to quality-control SBC activities, for example using guidelines or checklists (including control for potential rights-violations)</li> <li>• Health facilities work with civil society and NGOs to promote FP in the community, including to marginalized groups.</li> <li>• Health promotion/communication experts regularly advise the MOH and participate in planning meetings to scale up SBC.</li> <li>• District health teams and facilities coordinate with schools or educational departments to support promotion of FP among adolescents</li> <li>• National or regional activities (e.g. campaigns, mass/digital media) are coordinated and non-duplicative.</li> </ul>		
	<b>Networks</b>	<p><b>There are effective professional networks supporting scale-up of SBC for FP</b>  <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>• The RH TWG prioritises and plans to support SBC scale up</li> <li>• SBC is actively and regularly promoted through professional networks.</li> <li>• There are networks or communities of practice that support SBC scale-up and help with coordination of efforts</li> <li>• The country has learned from other similar country contexts on how to scale-up SBC</li> </ul>		
	<b>Community engagement</b>	<p><b>There is adequate community engagement on SBC for FP</b>  <b>Consider this statement:</b></p> <ul style="list-style-type: none"> <li>• Engagement is tailored to address local social and gender norms that affect reproductive health decisions</li> <li>• Health services and/or district health teams deliver community outreach on FP, including home-based SBC</li> <li>• Facilities and district health teams work with trusted community or religious leaders to promote FP</li> <li>• SBC initiatives are designed in collaboration with local communities</li> <li>• SBC coordinators /health promotion teams work with religious leaders to promote FP in settings of religious resistance</li> <li>• SBC coordinators/health promotion teams work with men and boys to promote male engagement in SRH</li> </ul>		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		<ul style="list-style-type: none"> <li>SBC coordinators/health promotion teams make efforts to ensure that SBC activities are rights-based and non-coercive</li> <li>Health facilities offering FP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)</li> </ul>		
Information	Reporting	<p><b>There is adequate reporting on SBC activities.</b> <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>There are agreed reporting standards and key performance indicators for monitoring of SBC for FP activities, including within health facilities, within community health programmes, and for national communication campaigns</li> <li>There is an agreed goal or target for SBC coverage.</li> <li>Data on SBC coverage, or information on different SBC initiatives (in both public and private/NGO sectors), is received and monitored at national and state/regional levels</li> <li>SBC approaches are routinely monitored and evaluated, while allowing for design iteration and adaptive programming</li> </ul>		
	Data & HMIS	<p><b>There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities, and data is used regularly for performance management.</b> <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Data trends on SBC coverage or outcomes on knowledge or acceptance of FP are shared with district health teams, facilities, and program managers to allow regular assessment and comparison of performance</li> <li>HMIS (used by facilities or CHWs) can capture referrals from community outreach/engagement efforts</li> <li>Client surveys capture data on how and why FP clients attended services and/or chose specific methods</li> <li>Data on SBC and its outcomes (knowledge, attitudes, practices, social norms, client perceptions of quality) is used regularly to assess and manage programming response</li> </ul>		
	Guidelines & tools	<p><b>Updated guidance on SBC for FP is available and widely used.</b> <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Guidance on facility-based health communication on FP exists and is available at all service delivery points</li> <li>Health facilities and community health programmes are equipped with guidance and tools to deliver community outreach for FP</li> </ul>		
	Client SBC/IEC	<p><b>SBC materials exist to support SBC for FP</b> <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>SBC/IEC materials/apps on FP provision exist for both health facilities and community outreach work, and are routinely distributed and available for use by providers with clients/ for client takeaway</li> </ul>		
	Health promotion	<p><b>Communication on FP is integrated with health promotion activities.</b> <b>Consider these statements when rating:</b></p> <ul style="list-style-type: none"> <li>Successful behavioural interventions to promote social norm change and FP uptake (individuals or couples) via mass media are known and scaled</li> <li>Successful behavioural interpersonal interventions to promote social norm change and FP uptake (individuals or couples) are known and scaled.</li> <li>Successful behavioural interventions to promote social norm change and FP uptake (individual or couple) via community groups or other forms of community engagement are known and scaled</li> </ul>		



**SBC Workshop Group 3: Medicines & Technology / Service Delivery / Human Resources**

**Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of SBC.**

**\*14 is the most important bottleneck, 1 is the least important**

<b>BNA Framework Theme</b>	<b>Categories</b>	<b>Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important</b>	<b>Individual Ranking</b>	<b>Final group ranking</b>
<b>Medicines &amp; technology</b>	<b>Infrastructure</b>	<p><b>There is adequate health infrastructure to deliver SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• Mass media and mobile phone technologies have sufficient market penetration/population coverage to be used as effective SBC tools</li> <li>• Community health infrastructure exists and is used for health promotion</li> <li>• There are effective linkages between community health and static health facilities</li> </ul>		
	<b>Supplies</b>	<p><b>District health teams, facilities and community health programmes have commodities, equipment, tools and other supplies required to deliver SBC for FP</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• Community health teams are fully equipped with supplies needed for any CHW or other community delivery of contraception</li> </ul>		
<b>Service delivery</b>	<b>Management</b>	<p><b>There is effective health management to support SBC</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• There is a designated manager in health facilities who is accountable for SBC activities in catchment populations</li> <li>• Implementation of SBC is included in performance review processes of district and facility managers.</li> <li>• Quality control and audit processes cover implementation of SBC including counselling, SBC/IEC materials and community outreach</li> <li>• Clinical leaders advocate for and promote improved client and couple communication in their facilities</li> <li>• The relevant healthcare and health promotion managers have sufficient capacity to manage the scale-up of SBC for FP on top of their other responsibilities</li> <li>• Management tools and procedures exist to support managers address constraints with implementing SBC</li> <li>• Managers regularly monitor trends in SBC activities and outcomes (knowledge, attitudes, social norms) to assess potential needs and gaps</li> <li>• Facility and health promotion managers regularly conduct learning reviews on SBC to assess what is working well and what needs change/adaptation.</li> <li>• Managers regularly conduct client journey mapping and/or client flow analysis to identify how to deliver education and counselling to clients attending for different services</li> </ul>		
	<b>Supervision</b>	<p><b>There is adequate supervision to support SBC</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• There are supervisors who are trained to advise on and quality-assure health promotion and SBC efforts for FP, including supervision of CHW activities</li> <li>• FP providers are competency assessed in their counselling skills</li> </ul>		
	<b>Team work &amp; coordination</b>	<p><b>Community health teams and CHWs work in a coordinated way with health facilities</b></p>		
	<b>Service organization &amp; scheduling</b>	<p><b>The organization of services makes SBC feasible</b></p> <p><i>Consider these statements when rating:</i></p> <ul style="list-style-type: none"> <li>• Health services have capacity to deliver SBC interventions to promote or educate on FP throughout the client journey (before, during and after service delivery)</li> </ul>		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		<ul style="list-style-type: none"> <li>Community health services have capacity for effective SBC and demand generation activities in the communities they serve</li> <li>Health service operating hours are accessible for the whole community population in need of FP including adolescents</li> </ul>		
	Referral systems	<b>There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities</b>		
	Fees	<b>There are no fees for accessing FP services, or specific methods</b>		
Human Resources	Training & education	<b>There is adequate training on SBC for FP</b> <i>Consider these statements when rating:</i> <ul style="list-style-type: none"> <li>Training needs for CHW FP provision are regularly assessed</li> <li>There is adequate training for district and/or facility-based health promotion teams on effective SBC approaches</li> </ul>		
	Capacity	<b>Staff working on FP across the health system have capacity to deliver SBC for FP</b>  <i>Consider these statements:</i> <ul style="list-style-type: none"> <li>Staff in national, regional and district health teams working on FP have capacity in their roles to deliver SBC scale-up.</li> <li>Staff turnover is low enough to allow institutionalisation of SBC approaches</li> <li>Health facilities have capacity to deliver counselling and other health education and communication on FP to clients</li> </ul>		
	Roles	<b>SBC is included in the relevant provider and manager job descriptions</b>  <i>Consider these statements:</i> <ul style="list-style-type: none"> <li>SBC for FP is included in role descriptions of FP technical programme managers at national, regional and district levels.</li> <li>CHWs have defined roles which include SBC for demand generation</li> <li>There are assigned roles in health facilities and the district health team for health communication/education/promotion and SBC</li> <li>Counselling skills are included in family planning provider job descriptions</li> </ul>		
	Skills & competencies	<b>FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC</b> <ul style="list-style-type: none"> <li>Staff working to support FP across the health system have relevant skills and competencies for SBC including in health communication and education, social and behaviour change, and community health.</li> </ul>		
	Motivation	<b>Health workers involved in SBC have positive attitudes towards the policy</b> <i>Consider these statements when rating:</i> <ul style="list-style-type: none"> <li>CHWs are motivated to inform, educate and counsel clients and their partners on FP</li> <li>CHWs are adequately remunerated and performance managed to deliver SBC for FP</li> <li>Facility-based FP providers are motivated to inform, educate and counsel clients and their partners on FP</li> <li>Staff working in FP provision have positive attitude towards the community (non-judgemental, empathetic, respectful)</li> <li>There is a supportive institutional culture that prioritises effective communication and community engagement.</li> </ul>		

## Annex 9: SBC Group Outputs

### Root cause Analysis of SBC

#### SBC FP Group 1: Leadership and Governance

##### **Bottleneck 1: Leadership and Commitment**

Effect (Bottleneck): **There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.**

Question 1: Why is there no strong leadership and commitment to support scale-up of SBC for FP at all levels?

Answer 1: SBC for FP doesn't fall in the priority of leaders at all levels.

Question 2: Why does SBC not for FP fall in the priority of leaders at all levels.

Answer 2: leaders at all levels don't understand the importance of SBC for FP.

Question 3: Why do leaders not understand the importance of SBC of FP?

Answer 3: Insufficient evidence collected, packaged and presented to the leaders at all levels by the program managers on the importance and effectiveness of SBC for FP.

Question 4: Why is insufficient evidence collected, packaged and presented to the leaders at all levels by the program managers on the importance and effectiveness of SBC for FP?

Answer 4: The government views SBC for FP as mainly the responsibility of the private sector and NGOs, assuming it will occur without significant effort. Hence, SBC for FP has not been institutionalized, especially at sub-national levels

#### SBC FP Group 1: Leadership and Governance

##### **Bottleneck 2: Accountability**

Effect (bottleneck): **There is no strong accountability for SBC for FP across institutions and among policy makers and program managers.**

Question 1: Why is there no strong accountability for SBC for FP across institutions and among policy makers and program managers?

Answer 1: We don't have dedicated human resources (focal person) to ensure the accountability mechanism for SBC for FP.

Question 2: Why do we not have dedicated human resources (focal person) to ensure the accountability mechanism for SBC for FP?

Answer 2: There is no clear JD specifying who among existing human resources is responsible to ensure the accountability for SBC for FP.

Question 3: Why is there no clear JD specifying whose responsibility is it to ensure the accountability for SBC for FP?

Answer 3: Senior management has not realized the importance of SBC for FP, hence, there is no clear JD.

Question 4: Why has senior management not realized the importance of SBC for FP?

Answer 4: Reporting on the status of SBC for FP is not required

#### SBC FP Group 1: Leadership and Governance

##### **Bottleneck 3: Budgeting**

Effect (bottleneck): **There is inadequate budget available at all levels for scale-up of SBC for FP.**

Question 1: Why is there inadequate budget available all levels for scale-up of SBC for FP?

Answer 1: Budget allocation for SBC-focused FP programs is insufficient and unspecified at all levels. The National Health Communication Policy specifies that 2% of the health budget should go to SBCC, but only 0.18% has been allocated for the SBCC.

Question 2: Why is the budget allocation for SBC-focused FP programs is insufficient and unspecified at all levels?

Answer 2: Of the 0.18% of the total health budget allocated to SBCC, only 0.017% is designated for SBC for FP.

Question 3: Why is only 0.017% of total SBCC budget designated for SBC for FP?

Answer 3: Because we lack a robust cost-benefit analysis and sufficient evidence, we haven't effectively presented our case to Ministry of Finance.

Question 4: Why have we not performed robust cost-benefit analysis and sufficient evidence?

Answer 4: We lack strong leadership and commitment, effective accountability mechanisms, and **the expertise to perform cost-benefit analysis.** (Former 2 are already addressed in 2 other bottlenecks.)

### SBC FP Group 1: Leadership and Governance

#### **Bottleneck 4: Equity**

Effect (bottleneck): **Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.**

Question 1: Why are the financing mechanisms and policy actions to ensure equitable scale-up of SBC not in place?

Answer 1:

- Adequate budget is not allocated for equitable SBC for intersectional groups including adolescents, women from poor and/or rural contexts, WLHIC, WLD, women from minority ethnic group, female sex workers. **(Link with the 'Budgeting')**
- People in the leadership and management position have limited realization of the tailored need of SBC for FP of intersectional groups of the people.

Question 2: Why do the actors in leadership roles and management position possessed limited realization of the tailored needs of intersectional group of the people?

Answer 2: There is lack of awareness and knowledge regarding the tailored need of the intersectional groups of the people.

Question 3: Why is there lack of awareness and knowledge regarding the tailored need of the intersectional groups of people?

Answer 3: Stakeholders have not able to meaningfully coordinate and collaborate with leaders and managers within the health system to raise awareness about these needs. These stakeholders include agencies and groups working with the intersectional groups.

Question 4: Why have stakeholders failed to meaningfully coordinate and collaborate with leaders and managers within the health system to raise awareness about these needs?

Answer 4: There is no existing mechanism (structures and processes are not defined) for the coordination and collaboration.

### SBC FP Group 1: Leadership and Governance

#### **Bottleneck 5: Planning**

Effect (bottleneck): **There is no coherent national plan for SBC scale-up.**

Question 1: Why is there a lack of coherence national plan for SBC scale-up?

Answer 1: There is a lack of coherent national objectives for SBC for FP, and we haven't implemented a holistic approach in challenges identification, objective and target setting.

Question 2: Why is there a lack of coherent national objective and target for SBC for FP?

Answer 2: We lack sufficient evidence and disaggregated data from the subnational level, including data segmented by intersectional subgroups.

## SBC FP Group 2: People and Information

Effect (priority 1): **Inadequate recording and reporting on SBC activities**

Question 1: Why is there a lack of recording and reporting for SBCC?

Answer 1: There is a lack of recording and reporting for SBCC as there are no agreed standards forums and formats for them.

Question 2: Why there are no agreed standards forums and formats for SBCC activities?

Answer 2: There are no agreed standards forums and formats for SBCC activities because there are no indicators set for SBCC activities.

Question 3: Why there are no indicators set for SBCC activities?

Answer 3:

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| <ul style="list-style-type: none"> <li>There are no indicators set for SBCC activities due to data uses clarity issues.</li> </ul> | <ul style="list-style-type: none"> <li>Also due to reliability, validity and credibility.</li> </ul> |
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Question 4: Why there is data uses clarity issues?

Answer 4:

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| <ul style="list-style-type: none"> <li>There are data uses clarity issues because discussion among decision makers is not extensive and inclusive.</li> </ul> | <ul style="list-style-type: none"> <li>Also, there is no advocacy and capacity at subnational level on planning and budgeting</li> </ul> |
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Question 5: Why there is issue with reliability, validity and credibility?

Answer 5:

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| <ul style="list-style-type: none"> <li>There is issue with reliability, validity and credibility because there is lack of awareness on data validity and data use at service provider level.</li> </ul> | <ul style="list-style-type: none"> <li>There is no client feedback mechanism on Monitoring and supervision to ensure credibility as well.</li> </ul> |
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Question 6: Why the discussion among decision makers is not extensive and exclusive?

Answer 6: The discussion among decision makers is not extensive and exclusive because there is lack of regular engagement and coordination of different stakeholders.

Question 7: Why there is no advocacy and capacity at subnational level on planning and budgeting?

Answer 7: There is no advocacy and capacity at subnational level on planning and budgeting because there is lack of regular/ capacity building activities, advocacy for related stakeholders.

Question 8: Why there is no awareness on data validity and data use at service provider?

Answer 8:

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| <ul style="list-style-type: none"> <li>There is no awareness on data validity and data use at service provider because there is performance-based monitoring and reward/ punishment system</li> </ul> | <ul style="list-style-type: none"> <li>Also, there is feedback mechanism accountability/ professional ethics.</li> </ul> |
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Question 9: Why there is no client feedback mechanism on monitoring and supervision to ensure credibility?

Answer 9:

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| <ul style="list-style-type: none"> <li>There is no client feedback mechanism on monitoring and supervision because HR is overloaded with multiple word, there is inadequate scientific distribution, allocation.</li> </ul> | <ul style="list-style-type: none"> <li>Also, it is due to accountability and professional ethics.</li> </ul> |
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## SBC FP Group 2: People and Information

Effect (Priority 2): **Inadequate consultation about SBCC among key stakeholders.**

Question 1: Why there is inadequate consultation about SBCC among key stakeholders?

Answer 1: There is inadequate consultation about SBCC among key stakeholders because the targeted group focus program/ forums including target groups are not developed.

Question 2: Why the targeted group focus program/ forums including target groups are not developed?

Answer 2: The targeted group focus program/ forums including target groups are not developed because the exact target groups/ alliances cannot be known or realized.

Question 3: Why the exact target groups/ alliances cannot be realized or known?

Answer 3:

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| <ul style="list-style-type: none"> <li>The exact target groups/ alliances cannot be realized or known as there is difficulty in identifying multi religion, culture society.</li> </ul> | <ul style="list-style-type: none"> <li>And the SBC program is more centralized.</li> </ul> |
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Question 4: Why is it difficult to identify multi religion, culture society?

Answer 4:

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| <ul style="list-style-type: none"> <li>It is difficult to identify the multi religion, culture, society because there is no dedicated/ specialized HR for SBC related in all three levels of government.</li> </ul> | <ul style="list-style-type: none"> <li>It is also due to the low level of community capacity awareness.</li> </ul> |
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Question 5: Why the SBC program is more centralized?

Answer 5:

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| <ul style="list-style-type: none"> <li>The SBC program is centralized because there is no proper consultation to develop strategy, program with related gaps and no policy strategy for decentralization.</li> </ul> | <ul style="list-style-type: none"> <li>It is also because there is no mechanism of feedback, bottom to top approach. Not aware with all mass media develop by NHEICC.</li> </ul> |
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Question 6: Why there is no specialized SBC related HR in all three levels of government?

Answer 6:

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| <ul style="list-style-type: none"> <li>There is lack of specialized SBC related person because there is less focus on Health education. O and M needed.</li> </ul> | <ul style="list-style-type: none"> <li>Also, there is no long-term plan on health action and education.</li> </ul> |
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Question 7: Why the community capacity awareness level is low?

Answer 7:

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| <ul style="list-style-type: none"> <li>There is low level community capacity awareness because they are unaware if the community meet expectations.</li> </ul>  | <ul style="list-style-type: none"> <li>The targeted group does not realize their own needs.</li> </ul>  |
| <ul style="list-style-type: none"> <li>Question 8: Why there is no proper consultation to develop strategy, program with related gaps and no policy strategy for decentralization?</li> </ul>   | <ul style="list-style-type: none"> <li>Question 9: Why there are no mechanism of feedback, bottom to top approach and unaware with all mass media developed by NHEICC?</li> </ul> |
| <ul style="list-style-type: none"> <li>Answer 8: There is no proper consultation to develop strategy, program with related gaps and no policy strategy for decentralization because there is no SBC related exact plan program and guidelines.</li> </ul> | <ul style="list-style-type: none"> <li>Answer 9: It is because forum like TWC has not been developed from subnational level as well as 3 tyros of engagement.</li> </ul>          |

## SBC FP Group 2: People and Information

Effect (priority 3): **There is inadequate community engagement on SBC for FP.**

Question 1: Why there is inadequate community engagement on SBC for FP?

Answer 1: There is inadequate consultation of SBC on FP because there is no program related to community engagement.

Question 2: Why there are no programs related to community engagement?

Answer 2: There is no program related to community engagement related to SBC because the program is focused on services quantity not for quality.

Question 3: Why the program related to community engagement is not focused on quantity of services not the quality?

Answer 3:

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| <ul style="list-style-type: none"> <li>The program is not focused on quality of services due to lack of clarity on the federal context.</li> </ul> | <ul style="list-style-type: none"> <li>And due to lack of engagement of the local needs of the community. There is local need of sensitization.</li> </ul> |
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Question 4: Why there is no clarity on the federal context?

Answer 4:

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| <ul style="list-style-type: none"> <li>There is no clarity on the federal context because it only depends on the federal program.</li> </ul> | <ul style="list-style-type: none"> <li>Also, there is lack of demand generation related by government.</li> </ul> |
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Question 5: Why are the local needs of the community not engaged?

Answer 5:

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| <ul style="list-style-type: none"> <li>The local needs of the community are not engaged due to the lack of focus in SBC to take it along with GEDSI.</li> </ul> | <ul style="list-style-type: none"> <li>There is also lack of community capacity service providers and district to service outlets.</li> </ul> |
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Question 6: Why SBC for FP depends on the federal program?

Answer 6:

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| <ul style="list-style-type: none"> <li>SBC for FP is depending on the federal program because all the government have not realized the importance of SBC on FP.</li> </ul> | <ul style="list-style-type: none"> <li>There is also no clarity in the roles on extended BHS and integration.</li> </ul> |
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Question 7: Why is there lacking in the demand generation related by government section?

Answer 7

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|---|---|
| <ul style="list-style-type: none"> <li>There is lacking in the demand generation by the government section because there are no priority programs and no stakeholders mapping standardization.</li> </ul> | <ul style="list-style-type: none"> <li>Also, the identification of the special focused program needs to be done.</li> </ul> |
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Answer 8

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| <ul style="list-style-type: none"> <li>SBC is lacking focus because there is no public hearing on FPSBC, training, education.</li> </ul> | <ul style="list-style-type: none"> <li>And the capacity of community female education, adolescents' marriage also has impact on SBC.</li> </ul> |
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Question 9: Why there is lack of community capacity service providers and district to service outlets?

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| <ul style="list-style-type: none"> <li>There is lack of district to service outlets and community capacity service providers because there is no coordination and effective work on SBC by the stakeholders including private.</li> </ul> | <ul style="list-style-type: none"> <li>There is also no mobilization of FCHV/ mothers' group.</li> </ul> |
|---|--|

### SBC FP Group 3: Medicine and Technology, Service Delivery and Human Resource

**Effect (Priority 1): HR-Training and education: Inadequate skilled human resources for SBC-FP (includes HR-capacity and service delivery-motivation)**

Question 1: Why there are no skill development in SBC-FP?

Answer 1: There is no skill development in SBC-FP because it is not in priority.

Question 2: Why SBC-FP is not in priority?

Answer 2: SBC-FP is not in priority because there is lack of evidence on SBC-FP.

Question 3: Why is there lack of evidence on SBC-FP?

Answer 3: There is lack of evidence on SBC-FP due to limited awareness about SBC-FP among the authorities at all levels.

Question 4: Why there is limited awareness about SBC-FP among the authorities at all levels?

Answer 4: There is limited awareness about SBC-FP among the authorities at all levels because there is no LRP for health workers in SBC-FP.

Question 5: Why there are no LRP for health workers at higher level in SBC-FP?

Answer 5: There are no LRP for health workers at higher level in SBC-FP because SBC-FP health worker need is not felt at higher level.

**Effect (Priority 2): HR-Roles: Roles and responsibilities of service providers not well defined**

Question 1: Why the roles and responsibilities of service providers are not well defined?

Answer 1: The roles and responsibilities of service providers are not well defined because there is lack of clear Job Description (JD).

Question 2: Why there is unclear Job Description (JD)?

Answer 2: JD is not updated as per the need of the federal system due to which it is unclear.

Question 3: Why is JD not updated as per the need of the federal system?

Answer 3: JD is not updated as per the need of the federal system because it is not considered a priority.

Question 4: Why updating JD is not considered a priority?

Answer 4: Updating JD is not considered a priority due to differing interests of different decision makers.

Question 5: Why decision makers have no interest in updating JD?

Answer 5: Updating JD is not considered interesting because there is inadequate evidence and advocacy on importance.

### SBC FP Group 3: Medicine and Technology, Service Delivery and Human Resource

**Effect (priority 3): Service Delivery-Management: Ineffective health management system to support SBC-FP**

Question 1: Why there is ineffective health management system to support SBC-FP?

Answer 1: There is ineffective health management system to support SBC-FP due to the lack of guiding document for SBC-FP.

Question 2: Why is there lack of guiding document for SBC-FP?

Answer 2: There is lack of guiding document for SBC-FP because SBC-FP is not a priority in the management system.

Question 3: Why SBC-FP is not a priority in the management system?

Answer 3: SBC-FP is not a priority in the management system due to inadequate knowledge and understanding of decision makers on SBC-FP.

Question 4: Why there is inadequate knowledge and understanding of decision makers on SBC-FP?

Answer 4: There is inadequate knowledge and understanding of decision makers on SBC-FP due to lack of evidence and inadequate advocacy.

## Annex 10: Main root causes in SBC for FP

### SBC Group 1: Leadership and Governance

Important Bottlenecks SBC Group 1: Leadership and Governance	Intermediate causes (5 Whys)	Problems (Main root causes)
There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.	<ul style="list-style-type: none"> <li>SBC for FP doesn't fall in the priority of leaders at all levels.</li> <li>Leaders at all levels don't understand the importance of SBC for FP.</li> <li>Insufficient evidence collected, packaged, and presented to leaders at all levels on the importance and effectiveness of SBC for FP.</li> <li>The government views SBC for FP as mainly the responsibility of the private sector and NGOs.</li> <li>SBC for FP has not been institutionalized, especially at sub-national levels.</li> </ul>	The government views SBC for FP as mainly the responsibility of the private sector and NGOs, assuming it will occur without significant effort. Hence, SBC for FP has not been institutionalized, especially at sub-national levels.
There is no strong accountability for SBC for FP across institutions and among policy makers and program managers.	<ul style="list-style-type: none"> <li>We don't have dedicated human resources (focal person) to ensure the accountability mechanism for SBC for FP.</li> <li>There is no clear job description (JD) specifying who among existing human resources is responsible for ensuring accountability for SBC for FP.</li> <li>Senior management has not realized the importance of SBC for FP, hence there is no clear JD.</li> <li>Reporting on the status of SBC for FP is not required.</li> </ul>	Reporting on the status of SBC for FP is not required.
There is inadequate budget available at all levels for scale-up of SBC for FP.	<ul style="list-style-type: none"> <li>Budget allocation for SBC-focused FP programs is insufficient and unspecified at all levels. The National Health Communication Policy specifies that 2% of the health budget should go to SBCC, but only 0.18% has been allocated for the SBCC.</li> <li>Of the 0.18% of the total health budget allocated to SBCC, only 0.017% is designated for SBC for FP.</li> <li>Only 0.017% of total SBCC budget is designated for SBC for FP because we lack a robust cost-benefit analysis and sufficient evidence, so we haven't effectively presented our case to the Ministry of Finance.</li> <li>We have not performed a robust cost-benefit analysis and provided sufficient evidence because we lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis. (The first two issues are already addressed in two other bottlenecks.)</li> </ul>	We lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis. (Former 2 are already addressed in 2 other bottlenecks.)

Important Bottlenecks SBC Group 1: Leadership and Governance	Intermediate causes (5 Whys)	Problems (Main root causes)
Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.	<ul style="list-style-type: none"> <li>• Adequate budget is not allocated for equitable SBC for intersectional groups, including adolescents, women from poor and/or rural contexts, WLHIV (women living with HIV), WLD (women living with disabilities), women from minority ethnic groups, and female sex workers. (This is linked with the 'Budgeting' bottleneck.)</li> <li>• People in leadership and management positions have limited realization of the tailored needs of SBC for FP for intersectional groups of people.</li> <li>• There is a lack of awareness and knowledge regarding the tailored needs of intersectional groups of people.</li> <li>• Stakeholders have not been able to meaningfully coordinate and collaborate with leaders and managers within the health system to raise awareness about these needs. These stakeholders include agencies and groups working with intersectional groups.</li> <li>• There is no existing mechanism (structures and processes are not defined) for coordination and collaboration to raise awareness about the needs of intersectional groups.</li> </ul>	Adequate budget is not allocated for equitable SBC for intersectional groups including adolescents, women from poor and/or rural contexts, WLHIC, WLD, women from minority ethnic group, female sex workers. <b>(Link with the 'Budgeting' in pointer 3)</b> There is no existing mechanism (structures and processes are not defined) for the coordination and collaboration.
There is no coherent national plan for SBC scale-up.	<ul style="list-style-type: none"> <li>• There is a lack of coherent national objectives for SBC for FP, and we haven't implemented a holistic approach in challenges identification, objective and target setting.</li> <li>• We lack sufficient evidence and disaggregated data from the subnational level, including data segmented by intersectional subgroups.</li> </ul>	We do not have sufficient evidence and disaggregated data from subnational level, including data segmented by intersectional subgroups.

## SBC Group 2: People and Information

Important Bottlenecks	Intermediate causes (5 Whys)	Problems (Main root causes)
Inadequate recording and reporting on SBC activities	<ul style="list-style-type: none"> <li>• No agreed standards, forums, and formats for recording and reporting for SBCC.</li> <li>• No indicators set for SBCC activities.</li> <li>• Data use clarity issues, reliability, validity, and credibility problems.</li> <li>• Discussion among decision-makers is not extensive and inclusive; no advocacy and capacity at the subnational level on planning and budgeting.</li> <li>• Lack of regular engagement and coordination of different stakeholders; lack of regular capacity-building activities, and advocacy for related stakeholders; inadequate awareness of data validity and data use at the service provider level; no client feedback mechanism on monitoring and supervision to ensure credibility.</li> </ul>	No Indicators set for SBCC activities
Inadequate consultations about SBCC among key stakeholders (target audience)	<ul style="list-style-type: none"> <li>• No establishment or formal mandatory mechanism/forums for inclusion of target groups or key stakeholders.</li> <li>• No strategic directions for SBCC-related programs.</li> <li>• Programs are more focused on service delivery and demand generation.</li> <li>• Lack of realization about the importance of consultations among government and key stakeholders, with gaps in stakeholder mapping.</li> <li>• Lack of understanding among community people and related stakeholders on the need and impact/importance of SBC.</li> </ul>	No strategic directions for SBCC related programs

Important Bottlenecks	Intermediate causes (5 Whys)	Problems (Main root causes)
Inadequate community engagement on SBC for FP	<ul style="list-style-type: none"> <li>No established strategy for designing SBC initiatives in collaboration with local stakeholders.</li> <li>Lack of familiarity with SBC for FP among the community and stakeholders.</li> <li>Lack of coordinated primary SBCC program in the context of federalization.</li> <li>More centralized SBC programs on FP in terms of TOR, HR, and resources.</li> <li>Lack of understanding among community people and related stakeholders regarding the needs of specific groups (religion, gender, geography, liability) and the impact/importance of SBC.</li> </ul>	No established strategy for designing SBC initiatives in collaboration with local stakeholders

### SBC Group 3: Medicine and Technology, Service Delivery and Human

Important Bottlenecks	Intermediate causes (5 Whys)	Problems (Main root causes)
<b>Inadequate skilled human resource for SBC-FP (includes HR-capacity and service delivery-motivation)</b>	<ul style="list-style-type: none"> <li>SBC-FP skill development is not a priority.</li> <li>There is a lack of evidence on SBC-FP HR competency status.</li> <li>Limited awareness about SBC-FP exists among authorities at all levels.</li> <li>No Learning Resource Package (LRP) for health workers in SBC-FP.</li> <li>The need for SBC-FP training is not felt at higher levels.</li> </ul>	SBC-FP skill development not a priority Limited awareness about SBC-FP (among authorities at all levels) No LRP for health workers in SBC-FP
<b>Roles and responsibilities of service providers not well defined</b>	<ul style="list-style-type: none"> <li>No clear Job Description (JD) for service providers.</li> <li>JD is not updated according to the needs of the federal system.</li> <li>Updating the JD is not considered a priority.</li> <li>Differing interests of different decision-makers hinder the process.</li> <li>There is inadequate evidence and advocacy regarding the importance of clearly defined roles.</li> </ul>	No clear Job Description (JD) Not considered a priority Inadequate evidence and advocacy on importance
<b>Ineffective health management system to support SBC-FP</b>	<ul style="list-style-type: none"> <li>There is a lack of a guiding document for SBC-FP.</li> <li>SBC-FP is not prioritized within the health management system.</li> <li>Decision-makers have inadequate knowledge and understanding of SBC-FP.</li> <li>There is a lack of evidence and inadequate advocacy for SBC-FP.</li> <li>Adequate evidence has not been generated from systems like HMIS, surveys/studies, or Organization &amp; Management surveys.</li> </ul>	Lack of guiding document for SBC-FP SBC-FP not a priority in the management system Inadequate knowledge and understanding of decision makers on SBC-FP Lack of evidence and inadequate advocacy

## Solutions and Strategies to scale up SBC

Group 1: Governance and Financing  
SBC: Solutions and strategies

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Feasibility* 1 – very low 3- moderate 5 – high	Impactful 1 – very low 3- moderate 5 – high	Primary Responsibility	Supporting agencies
There is no strong leadership and commitment to support scale-up of SBC for FP at all levels.	The government views SBC for FP as mainly the responsibility of the private sector and NGOs, assuming it will occur without significant effort. Hence, SBC for FP has not been institutionalised, especially at sub-national levels.	Institutionalised SBC for FP especially at the subnational level.  (Structure, focal person, processes)  Identify and assign the focal person. This focal person is the same focal assigned for FP/RH.	5	5	NHEICC	FWD  Provincial directorate  Health Office  Local government (Health Section)
There is no strong accountability for SBC for FP across institutions and among policy makers and program managers.	Reporting on the status of SBC for FP is not required.	Establish accountability mechanism and reporting of SBC for FP for public institutions (three tiers), private institutions and NGOs.	3	5	NHEICC	Management Division of HMIS, Donors  EDPs  Vendors
There is inadequate budget available at all levels for scale-up of SBC for FP.	We lack strong leadership and commitment, effective accountability mechanisms, and the expertise to perform cost-benefit analysis. (Former 2 are already addressed in 2 other bottlenecks.	Develop expertise to perform CBA and use the evidence for policy analysis and advocacy with focus on local government.	3	5	NHEICC	Donors/HDPs (capacity building), MOHP, NPC, MOF, Provincial Directorate planning section, Provincial planning commission, Local level
Financing mechanisms and policy actions to ensure equitable scale-up of SBC are not in place.	Adequate budget is not allocated for equitable SBC for intersectional groups including adolescents, women from poor and/or rural contexts, WLHIC, WLD, women from minority ethnic group, female sex workers. <b>(Link with the 'Budgeting' in pointer 3)</b>  There is no existing mechanism (structures and processes are not	Strengthen existing mechanism for coordination and collaboration for social inclusion in SBC for FP for public institutions (three tiers), private institutions and NGOs.	4	5	NHEICC	FWD  Provincial Directorate  Local Level

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Feasibility* 1 – very low 3- moderate 5 – high	Impactful 1 – very low 3- moderate 5 – high	Primary Responsibility	Supporting agencies
	defined) for the coordination and collaboration.					
There is no coherent national plan for SBC scale-up.	We do not have sufficient evidence and disaggregated data from subnational level, including data segmented by intersectional subgroups.	Generate nationally representative evidence from general population and sub population, from all tiers, through different mechanisms such as survey and routine data.  <i>Revise recording and reporting form of HMIS to capture SBCC in thematic areas (including FP).</i>	4	5	NHEICC	FWD  MD  PHD/P-MoHP  Local government

#### SBC Group 2: People and Information

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Feasibility* 1 – very low 3- moderate 5 – high	Impactful 1 – very low 3- moderate 5 – high	Primary Responsibility	Supporting agencies
Inadequate recording and reporting on SBC activities	No Indicators set for SBCC activities	Set indicators and targets Agreed standards forms and formats for recording and reporting for SBCC. EHRR Ensure Capacity building Monitoring on quality of data, RDQA	5	5	FWD/MD	Development agencies and subnational governments
Inadequate consultations about SBCC among key stakeholders (target audience)	No strategic directions for SBCC related programs	Develop a strategy with formal forum/mechanism for inclusion of key stakeholders/target groups Stakeholders and community specific groups mapping	5	5	NHEICC	FWD and related stakeholders

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Feasibility* 1 – very low 3- moderate 5 – high	Impactful 1 – very low 3- moderate 5 – high	Primary Responsibility	Supporting agencies
		More decentralize focused programs should be designed.: HR, focal point, TOR and roles should be clear Bottom-up feedback mechanism should be developed.				
Inadequate community engagement on SBC for FP	No established strategy for designing SBC initiatives in collaboration with local stakeholders	Design program with community engagement on SBC as a core intervention. Programs and interventions should be tailored as per the need of community. Mobilization of community key influencers for behaviour change and change in norms: mother group, FCHV, leaders	4	4	NHEICC	FWD and stakeholders

### SBC Group 3: Medicine and Technology, Service Delivery and Human

Important Bottlenecks	Problems (Main root causes)	Proposed solution	Feasibility* 1 – very low 3- moderate 5 – high	Impactful 1 – very low 3- moderate 5 – high	Primary Responsibility	Supporting agencies
Inadequate skilled human resource for SBC-FP (includes HR-capacity and service delivery-motivation)	SBC-FP skill development not a priority	Advocacy from SBC-FP champions	3	3	NHEICC, FWD, Provinces, local levels, NHTC	Partners
	Limited awareness about SBC-FP (among authorities at all levels)	Develop LRP for SBC-FP for health workers	5	5	PHTC	
	No LRP for health workers in SBC-FP	Orientation / training and mentoring on SBC-FP	3	5		
Roles and responsibilities of service providers not well defined	No clear Job Description (JD)	Rational designing of Job Descriptions	5	5	MoHP / DoHS	FWD, NHEICC, Partners
	Not considered a priority	Evidence generation / collation and analysis:	3	5	Local levels, Provinces	



## Annex 12: SBC BNA Process document

SN	Major activities	Process	When
1.	Inception meetings with Family Welfare Division and WHO (Nepal and HQ)	Shared the global updates and core protocol with the director and staff from the FP/RH section. Discussed the context and BNA priorities for Nepal. Decided to form a technical working group (TWG*) to guide the overall BNA work in Nepal. <i>*TWG members comprise experts on PFPF and SBC-FP both from GoN, Non-government sector including BNA leads from Anweshan and WHO Nepal.</i>	Feb-March, 2024
2.	National Data review	BNA leads (PFPF and SBC-FP) reviewed relevant published and grey literature for national data using key search electronic databases like MEDLINE, PubMed, and Google Scholar. Documented the useful data related to PFPF and SBC-FP.	Feb-March, 2024
3.	Assessment of policy and guidance alignment	BNA leads reviewed the relevant published and grey literature for the synthesis of policy and guidance alignment using key search electronic databases like MEDLINE, PubMed, and Google Scholar. Thematic analysis and documentation were done.	Feb-March, 2024
4	Case studies assessment	The BNA Leads conducted a rapid search of published and grey literature to find local reports of the implementation of some of the successful projects. The BNA lead (PFPF) identified the Integrated Nutrition Project as one of the largest projects, having the highest coverage and contribution to post-pregnancy family planning as guided by the TWGs. Similarly, the BNA lead (SBC-FP) identified the HC3 project as one of the best SBC-FP projects implemented in Nepal. BNA Lead (PFPF) also reviewed the routine data from service sites and selected Lumbini Hospital as one of the sites executing PFPF effectively as guided by TWG and WHO Nepal. The BNA lead developed checklists to document the best practices and lessons learnt from the Lumbini hospital in close coordination with FWD. Documentation of the case studies was done according to the BNA protocol.	March –July, 2024
5	Contextualization of the BNA Framework and tools		
5.1	TWG meeting (I)	Shared the core protocol with TWG members. Shared the major findings from national data, policy, and guideline alignment. Shared the KII tools Identified case studies and decided to review integrated nutrition (Suaahara II) and one of the GoN sites for PFPF and HC3 projects for SBC-FP. Decided to review the tools in the next separate TWG meetings for PFPF and SBC-FP.	April 2024
5.2	TWG meeting (II)	Reviewed key informant survey tools (PFPF) Reached a consensus on the contents of the tools. Revised the tool considering Nepal's context Decided to pre-test the tool in similar settings. Identified the KII conduction sites	April 2024
5.3	TWG meeting (III)	Reviewed key informant survey tools (SBC-FP) Reached a consensus on the contents of the tools Revised the tool considering Nepal's context Decided to pre-test the tool in similar settings. Identified the KII conduction sites.	April 2024
5.4.	Pre-testing	Pre-tested the tools in Kathmandu, Lalitpur, Kavre, and Karnali. Summarized the findings from the pre-testing. Modified the tools based on the pre-testing findings. Modified the BNA framework based on the revised tools.	April-May, 2024
5.5.	Meeting with FWD after pre-testing	Shared the result of pre-testing with FWD and WHO. Identified the key informants for the KII survey following the BNA protocol. Finalized the data collection time and places.	May, 2024
6	Key informant Survey	Conducted a key informant survey (face-to-face) in two provinces (Madhesh and Koshi) based on PFPF service utilisation. Conducted a key informant survey (face-to-face) at the federal level. Analysed the key informant survey data	May –June, 2024

		Shared the key findings with WHO HQ and FWD (including TWG members).	July 2024
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7	BNA consensus workshop		August 2024
7.1	Preparation of BNA consensus workshop	<p>Conducted a series of meetings with FWD and TWG members. Reviewed the BNA consensus workshop protocol and tools (individually and jointly). Contextualised the tools. Finalised the participants of the workshop. Finalised the workshop schedule. Divided the groups based on the expertise of the participants (as per protocol). All together, six groups were formed for both themes. Group facilitators were identified for each group (with the provision of a lead facilitator from GoN and a co-facilitator from the subject experts). Sent the invitation to the participants and made follow-ups. The group's norms for each session were prepared.</p>	

## 7.2. BNA workshop conduction (Aug 9-10, 2024)

### Day 1

<b>Opening session</b>	<p>The FWD Director (Dr. Bibek) chaired the session, and the FP/RH section chief (Ms. Sharmila) shared the workshop objectives. WHO HQ (Dr. Rita) shared the global perspective on PPF and SBC-FP, including scale-up plans and strategies. The respective section chiefs (Ms. Sharmila and Ms. Sheela) from FWD and NHEICC, respectively, shared country perspectives on PPF and SBC-FP. Key findings from the BNA of PPF and SBC-FP were shared by BNA leads (Madan and Manish), respectively, followed by a Q&amp;A session. Opening remarks were shared by FWD (Dr. Bibek).</p>
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<b>Technical Session 1: PPF and SBC-FP bottlenecks group ranking</b>	<p>Break out the workshop participants into two separate rooms for the PPF and SBC-FP components. Split into 3 groups (~6-8) for each theme, ensuring a mix of participant types (policy/programme, clinical, NGOs) across the three groups:</p> <p><b>PPFP</b></p> <p><i>Group 1: Governance and financing</i> <i>Group 2: People and information</i> <i>Group 3: Medicines/technology, service delivery &amp; human resources</i></p> <p><b>SBC-FP</b></p> <p><i>Group 1: Governance and financing</i> <i>Group 2: People and information</i> <i>Group 3: Medicines/technology, service delivery &amp; human resources</i></p> <p>Each group performed the following activities after the group formation: Choose one group leader and a rapporteur. Orientated the group members regarding the process of group discussion and anticipated outcomes by the facilitators. Distributed hard copies (4-5 copies/group) of the group ranking tool (thematic areas only) Asked the questions by facilitators and requested participants of the group rank the question/tool. Group participants in the group ranked the score as follows: <i>Group 1: Governance and financing (1-9, 1 least important; 9 most important)</i> <i>Group 2: People and information (1-11, 1 least important; 11 most important)</i> <i>Group 3: Medicines/technology, service delivery, and human resources (1-14, 1 least important; 14 most important)</i> Facilitators tried to get consensus for the collective score. Once the process is completed, the facilitator reviews and finalises the group ranking in the master tool. The average score from individual and group ranking was calculated, and the final mean score was shared with the team for consensus. Each group identified the top five bottlenecks, and consensus was reached in spite of lengthy discussions. The facilitator also asked for 'voices of dissent' to set out their case for bottlenecks that are missing from the top 5 or that have been prioritised at a low level. The team leader and rapporteur presented the final score to the larger group. The feedback from the floor was documented.</p> <p><b>Points that were consider while group ranking the bottlenecks</b></p>
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	<p><i>How big is the problem.</i></p> <p><i>If it was addressed, would we see likely improvements in scale and quality of program?</i></p> <p><i>Is this a problem preventing nationwide scale-up of program?</i></p> <p><i>How urgently does this bottleneck need to be solved?</i></p> <p><i>How many other bottlenecks does this problem cause?</i></p>
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**Programmatic areas for ranking the bottlenecks**

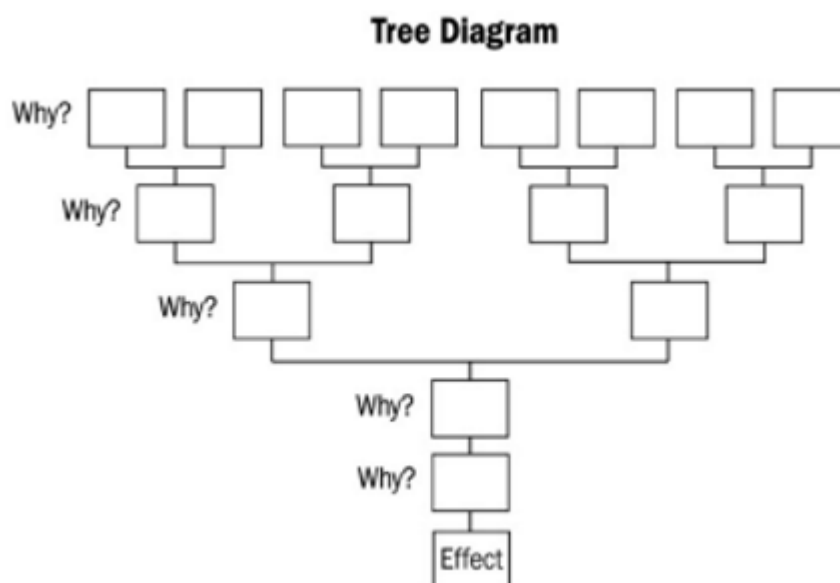
Group 1: Governance & Financing	Group 2: People & Information	Group 3: Medicines/technology, service delivery & HR
<p><b>Governance:</b></p> <ul style="list-style-type: none"> <li>• Leadership &amp; commitment</li> <li>• Accountability</li> <li>• Regulation</li> <li>• Guidance formulation &amp; coherence</li> <li>• Planning</li> </ul> <p><b>Financing</b></p> <ul style="list-style-type: none"> <li>• Budgeting</li> <li>• Donors</li> <li>• Spending</li> <li>• Equity</li> </ul>	<p><b>People:</b></p> <ul style="list-style-type: none"> <li>• Communication, knowledge &amp; awareness</li> <li>• Acceptability</li> <li>• Consultation</li> <li>• Coordination</li> <li>• Networks</li> <li>• Community engagement</li> </ul> <p><b>Information</b></p> <ul style="list-style-type: none"> <li>• Reporting</li> <li>• Data &amp; HMIS</li> <li>• Guidelines &amp; tools</li> <li>• Client SBC/IEC</li> <li>• Health promotion</li> </ul>	<p><b>Medicines &amp; technology:</b></p> <ul style="list-style-type: none"> <li>• Infrastructure</li> <li>• Supplies</li> <li>• Innovation</li> </ul> <p><b>Service delivery:</b></p> <ul style="list-style-type: none"> <li>• Management</li> <li>• Supervision</li> <li>• Team work</li> <li>• Service organization &amp; scheduling</li> <li>• Referral systems</li> <li>• Fees</li> </ul> <p><b>Human Resources:</b></p> <ul style="list-style-type: none"> <li>• Training &amp; education</li> <li>• Capacity</li> <li>• Roles</li> <li>• Skills &amp; competencies</li> <li>• Motivation</li> </ul>
<b>Total no. of potential bottlenecks: 9</b>	<b>Total no. of potential bottlenecks: 11</b>	<b>Total no. of potential bottlenecks: 14</b>

Day 2

<p><b>Technical session 2: Group report back (Ranking of top five bottlenecks)</b></p>	<p><b>Process</b></p> <p>Each group reported on its work, including the types of factors they discussed, the bottleneck ranking, and the rationale for the most important bottlenecks chosen. Facilitators asked the wider group to reflect on what they find surprising or interesting in the rankings.</p> <p>Facilitators asked again for 'voices of dissent' for any important bottlenecks that have not been prioritized by other groups.</p> <p>Facilitators asked each group if this bottleneck could actually be resolved with careful planning and resource allocation.</p> <p>Finally, the facilitators shared the <b>final 15 factors (bottlenecks)</b> for solution planning in each thematic area.</p> <p>As root causes were discussed and agreed upon, the facilitators entered them into the <b>matrix</b> (digitally on a laptop).</p>
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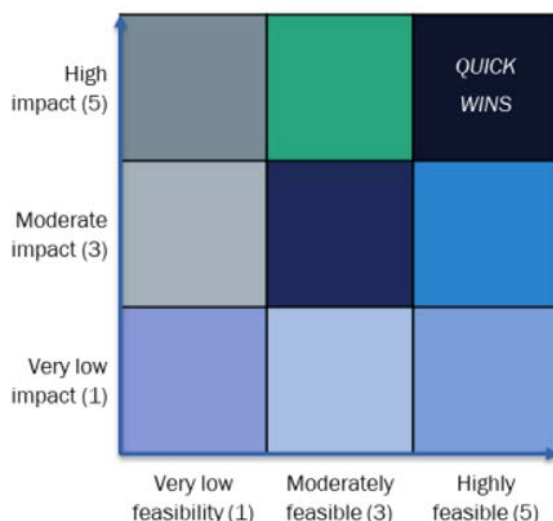
<p><b>Technical Session 3</b></p> <p>Develop a problem tree for each of their 5 bottlenecks (cause-effect relationship/5 whys)</p> <p>Identify the root causes of the key bottlenecks (9-15 bottlenecks - 3-5 from each group)</p>	<p><b>Process</b></p> <p>The same sub-groups worked on the root cause analysis, and the group members were kept the same as far as possible, depending on dynamics and needs.</p> <p>Facilitators shared the <b>15 bottlenecks (5-5) identified previously among the respective groups.</b></p> <p>Group facilitator asked each group to develop a <b>'problem tree'</b> for each of their five bottlenecks.</p> <p>First, Group facilitator wrote the <b>effect (i.e., the bottleneck)</b> and then asked <b>the 5 WHYS (along with their answers)</b> to analyse the root cause of the bottleneck and some solutions.</p> <p>The participants were requested to find the specific root causes, and the steps of the tree diagram might vary (may be less than 5). (The groups referred to the tree diagram (Fig. 1) below while working on the root causes.)</p> <p><i>The groups tried to focus on the key whys.</i></p> <p>As root causes were discussed and agreed upon, we entered them into the <b>matrix</b> (digitally on the laptop).</p>
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Figure 1: Root Cause Analysis, URC/USAID Assist Project



<p><b>Technical session 4</b>                  Identify intervention (solutions) based on the root cause analysis using solution grid (matrix)                  Prioritize <b>high impact</b> (among low, moderate and high impact solutions) and <b>highly feasible</b> (among very low, moderately and highly feasible) interventions (<b>Quick wins</b>)</p>	<p><b>Process</b>                  After a break, facilitators asked the groups to reconvene to discuss solutions based on their root cause analysis.                  When discussing solutions, group participants tried to focus on 'quick'wins'—actions that are both highly feasible and likely to have a high impact.                  Considered feasibility (cost-effectiveness and available budgets) and impact (health and health system outcomes, equity, and sustainability)                  Used the impact feasibility matrix (as per protocol) while developing solutions.                  As solutions were discussed and agreed upon, facilitators entered them into the <b>solutions grid</b> (digitally on a laptop).                  Finalized the institutions with primary responsibility and supporting agencies.</p>
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Figure 2: Impact feasibility matrix, Health Policy Plus



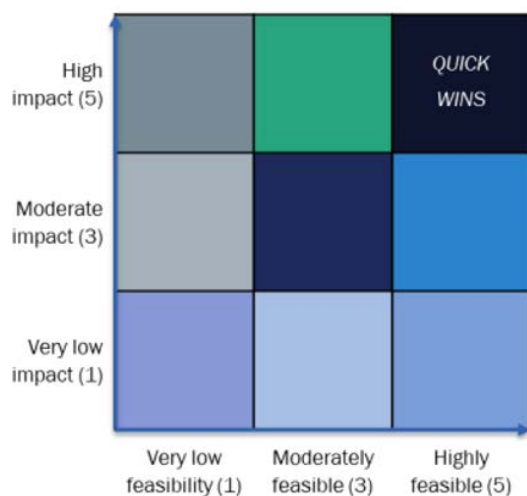
<p><b>Technical session 5</b>                  Present the group work on root cause analyses and solutions planning                  Collect feedbacks from the broader group</p>	<p><b>Process</b>                  Each group presented their root-cause analyses and solution planning in the plenary facilitated by the BNA lead (Madan).                  The root causes and solutions across the groups were discussed among the workshop participants.                  The facilitators asked the broader group for comments after reporting.                  Built consensus on the final solutions identified.                  The BNA lead (Madan) thanked all the participants and facilitators for their contributions.</p>
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Closing session	Process
Reflect on the major highlights of the workshop Deliver the vote of thanks to all and Wrap up the session	The workshop facilitator asked some of the key participants (local, provincial, and federal) to share their reflections on the workshop and exercise we had. Closing remarks were shared by section chiefs from NHEICC and FWD, who shared their commitment to strengthening the PFP and SBC-FP programs in the country. WHO HQ (Dr. Rita Kabra) thanked organizers and participants of the workshop for their active participation and contribution. At the end of the workshop, facilitators took a group photo for documentation purposes.

#### Session 6: Solutions identification

Major contents	Notes for facilitators
Identify intervention (solutions) based on the root cause analysis using solution grid (matrix) Prioritize <b>high impact</b> (among low, moderate and high impact solutions) and <b>highly feasible</b> (among very low, moderately and highly feasible) interventions ( <b>Quick wins</b> )	After a break, ask the groups to reconvene to discuss solutions based on their root cause analysis. In the example above, the solutions might be: Work with the relevant Ministry director to agree on a national KPI for PFP Work with the HMIS division to develop and test a workable PFP indicator, requiring national reporting and accountability. When discussing solutions, try to focus on 'quick wins' – actions that are both highly feasible and likely to have high impact. Feasibility should consider costs, cost-effectiveness and available budgets. Impact should consider likely health and health system outcomes, equity and sustainability. Please refer the figure (2) below while developing solutions. As solutions are discussed and agreed, enter them into the <b>solutions grid</b> (paper or digitally on laptop). Finalize the institutions with primary responsibility and supporting agencies

**Figure 2: Impact feasibility matrix, Health Policy Plus**



#### Session 7: Report back

Major contents	Notes for facilitators
Present the group work on root cause analyses and solutions planning Collect feedbacks from the broader group	Each group should present back their root cause analyses and solutions planning Note areas of common root causes and/or solutions across the groups. Ask the broader group for comment after report back. Build consensus on final solutions identified.

#### Session 8: Wrap up

Major contents	Notes for facilitators
Reflect on the major highlights of the workshop Deliver the vote of thanks to all and Wrap up the session	Facilitators to document the points shared by the key speakers Facilitators to thank everyone in the workshop and support FWD/NHEICC to wrap up the sessions smoothly. Take a group photo (if possible)

