HUMAN CENTRED DESIGN IMPLEMENTATION CASE STUDY NEPAL

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The Vaccine Alliance

APPLYING HUMAN CENTRED DESIGN (HCD) TO INCREASE VACCINATION RATES IN ZERO-DOSE COMMUNITIES:

EXPERIENCE FROM NEPAL

01 BACKGROUND

Causes for a child to be zero-dose or under-immunized are complex and wide-ranging. They include "socio-economic factors, deeply entrenched barriers and vulnerabilities related to poverty, conflict, forced migration, homelessness and religious or cultural marginalisation".[1] In these circumstances conventional methods to identify solutions become inadequate. Human Centred Design (HCD) provides tools to focus on people and create tailored solutions to challenges based on local insights, resources and capabilities, especially in missed or underserved communities.

The HCD methodology provides an organized process for working directly with users – families, communities and service providers – and proposes solutions to effectively address challenges related to vaccine uptake and the response to and demand for immunization and other essential health services.

HCD is an approach used by UNICEF to ensure immunization services reach the most marginalized children and communities. Since 2020, UNICEF has collaborated with national governments in 14 countries to use the HCD approach to develop tailored demand generation strategies, with a plan to expand it to a further 7–8 countries by the end of 2023.

In the context of zero-dose or under-immunized children, HCD enables government counterparts, other implementing partners and UNICEF to better understand people and what keeps them from seeking and/or supporting health services in their communities. Its introduction and roll-out across UNICEF-supported interventions in various countries allows implementers to perceive challenges from the perspective of the community and identify opportunities where previous solutions have failed.

This case study documents insights from applying HCD to increase vaccination rates in zero-dose communities in Nepal. Specifically, it draws out insights into issues such as what HCD is and how it was rolled out, the context in which HCD was applied, the effect of HCD on practice, and lessons learned.

[1] Gavi, 'Reaching Zero-dose Children', <www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities>, accessed 1 September 2022.

Key terms used in this case study

1 Social and Behaviour Change (SBC)

a set of approaches that promote positive and measurable changes toward the fulfilment of children's rights.

2 Human Centered Design (HCD)

a problem-solving process that begins with understanding the human factors and context surrounding a challenge.

3 Behavioural Design

is a systematic understanding of how individuals think and how they make decisions with a view to ethically design positive behaviour desired by both the individual and society.

4 Rapid Inquiry (RI)

is used at the research phase of HCD. It is based on applying fast techniques to understand the many social, cultural, political and economic influences and motivations in a community.

5 Prototype

an inexpensive, scaled down versions of the proposed change/product. It's anything a person can look at and respond to.

6 Prototyping

is a tool along the HCD continuum which involves inviting the community to shape the idea's form and function. It assists designer know if generated ideas align with community values, motivations and existing habits.

7 Iteration

is a tool along HCD continuum which involves making a series of design versions to the prototype to learning and improvement.

8 Palika(s)

the lowest/ smallest administrative unit in Nepal.

02

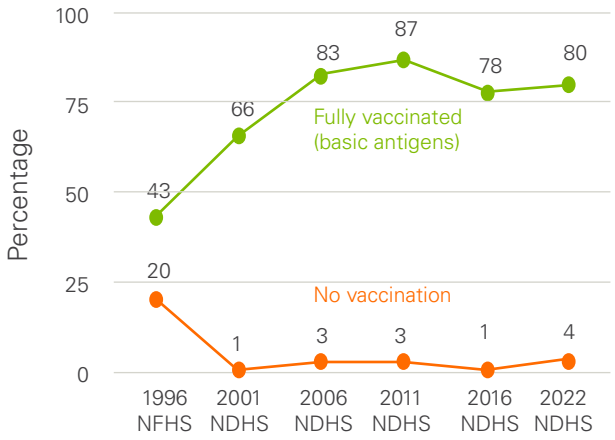
CONTEXT AND DESIGN APPROACH

Vaccination levels for children aged 12-23 months in Nepal remain below the country's Sustainable Development Goal target of 94.8 per cent coverage. According to the National Demographic Health Survey (2022),[2] only 80 per cent of children in this age group are fully vaccinated with basic antigens and slightly more than half 52 per cent are fully vaccinated according to the national schedule (see Figure 1).

In addition, there are persistent equity gaps in vaccination coverage. For instance, vaccination coverage is significantly lower (around 60 per cent) for the Tarai/Madesh Dalit caste in comparison to Janajati, where the coverage is 100 per cent. Moreover, Province 2 has the lowest coverage at around 69 per cent compared to Province 4's 92 per cent (Figure 2).

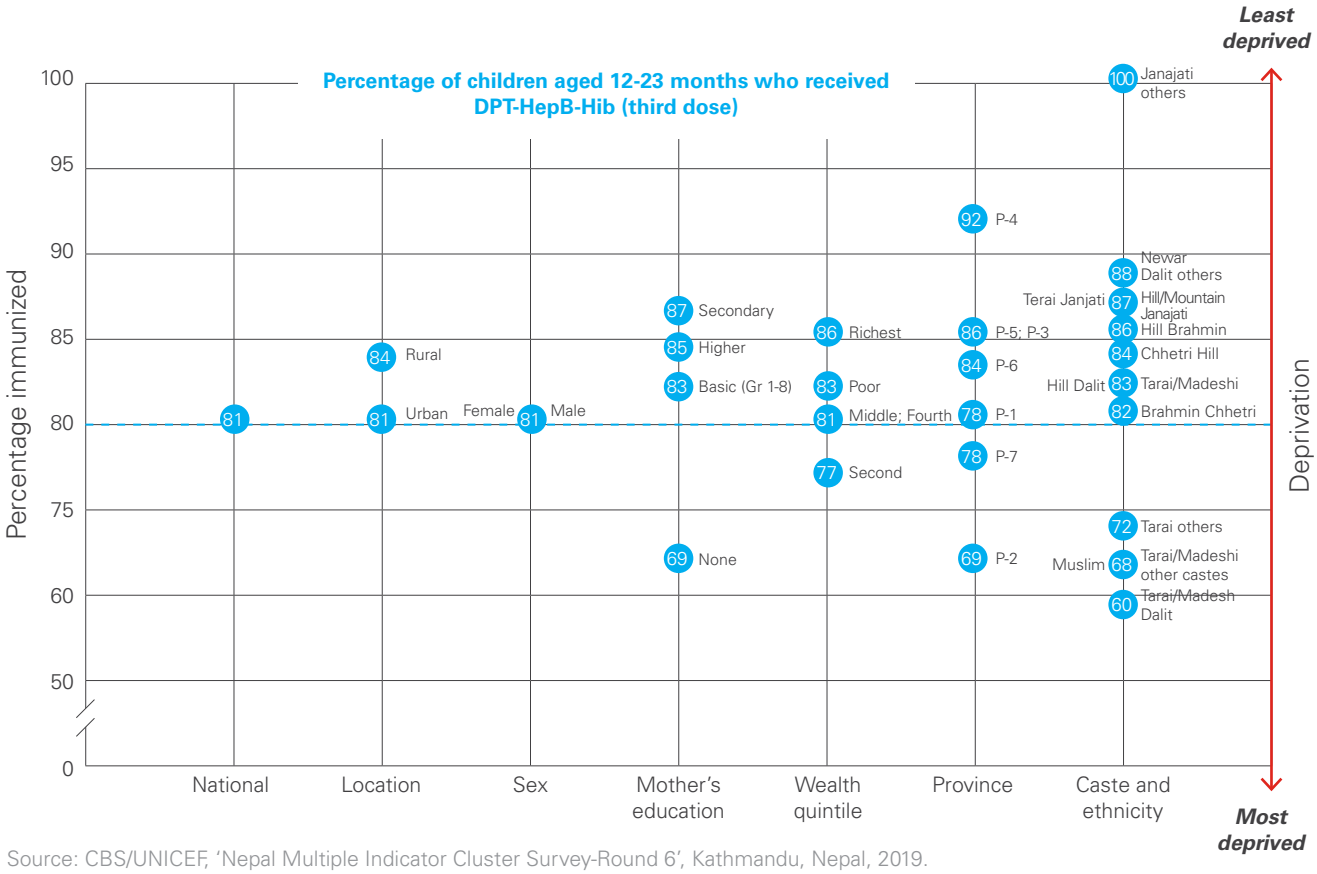
Figure 1. Trends in childhood vaccination

(Percentage of children age 12-23 months)



Source: Nepal Demographic and Health Survey (2022) Key Indicators Report

Figure 2. Equity Tree: Immunization coverage for DPT3, Nepal, 2019



Source: CBS/UNICEF, 'Nepal Multiple Indicator Cluster Survey-Round 6', Kathmandu, Nepal, 2019.

[2] Nepal Demographic and Health Survey 2022 Key Indicators Report. Available from https://mohp.gov.np/uploads/Resources/Nepal%20Demographic%20and%20Health%20Survey%202022%20Key%20Indicators%20Report.pdf

To address these challenges, the Government of Nepal, working collaboratively with UNICEF Nepal, has taken the initiative of applying HCD to tackle low immunization rates in specific subnational communities where zero-dose and under-immunized families are prevalent and coverage is below 70 per cent.

Starting from September 2021, the Ministry of Health, UNICEF Nepal, and other stakeholders have been working together to implement this initiative. The aim of this program is to inform tailored interventions using a holistic approach to increase immunization rates among zero-dose communities.

By taking the lead in this effort, the government of Nepal is demonstrating its commitment to ensuring that all children in the country have access to life-saving vaccines, regardless of their location or circumstances.

In order to select the most appropriate locations for HCD implementation, the government with the support of UNICEF Nepal Social and Behaviour Change team conducted a desk review covering a wide range of resources, including published and unpublished research reports, peer-reviewed journal articles, training materials, government policy and protocol regarding immunization. They also held consultative meetings with the municipality team of key informants, including the Health Coordinator, locally elected representatives, female community health volunteers (FCHVs), and local health service providers.

Using informal sociological and anthropological tools such as Kuragraphy, transact walks, clue observation, and service site observation, the data collected from the desk review and consultative meetings were further verified.

As a result of the findings, the government identified four locations for HCD implementation: Sudurpashchim, Madesh Pradesh, Karnali, and Kathmandu. These locations were selected due to their high proportion of poor, marginalized, and underserved communities and the presence of zero-dose children.

The Ministry of Health, local partners and UNICEF collaborated to introduce the theory and practice of HCD by undergoing multiple capacity-building workshops. The practical capacity building process employed the HCD process to swiftly identify and address underlying barriers to the uptake of vaccination and other health services in selected communities with low immunization coverage or a zero-dose rate.

The training and roll-out resulted in several outcomes and lessons that were learned. As described below, this effort produced valuable insights into the design and implementation of effective HCD interventions that could be replicated in similar settings.

This collaboration between the Ministry of Health and UNICEF was characterized by strong commitment and leadership, as evidenced by their active involvement in every aspect of the HCD initiative. The following sections provide an overview of the outcomes and lessons learned during the HCD process, which could help inform the scaling of HCD in similar contexts across Nepal.

03 HCD OUTCOMES

3.1 Enhanced/improved understanding and practice of the HCD concept and framework

Up to 42 stakeholders from the Ministry of Health, representatives of different *Palikas*[3]/ municipalities from the Central Southern belt and Far West regions, local partner non-governmental organizations and UNICEF staff experienced first-hand the concepts and practical aspects of HCD through a training of trainers (ToT). Figure 3 shows the breakdown of trainees by stakeholder.

A blended ToT with a mix of in-person and virtual (through Zoom) attendees was held in September and October 2021, with participants joining from four locations throughout Nepal. This ensured participation by provincial training teams based outside Kathmandu.

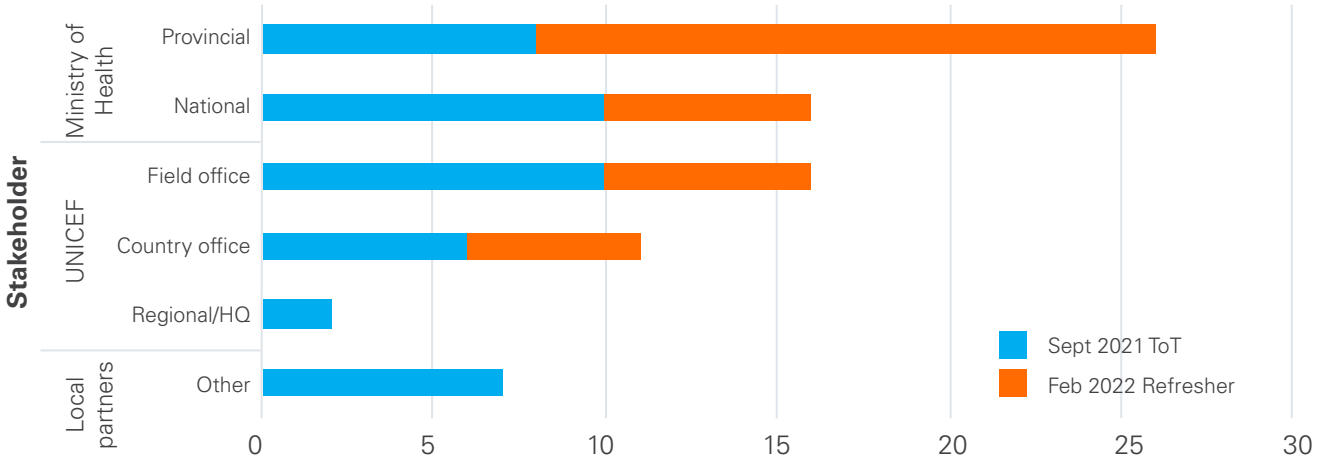
To further enhance understanding, the UNICEF Nepal team adapted the training materials into the Nepali language. This Nepali material was used for refresher training over three days in February 2022 attended by 25 participants. Using skills gained from the September 2021 ToT, the UNICEF Nepal team facilitated the refresher training – a strong indication of the success of the ToT model.

A unique characteristic of both training events was the focus on the practice and application of HCD for health service demand generation. This was achieved by complementing classroom/theoretical concepts with fieldwork to promote hands-on learning and reflection.

Training evaluations indicate that the training helped participants build HCD skills in a context that is familiar to them.

> "The concept is new to us, and we hope to learn the skills and knowledge associated with HCD, and hopefully from that knowledge we will be able to systematically design campaigns that involve the community in problem-solving."
> *– Ministry of Health training participant, Kathmandu, Nepal*

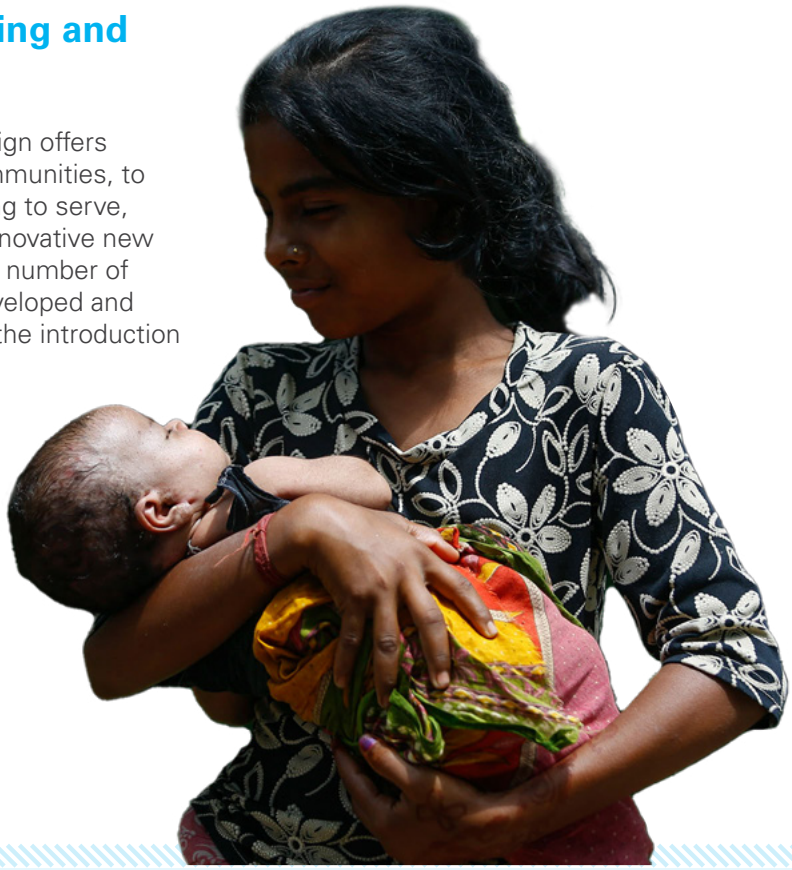
Figure 3. HCD trainees by stakeholder



[3] A Palika is the lowest/ smallest administrative unit in Nepal.

3.2 Developing contextually relevant solutions through microplanning and co-creation with stakeholders

According to IDEO.org, "Human-centred design offers problem solvers a chance to design with communities, to deeply understand the people they are looking to serve, to dream up scores of ideas, and to create innovative new solutions rooted in people's actual needs."[4] A number of contextually relevant solutions have been developed and continue to be developed in Nepal following the introduction and roll-out of HCD.



Central to the development of these contextually relevant solutions is the 'journey to health' framing, which is a systematic framework to unpack vaccine demand and supply factors. It considers the six domains of visiting, and returning to, a health facility to identify barriers and enablers and start to devise solutions. Applying the framework, the Ministry of Health, partners and UNICEF has so far identified the following initiatives during and after training:

Prioritizing safety – Chepang community (developed during training)

Issue/problem: Female health workers (female vaccinators) do not always feel safe travelling alone to conduct their activities in the community. Routine vaccination programmes are infrequent due to safety and mobility issues.

Solution: From speaking with communities and learning about daily life – beyond that of just immunization or health issues, Money lenders (who view themselves as protectors of the community) have been co-opted in the initiative. In Chepang, it is the money lenders, not the community leaders, who are the most influential members of the community.

They have taken up the job of ensuring safe passage for these health workers. They can also advocate for female health workers at local meetings and in places where community leaders gather to generate broader community support for and awareness of their activities and well-being. In return, the health sector will recognize money lenders for their service and positive impact.

Results/impact: While this solution was identified as part of the training and shared with the local government responsible for the Chepang community, discussions are under way to progress the idea into full implementation.

[4] IDEO.org, 'The Field Guide to Human-Centered Design', IDEO.org, San Francisco, <https://d1r3w4d5z5a88i.cloudfront.net/assets/guide/Field%20Guide%20to%20Human-Centered%20Design_IDEOorg_English-0f60d33bce6b870e7d80f9cc1642c8e7.pdf>, accessed 16 December 2022.

Health equity for marginalized communities – Madesh (developed after training)

Issue/problem: Community members of the Dalit caste reported feeling unfairly treated by some health workers and individuals from higher castes due to their social and economic status.

Solution: The health facility has dedicated a day for members of the Dalit community to access immunization and other health services. There are further plans to hire FCHVs from the Dalit community, and provide SBC and interpersonal communications (IPC) training to health workers and ward representatives so that ward offices and health facilities can provide quality and equitable services to the deprived community.

Results/impact: Client exit interviews (to measure service satisfaction) and observations have been planned as part of the initiative's results measurement framework. Results are expected in Quarter 1 of 2023.

Sudurpashchim (developed after training)

Issue/problem: Limited FCHV coverage, seasonal cross-border migration work opportunities in India and a high burden of household work results in caregivers missing critical immunization dates. Caregivers are unaware of the benefits of vaccination, the vaccination calendar and government incentives such as allowances for mothers who attend antenatal and postnatal check-ups and deliver in a health facility.

Solution: Boost the FCHV workforce and coverage by recruiting young champions to carry out community sensitization on key vaccine benefits and vaccination dates. Mobilize and work with Bhalmanshah (religious leaders), to communicate the importance of immunization and motivate caregivers to complete the full course of immunization.

Results/impact: This initiative has only recently started (third week of October), so no impacts have been measured/documented yet. However, a baseline survey with the support of a recently recruited Social Mobilizer and Coordinator covering 170 households has identified 10 zero-dose children (8 via the baseline work and 2 via FCHV-led community sensitization/mobilization). Work is now under way to enhance the capacity of the recently recruited young champions.

Kathmandu Metropolitan City (developed after training)

Issue/problem: The migrant community lacks information about service sites and times. Health workers and FCHVs do not have data and information about migrants' family and children. Neither FCHVs nor health workers visit migrants. Migrants do not know who their FCHVs are. There are serious language barriers between service providers and caregivers. The opening times of health services are not convenient for migrants. Most migrants do not have a vaccination card with them and are afraid of being scolded by health workers if they visit a health facility without the card. Migrants feel discriminated against and not heard by health workers. Some caregivers do not consider vaccinations important for their children, and some do not go for vaccinations due to fears of side effects.

Health workers do not feel accountable to the migrant community. Furthermore, they do not want to give vaccines to migrant children without a vaccination card. Most of the female caregivers have movement restrictions and do not have decision-making power to visit a health facility without their husband's permission.

Solution: Following an ideation workshop, the team developed a profile of a migrant family, identified zero-dose and under-immunized children, mobilized FCHVs to carry out home visits, and delivered IPC training to health workers and FCHVs on respectful services and accountability. Community dialogue was undertaken to make locally elected members accountable.

Results/impact: Implementation commenced in two wards – 12 and 18 – in October 2022. Monitoring efforts currently include the collection of service utilization statistics for health facilities to establish a full picture of who has been missed. Data will be shared with the government.

3.3 Enhanced community engagement

The field research phase of HCD is based on an immersive experience with members of the community. This phase offers stakeholders an opportunity to explore areas of enquiry and direct the right questions and activities to the right people.

Several communities have been visited by project teams and have shared invaluable insights and accounts of their 'journey to health'. Table 1 shows some examples of enhanced community engagement where issues raised by communities have informed intervention design.

Table 1. Enhanced community engagement initiatives

Community visited	Community members consulted	Issues discovered	Intervention design informed by issues
Province 1	• Caregivers (mothers, mothers-in-law, fathers) • Community influencers: FCHVs • Community influencers: local leaders	Members from the Dalit community have ceased utilizing government health facilities as they feel unheard and discriminated against by the health workers due to their caste and low economic status.	Government health workers have started marking efforts to re-engage with this population and show that their concerns and needs matter.
Madesh	• Caregivers (mothers, mothers-in-law, fathers) • Community influencers: FCHVs • Community influencers: local leaders	Caregivers felt discriminated against due to their Dalit caste and low economic and social status.	Dedicated day for Dalit communities and hiring of FCHVs from the Dalit community who have lived experiences and can interact with fellow members of the community
Sudurpashchim	• Community influencers: FCHVs • Caregivers (mothers, mothers-in-law) • Influencers: Bhalmanshah, SM, SMC chair	Low FCHV numbers and seasonal migration for work in neighbouring India result in caregivers missing critical immunization dates.	Boost FCHV numbers through young community champions. Use religious leaders as messengers to communicate vaccine benefits.
Kathmandu urban slums	• Caregivers (mothers, mothers-in-law, fathers) • Community influencers: FCHVs	Lack of vaccines at health centres. Vaccination card being torn and the fear of getting scolded by health workers, including having to pay extra for a new card. Husbands – the key decision makers – did not let their children get vaccinated. Migration and home deliveries are common.	Workplace vaccination campaigns for all types of workers, including labourers. Digitalization of RCI vaccination at the time of birth registration. Capacity-building of health care providers to ensure respectful service delivery

3.4 Enhanced participation of front-line health works in designing innovative health solutions

The HCD process involves the active engagement of the Ministry of Health, with a particular emphasis on the involvement of health workers at grassroots level. This collaborative approach between the Ministry of Health, UNICEF, health workers, and communities is unique compared to traditional participatory planning and design methods.

Health workers are a core stakeholder in the HCD process, playing a critical role in identifying behavioral changes or interests and tailoring solutions to meet the needs of communities. This approach has resulted in successful community-centric interventions that address underlying barriers to the uptake of vaccination and health services in Nepal.

The Nepal SBC team acknowledges the significance of engaging health and government workers in the HCD process. According to their reflections, the involvement of these stakeholders is essential for the ownership, acceptance and eventual success of community-centric interventions.

- "If we had not gone with the government people, if they had not seen it, then the trust or the acceptance of the fact would not have been there."

- "Everyone has really liked this approach, especially going to the community, understanding them from their own eyes, and also starting programme planning or doing something based on the findings that we have on the community."

3.5 Institutionalization of HCD

To date, HCD has been integrated into the curriculum of the National Health Training Centre, and efforts are under way to establish a Behavioural Science Centre. The latter is a collaborative effort with JSI International and Kathmandu University, which will see the incorporation of HCD as a module in the Master of Public Health qualification.

• National Health Training Centre curriculum development

This initiative aims to integrate HCD into the Nepal Health Directorate. By June 2022, up to 50 health cadres from all seven provinces responsible for planning and budgeting health interventions in Nepal had been trained in HCD. As part of the training, the cadres identified specific issues within their province, such as adolescent/teenage pregnancy, family planning and also immunization. HCD is therefore being expanded beyond just seeking to address zero-dose challenges.

• Behavioural science centre

Kathmandu University is hosting the Nepal Behavioural Science Centre, established in partnership with the Ministry of Health and Population, JSI International, and UNICEF Nepal. Seed funding from JSI, Kathmandu University and UNICEF has helped launch the initiative. A notable achievement of the Centre in 2022 has been its collaboration with Kathmandu Metropolitan City to utilize HCD to understand routine immunization-seeking behaviours among slum and migrant populations in the area.

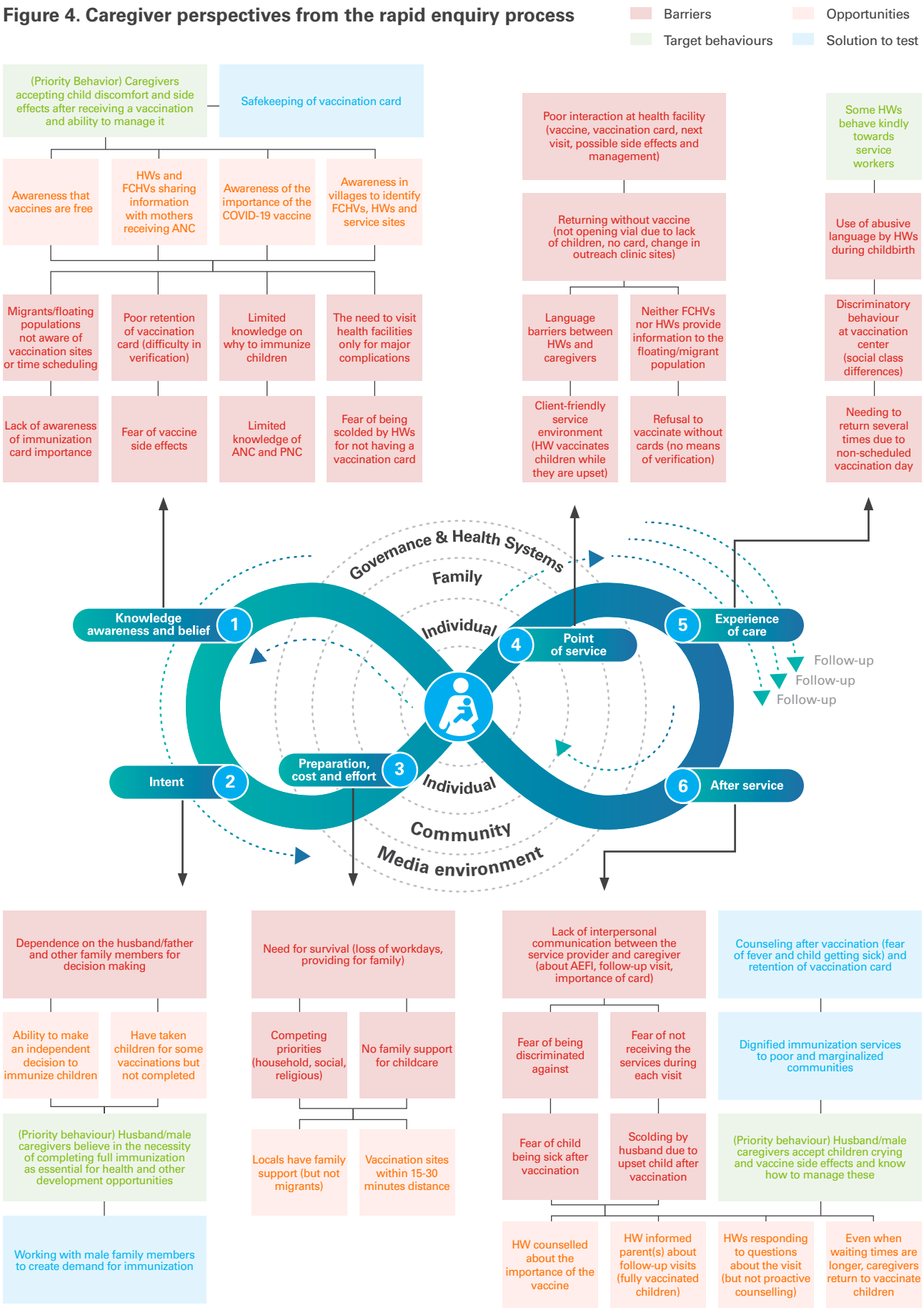
In order to gain insights into routine immunization-seeking behaviors among slum and migrant populations in Kathmandu, has since conducted a rapid inquiry in three wards (12, 18, and 27), with a total of 31 respondents including caregivers, fathers, health workers and community influencers. Through this inquiry, the partners aimed to capture the community's journey to health, which has informed a rich understanding of the communities' experiences, perspectives, and barriers to accessing immunization services (Figure 4). The findings will be critical in developing community-centric interventions to address these barriers and increase the uptake of vaccination and health services among these populations.

There is widespread interest in the results of the rapid inquiry, and confidence is building around the robustness of the methodology. At the time of developing this case study, discussions were under way on which solutions to prototype following the study.

In the medium to long term, HCD will be incorporated into the Master of Public Health qualification offered by Kathmandu University. The course currently has capacity to produce up to 25 graduates per year. Over time, this will produce a cadre of experts embedded in various levels of the government health system.

Pending the development and approval of modules, the current cohort of students in 2022 is actively practicing HCD through practical engagement in the rapid inquiry, journey to health mapping, and analysis of findings of the Kathmandu Metropolitan City study of urban slums. This hands-on experience of HCD is seen as a critical strategy to further embed HCD in Nepal's public health system, providing students with the expertise necessary for their professional careers. This approach to pre-service training is a good example of how students can gain practical experience to prepare them for their future roles.

Figure 4. Caregiver perspectives from the rapid enquiry process



Source: Kathmandu Metropolitan City study of urban slums rapid enquiry, 2022.

3.6 New ways of thinking

HCD has been an eye-opener for the Ministry of Health, collaborating partners, and the UNICEF Nepal SBC team, revealing the various dimensions of health-seeking behavior and their interactions that affect immunization uptake. This has resulted in emerging shifts in practice and ways of working, including:

- Changes in the SBC community's attitude, with evidence-informed introspection that HCD provides more useful insights into these kinds of contexts where previous solutions have been inadequate. This is shifting attitudes and mindsets away from using mass media as a vehicle for SBC.

- The government, along with collaborating partners, is increasingly interested in using data and insights from HCD in policy and practice. An example of this is the Kathmandu Metropolitan City exploratory study on institutional delivery, routine child immunization, and COVID-19 vaccination, which has received positive feedback. The government and collaborating partners are now exploring effective ways to share the formative study results with the broader immunization community, with the aim of influencing a shift from traditional Communication for Development (C4D) approaches.

3.7 Catalysing new funding

To leverage the growing interest in HCD within Nepal's health sector, the UNICEF Nepal SBC team has employed various techniques to secure new funding for expanding the approach. These include advocating for the potential of HCD, supporting government and collaborating partner efforts in sharing completed activity findings, and inviting potential collaborators to participate in HCD training or rapid inquiry. As a result, the following funding or commitments to fund/use HCD as a preferred approach have been secured:

- There are ongoing efforts to secure funding and support from the private sector and other international non-governmental organizations to further drive the collaboration of the Behavioural Science centre. This will supplement the initial funding provided by Kathmandu University, JSI, and UNICEF.

- The Ministry of Health and Population through the National Health Training Centre has allocated funds for HCD training within the organization and for cascading it further in the government system. Implementation modalities are being worked on. NHTC oversees all health training activities at the federal, provincial, and local level.

- The Nepal Health Research Council is training researchers on a cost-shared basis with UNICEF.

- The local government has committed to provide funding for HCD training in Karnali Province.

3.8 Immunization uptake

A HCD-designed intervention in the Raji and Loniya community of Bhajani municipality in Kailali has successfully identified 10 zero dose children, who have now been enrolled in the regular routine immunization process. All the children were born at home, and three of them are over 2 years of age, highlighting the importance of identifying and addressing specific barriers to immunization.

The community had various barriers to immunization, including high dropout rates, loss of vaccination cards, lack of awareness of the importance of vaccination and vaccination times, and home deliveries. Reliance on traditional birth attendants and fear of side effects also contributed to high dropouts. Despite a local health center being present, service delivery had not been extended to accommodate community members' schedules.

The HCD-informed intervention uses a two-pronged approach addressing both supply side and demand side opportunities. The demand side focuses on community engagement, social mobilization activities, and interaction/orientation with caregivers and service providers. Joint monitoring and supervision by vaccinators, FCHVs, and community leaders have helped tackle social norms and beliefs. On the other hand, to address service-level issues (supply side) which may hinder uptake by caregivers, FCHVs have completed IPC skills training, and HCD demand and barrier identification training has been completed, targeting all health facilities, vaccinators and health workers in the intervention catchment area.

This early success in the Raji and Loniya community of Bhajani municipality demonstrates the importance of addressing specific barriers to immunization and utilizing HCD-informed interventions. By engaging with the community and taking a comprehensive approach, progress can be made in improving immunization rates and ensuring better health outcomes for all.

04

WHAT HAS CHANGED IN NEPAL?

Several changes are observable at multiple levels in Nepal following the introduction and roll-out of HCD.

4.1 Tailored solutions

HCD is enabling the Ministry of Health and Population, local government, academic partners, other local partners, development partners and UNICEF to approach challenges from the perspective of community members. This case study presents examples of tailored solutions under outcome 2 – developing contextually relevant solutions through microplanning and co-creation with stakeholders. They demonstrate how HCD has allowed all stakeholders to tailor solutions to individuals' or groups' daily reality, personal motivations, existing habits and community influences using persona models that represent a mix of key actors (caregivers, health workers, families, communities, religious leaders, etc.). Furthermore, communities have been given a voice and can now share their perspectives and concerns by testing, improving or contributing solutions that work best for their contexts.

4.2 Integrated approaches

Health-seeking behaviour is multifaceted, and HCD enables teams to understand these various dimensions. The use of HCD tools such as personas and the 'journey to health + immunization' tools for planning and solving community challenges has concentrated focus not only on the caregivers and health workers but also the wider health system. The rich interaction with caregivers and community and health workers often yields evidence-based insights that inform the work of many sectors and identify underlying systemic challenges.

To develop tailored solutions, the immunization demand team is always looking sideways and thinking about aligning with other services. As such, the HCD approaches for immunization have been replicated in other sectors, including Maternal, Newborn and Child Health (MNCH), Nutrition, Water, Sanitation and Hygiene (WASH), etc., which are all critical to decisions and behaviours around immunization.

05 CHALLENGES

While HCD promises to help Nepal address the zero-dose/immunization challenge in communities where previous C4D approaches have been unsuccessful, gaining traction has been rather slow. A number of challenges include:

- HCD is a groundbreaking approach in Nepal, and as a result, obtaining the support and buy-in from key stakeholders, especially government counterparts, required significant effort. Initially, convincing stakeholders of HCD's unique features, potential, and importance, as well as how it varies from other participatory approaches, was a daunting task. The absence of data on the effective implementation of HCD in the Nepalese context compounded this issue during the early stages of engagement. In this regard, training and brainstorming sessions played a pivotal role in overcoming this obstacle and fostering a constructive shift in stakeholders' perceptions of HCD.

- The COVID-19 pandemic resulted in remote/virtual delivery of the master ToT. While it allowed the team to kick-start the introduction of HCD in Nepal, the level of understanding was not as high as originally expected. Participants emerged with various levels of understanding, resulting in the need to undertake a second wave of training. Further challengers linked to this issue included:

  - The absence of a step-by-step training manual, which reduced the effectiveness of the initial training. However, some useful HCD tools were shared which the trainees were able to start using.

  - The absence of HCD tools in the Nepali language. It was realized that greater traction with government counterparts would be achieved with Nepali tools and manuals. This learning informed the design and delivery of the second/ refresher training.

06

LESSONS LEARNED

Over the course of the implementation and roll-out of HCD, a number of lessons emerged, as follows:

- Start with small investments, test ideas and then scale up only when there is evidence of both desirability and sustainability from a community.

- Solutions must be tailored. Diversity of languages, customs and geography within a population often means that one community's solution does not work in the village next to it. You have to spend time and effort developing tailored solutions for each target community with which you are working. To succeed, teams have to listen and pay attention to the community's diverse perspectives and use the ideation and prototyping tools to test appropriate solutions.

- Health services are available but not used. In most 'last-mile' communities in Nepal, health posts are physically present, but services are not utilized. Examining and understanding the perspectives and needs of both caregivers and service providers reveals deep-rooted social issues that limit the use of the services. They include discrimination, poverty which forces caregivers to migrate for work or spend most of their time providing for their families, inefficient communication channels and a lack of insight into such things as government incentives. HCD has provided UNICEF Nepal and its partners with pivotal insights into how to tackle these issues, as shown by the examples shared in this paper.

- Holistic/integrated health services are needed. Using HCD tools – particularly the rapid enquiry process – has reaffirmed that immunization services do not work in isolation. Rather, holistic or integrated services that target improving the life of the whole family or their health-seeking behaviours are needed to achieve success. The participation of government counterparts in the process allows for joint identification of these issues and improves planning with other ministries or departments. Government involvement improves trust and builds acceptance of the issues, which would otherwise be absent if UNICEF were to approach communities on its own.

07

ON THE HORIZON

Despite the early challenges in gaining traction on the utility of HCD in addressing the challenge of zero-dose/ missed communities in Nepal, steady momentum is now building. After the early interest and support from the government of Nepal for HCD as a potential approach for the Expanded Program on Immunization in zero dose or missed communities, the next steps include:

- It is crucial to maintain the momentum gained in HCD adoption by the government of Nepal. This will require continued efforts to invest resources and provide technical support for the application of HCD in subnational programs of the Expanded Program on Immunization. It is also important to regularly review and reflect on the outcomes of these joint efforts to ensure that the desired impact is achieved.
- Using the HCD tool and approach to inform the national FCHV survey and strategy. Embedding HCD in the strategy will root the approach at the lowest and one of the most critical levels of the health system.
- Including the HCD tool in the government's IPC modules. IPC is a critical element of the journey to health, addressing how health workers deliver their service respectfully in the community.
- Finalizing the modules of the Master of Behavioural Science training programme, collaborating closely with Kathmandu University and attracting other interested academic institutions. This is critical to ensure the sustainability of the initiative and produce high-calibre health cadres for Nepal's health sector.
- Bringing more partners on board by disseminating the Nepali HCD training manual. This will create a pool of local partners with the skills to apply HCD in the sectors in which they work. Furthering the implementation research with Kathmandu University and JSI to improve implementation of HCD-informed interventions.

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