NATIONAL PLANNING COMMISSION
SINGHA DURBAR, KATHMANDU, NEPAL

Final Report

TABLE OF CONTENTS

List of Tables

List of Figures

FOREWORD

Good nutrition is crucial for the human capital development and socio-economic transformation of the nation. Realizing this, Nepal has been at the forefront of efforts in developing nutrition-related policies, enacting legal frameworks, and implementing various nutrition programs and projects since 1978. Based on the recommendations from Nutrition Assessment and Gap Analysis in 2011, the Government of Nepal adopted a multi-sectoral approach to address malnutrition in all its form and developed Multisector Nutrition Plan covering the period 2013-2017. Building on lessons from MSNP-I, Multi-sector Nutrition Plan (MSNP) II (2018-2022) was endorsed in November 2017 to provide continuity to the achievements of MSNP I (2013-2017). Following three and half years of implementation of MSNP-II, National Planning Commission (NPC) commissioned a Mid-term Review (MTR) with financial and technical support from the European Union (EU) and UNICEF Nepal to assess progress towards the achievement of the MSNP-II's objectives, assess factors of success and challenges associated with MSNP implementation and obtain recommendations to guide the formulation of the third phase of MSNP.

This 2022 MTR Report shows that there are encouraging signs of progress toward MSNP's results and Sustainable Development Goals (SDG) 2030 targets. The prevalence of stunting declined by one-third (from 57 percent in 2001 to 32 percent in 2019), indicating significant progress toward World Health Assembly (WHA) targets in 2025 and SDG targets in 2030. However, progress has been slow in meeting SDG targets. One in three 3 children is still stunted and child wasting, and anemia have plateaued for over two decades now. Marked disparities in nutritional outcomes have been found by gender, wealth quintile, caste/ethnicity, province, and geographical areas. A notable and gradual increment in the investment to implement MSNP has been found, however, a greater portion of the funds mobilized for MSNP is externally financed, primarily, from the EU.

The 2022 MTR Report brings together the latest available data and experiences from the sub-national level and provides an important resource to support efforts to reduce all forms of malnutrition. The Report offers forward-looking steps to strengthen efforts, governance, coordination, coherence, alignment, financing, and accountability that contribute to ending all forms of malnutrition. The report has come up with pivotal recommendations and calls for a more holistic approach and striving for better nutrition across the entire life course. The report has explicitly underscored the need to shift from distributive to production-based intervention in the agriculture sector and adopt a gender-transformative approach. This MTR Report calls for more domestic funding to finance both nutrition-specific and nutrition-sensitive interventions. The report implicitly urges the government, development partners, and relevant stakeholders to renew their commitment to achieving national and global goals. The report has restated the need for Government-led door program intervention to achieve targeted results and greater impacts of the interventions. MTR Report has made further clear that good data is key to reaching every child – revealing who we are missing and how we can improve the coverage and quality of essential nutrition interventions for children, adolescents, and women. This report has further validated that targeted programs of nutrition and social security in favor of the poor, deprived, vulnerable, disadvantaged, and marginalized groups are crucial to promoting equity, empowerment, and inclusiveness and ensuring no one is left behind. To this end, GoN has already initiated *Chepang* Special Nutrition Program in the Chitwan district and has planned to scale up such a targeted and tailored approach in other parts of the country to address the specific nutrition needs of the poorest of the poor such as Terai Dalits *(Musahar)* among others.
The MTR Report came at an opportune time as the Government of Nepal (GoN) is in the process of formulation of MSNP-III with Nepal being committed to achieving SDG 2030 targets related to nutrition. The MTR Report has already been influential in helping us think about our nutrition work. NPC strongly believes that the 2022 MTR Report acts as a source of action-oriented nutrition knowledge and thus calls upon sectoral ministries, all levels of government, and concerned stakeholders to make recommendations for their sectors and implement them accordingly. We also call on stakeholders working in the nutrition and food security sectors to read, share and act on the recommendation of the 2022 Mid-term Review Report of MSNP-II from decision-making to implementation.

The National Planning Commission would like to extend its appreciation and acknowledgment to all the sectoral ministries, provincial government and provincial planning/policy commission, local governments, UN agencies, development partners, and relevant stakeholders including the private sector, and civil society organizations among others for their inputs, suggestions, and feedback during the review process. Our sincere thanks go to UNICEF Nepal for its longstanding partnership with NPC and the continued support provided during every stage of the review process. Nepal will continue working together with the EU, UNICEF, and other development partners for a common cause and with a shared commitment to reach every child.

Considering the scale of the challenges being faced in the fight to end malnutrition we must embrace an integrated and cross-sectoral approach and come together and go bigger, broader, and bolder than ever before to respond to issues of malnutrition and the unprecedented threat posed by COVID-19 on nutrition and food security.

…….
Uma Shankar Prasad, PhD
Member
National Planning Commission

PREFACE

National Planning Commission (NPC) is pleased to share the results of the Mid-term Review Report of MSNP-II (2018-2022). This review is conducted with financial support from the European Union and technical assistance from UNICEF Nepal. The primary objective of the MTR of MSNP-II (2018-2022) is to assess the progress made towards achieving the planned MSNP's objectives, highlight the key success of MSNP and identify the barriers encountered for making progress towards MSNP's result and reinforce interventions that demonstrate the potential for success in the next phase of MSNP.

The MTR Report 2022 will be instrumental in guiding the formulation of MSNP-III. This report has signaled that renewed and integrated efforts and innovative ways of working are required – now – to end malnutrition in all its form. NPC also recognizes the importance of the 2022 MTR Report of MSNP-II in providing strategic guidance and recommendations for the formulation of the third phase of MSNP. I believe in the effective implementation of the MTR recommendation by all levels intending to improve the nutrition situation in Nepal, thus, I would like to encourage all the concerned stakeholders for the using this report to inform the planning and implementation of nutrition policies and programs for the enhancement of the well-being of the children and women in Nepal. Advantage should be taken of the availability of this information in this report to further strengthen nutrition programming in Nepal.

I would like to extend thanks to Dr. Kiran Rupakhetee, Joint Secretary/ Division Chief, Good Governance and Social Development Division and SUN Country Coordinator, for his leadership and his team within Good Governance and Social Development Division and colleagues from the National Nutrition and Food Security Secretariat for their inputs during the drafting of the MTR report. I would also like to thank sectoral ministries including the Ministry of Federal Affairs and General Administration (Local Level Coordination Section within the Federal Affairs Division) and Ministry of Health and Population (particularly the Nutrition Section of the Department of Health Services), the Provincial Policy/Planning Commission and all others who directly and indirectly contributed to conducting the MTR.

Last but not the least, on the behalf of NPC, I would like to extend my appreciation to Monitoring, Evaluation and Documentation consultant Mr. Sanjeev Kumar Sahani for his diligent efforts in carrying out this review and drafting the report. I would also like to acknowledge the contribution of UNICEF Nepal, in particular the Nutrition Section for their valuable technical guidance throughout the MTR process support and dedication to the completion of the report.

…….
Kewal Prasad Bhandari
Secretary
National Planning Commission

ACKNOWLEDGMENT

National Planning Commission (NPC) is pleased to present the report of the Mid-Term Review (MTR) of the implementation of MSNP-II (2018-2022). This work is the outcome of high-level commitment from the Government of Nepal which made sure that the review was conducted successfully. NPC would like to extend deep appreciation to the European Union (EU) for providing financial assistance for the conducting Mid-term Review of MSNP-II (2018-2022). This review could not have been completed without the technical support of UNICEF Nepal and their technical staff from the Nutrition Section whose inputs were key in finalizing the methodology and tools for the mid-term review. Special thanks to Karan Courtney Haag, Nutrition Section Chief, and Dr. Sanjay Rijal, M&E Officer, Nutrition Officers: Mr. Gyanu Bhujel and Mr. Naveen Paudyal and Nutrition Specialist Mr. Anirudra Sharma Gautam and Mr. Phulgendra Singh, from UNICEF Nepal for their timely inputs during the planning and implementation of review and their insightful comments on earlier drafts of the MTR report. Indeed, enormous support from UNICEF enabled us to realize our expectation of having a considerably smooth, rapid, and transparent MTR.

NPC would like to sincerely thank a multitude of people and agencies that have helped make the MTR Report 2022 possible. The generous inputs of time and attention from sectoral ministries, departments, EU, UN agencies, development partners (FCDO, USAID, FAO, WHO, WFP, World Bank), international NGOs, civil society organizations and private sector (Baliyo Nepal, FNCCI) is highly appreciated who were involved and provided technical advice during the revision of review tools and guided to shape the results, gaps, and recommendations in the report. We are also grateful to the Ministry of Federal Affairs and General Administration (MoFAGA) and the National Nutrition and Food Security Secretariat for all the field-level facilitation, coordination, and support during the review process. The specific note goes to Ms. Laxmi Ghimire, Program Director, and Program Officers Ms. Sarita Gurung and Ms. Sushila Panth from Women Children and Senior Citizen Section of Good Governance and Social Development Division, and colleagues from National Nutrition and Food Security Secretariat- Ms. Anju Acharya and Ms. Prativa AC for their advice and support extended during the conduction of MTR and development of report of MTR.

NPC would like to extend gratitude to the Provincial Policy/and Planning Commission of Province 1, Madhesh Province, Bagmati Province, Karnali Province, and Sudurpaschim Province, the District Coordination Committees, and local government authorities for their participation in making this review a success. Sincere gratitude is expressed to the Nutrition and Food Security Steering Committee at the provincial and local levels for sharing their on-the-ground experience to shape the results, gaps, and recommendations in the report. We are particularly grateful to the Provincial MSNP Coordinators and MSNP Volunteers for their unwavering support during the field mission.

In addition, we are grateful to the following government officials who helped us with data access: Mr. Anil Thapa Chief of the Health Management Information System Section, Management Division, Department of Health Services under the Ministry of Health and Population for providing updated data on several nutrition-specific program coverage indicators; Mr. Bhola Gautam, Information Management and Reporting Consultant, MoFAGA for providing updated data on progress (both programmatic and financial) towards nutrition-sensitive programs. Likewise, NPC would like to express heartfelt gratitude to participants of focus group discussion (mother's of children under five) from different provinces for their generosity in sharing their experience and giving their time in the realization of the review during data collection.

Finally, NPC would like to recognize the good work and commitment of the Monitoring, Evaluation, and Documentation Consultant, Mr. Sanjeev Kumar Sahani, and utter sincere thanks for his tireless efforts to ensure that the review is conducted to the highest possible standard.

…..
Dr. Kiran Rupakhetee
Joint Secretary
National Planning Commission

A. ACRNOYM

ACF	Action Contre La Faim
ANC	Antenatal care
CCG	Child Cash Grant
CF	Complementary Feeding
CNSI	Comprehensive Nutrition Specific Intervention
CSOs	Civil Society Organizations
DCC	District Coordination Committee
DoHS	Department of Health Services
DPs	Development Partners
EBF	Exclusive Breastfeeding
ECED	Early Childhood Education Center
EDPs	External Development Partners
EMIS	Education Management Information System
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
FNCCI	Federation of Nepalese Chambers of Commerce and Industry
GHI	Global Hunger Index
GMP	Growth Monitoring and Promotion
GoN	Government of Nepal
HHs	Households
HFs	Health Facility
HLNFSSC	High Level Nutrition and Food Security Steering Committee
HMIS	Health Management Information System
IDI	In-depth Interview
IDD	Iodine Deficiency Disorder
IFA	Iron-Folic Acid
INGOs	International Non-Government Organizations
IYCF	Infant and Young Child Feeding Practices
KII	Key Informant Interview
LLNFSSC	Local Level Nutrition and Food Security Steering Committee
MAD	Minimum Acceptable Diet
MDD	Minimum Dietary Diversity
MFF	Minimum Meal Frequency
MNP	Micronutrient Powder
MoALD	Ministry of Agriculture and Livestock Development
MoEST	Ministry of Education Science and Technology
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MoWCSC	Ministry of Women Children and Senior Citizen
MoWS	Ministry of Water Supply
MSNP	Multi-Sectoral Nutrition Plan
MTR	Mid-Term Review
NAGA	Nutrition Assessment and Gap Analysis
NCDs	Non-Communicable Diseases
NDHS	Nepal Demographic Health Surveys
NLNFSCC	National Level Nutrition and Food Security Coordination Committee
NMICS	Nepal Multiple Indicator Cluster Survey
NNFSS	National Nutrition and Food Security Secretariat
NPC	National Planning Commission
NPR	Nepalese Rupee
NRH	Nutrition Rehabilitation Home
PIN	Partnership for Improved Nutrition
PLNFSSC	Provincial Level Nutrition and Food Security Steering Committee
PLW	Pregnant and Lactating Women
PNC	Postnatal care
PP	Postpartum
PPE	Pre-primary Education
PSE	Private Sector Engagement
SAM	Severe Acute Malnutrition
SBC	Social Behaviour Change
SDGs	Sustainable Development Goals
ToC	Theory of Change
ToR	Terms of Reference
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organisation
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organisation
WRA	Women of Reproductive Age

Executive Summary

Recognizing the importance of nutrition for human capital development and the economic prosperity of the nation, Nepal adopted a multisectoral approach to address the issues of malnutrition following the recommendation from Nutrition Assessment and Gap Analysis (NAGA) in 2011. Multi-sector Nutrition Plan- II (2018-2022) – a continuation of the first multisector nutrition plan, MSNP-I which ran from 2013 to 2017- was formulated and is under implementation since 2018 with the involvement of key nutrition-specific and nutrition-sensitive sectors to address all forms of malnutrition among women and children and make a crucial contribution to achieving the Sustainable Development Goals (SDGs) related to nutrition.

With the MSNP-II being implemented for almost three and half years now, this Mid-term Review (MTR) was commissioned under the leadership of the National Planning Commission (NPC), with financial and technical support from the EU/UNICEF Nepal. The overall objective of the MTR of the MSNP-II (2018-2022) was to assess progress toward expected results after 3.5 years of implementation of MSNP-II (January 2018 to October 2021), recommend relevant measures to accelerate the achievement of MSNP-II's results, and obtain recommendations for the next phase of MSNP. It also highlights the key success factors that contributed to the desired change and challenges encountered during MSNP implementation.

Methodology:

This review was carried out through desk review, secondary data analysis, and primary data collection (qualitative in nature). Primary data were collected at federal, provincial, and local levels from November 2021 to January 2022 through interviews with relevant stakeholders (focal person of the sectoral ministries, members of the nutrition and food security steering committee, chief of basic health care centers, development partners, civil society organizations, private sectors) and focus group discussion with mothers with children under five years of age. Local-level data were collected from 8 local governments (one urban and one rural municipality) selected purposively from four different districts (2 municipalities from each district) of four different provinces (Province 1, Madhesh Province, Karnali Province, and Sudurpaschim Province) to represent the diversity of the implementation across different provinces. For secondary data analysis, the review gleaned information from multiple data sources including Health Management Information System, a Web-based Reporting System, and national surveys (National Demographic Health Surveys, Nepal Multiple Indicator Cluster Surveys) to assess the progress towards meeting the national and global targets.

Summary of main findings:

MTR revealed some progress towards selected global nutrition targets included as impact level indicators in MSNP-II and the MSNP has played a strong role in improving the nutrition outcomes. This is further validated by a recent evaluation of the MSNP commissioned in 2022 that reported significant improvement in nutrition indicators with the implementation of MSNP in the intervention groups compared to controls between 2014 and 2019. Moreover, the gap in the nutritional outcomes by provinces and the population characteristics (age and sex of child, place of residence, wealth quintile, and educational status of mother) has narrowed between 2014 and 2019 signaling positive trends across the indicators of inequality. Over the same period (between 2014 and 2019), improvement in IYCF practices has been found in the MSNP intervention districts indicating the activities implemented under MSNP have improved IYCF-related knowledge and behavior of mothers compared to control districts.

Between the review period (January 2018 to October 2021), the coverage of most nutrition-specific programs and nutrition-sensitive interventions has improved. The coverage of nutrition-specific programs such as Vitamin A supplementation, Deworming, Prevention of Iodine Deficiency Disorders, antenatal care visits, institutional delivery, and postnatal care has increased between FY 2075/76 (2018/2019) and FY 2078/79 (2021/2022). Significant improvement in the proportion of pregnant women attending four or more antenatal care (ANC) services has been reported- from 59 per cent in 2016 to 78 per cent in 2019. Similarly, over the same period, there has been a remarkable reduction in diarrheal incidence among children under five years of age (from 398 per 1000 children in FY 2075/2076 to 339 per 1000 children in FY 2077/78). Likewise, the percentage of children under five suffering from diarrhea treated with ORS and Zinc has remained over 95 per cent during the same period. Moreover, high success in the treatment of Severe Acute Malnutrition (SAM) cases (SAM cure rate of 75 per cent) has been sustained between the review periods. Coverage of nutrition-specific programs such as the Micro-Nutrient Powder-MNP *(Baalvita)* Community Promotion Program and Integrated Management of Acute Malnutrition (IMAM) has been scaled up to 70 districts of 77 districts during this review period.

MTR revealed some promising progress in some of the nutrition-sensitive indicators related to agriculture, livestock WASH, local governance, and education with the implementation of nutrition-sensitive MSNP interventions. There has been improvement in the production of milk, fish, and meat at the national level holding the potential of self-sufficiency in livestock production, particularly eggs and meat. Indicators of the education sector such as gross enrolment rate in early childhood education and development (ECED)/pre-primary education (PPE) showed reasonable growth i.e., from 85 per cent at baseline (2075/2076) to 88 per cent in (2078/2079) and surpassed the national target (86 per cent) for FY 2078/2079. Data and reports showed that the mid-day meal program contributed substantially to the improvement in attendance, enrollment rate, and retention rate. Similarly, remarkable progress was found in the WASH sector. Rapid progress was observed in sanitation coverage, heading towards ensuring basic sanitation for all and eliminating open defecation from the country. Nationally, access to improved sanitation facilities and drinking water services at the household level has reached over 95 per cent (NMICS, 2019). Coverage of social protection programs has also scaled up during the review period. For instance, the child cash grant (CCG) has been scaled-up from 14 districts in 2076/207 to 25 districts in 2077/2078 and has contributed to improving the food availability, health services-seeking behavior, and WASH outcomes.

In terms of creating a conducive environment for nutrition, commendable efforts have been made for improved nutrition governance and strong leadership at local levels during the review period (Jan 2018- Oct 2021). There is an increased political commitment, ownership, and accountability at all levels. Most of the local levels have mainstreamed MSNP into their periodic and annual policies, plans, and budget and have also allocated budget for MSNP indicating that the advocacy and facilitation in the preceding years worked which is gradually reaping positive results. Several national policies and sectoral development plans have been formulated by the government that has placed greater emphasis on nutrition and food security and are explicitly aligned with MSNP. There are upward and rising trends of resource mobilization for MSNP by federal and local government in the form of conditional, equalization, and special grants indicating financial commitment from all layers of government for MSNP.

Facilitators of success of Multi-sector Nutrition Plan:
The key factors for the success of MSNP that contributed to achieving the results gained so far which require further strengthening are: government commitment to embrace a multi-sectoral approach to nutrition, strong leadership of the NPC, and proactive engagement of the Federal Affairs Division (specifically Local Level Coordination Section) of Ministry of Federal Affairs and General Administration (MoFAGA) and Family Welfare Division (specifically Nutrition Section) under Department of Health Services of Ministry of Health and Population (MoHP), mainstreaming of MSNP into subnational policies and plans, increased ownership and resource mobilization for MSNP at the subnational level, endorsement of coherent sectoral policy at the federal level, well-established nutrition governance mechanism and coordination structures and positioning MSNP Coordinators and volunteers as key operatives.

Issues and Challenges:
Remarkable progress has been achieved towards addressing malnutrition with the implementation of MSNP, particularly in terms of stunting reduction (from 36 per cent in 2016 to 32 per cent in 2019), however, the pace of progress is too slow to reach the SDG targets. Even for stunting, average annual rate of reduction is too slow to meet the SDG 2030 targets. Wasting on the hand has remained stagnant for decades averaging approximately between 10-12 per cent since 2001. Further, stunting and wasting outcomes are differentiated by several factors, such as the age and gender of the child, the wealth quintile, place of residence, province, and the mother's nutritional status, among others. The stunting rate is highest among children aged above 18 months, and this rate rose sharply among the youngest age group of children. In contrast, the wasting rate is observed the highest for the youngest age groups with declining rates of wasting among old-aged children.

Nutrition Specific (Health Sector):
Improvement in the coverage of nutrition-specific programs is notable, however, progress on some indicators is nearly stagnant or in a reverse direction. For instance, the average growth monitoring (GM) visits per child have plateaued over the last few years, and uptake of GMP has continued to be low. According to national-level data from the Department of Health Services, between FY 2075/2076 (2018/2019) and FY 2078/2079 (2021/2022), the average number of GMP visits per child (0–23 months) remained the same at 3 GM visits per child signaling the need for strengthening of growth monitoring and promotion (GMP) program. Identification of moderate acute malnutrition (MAM) and SAM cases has continued to remain a critical issue. Similarly, the proportion of pregnant women receiving 180 Iron and Folic Acid (IFA tablets) has declined by 11-point percent in 2078/2079 (from 56 per cent to 45 per cent) compared to the baseline year 2075/2076 (2018/2019). Besides, there are issues with intake adherence to IFA. Between 2016 and 2019, Infant and Young Child Feedings (IYCF) practices such as initiation of breastfeeding within one hour and Exclusive Breastfeeding (EBF), timely introduction of complementary feeding, and intake of a diverse and nutrient-rich diet is not encouraging and are on a declining trend. The rate of EBF has declined by 4-point per cent from 66 per cent in 2016 to 62 per cent in 2019. On contrary, the rate of bottle feeding has increased by 77% in 2019 compared to 2016. Moreover, subnational variation has been observed in the rates of EBF in 2019, with the highest rates of EBF in Madhesh Province and lower rates of EBF in Bagmati Province and Gandaki Province. In contrast, the introduction of solid food and minimum diet diversity is lower among children from the poorest households, living in rural areas, or with a less educated mother. The disparity in dietary diversity was also observed based on the sex of the child, the mother's educational status, wealth quintile, and the province. Women and their babies tend to eat less diverse and nutritious food which is more common among women from poor households and marginalized groups. Besides, MSNP intervention is centered around women and children while adolescent nutrition has been given the least priority in terms of the budget and scale of the program.

Nutrition Sensitive Sectors:
The progress towards different nutrition-sensitive indicators is uneven across different provinces and groups. There are marked differences in the outcomes based on key sociodemographic characteristics for instance by province, place of residence, age, gender, ethnicity, education, and wealth. Nepal is heading toward the road to universal access to basic water supply and sanitation facilities, however, there is inequity in the access to improved sanitation services by province and other socio-economic characteristics such as place of residence and wealth quintile. The handwashing practices at critical times (after handling a child's feces, during handling of foods, and breastfeeding) and health and hygiene practices, and use of appropriate water treatment method has remained poor. The quality of the water at the household level remains alarming. A recent survey (NMICS, 2019) reported that three-fourths of the water sources (75 per cent) at the household level were contaminated with E. coli. At the same time, the availability of WASH amenities at health facilities (HFs) though have improved (sanitation from 82 percent in 2015 to 89 per cent in 2021 and improved water sources from 81 per cent to 94 per cent), functionality and conditions of these amenities were poor (at the places visited) in terms of cleanliness, maintenance, availability of regular supply of running water and sanitation supplies, client friendliness. Similarly, interventions from the education sector though have improved the enrollment and retention rate, but disparities exist by province and gender underscoring the need to accelerate the efforts at the local level to increase the enrollment of girls particularly in Madhesh Province and Karnali Province. Over time, the GER among girls has increased, however, compared to boys its low (boys- 54 per cent; girls 46 % in FY 2078/2079), with a similar pattern across all the seven provinces. Access to child cash grants (CCGs) has been found relatively low among the marginalized community either due to delayed or no birth registration.

Early marriage continues to remain high in some communities. A recent national survey (NMICS 2019) showed that 33 percent of the women aged 20-24 years were married before the age of 18 years (NMICS, 2019), and its prevalence varied with the place of residence, province (highest in Madhesh Province-53 percent), educational attainment, and household wealth quintile despite the implementation of various behavior change intervention at the local level. Similarly, menstrual seclusion *(Chhaupadi)* still stands as a widespread problem in Nepal despite the implementation of various awareness activities and criminalization of menstrual seclusion. Data revealed that nearly one-fourth (21 per cent) of women in Sudurpaschim province (21.1%) practice *Chhaupadi*, which is an 18-point percentage higher than the national average (3.8%). The higher prevalence strongly indicates that the interventions under implementation (legislation, community sensitization, and social campaigns) are not adequate to deter women in the western part of Nepal from practicing *Chhaupadi* and improving menstrual hygiene and making them realize to abolish this harmful practice. The current conventional gender-sensitive approach has not been able to adequately address the structural determinants of harmful social and cultural malpractices and is seemingly not working.

Nutrition Governance:

Nutrition governance structure and mechanism have been established and are functional with the implementation of MSNP at all three layers of government from the federal up to the ward level. However, the capacity of these committees to plan, coordinate and review MSNP, particularly at the local level is limited. In addition, there is a deficit in mutual accountability among the various actors involved with the implementation of MSNP across the sectoral ministries and at all three tiers of government. There is variation in the leadership, ownership, and mainstreaming of MSNP into local-level plans and resource mobilization for its implementation across the local government. Meetings of the nutrition and food security steering committee are held regularly, however, agenda-based meetings, data-guided discussions, and reviews as per the terms of reference of the steering committee are minimally practiced particularly at the provincial and local levels.

There exists a certain level of coordination between six different sectoral ministries involved in MSNP-II implementation. However, the coordination is limited to a formal meeting conducted occasionally at the federal level and the extent of coordination is not to extent that could lead to joint planning and resource allocation and mobilization, and shared accountability to achieve the desired common goals of better nutritional outcomes. It was found the nutritional governance structure exists, and principally there are cross-linkages between these structures and the sectoral ministries but in the real sense, these governance structures and sectoral ministries are not sufficiently cross-linked to promote shared accountability. The integration and harmonization of the nutrition and food security-related projects supported by development partners (such as USAID funded SUAAHARA project) and sectoral ministries (e.g., FANSEP project, PM-AMP) with MSNP-II are inadequate as there are neither known clearly defined shared activity goals and targets nor there is an alignment of approaches of these projects with MSNP. In addition, mechanisms of shared planning, budgeting, resource mobilization, and integrated reporting are not known either for ensuring coherence, complementarity, and contribution of these projects to MSNP.

The functionality of the existing monitoring and reporting mechanism of MSNP was found weak. Program monitoring in most cases was done without proper costed M&E plans and appropriate monitoring tools. Most often monitoring visits were limited to completing the ritual process and barely submitting a few pages of reports of monitoring visits with no adequate follow-up of the corrective actions recommended during the monitoring visits. District Coordination Committee (DCC) is mandated with the coordination, review, and monitoring of MSNP interventions at local levels. However, the absence of clear guidelines to coordinate and monitor the works at the local level has caused disillusionment not only on the part of the DCC but even the local government has no clear clue on how to work with DCCs under the existing constitutional regime. Moreover, there is no integrated nutrition information system to monitor the performance and to collate and interpret the data on progress indicators of MSNP, as a result, pulling a progress report from the disparate information system of sectoral ministries is not only time-consuming but also invites the possibility of errors because it has to be done manually. Moreover, indicators included in MSNP are not sufficiently integrated and aligned with the sectoral information system. Reporting the progress from development partners and I/NGOs is another key concern as they have their own data management systems which are not linked or integrated with the existing information system of sectoral ministries making it difficult for the government to track the progress made by projects supported by DPs.

The advocacy and facilitation work by MoFAGA, NPC, Provincial Coordinators, and MSNP Volunteers has been successful in ensuring the budget for the activity at most of the local level, however, still few of the local levels have not allocated a budget for MSNP and there is fluctuation in the budget allocated for MSNP across the years. The MSNP-II has established that 60 per cent of the budget will be mobilized by the government, 30 per cent by development partners. However, contrary to the expectation to gradually increase the budget share from the government end, until this current fiscal year FY 2021/2022, resource allocation for MSNP remains heavily dependent on funding/ contribution from development partners. Also, in the absence of a 'nutrition budget code', it is tasking to track the budget allocation and expenditure for nutrition.

Summary of conclusion and recommendations

In nutshell, there are modest progress in the selected maternal, infant, and young child nutrition (MIYCN) related indicators with the implementation of MSNP-II. The implementation of MSNP (2018-2022) has been successful to reach the unreached, remote, and poor communities, and promoting equitable access to nutrition-specific and sensitive services as indicated by the narrowing gap in nutritional outcomes by socio-demographic characteristics of the target population. However, Nepal is off-track to meet global maternal, infant, and young children nutrition (MIYCN) targets, on stunting, wasting, low birth weight, anemia, and childhood overweight. Even the rate of decline is slower for stunting reduction to meet the global nutrition targets. In addition, the country is off course for meeting all diet-related non-communicable disease (NCD) targets. At the current rate of progress, the global nutrition targets will not be achieved by 2030, thus, to achieve national MSNP targets, global commitments and targets related to the SDG 2030 and WHA targets 2025, a sharper rate of decline is required in some

indicators. For this, continued attention to nutrition-related interventions is imperative. The efforts need to be deepened and widened while dealing with the most vulnerable population.

A targeted approach should be adopted, and the interventions should be tailored to the aspiration and needs of the community. Specific nutritional support programs targeting particular geographic territories and ethnic groups to intervene in the worsening situation of malnutrition among these groups should be developed. Inequities in the food system from production to consumption should be addressed. The approach should be shifted to ensure that healthy and sustainably produced food is the most accessible, affordable, and desirable choice for all. Nutrition Inequities in health systems should be addressed as those who need essential nutrition services (both preventive and curative) cannot access them. Social Behavior Change Communication (SBCC) approaches should be adapted to the local context considering prevailing social, cultural, and environmental circumstances, and other structural determinants that influence IYCF practices, WASH behavior, and utilization of nutrition services. A gender-transformative approach over a gender-sensitive approach needs to be adopted to address the rigid gender norms and roles, harmful practices, and unequal formal and informal rules that adversely affect the nutritional status of women, adolescents, and children.

The existing MSNP interventions are mostly centered on children and women of reproductive age, thus, the next phase of MSNP should cover all the stages of a woman's life cycle with heightened attention to the nutritional vulnerability period i.e., adolescence, pre-pregnancy (newlyweds), pregnancy and lactation (mothers of children under two). Growth Monitoring and Promotion (GMP) services and Outpatient Treatment Centre (OTC) should be strengthened to address the problems of wasting. Moreover, to combat wasting, priority should be given to addressing the level of food insecurity, mostly focusing on household access, affordability, and utilization of food, and targeting the mothers from the lowest wealth quintile, where the severity of food insecurity is high. Treatment of Severe Acute Malnutrition (SAM) cases at Nutrition Rehabilitation Homes (NRH) should be coupled with development support and social protection services that lead to sustainable change in their household's economic conditions. Iron-folic Acid (IFA) supplementation programs and Micronutrient Powder (MNP) supplementation programs intended to reduce anemia should be coupled with intervention for increased consumption of iron- and vitamin A-rich foods through the implementation of context-specific Social Behavior Change Communication (SBCC) interventions through individual or group counseling.

Agriculture interventions for increasing productivity and crop diversification should be prioritized to make the country self-sufficient in the production of cereals, rice, egg, and potatoes. Subsidies in the form of fertilizers, credit, irrigation, and crop insurance should be provided particularly to women-operated small farm-holding households to encourage the production of nutrient-rich diverse local and indigenous crops. Future agriculture interventions should promote sustainable and resilient farming systems and account for the environmental impacts of the program as the sustainability of agriculture and food production are threatened by climate change, urbanization, and dietary transition among others. Initiatives to enhance the livelihood of women and uplift their economic status such as providing life skills training or supporting them in establishing a small business are highly recommended.

School Mid-day Meal Programs, Early Childhood Development programs, and School Health and Nutrition Programs should be strengthened and integration across these programs should be ensured to intensify and complement the efforts. A conducive environment should be created to retain girls in schools and more investment should be made in girls' education to prevent early child marriage (ECM). The efforts on improving girls' education through strategies such as *Beti Bachao, Beti Padhao* (Save girl child, educate a girl child) in Madhesh Province should be scaled up and strengthened. Youth clubs should be mobilized to make their peers self-reliant and empowered to prevent early child marriage rather than the advocacy campaign and street drama on a sporadic basis. Parents, local leaders, and religious leaders should be engaged by orienting them about the consequences of ECM on the nutritional status of the mother and the child and cater their support to eliminate ECM from society.

Human resources across the sectors and at all levels of government particularly at the local level such as MSNP volunteers, planners, and focal persons of the different sections should be capacitated. Investment in human resources should be made to increase the number of qualified nutrition professionals at the local level for technical backstopping to local government and level out access to quality nutrition care. The functionality of the monitoring, documentation, and reporting mechanism should be strengthened at local levels. Information systems should be improved to obtain better and more granular data should be developed, including on financing, to fully understand the current state of nutrition and inform effective action at local levels.

MSNP should strongly consider the interventions to strengthen the nutrition governance mechanism at all levels and make the institutions empowered. Concerted and continued advocacy for mainstreaming MSNP into subnational policies and plans, resource mobilization for MSNP at the local level, and increasing ownership of MSNP at the sub-national level should be made. The minimum package for MSNP should be defined to ensure the integration and alignment of different nutrition and food security-related projects with MSNP. Strong advocacy should be made for creating a 'nutrition budget code' to track the allocation and expenditure. Shift from a traditional incremental line-item-based budgeting system to a Goal-oriented performance-based or program-based budgeting system should be made to improve efficiency and accountability toward the results.

The roles and responsibilities and lines of accountability of the sectoral ministries and government institutions need to be clarified for multisectoral work. The avenues and aspects of sectoral coordination and integration at all levels of government particularly at local levels and across institutions should be defined. DCC needs to be empowered with clear-cut jurisdictions to perform M&E functions to make good use of this structure and enable them to work with *palikas* within the districts. Meaningful partnership, coordination, and collaboration with development partners, civil society, and private sectors based

on their areas of expertise should be fostered to streamline their efforts and ensure a one-door integrated approach to address malnutrition.

Structure of the Report:

This mid-term review (MTR) has assessed the status of progress (coverage and trends) of the Multi-Sector Nutrition Plan (MSNP) and starts with the introduction in the first chapter. The second chapter is on the rationale, purpose, scope, and approach of MTR. The third chapter includes the methodology adopted to conduct the review. The fourth chapter outlines key findings of the MTR and describes progress made toward impact, and outcome indicators including some major output indicators and critical factors for the success of MSNP. It also reports on the coverage and trends of major nutrition-specific and sensitive interventions made under six different sectors viz. Health, Education, Agriculture and Livestock, WASH, Women, and children. It also highlights the effects of the COVID-19 pandemic on the implementation of MSNP-II. In addition, this chapter of the report elucidates the existing institutional framework, nutrition governance structures, and coordination structures and discusses the existing policy environment creating enabling environment for MSNP-II's implementation and analyses the coherence of the national policies and sectoral policies with the MSNP. The fourth chapter further presents the findings of analyses of the alignment and mainstreaming of the subnational government policies and plans with MSNP and the complementarity and integration of efforts of government and developmental partners to achieve the objectives of MSNP-II. The fifth chapter discusses the Review, Monitoring, and Evaluation system to monitor, review, and evaluate the efforts of MSNP. The sixth chapter is on the financial analysis of MSNP-II. Chapter seven presents the key constraints, challenges, and issues faced during the implementation of MSNP-II. The eighth and final chapter includes the conclusion, lessons, and key recommendations for the Government of Nepal to inform the formulation of the next phase of MSNP.

1 CHAPTER ONE: INRODUCTION OF MSNP AND OBJECTIVES OF THE MID-TERM REVIEW

1.1 Nutrition context in Nepal:

Nepal has made considerable efforts to address adolescent, maternal and young child malnutrition based on the life cycle approach. The nutritional status of children under five years of age has improved in recent years. According to Nepal Demographic Health Surveys (NDHS), stunting among children under 5 years reduced from 57 percent in 2001 to 35.8 percent in 2016. Similarly, according to the Nepal Multiple Indicator Cluster Survey (NMICS), stunting (low height-for-age) of the same age group reduced from 37.4 percent (2014) to 32 percent (2019). However, wasting (low weight-for-height) has remained almost stagnant for the last 2 decades and other forms of micronutrient deficiencies are also alarming among younger children and women of reproductive age. In recent years, overweight and obesity rates among women have increased and a similar trend is emerging for children.

1.2 Multisector Nutrition Plan (MSNP)

Based on the recommendations from Nutrition Assessment and Gap Analysis (NAGA) 2009, the Government of Nepal (GoN) embraced a multisectoral approach and multistakeholder action to improve all forms of malnutrition in pregnant and lactating women, adolescents and infants, and young children, through its Multi-Sector Nutrition Plan (2013–2017) and continued the implementation of MSNP-II in 2018. Within the MSNP framework, the nutrition-specific intervention has been implemented by the health sector led by the Ministry of Health and Population (MoHP), while activities to improve the enabling environment have been implemented by the National Planning Commission at the federal level; and by the Ministry of Federal Affairs and General Administration (MoFAGA) at the local level in coordination with health, education, agriculture, livestock, water and sanitation, and women and children sectors. The Policy and Planning Commission and key sectors at provincial levels are also coordinated by NPC for MSNP planning and monitoring from the provinces to the local levels.

1.2.1 Vision, Goal, and Objectives of MSNP II:

Vision (2013-2022):

- **The 10-year vision (2013-2022) of MSNP is "To reduce malnutrition so that it no longer impedes people's potential and performance towards enhanced human capital and overall socio-economic development".**

Goal (2018-2022):

- **Improved maternal, adolescent, and child nutrition by scaling up essential nutrition-specific and sensitive interventions and creating an enabling environment for nutrition.**

Objectives of MSNP-II (2018-2022):

The three objectives that are related to MSNP-II's three outcomes are:

- **To increase the number of service delivery institutions to improve access to and the use of nutrition-specific services.**
- **To increase access to and the use of nutrition-sensitive services including improving health-related behavior.**
- **To improve policies, plans, and multi-sectoral coordination at federal, provincial, and local government levels to create an enabling environment**

2 CHAPTER TWO: RATIONALE, OBJECTIVE, PURPOSE AND SCOPE OF THE REVIEW

2.1 Rationale:

The implementation of MSNP-II started in 2018 to improve all forms of malnutrition in adolescents, pregnant and lactating women, infants, and young children. Since then, there have been significant changes in the global, and country contexts including in the nutritional situation of children in Nepal, as shown by different data sources and surveys including the latest Nepal Multiple Indicator Cluster Survey 2019. Furthermore, the ongoing global COVID-19 pandemic has unprecedentedly affected all sectors including nutrition across the world and Nepal is no exception. With the transition from a unitary to a federal governance system, the country faces a very different landscape than before, with new opportunities and challenges to implement MSNP. With the restructuring of government systems under a new federalist structure, enough power and authority and several responsibilities have been devolved to local government[1]. As per the new mandate, the local level plays a central role in the planning, budgeting, and implementation of MSNP-II. Recognizing the recent changes in the governance system and nutrition landscape since the implementation of the MSNP-II and based on the approval granted during the official launch of MSNP II in November 2017, the review was planned.

2.2 Objectives of Review:

The objectives of the review were as follows:

- To critically assess the coverage trends (programmatic and financial) of the MSNP-II
- To explore the factors affecting the successful implementation and result achievements of MSNP and identify interventions with the potential for continued focus and scale-up
- To identify the problems or challenges encountered during the implementation of MSNP-II
- To analyse the leveraging of financial resources (domestic public funding, and funding from development partners) to support the implementation of the interventions and activities detailed in the MSNP at different levels
- To obtain strategic inputs and recommendations to inform the formulation of the next phase of MSNP

2.3 Purpose of Review:

The review aimed to generate sound evidence that will increase the knowledge of stakeholders about successful strategies toward improving nutritional status and food security, among those targeted for implementation. Also, the review aimed to make recommendations for potential strategies that could increase operational and strategic learning in the nutrition realm, by also enabling the scale-up of impactful initiatives. The lessons and recommendations obtained from this review will be useful to Government, UN agencies operating in Nepal, key donors, and development partners to strategize and capitalize on successful initiatives and interventions and identify bottlenecks and reshape approaches, adopt responsive measures, that can be used in the development of the next phase of MSNP.

2.4 Scope of Review:

I. Thematic scope

A. Assessment of Effectiveness and Coverage- Progress towards Results:

The effectiveness of the MSNP-II was assessed in two dimensions: (i) progress towards the impact and outcomes and (ii) the achievement of outputs.

i. Progress towards the impact and outcomes

The review assessed the extent to which the MSNP-II's stated outcomes (as shown in the Result Framework) have been effectively achieved or are expected to be achieved by the end of the MSNP-II. For this purpose, data from Nepal Multiple Indicator Cluster Surveys (NMICS), National Demographic Health Survey (NDHS), MSNP evaluation report, and secondary data from sectoral ministries amongst others, annual reports from different sectors, and implementation reports were examined and analyzed.

ii. Achievement of outputs:

The review assessed, for each sector, success in producing the planned outputs and the achievement of the milestones as presented in the MSNP-II's Result framework (Refer to Annex 2.1) for the outcome and output to be assessed).

B. Assessment of Implementation & Adaptive Management[2] aspects of MSNP

The review assessed the implementation and adaptive management aspects of MSNP-II to identify the challenges encountered during its implementation and measures undertaken to address the identified challenges. The review assessed the following elements related to MSNP-II implementation:

i. Governance structure and mechanism/management arrangement:

---

1 Chaudhary, D. (2019). The decentralization, devolution and local governance practices in Nepal: the emerging challenges and concerns. Journal of Political Science, 19, 43-64.

[2] Adaptive management is defined in ADS 201.6 as "an intentional approach to making decisions and adjustments in response to new information and changes in context." Adaptive management is not about changing goals during implementation, it is about changing the path being used to achieve the goals in response to changes.

- **Frameworks, policies, governance structures, and processes that have created mechanisms for accountability, transparency, and ownership**
- **Progress made in strengthening Local Government capacity and governance**

ii. **Institutional and Human Resource Capacity: The review assessed the capacities created by MSNP-II in terms of institutional set-up, service delivery, supplies of nutrition commodities, and trained human resources.**

iii. **Funding and Financing Mechanism: The trends of budget allocation and expenditure were assessed. The review examined an alternative source of fund allocations (if any) for MSNP-II by provincial and local governments. Furthermore, the variances in the budget allocation and actual expenditure (burn rate) were also calculated.**

iv. **Monitoring and Evaluation mechanism:**
The review assessed the monitoring and evaluation mechanism in place at the provincial and local levels to monitor the activities at these levels. The following key aspects of M&E were:
- **Resources (Funds and Human Resources) allocated for the monitoring**
- **Availability and relevance of tools for monitoring for providing the necessary information.**
- **Frequency of monitoring from the provincial and local level**
- **Stakeholders involved.**

v. **Reporting Mechanism: The review assessed the existing reporting mechanism to share the progress of the MSNP interventions across the sectoral ministries and at all levels of government.**

vi. **Coordination mechanism: The review assessed the mechanism available for coordination across the sectors and at all levels of government and with other relevant stakeholders to achieve the intended results of MSNP in a coordinated way. The ownership of MSNP by the national and sub-national governments including complementarity and coherence of the different nutrition and food security projects with MSNP were also explored.**

vii. **Cross-cutting issues (Equity and Gender Equality):**
The review further explored the cross-cutting aspects of the MSNP intervention. It assessed the extent to which the MSNP-II has addressed the inequalities in combatting child malnutrition and incorporated gender equality and the empowerment of women and girls into its design and implementation. The review assessed the efforts made for improving nutrition with an "equity" approach (i.e., geographic, gender, income, ethnicity, disability).

II. Geographic Scope

Considering the geographic spread of the MSNP across 720 local levels of 72 districts of all the seven provinces, the review measured the coverage of programs/activities across these geographical areas. For the field visit, the proposed geographic scope specifically, included four provinces and four districts from each of the four selected provinces. Of the four districts, two local levels were selected for field observations.

III. Periodic Scope

The review took place during the third quarter of 2021 and broadly covered the first 3 years and 10 months of implementation of MSNP-II from January 2018 to October 2021.

3. METHODOLOGY

The review relied on desk review, secondary data analysis, and primary data collection. The primary data collection was qualitative and employed different qualitative tools to ensure that the review was thorough and reliable to the extent possible (Details in Figure 1). All the relevant stakeholders were approached, and findings were triangulated.

The review employed the following methods

1. Desk Review of existing reports and documents
2. Key Informant Interviews (KIIs) with a focal person of the sectoral ministries, UN agencies, developmental partners, private sector, and civil society organization
3. In-depth interview with the Chief of the Health Post/Primary Health Care Center.
4. Interactions with the Nutrition and Food Security Steering Committee at the provincial and local level
5. Interaction with District Coordination Committee (DCC)
6. Focus Group Discussions (FGDs) with beneficiaries (Women with under 5 children)
7. Observation

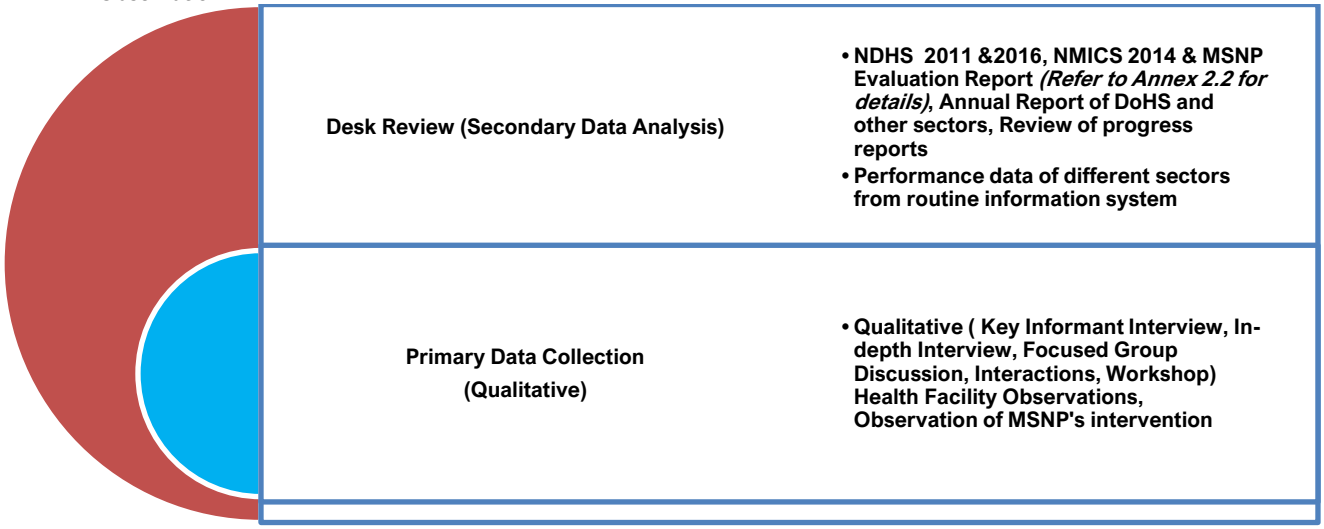


Figure 1: Review Methodology

3.1 Data collection methods:

i. Desk Review:

The desk review was conducted to obtain information on the progress (coverage and trends) of the selected nutrition-specific and sensitive interventions in the last 3.10 years (January 2018- October 2021) of MSNP-II implementation since 2018. Long-term plans, periodic plans, and strategies were reviewed to assess their alignment and coherence with the MSNP such as the 15th Plans and the plan documents of the provincial and local levels (Refer to Annex 2.3 for data sources for desk review). In addition, a review of some of the relevant literature and publications on the MSNP examining the outcome and effectiveness of different nutrition-sensitive and nutrition-specific interventions in other countries was also considered.

ii. Key Informant Interviews (KIIs)

The key informant interviews (KIIs) were conducted with purposively selected stakeholders with distinct roles vis-à-vis the MSNP-II implementation at the federal level (Refer to Annex 2.4 for the list of Key Informants). The key stakeholders were approached to obtain specific retrospective views on what elements were of success for MSNP-II implementation, what components worked less, and what was the enabling and impeding factors for its implementation. Also, areas of success requiring continued focus were identified and followed by areas with potential for improvement at the thematic and geographic levels. Moreover, input and prospective insight to inform the next phase of MSNP beyond 2022 were also obtained.

iii. In-depth Interviews (IDIs)

The in-depth interviews (IDIs) were conducted with the Chief of the Basic Health Service Center (BHSC)- (Health Post, Primary Health Care Center) for nutrition-specific services approached to obtain specific retrospective views on what elements were of success for MSNP-II implementation, what components worked less, what were the enabling and impeding factors for its implementation. Also, areas of success requiring continued focus were identified and followed by areas with potential for

improvement at the thematic and geographic levels. The BHSCs nearest to the respective palika[3] were selected from the local level.

iv. Interactions with the nutrition and food security steering committee at provincial and local levels

To add a richness of information and attain credibility towards the progress of MSNP-II and to get a better understanding of the roles and functionality of steering committees in three spheres of government and their experience in implementing MSNP-II, interactions were made with steering committees at subnational levels. The review also captured insights into how steering committees are working to institutionalize MSNP-II, promote ownership, and improve the local governance including coordination among the different stakeholders. Furthermore, the discussion was directed towards soliciting the 'best practices, and innovative actions undertaken at the local level for improved nutrition with potential for scale-up in the next phase of MSNP.

v. Focus Group Discussion (FGDs):

During the field visit, beneficiaries particularly women who have children under five with different socio-economic backgrounds were approached to elicit qualitative information regarding their individual experiences, changes in their nutritional knowledge, and practices/behavior. The acceptance of different nutrition-based initiatives (both specific and sensitive) including the credibility of success of MSNP-II implemented at the local level was also explored. In addition, FGDs were organized with the participants to obtain recommendations for improvement and future focus of the next phase of MSNP. Particular attention was paid to identifying and including women from disadvantaged groups who benefitted from MSNP-II interventions in the FGDs.

3.2 Field visit sites:

Of the seven provinces, three provinces representing the three ecological regions were selected. Of these three selected provinces, four districts (one from each province) were selected. From these four districts, a total of 8 local levels (two local levels from each district- one urban and the other rural) were selected (Figure 2)- Refer to Annex 1 (Table 14).
The selection of study areas (Province, district, and local level) was done in close consultation with the NPC and UNICEF Nepal. The following criteria were considered while selecting the study sites:

1. Burden of malnutrition (stunting, wasting and underweight among children, anemia prevalence in women and children) in the respective province, district, and local level
2. Performance on impact indicators
3. Duration and stage of maturity of program implementation
4. Geographical Region (Hill, Mountain and Terai)
5. Province/Local Level 'performance' vis-à-vis nutritional outcome
6. Types of residence: Rural vs. Urban
7. Logistic constraints such as availability of proper accommodation, ease of transportation, etc.

Also, in addition to the geographical, nutrition, and socio-economic context of the study following criteria were considered:

- Dynamics of the enabling environment (political environment, accessibility in terms of transportation among others) in the selected area
- Other contextual factors influencing the multi-stakeholder, multisectoral coordination.

3.3 Review tools

The qualitative data collection tools: the guidelines for interaction with the nutrition and food security committee, key informant interview guidelines, in-depth interview guidelines, and the focus group discussion guides were used.

3.4 Analysis and Reporting

The data were collected through face-to-face interviews using a manual paper-based format. Before data collection, the qualitative tools (Nepal version) were pre-tested at Parsagadi Municipality of Parsa district. Following the pretesting, the tools were revised and finalized. For quantitative analysis, descriptive statistics (frequency and percentage) were used. For qualitative analysis of qualitative data (interviews, FGDs, interactions) collected from the field, were transcribed verbatim while key points and exemplar quotes from each interview and discussion were obtained through an iterative process. Context memos were written to elaborate on key observations and reflections.

3.5 Implementation of MTR:

The MTR of MSNP-II was initiated with an Inception Workshop conducted at Hotel Himalaya, Lalitpur on 29 October 2021. The Review was coordinated by the National Nutrition and Food Security Secretariat (NNFSS) under the leadership of the National Planning Commission (NPC). The following committees and officials supported and coordinated the field mission for the MTR.

- Steering Committee at the provincial and local level
- UNICEF's Technical team
- NNFSS Secretariat
- MSNP Coordinators
- MSNP Volunteers

[3] *Palikas refers to rural municipality (Gaaupaalika) and Urban municipality (Nagarpaalika)*

In each province, 3 interaction meetings [(Provincial Level Nutrition and Food Security Steering Committee (PLNFSSC)-1; Local Level Nutrition and Food Security Steering Committee (NLNFSSC)-1; District Coordination Committee (DCC-1)], one in-depth interview, and one focus group discussion were completed (Refer to Annex 2.4). Each FGD and interview took between 50 to 90 minutes and were recorded. Before starting each session, oral consent was obtained regarding the agreement to participate and willingness to have the session to be audio recorded. In addition, a SWOT analysis was done to identify the strengths, weaknesses, opportunities, and threats of MSNP (Refer to Annex-1 Table 13 for the details).

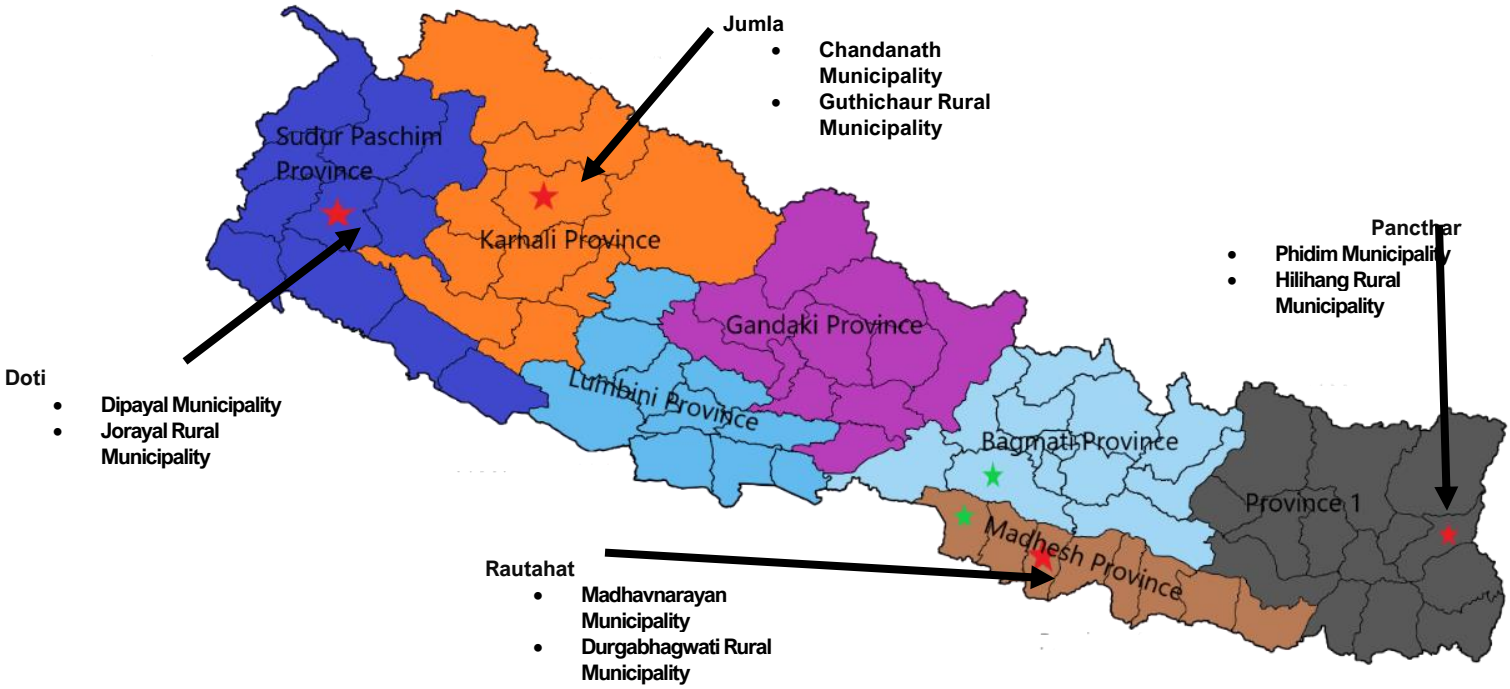


Figure 2: Map of Nepal with places visited for MTR

4.1 Impact-level progress and challenges

Nepal has committed to achieving all six global nutrition targets of the World Health Assembly (WHA) by 2025 and Sustainable Development Goals (SDGs) by 2030. The targets are adopted by MSNP and included as impact-level indicators.

Prevalence and trends of stunting among children under five:

Nepal saw a decline in stunting- an indication of chronic malnutrition- from 36% (NDHS 2016) to 32% (NMICS 2019). With the implementation of MSNP, a significant decline in the stunting rate among children under 5 years of age is observed between 2014 to 2019. The findings from the evaluation of MSNP evaluation conducted in 2022 found that the prevalence of stunting among children under 5 was significantly lower in MSNP intervention areas compared to non-intervention areas. The prevalence of stunting at the time of the 2019 End-line survey was 30.81% in treatment districts and 33.43% in comparison districts (Figure 3). This depicts that the MSNP interventions have been able to address the issues of stunting among children.

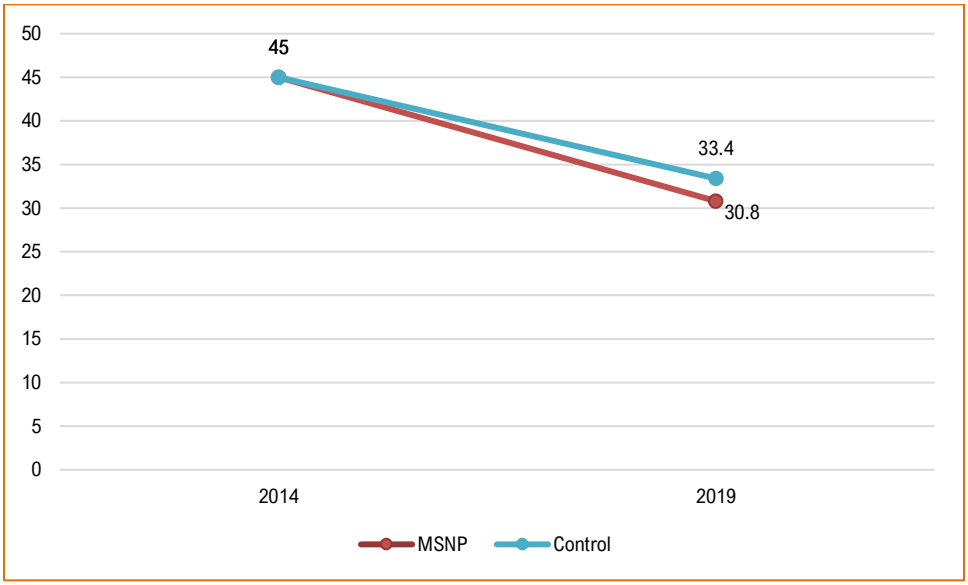


Figure 3: Percentage of Stunting among children aged under 5 years (Source: MSNP Evaluation Report 2022)

Considerable decline in stunting has been noted among the households participating in MSNP in treatment areas (red bars) for almost all age groups whereas the effect is less visible in the control group (purple bars) in Figure 4. Moreover, MSNP has been able to reach the vulnerable and marginal communities such as *Doom* and *Musahar*, sub-groups of *Dalit*, *Sunuwar*, and *Majhi* communities (MSNP Evaluation Report 2022).

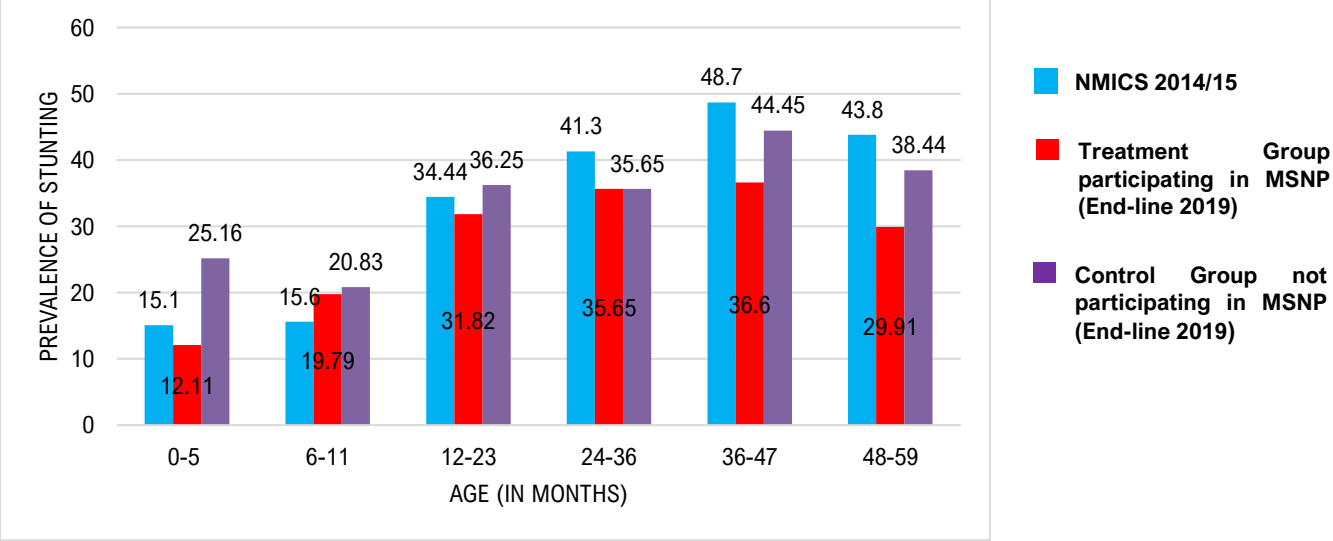


Figure 4 Prevalence of stunting by age (Source: MSNP Evaluation Report 2022)

Despite the significant reduction in the stunting across these years, Nepal is off-track to achieving SDG 2030 target and MSNP-II target for 2019 (illustrated in Table 2). Furthermore, the rate of decline of stunting is not uniform and is disproportionately distributed across provinces and among groups with different socio-economic backgrounds. For instance, the prevalence of stunting decreased by 17.61% from 2016 (NDHS 2016) to 2019 (NMICS, 2019) for the HHs in the richest wealth quintile while stunting reduced by only 5.47% among the poorest wealth quintile during the same period as shown in Table 1. Similarly, the stunting prevalence is highest in Karnali Province (48%) while lowest in Bagmati Province and Gandaki Province (23% each). Data from NMICS 2019 revealed that male children, urban children and older aged children (children aged 11 months to 59 months), and children born to uneducated mothers were more likely to be stunted (Refer to Table 1). These deep disparities in the prevalence of stunting across the province and the socio-economic group are further confirmed by the evaluation of MSNP. The evaluation of MSNP has shown that the risk of stunting was higher among sub-groups – infant boys compared to girls and children of mothers with poor nutritional status, economically disadvantaged, Muslim communities, children from Dalits and Terai Madhesi households (Figure 5), and those living in remote high altitudes or flood-prone regions (MSNP 2019 End line Survey).In addition, data from NMICS 2019 revealed that the prevalence of stunting increased substantially with growing age among children below five years of age with rates higher among children aged between 6 and 23 months (Refer to Figure 7).

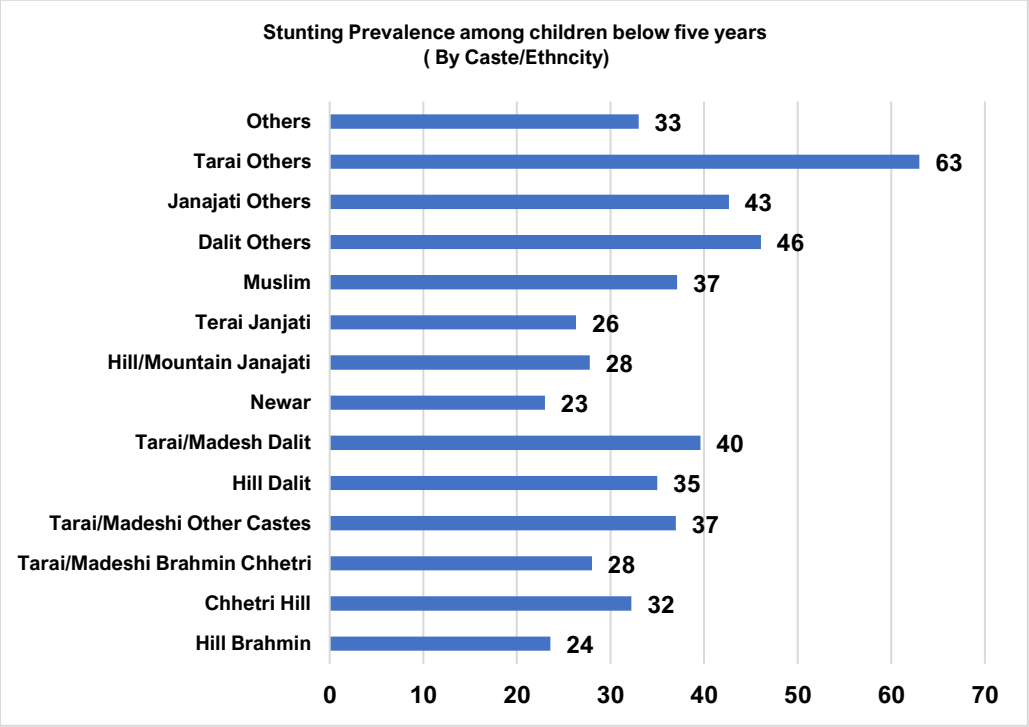


Figure 5: Prevalence of stunting by caste/ethnicity (Further Analysis of NMICS 2019)

Prevalence and Trends of Wasting among children under five:

While comparing the data of NMICS 2014 and NMICS 2019, improvement in the prevalence of wasting has been observed among children under five years of age with the implementation of MSNP. The evaluation of MSNP found a 3-point percentage decline in wasting among children below five years among the MSNP intervention group (16 percent in 2014 to 13.4 percent in 2019) compared to 2 -a point percentage decline among the control group (12 percent in 2014 to 10.1 percent 2019)[4] (Figure 6). The findings from the evaluation demonstrated that participation in the MSNP activities by the mother, access to safe sanitation, and gender of the child contributed to a reduction in the prevalence of wasting since 2014. However, wasting has remained high and variable at ≥10% and is off-track to meet the MSNP target for 2019 (depicted in Table 2). Moreover, the rate of decline of wasting is not uniform by province, ecological region, education, and wealth quintile. The wasting rate was higher among male children (13.5%), in Madhesh Province (14%) in rural areas (13.5%), and among children born to mothers with no education (16%) and belonging to the lowest wealth quintile (13%) higher than the highest wealth quintile) in 2019 (Refer to Table 1). These findings corroborated with the findings from the MSNP evaluation. The MSNP evaluation found that the prevalence of wasting was higher among newborn boys, Dalit and Terrai Madhesi ethnics groups, Janajati households, and Madhesh Province.

4 Initial intervention areas were selected in MSNP-I on the basis of having the highest prevalence of child undernutrition

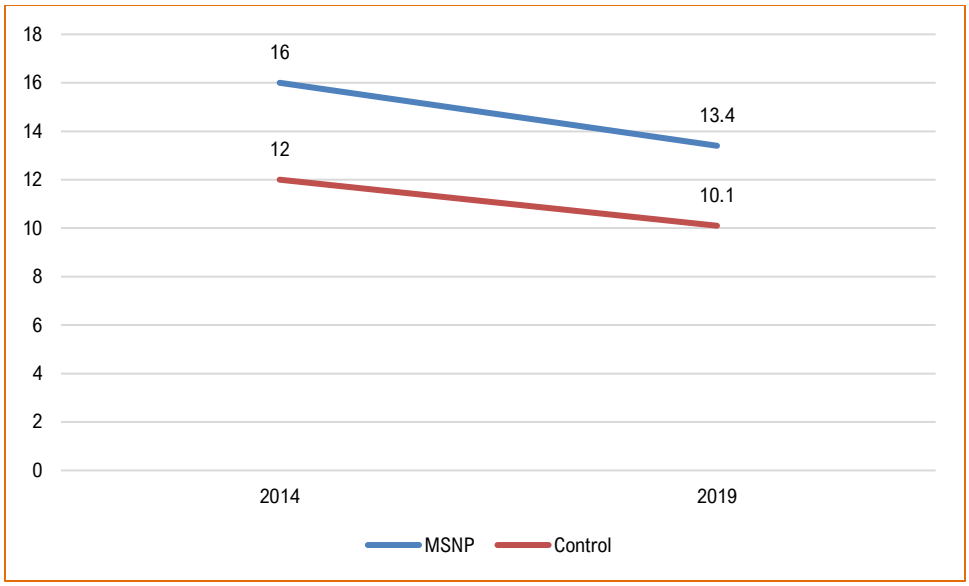


Figure 6: Percentage of Wasting among children aged under 5 years (MSNP intervention group vs control group)- (Source: MSNP Evaluation Report 2022)

The prevalence of wasting is highest among children below 6 months of age (16%) Moreover, MSNP evaluation reported the highest negative impact was mothers' Chronic Energy Deficiency (CED) on child wasting with a high number of wasted children born to mothers with nutrition deficiencies.

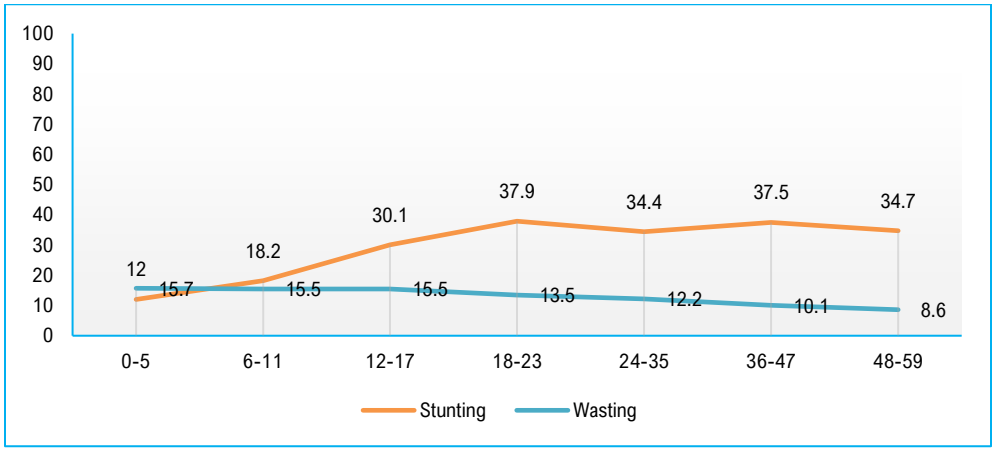


Figure 7 Prevalence of stunting and wasting among children under 5 years of age (by age category) (Source: NMICS, 2019)

Prevalence and trends of Underweight among children under five and women of reproductive age:

The prevalence of underweight children was found to be reduced from 40% to around 27% in intervention areas following the implementation of MSNP between 2014 and 2019 (MSNP Endline 2019). Moreover, an impressive improvement in underweight rates at ages 00- 05m (from 21 percent in 2014 to 8% in 2019) was found during the evaluation, indicating the positive contribution of participating in the MSNP activities in terms of reduction of underweight. In congruence with the result from the MSNP evaluation, the recent NMICS 2019 also showed that the prevalence of underweight among children under 5 has declined by a marginal reduction of a 3-point percentage from 27% in 2016 (NDHS, 2016) to 24.3% in 2019 (NMICS 2019). This finding is congruent results of the evaluation of MSNP.

Despite the remarkable progress, Nepal is off-track to achieving the MSNP target for the reduction of underweight among children under five (Table 2). Moreover, the in-country disparities in child underweight among children under the age of five persist. There exists variation in the prevalence of undernutrition across the province and by sex, place of residence, and wealth quintile (illustrated in Table 1). For instance, the underweight rate was found higher in Karnali Province (37.4%) followed by Sudurpachim Province (33.3%) compared to other provinces (NMICS, 2019). Corroborating with review findings, the results from the MSNP evaluation also showed that the prevalence of underweight children was highest in Dalit and Terai Madhesi families, boys, and older children. The evaluation found that the rates of underweight rose with age for both boys and girls (Refer to Figure 5).

Table 1: Stunting, Wasting, and Underweight disparities by sex, place of residence, wealth quintile (Equity Analysis)

Background Characteristics of Child		Stunting		Wasting		Underweight	
		2016 (NDHS)	2019 (NMICS)	2016 (NDHS)	2019 (NMICS)	2016 (NDHS)	2019 (NMICS)
Sex	Male Child	36	32.8	9.5	13.5	26.7	24.8
	Female Child	35.7	30	9.8	10.4	27.4	23.7
Place of Residence	Children living in urban areas	32	28.8	9.2	11.2	23.4	22.3
	Children living rural areas	40.2	36.4	10.2	13.5	31.1	28
Wealth Quintile	Poorest wealth quintile	49.2	43.5	8.8	13	32.9	31.6
	Highest wealth quintile	16.5	17.9	7.3	7.1	11.6	11

Prevalence and Trend of Anemia among women and children in Nepal:

In 2016, forty-one percent of WRA were anemic in Nepal, while anemia prevalence among under-five children was reported to be 53% in 2016 (a 7-point percentage increase in prevalence compared to 2011) and is off-track to achieve national and global targets. Further, the prevalence of anemia (<11.0 gm/dl for children < 5 years) has been observed higher among female children, younger children aged less than 11 months, children of uneducated mothers, and children who did not receive deworming tablets in the last 6 months. NDHS 2016 data shows variation in the prevalence of anemia among women and children across the province. In 2016, the prevalence of anemia was highest in Madhesh Province (59%) and lowest in Bagmati Province (43%)

Socio-economic inequalities have been found as a significant challenge to GoN in meeting global targets for anemia (<12.0 gm/dL for WRA) reduction. Anemia prevalence was found higher among children from the lowest wealth quintile compared to the highest health quintile (49% vs. 41%) and among children in terai (60%) compared to the mountain (57.4%) and hill regions (40%). Analysis of NDHS 2016 data showed that the prevalence of anemia was higher among underweight[5] and stunted[6] children and children born to mothers who are underweight and anemic, and among children residing in a household without improved sanitation.[2] In addition, a study conducted in 2018 using NDHS data, revealed that undernourished women and women lacking sanitation facilities at the household level have a higher prevalence (52%) of anemia.

The prevalence of anemia among adolescent women (15-19 years) increased from 38.5 percent in 2011 to 43.6 percent in 2016 (NDHS, 2016). The age of women, maternity status, wealth index, educational status, and place of residence of women has been also reported to influence the occurrence of anemia in women. For instance, pregnant and lactating women were more likely to be anemic (46 percent each) compared to women who were neither pregnant nor breastfeeding (39 percent (NDHS, 2016). The young women were found to be more anemic. For example, the prevalence of anemia among women aged 15-19 years was 44 percent while its prevalence was 8-point percent (36 percent) lower among women aged 40-49 years (NDHS, 2016). A higher prevalence of anemia was found higher among women who attended at least secondary level education (43 %) and women belonging to households from the middle wealth quintile (49%). Further, over half of the women who consumed less than five food groups were found to have higher rates of anemia (51%) (NDHS, 2016).

[5] Chowdhury, M. R. K., Khan, M. M. H., Khan, H. T., Rahman, M. S., Islam, M. R., Islam, M. M., & Billah, B. (2020). Prevalence and risk factors of childhood anemia in Nepal: A multilevel analysis. *Plos one*, *15*(10), e0239409.

[6] Harding, K. L., Aguayo, V. M., Namirembe, G., & Webb, P. (2018). Determinants of anemia among women and children in Nepal and Pakistan: An analysis of recent national survey data. Maternal & child nutrition, 14, e12478.

Table 2 Nepal's progress against the targets for the nutrition of WHA 2025 and SDG 2030 and the MSNP-II targets between the review period

SN	Impact Level Indicators	Baseline		Yearly target for MSNP-II			Nepal's WHA target	SDG target	Progress by 2019 against WHA 2025 and SDG 2030 targets	Remarks
			2018	2019	2021	2022	2025	2030		Based on data for 2019
1	Prevalence of stunting among under 5 years children reduced	35.8 (NDHS 2016)	34	31	29	28	25	15	32 (NMICS 2019)	Off track
2	2 a Reduced % of anemia among WRA (15-49 years)-Outcome 1.5	40.8% (NDHS 2016)	-	-		24	NA	10%		
	2b Reduced % of anemia among children aged 6-59 months (Outcome 1.3)	52.7% (NDHS 2016)	40	37	30	28	NA	10%		
3	Prevalence of low birth weight reduced	12 (NDHS2016)	20	17	11	10	8		Data not available	
4	% reduction in children under-5 with overweight and obesity	2.1 (NDHS 2016)	2	1.9	1.6	1.4	≤1.4		2.6 (NMICS 2019)	Off-track
5	Increased % of children under 6 months with exclusive Breastfeeding (Outcome 1.2)	66 (NDHS 2016)	68	70	77	80	85	90	62.1% (NMICS 2019)	
6	Prevalence of wasting among under 5-year-old children reduced (Reduce and maintain childhood wasting	9.7 (NDHS 2016)	9.5	8	7	7	5	4	12 (NMICS 2019)	Off track
7	2.2.1 Prevalence of underweight children under five years of age	27 (NDHS 2016)					15	10	24.3 (NMICS 2019)	Off track
8	% reduction in overweight and obese women of reproductive age (WRA)	22 (NDHS 2016)	22	21	20	18	15	<13	Data not available	
9	% of women with chronic energy deficiency (measured as body mass index) reduced	17 (NDHS 2016)				12			Data not available	
10	1.1. Increased % of children aged 6-23 months having minimum acceptable diet	35 (NDHS 2016)	40	45	55	60			Data not available	

Prevalence of Overweight and obesity:
In 2016, the percentage of WRA who were overweight and obese- an indication of overnutrition- was 22 percent. Geographic and socioeconomic variation in the prevalence of overweight/obese was reported in the NDHS survey. According to NDHS 2016, compared to the women from the lowest wealth quintile household, women from higher wealth quintile households were more likely to be overweight/obese (10% vs. 45%). In addition, urban women from the highest wealth quintile were found to be more vulnerable to being overweight and/or obese. Similarly, women with primary education were reported of being overweight and obese. Likewise, at the provincial level, Bagmati Province has a higher proportion of women who are overweight/obese 4-fold (35%) compared to Madhesh Province (9%) in 2019.

The national rate of overweight- an indication of overnutrition- among children under-five years of age has increased to 2.6% in 2019, up from 1% in 2016. The GoN has aimed to reduce the proportion of mothers and children who are overweight to 22% and 2.1% respectively by 2030 and hence is off-track to achieve the targets related to the reduction of overweight/obesity.

4.2 Factors for the successful implementation of MSNP and result achievements

In this sub-section of the report, the key factors for the success of MSNP have been described that have enabled and are critical for producing better nutrition outcomes through the implementation of MSNP. Multiple elements have contributed to achieving the results gained so far which need to be further sustained and strengthened have been described below:

4.2.1 Government commitment to embracing a multi-sectoral approach to nutrition: Most of the respondents highlighted that since 2013 government has led and owned the MSNP which has provided a strong foundation and platform to apply a multisectoral approach to nutrition. The government has been successful in bringing together different sectoral ministries, three tiers of government, and Development Partners (EDPs) of diverse nature on a single platform that has contributed to materializing the multisectoral approach to nutrition which in turn has been successful in generating better nutrition outcomes.

4.2.2. Strong leadership of the NPC and proactive engagement of MoFAGA and MoHP: The NPC has played a key role in leading nutrition governance since 2013. Most of the respondents stated that the leadership and stewardship including the coordination role of the National Planning Commission (NPC) have been "instrumental" to align the efforts of different sectors and translate the national commitment to reduce malnutrition through a multisectoral approach. Further, together with NPC, the Federal Affairs Division (specifically Local Level Coordination Section) of MoFAGA's effort for accelerating the implementation of MSNP intervention (particularly nutrition-sensitive) through increased financial resources accountability was highly acknowledged and was indicated as a key element for the success of MSNP together with the leadership demonstrated by the Family Welfare Division(in particular nutrition section) under Department of Health Services in increasing the coverage of nutrition-specific services.

4.2.3 Mainstreaming of MSNP and increased ownership at the subnational level: MSNP is translated at the subnational level and has been able to establish "Nutrition" as a priority agenda at the local levels visited. This is evident in the provincial and local level policies, periodic plans, and annual work plans and budgets. The ownership of the MSNP at the provincial and local levels was highlighted as a positive characteristic and critical factor for the success of the MSNP. During field assessment, it was found that municipalities have included MSNP-II in their Annual Workplan and Budget, and four of them have allocated budgets for MSNP-II for the FY 2078/2079 (2021/2022) which was marked as a significant step toward the sustainability of the program.

4.2.4. Endorsement of Coherent sectoral policy: Following the endorsement of MSNP, a slew of sectoral policies and strategies were formulated ensuring coherence with MSNP and is considered a key success of MSNP. Major national and sectoral policy documents that have prioritized MSNP are the 15th National Development Plan (2019/20-2024/25), National Health Policy 2076 (2019); Zero Hunger Challenge National Action Plan (2016 - 2025), Agriculture Development Strategy (2015-2035), National Education Policy 2076 (2019), National Climate Change Policy 2076 (2019); National Nutrition Strategy 2020; Nepal Water Supply, Sanitation and Hygiene Sector Development Plan (2016 – 2030), Multisectoral Action Plan for Prevention and control of NCD (2021-2025), Nutrition Friendly Local Level: Implementation Guideline 2078 (2021); National Standards on WASH for Health Institutions 2078 (2021), Joint Action Plan (2014/2015-2019/2020) (Revised); National Gender Equality Policy 2077(2020); School Development Plan (2016-2022).

4.2.5. Increased financial commitment and resource allocation for nutrition program: Following the continuation of MSNP-II, MTR findings indicate that as time went on, the government's financial commitment to the resources and level of programming on nutrition grew, particularly to nutrition-sensitive interventions. Incremental allocation of budget for MSNP by the provincial and local government from internal sources- particularly for nutrition-sensitive intervention- is an encouraging and positive development in terms of resource mobilization for MSNP. This increased commitment of the provincial and local governments to leverage the budget has been viewed as a crucial factor for the success of MSNP. Equally pivotal is the concerted advocacy with the Mayor/Chairperson of the municipalities about the significance of investing in nutrition, and the engagement of bureaucratic leaders such as the Chief Administrative Officer, Health Coordinators, and focal person of the MSNP for resource mobilization and fund allocation at the local level.

4.2.6 Established nutrition governance mechanism and coordination structures: Adhering to the principles of the Federal Constitution of Nepal, the nutrition governance and coordination mechanism is set up at all levels of government. For instance,

a formal government-led multi-sector and multi-stakeholder national coordination structure i.e., National Nutrition and Food Security Coordination Committee) exists for sector planning and review. Most of the members of the nutrition and food security steering committee at provincial and local levels including most Kathmandu-based KIs recognized establishing governance and coordination structures at federal, provincial, and local levels as a key facilitator to achieving MSNP results. Consistent with the findings from MTR, a study by Ruduch et al. (2022) found that Multisectoral Nutrition Plan in Nepal has led to the establishment of strong governance structures at the national level and has fostered a high level of organizational connectivity between sectors and stakeholders.

4.2.7 Positioning MSNP Coordinators and volunteers as key operatives: MSNP coordinators and volunteers work very closely with the local and provincial governments and facilitate them to formulate annual policies, plans, and budgets and implement the MSNP intervention at the local level. The continued technical assistance and monitoring from MSNP Coordinators and facilitation from MSNP volunteers for MSNP at the local level have been regarded as key to the successful implementation of MSNP. MTR findings affirmed that deliberate efforts have been made by *palika* and MoFAGA to recruit, and allocate funds for MSNP Volunteers, and capacitate them for effective implementation of MSNP. In addition, external backstopping and technical support from EU/UNICEF Nepal including other development partners for institutional and human resource capacity development have acted as a facilitator to the success of results produced by MSNP.

4.3 Outcome- and output-level progress:

To date, FY 2078/79 (2021/2022) MSNP covers 720 *palika* of 72 districts across all seven provinces (depicted in Figure 8). The coverage of MSNP by Province and district is depicted in Annex 1 (Table 15).

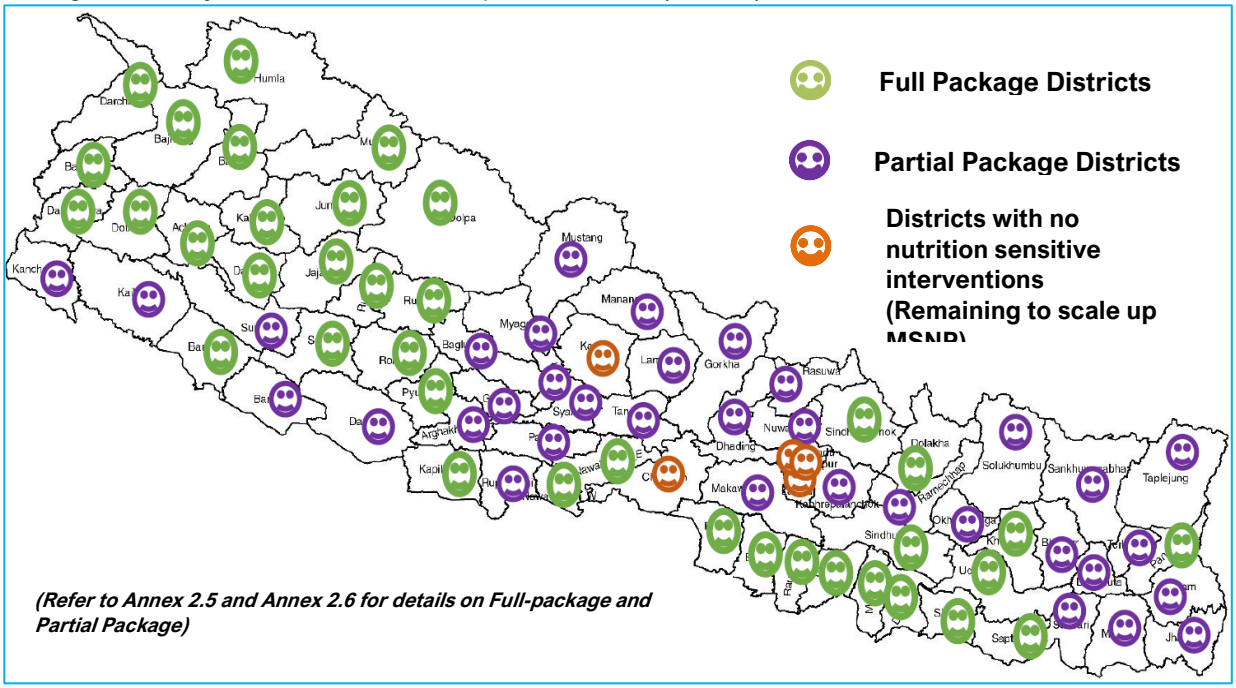


Figure 8 Map of Nepal illustrating coverage of MSNP by districts

The majority of the nutrition-specific program is in all 77 districts with a few programs under piloting and some programs under a phase of expansion (Refer to Annex-1, Table 16). The coverage and trends of selected indicators from NDHS 2016 and NMICS 2019 and the Annual Reports of the Department of Health Services from 2075/76 (2018/19), 2076/2077 (2019/20), 2077/2078 (2020/21), and 2078/2079 (2021/2022) (Till Kartik 2078; October 2021) including the changes observed in these indicators across these years was analyzed [Refer to Annex 1 (Table 18&19) and Figure 9)]. Mixed progress (good progress on a few indicators while poor performance on others) is observed while analyzing the coverage and trends across these years. Improvement on a few of the following indicators has been achieved: Percent of the children aged 0-23 months were registered for growth monitoring (New); Introduction to Complementary Feeding [Percentage of children (6-8 months) registered for growth monitoring who receive solid, semi-solid or soft foods]; Postpartum Iron Folic Acid (PP- IFA) Intake [Percentage of Post-Partum Women Receiving 45 IFA tablets]; Coverage of Vitamin A and Deworming distribution, Diarrheal Treatment with Zinc+ORS; Incidence of diarrhea (per 1000); Feeding during illness; Institutional delivery, PNC (postnatal care) visits; with sustained SAM (Severe Acute Malnutrition) cure rate.

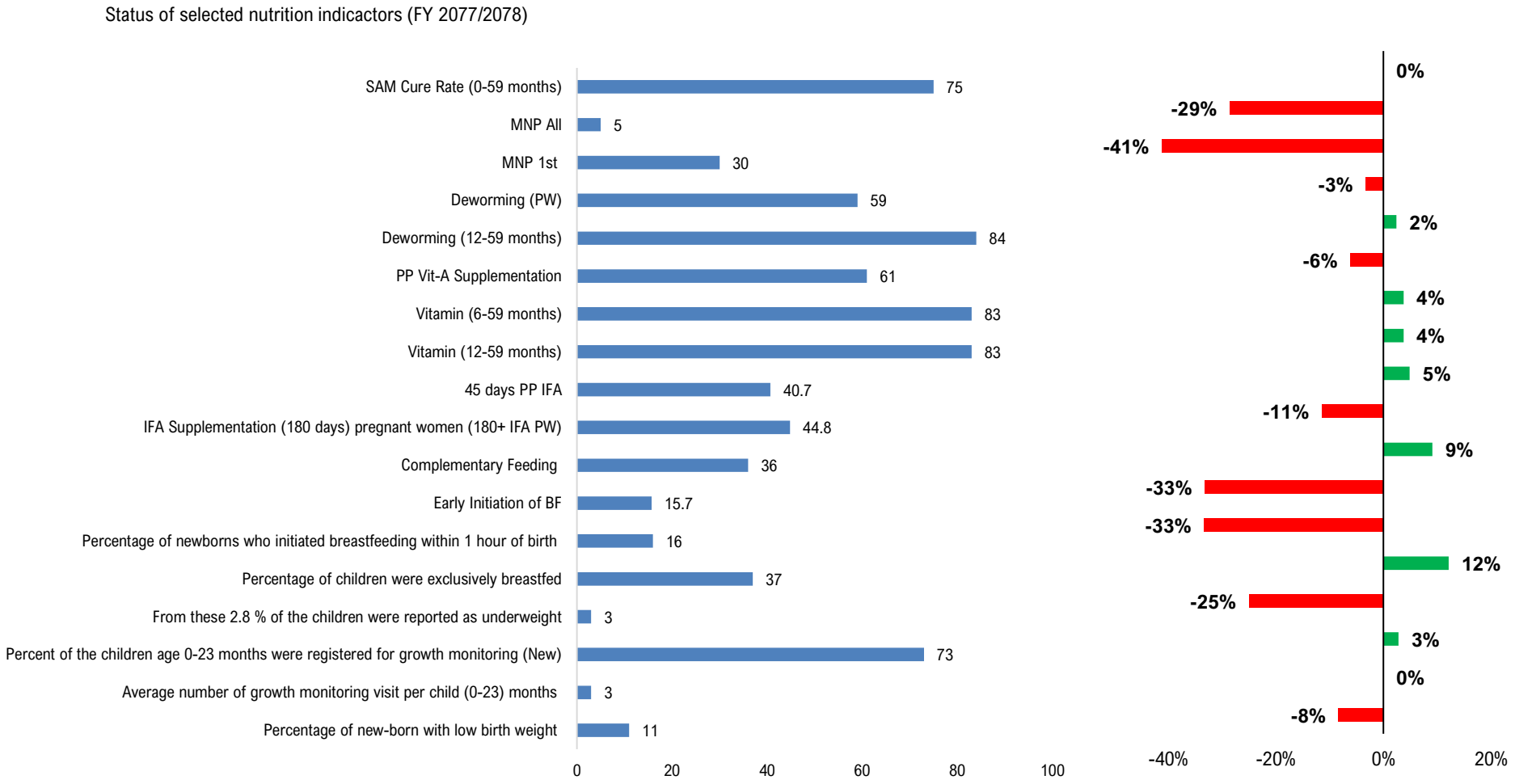


Figure 9: Status of selected nutrition indicators in FY 2077/2078 and changes between 2075/2076 and 2077/2078 (Annual Report of DoHS)

4.4 Progress against outcome 1: Coverage and trends of nutrition-specific interventions

A. HEALTH SECTOR

Progress and Trends of Infant and Young Child Feeding (IYCF) Practices:

Appropriate and optimal infant feeding is fundamentally important to assure adequate nutrition and growth during infancy. MSNP evaluation has shown that the IYCF practices differed significantly and were 10-point percentage higher among the mothers who had participated in MSNP intervention compared to mothers who hadn't (61 % vs 51%). Similarly, the percentage of women who knew about exclusive breastfeeding for up to 6 months was higher among women receiving the MSNP interventions compared to the percentage of mothers who had not received MSNP interventions (89% vs 80%).

However, between 2016 and 2019, initiation of breastfeeding within one hour and Exclusive Breastfeeding (EBF), timely introduction of complementary feeding, and intake of a diverse and nutrient-rich diet is not encouraging and are on a declining trend (illustrated in Figure 10). In Nepal, only 42% of infants under 1 month are put to the breast within one hour of birth (NMICS 2019). Similarly, between 2016 and 2019, a slight decline in the rate of exclusive breastfeeding among children below 5 months of age has been reported. The EBF has decreased to 62% (NMICS, 2019) in 2019 compared to 66% (NDHS, 2016) in 2016. Subnational variation was observed in the rates of EBF in 2019, with the highest rates of EBF in Madhesh Province while lower rates of EBF in Bagmati Province and Gandaki Province.

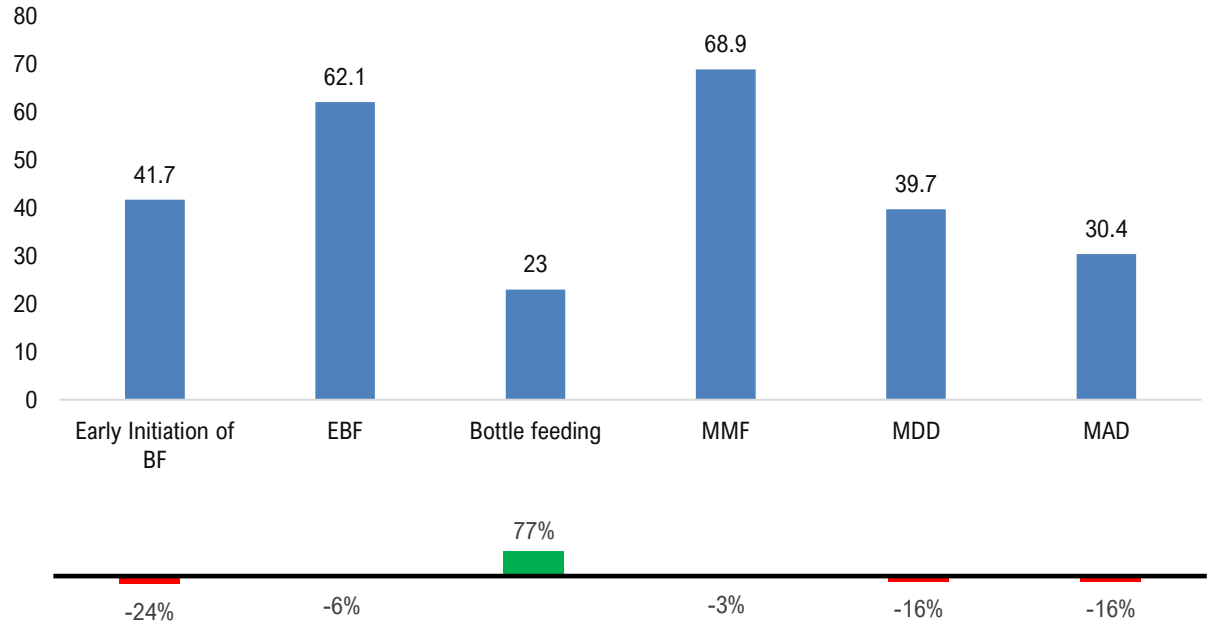


Figure 10: IYCF Indicators (NMICS, 2019) and percentage change in the indicators in 2019 (NMICS) compared to 2016, (NDHS)

During the field visit, the poor infant and young child feeding practices were traced to inadequate awareness among mothers about the IYCF practices, particularly about the initiation of BF following the delivery. This was evident during the group discussion with women across all the municipalities visited, as many of the women were not able to correctly respond upon asking about the timing of initiation of BF. This is further validated by the data from NDHS 2016, which revealed that of the total mothers visiting the health facilities, only 15% of the women were informed and provided counseling on breastfeeding within an hour following the delivery.

It is interesting to note that though the percentage of institutional delivery has increased between 2016 to 2019, from 57% to 77.5%, the prevalence of early initiation of breastfeeding, however, has decreased from 55% in 2016 to 42% in 2019. On the other hand, contrary to information shared by the Chief of HFs and women during the FGDs, the consumption of infant formula as a pre-lacteal feeding has been found higher in infants born at private HFs (22.6%) compared to those born at home (1%), in children born to educated mothers (23.9%) and in infants from the richest wealth quintile (21%) compared to infants from the poorest wealth quintile (2%). In addition, the bottle-feeding practice has been increasing and has nearly doubled between 2016 and 2019 (increased from 13% in 2016 to 23% in 2019). This is further validated by the decreasing trend of the median duration of EBF. The data from national surveys revealed that the median duration of EBF has reduced to 3.4 months in 2019 (NMICS, 2019) from 4.2 months in 2016 (NDHS, 2016).

During the field mission, it was witnessed that women, despite being aware of the duration and significance of the EBF, are unable to practice EBF. For instance, a woman from Jorayal Municipality said, *"I was unable to practice exclusive BF as I need to get involved in agriculture and other household works for their livelihood which compromised my willingness to practice EBF. On top, my husband went to work outside the country and even if he is at home he does not least engage and support me to ensure the baby is exclusively breastfed."*

A higher preference for bottle feeding and formula milk among mothers in urbanized areas over the EBF is concerning. Global evidence also showed that there has been a marginal improvement in breastfeeding rates in the past two decades, while sales of formula milk have more than doubled at the same time. In the present context where mothers are more attracted particularly in urban areas towards formula milk, simply delivering information on the benefits of breastfeeding alone will not be sufficient to counterweigh the breast milk-substitute industry's great marketing power that influenced mothers to buy their products. This calls for urgent action and modification of the current approach of EBF.

Complementary feeding

Improved complementary feeding practices (introduction of semi-solid food after 6 months of EBF) have been found in the MSNP intervention districts indicating the activities implemented under MSNP have improved IYCF-related knowledge and behavior of mothers. Compared to control districts, the percentage of children aged 6-8 months registered for growth monitoring (GM) who received semi-solid foods (Figure 11) was consistently higher in MSNP intervention districts between 2014 and 2019.

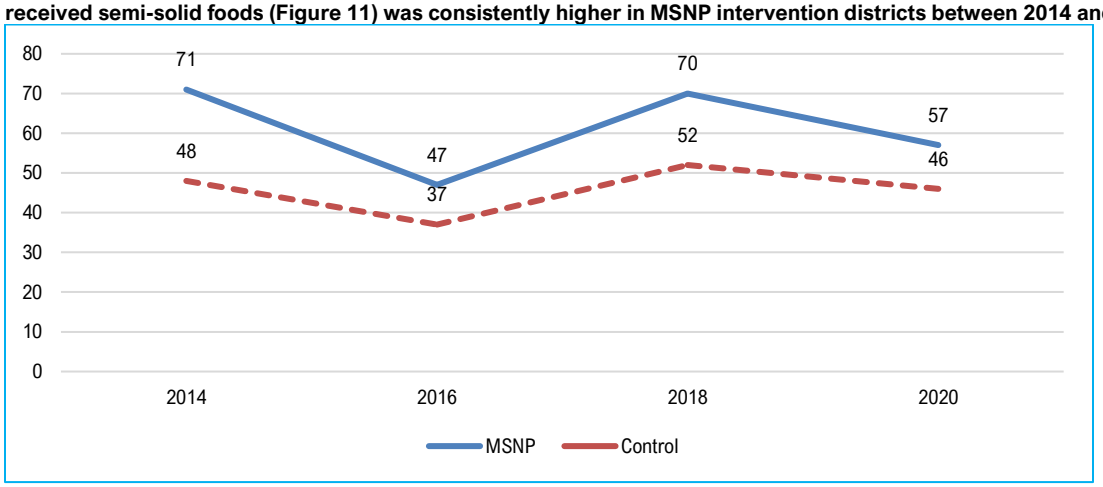


Figure 11:Percentage of children aged 6-8 months registered for GM who received semi-solid foods (MSNP Evaluation 2022)

During the field assessment, it was found that complementary feeding in Karnali and Sudurpaschim Province begins either too early or too late, and the foods provided are often nutritionally inadequate. During FGD with women with children under five years of age, it was noted that female children particularly in Karnali and Sudurpaschim Province were introduced to solid food, semi-solid, or soft foods at age of 5 months, one month earlier than the recommended practices, thereby compromising the EBF among these infants.

During the FGD, it was noted that women are quite aware of dietary diversity, but in practice, they could not buy nutritious and diverse food due to weak economic conditions. The knowledge about IYCF by the mothers could not compensate for the effect of poverty on their ability to purchase adequate nutritious foods and presumably to follow the advice given about young child feeding as a result child suffers from inadequate diets and suboptimal health.

Dietary Diversity: **Infants and young children are vulnerable to malnutrition, especially stunting and micronutrient deficiencies, and to increased morbidity and mortality without adequate diversity and meal frequency. Table 4 and Figure 10 illustrate the percentage of children aged 6-23 months who were fed according to minimum recommended standards. The proportion of children fed according to the minimum recommended standards decreased between 2016 to 2019. In 2019 only 30% of children aged 6-23 months were fed a minimum acceptable diet (NMICS, 2019), which has decreased by 6 percentage points compared to 2016. Likewise, over the same period, minimum dietary diversity has decreased by a 7-point percentage while minimum meal frequency has reduced to 69% (3-point percent decline) in 2019 (NMICS, 2019) from 71% (NDHS, 2016) in 2016. Further, the disparity has persisted in dietary diversity according to the mother's educational status, wealth quintile, and province. It was found that women and their babies tend to eat less diverse and nutritious food which is more common among women from poor households and marginalized groups and as a result languish from malnutrition.**

Table 3: Dietary Diversity among children under 5 by socio-demographic characteristics

Percentage of children aged 6-23 months who received	Minimum Dietary Diversity (MDD)[7]		Minimum Meal Frequency (MMF)[8]		Minimum Acceptable Diet (MAD)[9]	
	2016 (NDHS)	2019 (NMICS)	2016 (NDHS)	2019 (NMICS)	2016 (NDHS)	2019 (NMICS)
National	46.5	39.7	71.4	68.9	35.8	30.4
Male Child	45.8	41.4	71.4	69.2	34.4	31.7

[7] Minimum Dietary Diversity (MDD): Percentage of children age 6–23 months who received foods from 5 or more food groups during the previous day

[8] Minimum Meal Frequency (MMF): Percentage of children age 6-23 months who received solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum number of times or more during the previous day

[9] Minimum Acceptable Diet: Percentage of children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day. It is a combination of MDD and MMF.

Female Child	47.8	37.7	71.5	68.7	37.3	28.9
Children from urban areas	48	40.3	70.8	68	36.4	30
Children in rural areas	44.8	38.6	72.2	70.8	35	31.2
Poorest wealth quintile	39.6	35.1	74.2	66.8	30.8	27.4
Highest wealth quintile	64.9	53.8	76.9	70.1	49.9	39
Children of mothers with no education		24.9		66.2		18.9
Children of mothers with higher education		56.1		63.9		38.9
Children from Madhesh Province	30	28.1	63.6	70.9	20.4	22.8
Province 1	43	44	72.5	67.4	33.9	34.1
Children from Karnali Province	53.6	29.5	70.9	59.9	40.3	23
Children from Sudurpaschim Province	50	44.5	68.9	52.4	35.6	27.9
Children from Gandaki	61.8	51.1	81.2	75.2	52.2	39.5

Progress and Trends of Growth Monitoring and Promotion (GMP):

Growth Monitoring and Promotion (GMP) is a national priority intervention targeted at children aged 0-23 months and is implemented across all 77 districts of Nepal. As per the WHO's new growth standards, health workers should monitor the growth of children once a month using the growth monitoring card (totaling 24 visits per child in 2 years). GoN is committed to strengthening the GMP services and different guidelines are developed, and training is also rolled out, however, the average GM per child has plateaued over the last few years and uptake of GMP has continued to be low. According to national-level data from the Department of Health Services, between 2075/2076 (2018/2019) and 2078/2079 (2021/2022), the average number of GMP visits per child (0–23 months) remained the same at 3, contrary to what was informed and shared by Chief of Health Facility during the field visit. As far as provinces are concerned in FY 2076/77 (2019/2020), the Madhesh Province has the lowest average growth monitoring visit which is 2.1 (Annual Report of DoHS, 2076/77).

Data from NDHS 2016, revealed that only 26% of the women with children aged 0-23 months were aware of growth monitoring and promotion, and of those who were aware, over forty percent participated in GMP. This finding aligns with the findings of the report published by Suaahara-II, which reported that of the mother attending the GMP, only half of them received information about their child's growth (Suaahara-II, 2020). The inadequate information about the benefits of GMP constrains the utilization of GMP services. Moreover, during the field mission, it was noted that mothers were unable to attend the GMP because of competing household priorities, lack of transportation facilities for HFs as well a limited understanding of the significance of GMP in terms of monitoring the nutritional status of children. Besides these, two-way communication allowing the mothers to share their experiences about their child's current nutritional status was least reported by FGD participants. During the field visit, it was informed that mothers are least frequently informed about child growth by comparing the status to the previous visit using the growth card and supported to address the problems that have led to growth faltering. This in turn discourages them from attending the sessions on GMP.

Vitamin A Supplementation Program:

The national vitamin A supplementation program has maintained impressively high coverage over time. In the FY 2078/2079 (2021/2022), coverage of Vitamin A supplementation among children aged 6-59 months was 83% and has increased by 3% over the base year 2075/2076 (2018/2019). Considering the success of the vitamin A supplementation program for all children aged 6-59 months, efforts should be made to sustain the program and maintain its achievement so far.

Despite achieving over eighty percent of coverage, on an annual basis, approximately 15 percent of the children are missed by the Vitamin A supplementation program and represent the poorest of the poor families, mothers with no education, and residents of rural areas and selected ecological regions. Furthermore, Vitamin A coverage for young children is low, especially in children aged 6-11 months and children residing in urban areas. Thus, efforts to ensure universal and equitable coverage of the Vitamin A program should be made.

Micro-Nutrient Powder-MNP (Baalvita) Community Promotion Program:

By 2078/2079 (2021/2022) (Till October 2021), the distribution of Micro-Nutrient Powder (MNP)[10],[11] to children 6-23 months of age has been scaled up to 70 districts from 46 districts in 2075/2076 (2018/2019).

In FY 2077/78 (2020/2021), 30 percent of children aged 6 to 23 months had taken their first dose of multiple micronutrient power (60 sachets of Baal Vita) and only 5 percent of the children aged 6 to 23 months had received three cycles of Baalvita in program districts. A marginal decline is observed in the intake of MNP *(Baalvita)* compared to the baseline year 2075/2076 (2018/2019) (Refer to Annex

[10]Micronutrient Powder (MNP): a mixture of vitamins and minerals delivered in single-dose sachets, that can be mixed with a variety of semi-solid foods immediately before consumption to increase the availability of vitamins and minerals in children's diets

[11] Micro-nutrient sprinkles supplementation is a preventive measure against different micronutrient deficiency disorders among the children aged 6-23 months old. MNP has been locally branded in Nepal as Baal Vita (translated as "Vitamins for Children"); each sachet contains 15 micronutrients including iron and zinc at ~1x the Recommended Nutrient Intake (WFP/WHO/UNICEF, 2007).

1-Table 18). Moreover, compared to the first cycle of MNP intake, the third cycle of intake indicates that compliance (poor adherence to the recommended intake[12] of MNPs) is drastically low at 6 percent. Poor adherence to MNP intake limits the impact of efficacious nutrition interventions.

During the visit to most of the Health Facilities (HFs), the Chief of the HFs complained about the quality of the *Baalvita*. Most of these sachets were either damaged or near expiry. Additionally, the supply of MNP was interrupted during the lockdown. During the field visit, instances were reported in which MNP had to be destroyed because they were not used before their expiry date or because of quality issues.

Integrated Management of Acute Malnutrition (IMAM):

By 2078/2079 (2021/2022) Integrated Management of Acute Malnutrition (IMAM) Program has been scaled up to 70 districts of Nepal from 56 districts in the base year 2075/2076 (2018/2019) (Refer to Annex 1- Table 18).
MSNP evaluation reported that the SAM cases identification and treatment are higher in MSNP intervention districts compared to the control district between 2014 to 2020, reflecting the improved access and use of nutrition services in MSNP intervention districts. While referring to data from the Annual Report of DoHS, between, 2075/2076 (2018/2019) and 2077/78 (2020/2021), no substantial increment was found in the SAM cure rate but was maintained at around 75%, which is a key success as the sphere standard for IMAM program is (recovery rate >75 percent, defaulter rate <15 percent and death rate <10 percent).

Though the case identification and treatment have improved over the years, during the field assessment, it was noted that the identification of SAM cases has remained a challenge in many of the *palika* visited and requires more community-based approaches such as regular HHs visits and mass screening of the children to improve the identification rate. Further, only expanding the Outpatient Treatment (OTC) is not sufficient. It was found that health workers had not received training on MAM and SAM case management at a few of the HFs of the *palika* visited. Further, there was an inadequate logistic supply that constrained the effective functioning of the OTC.

During the field assessment, a visit to Nutrition Rehabilitation Homes (NRH)- a health facility-based inpatient care to treat severe acute malnutrition cases integrating with hospital services- in Birendranagar Municipality (Surkhet district), Dhangadi Municipality (Kailali district), and Amargadhi Municipality (Dadeldhura)was made (one NRH in each district). The majority of the children admitted to these NRHs were female and from poor families and the Dalit community.

The recovery rate was reported to be high and confirmed from the annual report of DoHS (of 2226 children admitted in 18 NRH in 2075/2076 (2018/2019), 98.5% were recovered). However, some challenges and concerns with NRH admission were reported, basically due to a longer period of stay at NRH and the risk of relapse following treatment. Firstly, the mothers of malnourished children undergoing treatment have to choose between staying at NRH for an average of 30 days and all their other competing activities essential to the integrity of the household. Secondly, after treatment children return to their original poverty-stricken households and the same vulnerable environment that they endured whilst becoming malnourished. A study found that the following discharge from NRH, a relapse rate of 35% to MAM and 6.5% SAM in HH with low food security compared to an 8.7% rate of relapse to MAM and 0.7% rate of relapse to SAM in HH with high food security. There prevails a high risk of relapse in the absence of continued support and other intervention beyond the NRH.

Prevention and control of iron deficiency anemia:

As per NDHS 2016, of the pregnant women who received Iron Folic Acid (IFA) supplements[13], only 42% of women took IFA for the recommended 180 days during their last pregnancy. Moreover, the proportion of women who took IFA supplements for the recommended 180 days during pregnancy was considerably lower in the Terai region than in the Hilly region (37% vs. 49%), in Madhesh Province compared with Sudurpachim Province (28% vs 52%), in the lowest wealth quintile compared with the highest (37% vs. 59%) and in those with no education compared with those who had completed secondary school (28% vs. 59%). There is variation in the proportion of intake of IFA for at least 90 days across the region, wealth quintile, and educational status (depicted in Figure 12).

12 The WHO recommended intake regimen of MNP for children aged 6-23 months is to consume at least sixty MNP sachets every 6 months
13 The protocol of IFA intake is to provide 60 mg elemental iron and 400 microgram folic acid to pregnant women for 225 days from their second trimester.

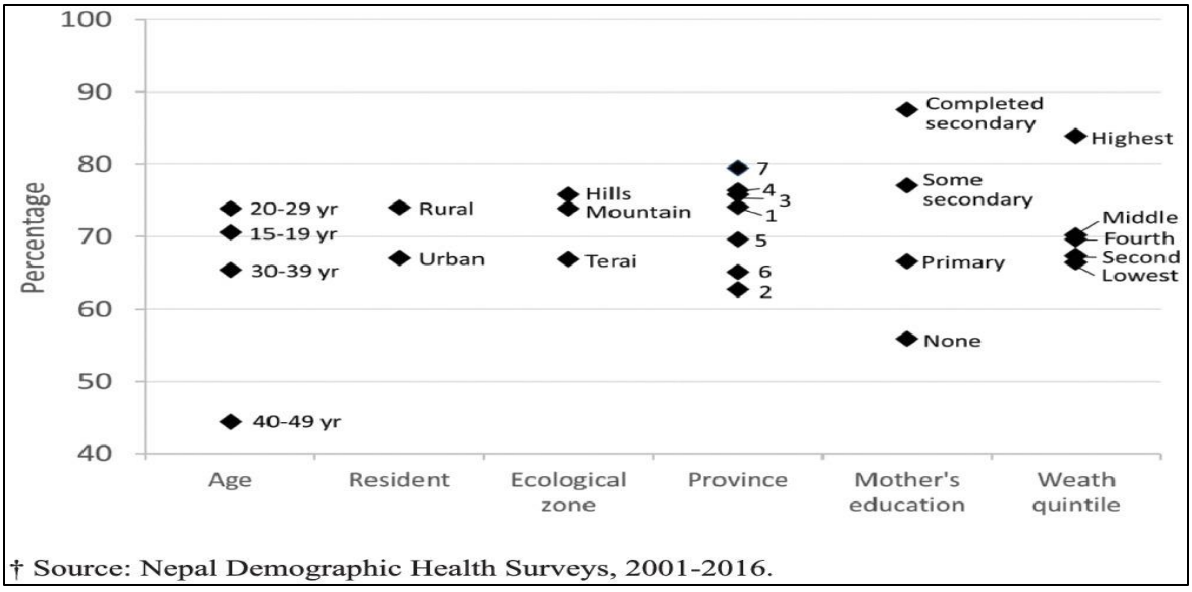


Figure 12 Percentage of IFA intake by socio-demographic variables

Adapted from "A review of the maternal iron and folic acid supplementation program in Nepal: Achievements and challenges"; "Maternal & Child Nutrition, Volume: 18, Issue: S1, First published: 24 March 2021, DOI: (10.1111/mcn.13173)"

As per the Annual Report of DoHS, in FY 2077/2078 (2020/2021), the proportion of pregnant women receiving 180 IFA tablets is 45 percent- an 11-point percentage decline compared to the baseline year 2075/2076 (2018/2019). When disaggregated by province, the highest coverage of IFA (women receiving 180 IFA tablets) is in Karnali Province at 74 percent and the lowest in Bagmati Province at 28 percent. Likewise, in FY 77/78 (020/021), the proportion of post-partum women receiving 45 IFA tablets was 41 percent indicating the difference between the pregnant women receiving 180 iron-folic acid tablets and post-partum women receiving IFA tablets. A study conducted by Khanal et. al (2014) found that IFA intake compliance during the post-partum period was significantly lower among the women who were less educated and had fewer antenatal and postnatal visits. In sum, national coverage of "any" IFA during pregnancy is high, but IFA for lactating women is much lower and compliance with taking 180 tablets during pregnancy and 45 tablets post-partum remains an issue.

Biannual Deworming Tablet Distribution:

Based on the in-depth interview with the chief of the basic health facilities, it can be concluded that the overall perception of the health workers toward the program is good, and the data shows the coverage is also encouraging. The coverage of deworming tablet distribution continues to remain over eighty percent between 2075/2076 (2018/2019) to 2077/2078 (2020/2021). However, during the field mission, it was found that the school deworming program was adversely affected and, in many cases, has completely stopped due to the closure of schools because of the COVID-19 pandemic. Further, no marked improvement is observed intake of deworming tablets by pregnant women across these years. The coverage of deworming among pregnant women has remained around 60 percent between 2075/2076 (2018/2019) to 2077/2078 (2020/2021).

Prevention and control of iodine deficiency disorder:

Nepal has made substantial progress in expanding universal salt iodization and increasing household use of iodized salt. It has been one of the successful programs and a successful demonstration of public-private partnerships to address micronutrient deficiencies[14] . Coverage and access to iodized salt have increased considerably. As per the NDHS 2016, 95% of the households had iodized salt. Although the coverage of salt with adequate iodine content (>15 mg/kg) has increased, some reasons require attention as disparities in HH use of iodized salt are noted by ecological regions, provinces, and wealth. The proportion of households with iodized salt was 90% in the mountain ecological zone, which is the lowest among the three ecological zones. Similarly, 85% of HH in Karnali Province use iodized salt, which is the lowest of all the seven provinces. Likewise, the use of iodized salt is lowest in the lowest wealth quintile -at 84%. Thus, efforts to increase the coverage of adequately iodized salt to >90% across all the provinces should be made.

As there is a growing proportion of the population has high median urinary iodine levels which signals adequate iodine intake than recommended. National data showed that the national median urinary iodine concentration (mUIC)[15] values in 2016, was 286 ug/L

---

14 Paudyal, N., Chitekwe, S., Rijal, S., Parajuli, K., Pandav, C., Maharjan, M., ... & Gorstein, J. (2022). The evolution, progress, and future direction of Nepal's universal salt iodization program. Maternal & Child Nutrition, 18, e12945.

[15] Median urinary iodine concentration (mUIC) : An indicator used to assess population-level iodine status

Among non-pregnant women, a population median UIC <100 µg/L is indicative of insufficient iodine intake (iodine deficiency),100–199 µg/L of adequate intake, 200–299 µg/L of intakes above requirements, and ≥300 µg/L of excessive intake. Among groups of pregnant women, a median UIC <150 µg/L is indicative of insufficient iodine intake, 150–249 µg/L of adequate intake, 250–499 µg/L of intakes above requirements, and ≥500 µg/L of excessive intake [11] (WHO/UNICEF/ICCIDD).

among women of reproductive age (WRA) which falls under the more than requirement category, and in the Terai (mUIC) values were above 300 ug/L, which is the WHO/UNICEF/IGN cut-off point, suggesting an excessive iodine intake. In recent times, changes in dietary patterns and preference for processed and packed foods and condiments among the urban population have led to an increased salt intake (more than recommended) which has been emerging as a challenge.

Community-based Integrated Management of Neonatal and Childhood Illnesses (CB-INMCI):

In line with the information shared by the Chief of Health Facilities and FGD participants, HMIS data revealed that the prevalence of diarrhea has reduced significantly in recent years. As per the Annual Report of DoHS and HMIS data, the incidence of diarrhea among children under 5 years (CU5) has reduced by 15% from 398 per 1000 children in 2075/2076 (2018/2019) to 339 per 1000 children in 2077/78 (2020/2021). Likewise, the percentage of children under five suffering from diarrhea treated with ORS and Zinc has remained over 95% during the same period (Refer to Annex 1- Table 18). This could be attributed to the improved care-seeking practices and WASH practices at the HH level.

Progress and Trends of Utilization of Maternal Health Care Services:

There has been a steady increase in the proportion of women who received ANC during all four of the recommended months with four or more ANC visits, from 59% in 2016 to 78% in 2019. As depicted in Figure 13, over the same time, there was a remarkable 22-percentage-point increase in the proportion of institutional deliveries. In addition, an increasing trend is observed in the proportion of women with newborns receiving a postnatal check within the first 2 days after birth (from 57% in 2016 to 69% in 2019). Though there is variation in the utilization of maternal health care services (ANC, institutional delivery, and PNC), as illustrated in Figure 13, it is upward and increasing. This finding corroborates with information shared by the Chief of the Health Facility and women from all the *"palika"* visited.

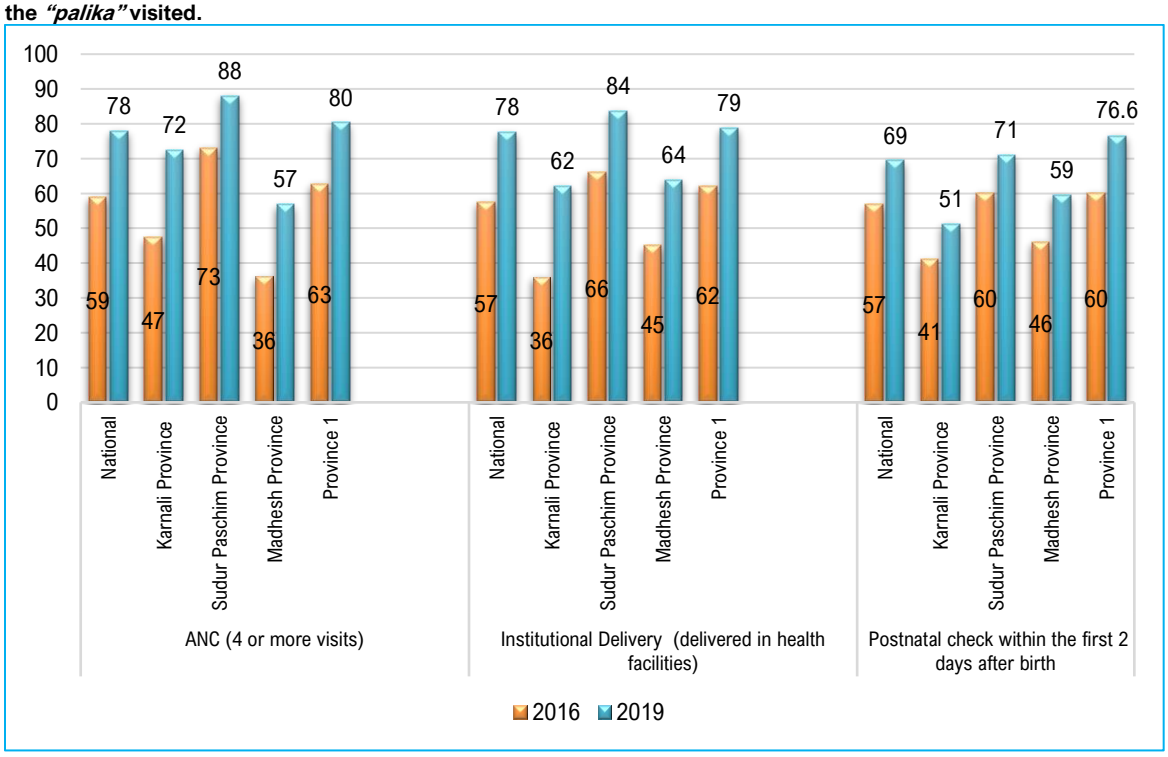


Figure 13 Utilization of Maternal Health Care Services between 2016 (NDHS) and 2019 (NMICS) (By Province)

School Health and Nutrition Program:

With gradual scaling-up, the school nutrition and health program covers all 77 districts by the fiscal year 2077/78 (2020/21). However, several challenges were reported that have impacted the success of the school health and nutrition program.

The issues regarding the inadequate supply of deworming and iron tablets for schools were highlighted. The field assessment found that the distribution of IFA and deworming tablets for adolescent girls was affected and has completely stopped at many schools due to a shortage of IFA and deworming tablets followed by the closure of schools due to the COVID-19 pandemic. A nationwide lockdown in the early stage of the pandemic caused disruptions in the supply chain for the transportation of nutrition commodities leading to the shortage of nutritional commodities including deworming tablets. The review findings echoed findings from a recent study that found that lockdown caused disruptions in routine and essential health care such as immunization and the supply chain for medicines and equipment.[16]

[16] Singh, D. R., Sunuwar, D. R., Shah, S. K., Karki, K., Sah, L. K., Adhikari, B., & Sah, R. K. (2021). Impact of COVID-19 on health services utilization in Province-2 of Nepal: a qualitative study among community members and stakeholders. BMC health services research, 21(1), 1-14

Most of the respondents from HFs pointed out that the insufficient coordination between HFs, the municipality, and the school has acted as a barrier to the effective implementation of the IFA and deworming at schools. Moreover, the lack of effective integration and coordination between Early Childhood Development (ECD), the school-mid-day meal program, and the school health and nutrition program was noted. Concerns related to weak and infrequent reporting of the distribution of the deworming tablet and iron tablet distribution from the school were reported by the Chief of HFs during the interview.

Adolescent Nutrition:

The current MSNP intervention particularly nutrition-specific interventions have little focus on nutrition issues pertaining to school-aged children, adolescent girls, and newly married adolescents residing in urban areas which are reflected in program interventions and budget allocation for adolescent nutrition. Even the nutrition-sensitive (prevention of early marriage, promotion of girls' education, life skills of adolescents, targeting their unmet needs of contraception, improved WASH practices) targeted at adolescents are poorly funded, implemented, and monitored. Currently, under-five and pregnant women (G1000 days mothers) are the main focus. Adolescents' lifestyles and eating patterns are changing, and interventions to address these issues are not top of the priority list despite the increasing trend of overweight and obesity among these groups due to changed dietary behavior and lifestyles.

Knowledge and Practices related to IYCF and WASH practices:

MTR findings revealed that the knowledge and practices related to a few of the IYCF and WASH practices among women with children under five have improved following the implementation of MSNP interventions. This finding is confirmed by the evaluation of MSNP that found that the percentage of mothers aged 15-49 years who knew about exclusive breastfeeding up to 6 months was significantly higher (89.3 percent) among households receiving the MSNP interventions compared with the households that have not participated in MSNP interventions (79.6 percent) (illustrated in Table 4).

During the field visit, it was noted the WASH knowledge and practices were poor among most FGD participants. This finding was validated by an MSNP evaluation that reported that only 58 percent of the women who had participated in the MSNP activities knew about handwashing before feeding a child. Moreover, as per the evaluation report knowledge about WASH practices was low in women who had never attended school and belonged to Janajati and Muslim households compared to women from Brahmin/Chhetri.

Table 4 Knowledge and Practices related to selected IYCF practices among intervention and control group (Source: MSNP Evaluation Report 2022)

Indicators	Percentage		
	Participating	Not	P-value
Knowledge			
Percentage of women aged 15-49 years are aware of:			
Exclusive breastfeeding up to 6 months	89.3	79.6	<0.001
Handwashing after going to the toilet	97.7	96.7	0.014
Handwashing before feeding a child	58.0	63.4	<0.001
Handwashing before preparing food	63.7	65.3	0.051
Practice			
Percentage of:			
Children born in last 0-23 months who had initiated breastfeeding within one hour of birth	61.1	50.9	<0.001
6-23 months children consumed multiple micronutrient powder in previous 7 days	19.8	7.3	<0.001
Under-5 children had diarrhea in two weeks preceding the survey	3.2	4.8	0.002
Households using improved sanitation facilities that are not shared	74.4	66.0	<0.001

Chi-squared (χ^2) test; P -value[17]<0.05 (Level of significance =5%)

4.5 Progress against outcome 2: Coverage and trends of nutrition-sensitive interventions

B. EDUCATION SECTOR:

Progress toward Outcomes related to Education Sector:

Output 2.6 Gross enrolment rate (GER) (boys and girls) in early childhood education and development (ECED)/pre-primary education (PPE)

Progress in the Gross Enrolment Rate (GER) for ECED/PPE continues to show reasonable growth. At baseline, the gross enrolment rate in early childhood education and development (ECED)/pre-primary education (PPE) was 81 percent. In 2019/2020, the Gross Enrolment Rate of total children enrolled in ECED/PPCs was 86.4%, with 85.1% girls and 87.5% boys compared to a total of 84.7%,

[17] P value as an index measuring the strength of evidence against the null hypothesis (no effect or no difference); measures how likely it is that any observed difference between groups is due to chance. Being a probability, P can take any value between 0 and 1. Values close to 0 indicate that the observed difference is unlikely to be due to chance, whereas a P value close to 1 suggests no difference between the groups other than due to chance.

with 81.2% girls and 88.0% boys in 2018/2019, demonstrating 1.7% increase compared to 2018/2019. This has now increased to 87.6 percent in 2077/2078 (2020/2021) and has surpassed the target for 2020 (demonstrated in Table 5).

Table 5 Gross Enrollment Rate for ECED/PPE between FY 2075/2076 and FY 2078/2079

FY	Gross Enrollment Rate (%)			
	Target	Achievement (Total)	Girls	Remarks
2075/2076 (2018/2019)	82.6%	84.7		
2076/2077(2019/2020)	84.3%	86.2	85.1	
2077/2078(2020/2021)	86	87.6		On track
2078/2079 (2021/2022	87.7	NA		

(Source: Nepal: Education Sector Analysis Report 2021)

Like previous years, at the national level, in 2019/2020, the boys (54%) outnumbered girls (46.0%) in ECED/PPE and was similar pattern has been found across all seven provinces. The analysis at the provincial level suggested that Madhesh Province has the lowest GER (52.6% against the national average of 86.4%), followed by the Karnali province (71.6%), and is lagging to meet the target by 2021/2022 (Refer to Annex 2-Table 20). The GER in ECED is higher in Bagmati at 108 % and much higher than the national average.

While analyzing the data from an equity perspective, it was found that, of the total enrollment (1,105,561) in 2019/2020 in ECED and PPE centers, 19% were Dalits (a 2-point percentage increase from the previous year) and 36.6% were Janajati. Further, among the total Dalit and Janajati children enrolled, 19.3% were Dalit girls and 36.8% were Janajati girls.

At the sub-national level, of the total Dalit children enrolled, the highest share is in Karnali province (27.9%) and the lowest in Bagamati province (8.0%). Similarly, data revealed that, of the total Janajati children enrolled, the highest share is in Bagmati province (55.6%) and the lowest in Karnali province (11.9%). Compared to 2018, the gender gap in 2019 has reduced to 2.4% from 6.8%. Despite the increase in GER among girls by 4% in 2019, there is a need to accelerate the efforts at the local level to increase the enrollment of girls particularly in Madhesh Province and Karnal Province.

Output 2.8: Basic education cycle completion rate (boys and girls)

Once children are enrolled, it is important to keep them in school until at least the end of primary education. Data from Education Management Information System (EMIS) revealed that the completion rate has increased in the last three years. In 2077/2078 (2020/2021), three-fourths of the children enrolled had completed the basic education cycle. However, the completion rates for basic level education show a lagging bit of the set targets for the MSNP (refer to Table 6).

Table 6: Basic education cycle completion rate (boys and girls)

FY	Completion Rate (%)			
	Target	Total (Achievement)	Girls	Remarks
2075/2076(2018)	72.4	71.3		
2076/2077(2019)	75.4	72.7		
2077/2078 (2020)	78.5	75.3	73.1	Off-track to achieve the target
2078/2079 (2021)	81.7			
2079/2080 (2022)	85.0			

(Source: Nepal: Education Sector Analysis Report 2021)

Output 2.7 Decreased % of out-of-school children (boys and girls) in basic education:

There has been an improvement in the percentage of dropouts between the review period from 7.3 percent in 2018 to 5.4 percent in 2020 and has surpassed the target (illustrated in Table 7)

Table 7: % of out-of-school children (boys and girls) in basic education

FY	Out-of-school children (%)			
	Target	Total (Achievement)	Girls	Remarks
2075/2076(2018)	9.06	7.3		
2076/2077(2019)	7.5	6.7		
2077/2078(2020)	6.0	5.4		On track to achieve the target
2078/2079 (2021)	4.5	NA		

(Source: Nepal: Education Sector Analysis Report 2021)

Information on some of the output indicators such as Increased adolescent girls' awareness and improved behavior on nutrition, and the number of schools using nutrition-sensitive literacy materials could be tracked as the EMIS system does not have these indicators embedded in their system reflecting the issues of alignment of MSNP result framework and EMIS.

Mid-day Meal Program:

To address the nutritional needs of young school-going children and provide social protection to families, global efforts have largely focused on school feeding. The school mid-day meal program is targeted at children enrolled in primary education and is rolled out in public schools of the 77 districts.

In general, the provision of the school meal at the school level is well implemented and managed. In 2078/79 (2021/2022), a total of 30,75,236 children in basic education had received a midday meal compared to 29, 407,89 children in 2077/2078 (2020/2021)- a slight incline in the numbers of children receiving the mid-day meal compared to the previous year. It has been reported that the mid-day meal program has contributed positively to increasing the school enrollment rate and school attendance in Nepal (2019 Global Survey of School Meal Program Report, Global Nutrition Child foundation). Even the many key informants mentioned that the program has improved the attendance, enrolment, and retention rates in schools.

Despite the achievement of the mid-day meal program in improving the enrollment and attendance of the schools few operational challenges were placed by education officers across all the *palikas* visited. During the field visit, while interacting with education officers at *palika*, the majority of them said that there is insufficient infrastructure such as a kitchen, gas stoves, and cooking and the amount provided is insufficient to implement the school midday meal program. For instance, an education officer from Madhav Narayan Municipality of Rautahat said, "*Schools with a high number of students are unable to cook food on their own and provide locally available food with the amount provided, because of lack of kitchen facilities and support staff and hence have to rely on the food from outside."*

Despite challenges identified by the respondents, all of them acknowledged that efforts should be made to make the program sustainable, because of its positive impact on students. Prior evidence has shown the positive outcome of the mid-day meal program if effectively implemented and complemented by other programs. Thus, the school feeding program should be sustained.

C. Women and Children sector

The women and children sector is involved in raising the awareness of G1000 Days mothers, caregivers, and adolescent girls on nutrition, hygienic behavior, child marriage, gender discrimination, and empowering women and adolescents.

Status of Early Child Marriage (ECM) and other harmful social practices following the implementation of MSNP-II

At the local level, various behavior change interventions are being conducted to end Early Child Marriage (ECM), and accordingly, the impact of these efforts is visible considering the steady decline in adolescent marriage. However, change in social and cultural practices and behavior at the local level is often inadequate and not as anticipated. For instance, though Nepal's Civil Code has set the legal age for marriage at 20 years old for males and females in 2017, early marriage continued in some communities, and its prevalence varies with place of residence, province, educational attainment, and household wealth quintile (illustrated in Fig 14). The prevalence of marriage among young women (aged 15-19 years) is 19 percent and the proportion of women aged 20-24 years who were married before the age of 18 years was 33 percent (NMICS, 2019). Women aged 20-49 years with no or basic education are far more likely to be married before the age of 18 than are women who have secondary education or higher. Similarly, women from the richest households are significantly less likely to be married before the age of 18 (25%) compared to women in the fourth, middle, second and poorest households (range 41-44%). In addition, the prevalence of child marriage is highest in Madhesh Province (53%) followed by Karnali and Sudurpaschim Province among women aged 20-49 years.

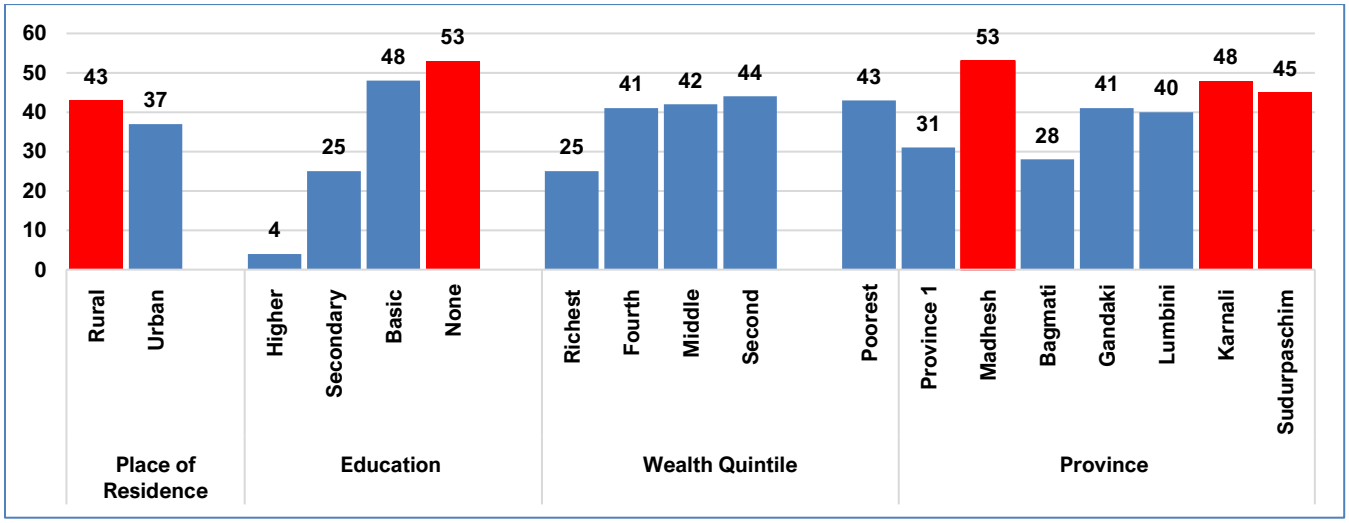


Figure 14: % of married women aged 20-49 years who were first married or in union before the age of 18 (By place of residence, education, wealth quintile, and province)- (Source: NMICS, 2019)

Corroborating with the findings from NMICS 2019, during FGD with women of children under five in all the eight palika, it was found that nearly all participants had married at an early age, despite being knowledgeable about the consequences of ECM and its impact on nutritional status of women and children to be born to young mothers. Note that the majority of the FGD participants were from disadvantaged and marginalized groups. During the field visit, even members of the nutrition and food security steering committee agreed that palika have not achieved the desired results, despite their ongoing efforts to reduce ECM.

Closely related to the issue of early child marriage is early childbearing and childbearing at a very young age is associated with an increased risk of child malnutrition. Besides adverse nutritional outcomes, early childbearing also challenges young women's engagement in education and employment opportunities (Watts, Liamputtong, and Mcmichael 2015). According to NMICS 2019 2016, childbearing at an early age among the 20 -24 age band was found more prevalent and higher than the national average (14%) in Karnali (24%) followed by Madhesh province (19%) Further, early childbearing was found in rural women compared with urban women, (18% vs. 12%) in women with no education at 34% and in women from and in women from the lowest wealth quintile compared to women from the highest wealth quintile (20.4% versus 6%) (NMICS, 2019)). Moreover, childbearing was found to be decreasing with an increase in the education level (33% among women with no education vs. 7% among women with secondary education, NMICS, 2019) underscoring the need to invest in girls' education. Significant ethnic differentials were also evident in terms of initiation of childbearing, with the Terai/Madhesi other caste groups (50%) having the highest proportion of young women (15-24 years) who have already begun childbearing, followed by Muslims (43%) and Dalit women (41%) (NDHS Further Analysis, 2016)18.

Menstrual Seclusion

The malpractice of menstrual seclusion [(Chaupadi- a deeply rooted taboo and harmful religious-cultural practice of banishing women and girls to "menstrual hut" *(chhaugoth)*] is still prevalent in some areas of Karnali and Sudurpaschim Province of Nepal. During the field visit, it was found that adolescent girls from Doti and Jumla districts still follow menstrual seclusion, despite the Supreme Court ban on Chaupadi and the criminalization of acts under the Criminal Code Act (2017). Resonating with the observation from the field, NMICS 2019 reported that nearly one-fourth (21%) of women in Sudurpaschim province (21.1%) practice Chhaupadi, which is an 18-point percentage higher than the national average (3.8%). Menstruating women are excluded from social activities such as (excluding religious activities/ temple visits), school or work. Nearly one-fifth of women in Karnali and 40.7% of women in Sudurpaschim Province did not participate in social activities during menstruation (NMICS, 2019). Together with the women, school-aged girls (female adolescents were also invited to discuss their issues separately) mentioned that. *"We are restricted to do household activities and not allowed to attend religious ceremony or drink cow milk even with a belief that cows may not give milk if these menstruated women and girls touches or drink cow milk. We are forbidden to touch male members of their family as well as flowers and plants and forced to live in a separate shed away from home."*

A recent study conducted by Dipendra et al (2021) revealed that over eighty percent of girls practiced Chaupadi during their recent menstruation and found that this malpractice is more common among 15-17 years of girls and girls born to illiterate mothers. On top, more than one-third of the women aged 15-49 years did not use menstrual hygiene materials during their last menstruation in both these provinces. Surprisingly, the majority of the adolescent girls during the field visit said that they do not want to practice menstrual seclusion and are well-informed but cannot defy the tradition because of family and social pressure, they are left with no option rather than practicing Chhaupadi. This strongly indicates that the interventions under implementation (legislation, community sensitization, and social campaigns) are not adequate to deter women in the western part of Nepal from practicing Chhaupadi and improving menstrual hygiene and making them realize to abolish this harmful practice.

D. AGRICULTURE AND LIVESTOCK SECTOR

Over the past 10 years, Nepal has incremental gains in the overall food security score. In Global Hunger Index (GHI)19 2021, In 2021, Nepal ranked 76th out of 116 countries on GHI. In 2000, Nepal's GHI score was also in the alarming category, but experienced an impressive decline in GHI score since then, dropping from 37.4 points in 2000 to 19.4 points in 2021 which is considered a moderate category (Figure 15).

[18] ***Kafle, Ramesh Babu, Rasmita Paudel, Pragya Gartoulla, and Kerry L. D. MacQuarrie. 2019. Youth Health in Nepal: Levels, Trends, and Determinants. DHS Further Analysis Reports No. 116. Rockville, Maryland, USA: IC***

19 The status of each of the GHI indicators (the prevalence of undernourishment, child stunting, child wasting, and child mortality) provides insight into the particular nature of hunger in each country.

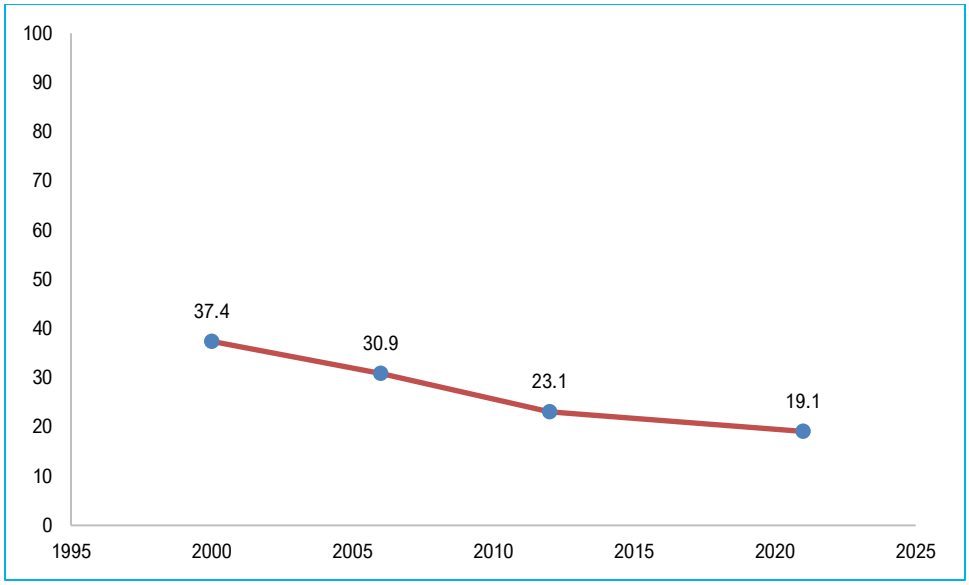


Figure 15 GHI Trend score of Nepal between (2000-2021) (Source: GHI Report 2021)

Nepal's Global Food Security Index- a composite indicator that measures the underlying drivers of food security based on affordability, availability, quality and safety, and natural resources and resilience- has improved by 7 points (from 46.7 points in 2012 to 53.7 points in 2021) in last one decade. Widespread adoption of nutrition and food security policies and strategies, improved availability of food, cutting back on volatility in food production, increased access to the market, and provision of food safety nets across these years could have led to the observed improvement in the GFSI score in Nepal. However, Nepal still secured a lower rank on Global Food Supply Index. According to the report, Nepal held the 79th position with an overall score of 53.7 points on the GFS Index 2021 of 113 countries. Further, in the food affordability and availability category, out of 113 countries, Nepal ranked 83rd (with a score of 48.3) and 27th position (with 64.5 points) on the GFS Index 2021. Despite improvements in the food security status of the Nepalese population, only half of the household is food secure and has access to food throughout the year. Data from NDHS 2016 revealed that of the total food insecure HHs, 20% of HHs are mildly food insecure while 10 % of the HHs are severely food insecure totaling 4.6 million of the population food insecure.

Interestingly, the rural areas were found to be less food secure (39%) where agriculture activity is higher compared to urban areas (54%). Geographical and socio-economic variation in food security was noted. Over forty percent of the household in Karnali Province is moderately food insecure which is the highest compared to all other provinces. Similarly, the proportion of households facing severe food insecurity is highest in Karnali Province (18%) followed by Sudurpaschim Province (13%) and Madhesh Province (11%) (illustrated in Figure 16). Moreover, less than twenty percent (18%) of the HHs in the lowest wealth quintile were food secure while of the food insecure HHs, twenty-two percent of the HHs from the lowest wealth quintile are severely food insecure and highest across the wealth quintile (Refer to Table 8). There exists ecological variation in food security. Over fifty percent of the HHs in Terai are food secure while thirty-eight percent of the HHs are food secure in the mountain.

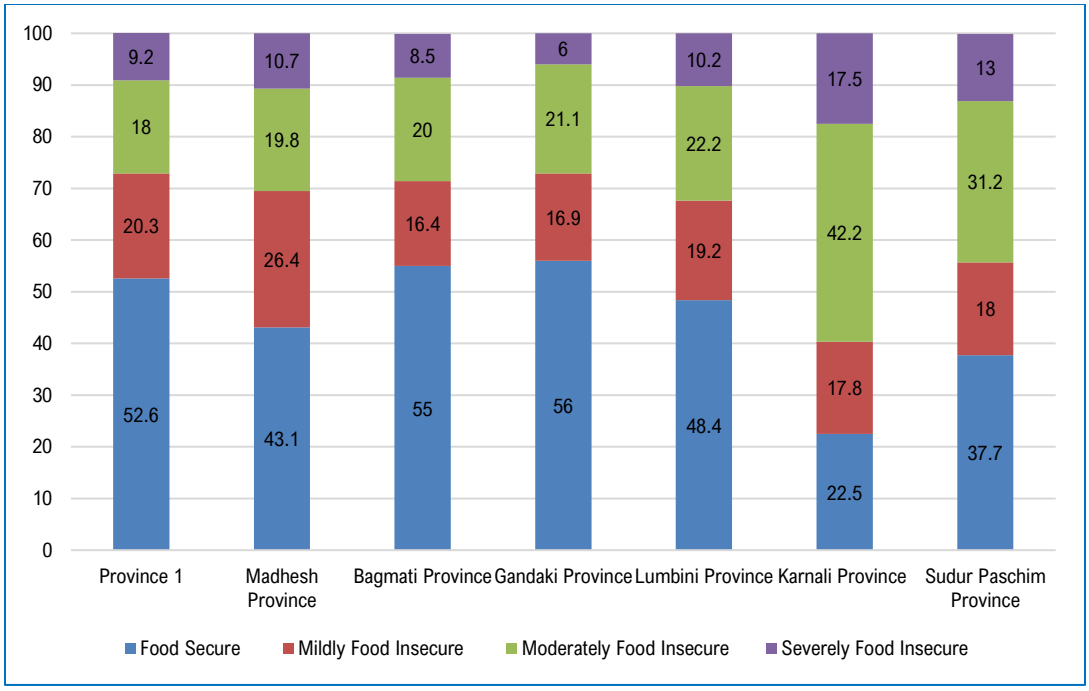


Figure 16 Percent distribution of households by the level of food insecurity (Source: NDHS, 2016)

Output 2.1: Increased availability and consumption of safe and nutritious foods

Table 18 depicts the progress towards Output 2.1. in terms of the percentage of change in Crop production and productivity between 2018/2019 to 2019/2020. During the review period, the production of cereals and pulses has increased and has exceeded the target whereas there has been a decline in the production of vegetables and potatoes. In recent years, there has been notable growth in livestock products (Refer to Table 18). For instance, the production of milk has increased from 2168434 metric tonnes in 2018/2019 to 2,302,000 in 2019/2020, while the production of eggs has increased by 4.5% totaling 1,620,000 metric tonnes during the same period (Refer to Annex 1, Table 21) and has surpassed the target.

There have been positive developments on several fronts in the agriculture and livestock sector to address malnutrition and food insecurity and increase production and productivity. However, there are still deep inequalities in hunger and malnutrition at the national and sub-national levels. Women typically from the lowest wealth quintile households lack access to the diverse and quality of food in the quantity they require. Less than twenty percent (18%) of the HHs in the lowest wealth quintile are food secure while of the food insecure HHs, twenty-two percent of the HHs from the lowest wealth quintile are severely food insecure and highest across the wealth quintile (Refer to Table 8).

One of the key informants from MoALD acknowledged the issue of prevailing food insecurity and said that *"Several efforts have been made to increase the productivity of crops and livestock. However, there still exists a gap in the supply and demand of food which is concerning in terms of food security."*

Table 8: Distribution of HH food security (By Wealth Quintile)

Wealth Quintile	Food Secure	Mildly Food Insecure	Moderately Food Insecure	Severely Food Insecure
Lowest	18.1	20.8	38.9	22.2
Second	36.7	23.5	28	11.7
Middle	45.5	25.8	21.4	7.3
Fourth	61.2	19.3	14.3	5.2
Highest	78.5	9.5	8.9	3.1

- (Source NDHS, 2016)

The MTR findings indicated that the most often consumed foods across all the ecological regions and provinces visited were cereals, oils and fats, and pulses. Though women are quite aware of the diverse food intake, HH accessibility and affordability to diverse food including animal source food and fruits are limited. Fill the Nutrient Gap (FNG) Analysis 2020, reported lower availability and higher prices of nutritious food in the Mountain areas compared to the rest of the country. As per the FNG 2020 report, the lowest-cost

nutritious diet is, at the national average, 348 per five-person household per day while the cost of a diet that meets only energy needs is NPR 141 (USD 1.22). As a result, a larger proportion of households (at least 22 percent) are unable to afford a nutritious diet.

Issues identified during the field mission and interview with key informants:

- Agriculture Knowledge Centers and Livestock Centers in districts work as wings of the province, however, there is a gap in the coordination of these centers with the local level that acts as a constraint to the effective implementation of MSNP interventions. Most of the local government lacks technical capacity and at a few "palikas" the post of agriculture extension worker is vacant. In the absence of these extension officers, it was witnessed at the "palikas" visited, CAOs or officers from other units were assigned the roles to plan for MSNP interventions related to the agriculture sector, who are necessarily not technical experts in the area.
- While interacting with the LLNFSSC at "palikas", it was indicated that the distribution of eggs and chicken is not delivering the anticipated result of improving the food diversity among the target beneficiaries and influencing their feeding practices, and improving their livelihood.

"Despite the realization that the distribution of seeds, eggs, and saplings does minimal to improve food diversity and is not making a tangible contribution to improving the livelihood of the recipients in absence of proper training and monitoring, we (the focal person of the agriculture unit and member of LLNFSSC), plan for the distribution of physical inputs with the limited resources allocated to agriculture sector under MSNP," - (Member of LLNFSSC, Hilihang Municipality, and Madhavnarayan Municipality).

- During the discussion with FGD participants, the majority of the women welcomed the intervention of the local government in distributing eggs, chicken, greenhouse tunnels, and seeds. However, they showed their concerns over the limited size of the commodity distributed that doesn't even cover and reach the target group (mothers of golden 1000 days). They informed that these physical inputs are distributed once a year on a rotation basis (because of resource constraints) that merely lasts for a month. Few of the FGD participants from all the "palika" visited demonstrated their dissatisfaction over the unfair distribution of the agriculture inputs and regarding the selection of participants for agriculture training. Most of them said that the distribution of agriculture inputs is not done in a way to reach out to those in real need.
- During the meeting with LLNFSSC members, it was informed that farmers lack sufficient knowledge about the rational use of pesticides and fertilizers and thus they tend to use pesticides haphazardly adversely affecting the yield of the land. Respondents shared that in recent years there has been an increase in the trend of land fallowing and abandonment largely due to male migration leading to slow growth of the agriculture sector.
- During the field visit, it was noted that farming is practiced on small and fragmented pieces of land by small-scale farmers and is largely dependent on rainfall. A member of the Provincial Policy and Planning Commission from Sudurpaschim during an interaction informed that inadequacy of irrigation services and insufficiency of agriculture inputs especially seeds and fertilizers, and the weak market network have adversely affected agribusiness and the productivity of the crops and livestock.
- Most of the participants during the interaction mentioned that accessibility to food has remained a pertinent issue, particularly in mountain and hill regions. It was shared that poor road connectivity due to difficult topography and lack of warehouse infrastructure limits the accessibility to food. Echoing the views shared by FGD participants, most of the members from DCC reported that the food supply system including food collection and distribution is the least developed and the marketing network is weak across all three ecological regions. In addition, participants from the nutrition and food security steering committee stated that subsidy to support local production for a farmer is negligible which further discourages them to cultivate indigenous food. In addition, it was observed that small-scale farmers particularly women were not encouraged to cultivate the indigenous crops because of their low yield.
- Most of the participants from LLNFSSC in Dipayal and Chandannath Municipality reiterated that locals have inadequate knowledge about the nutritional value of the local foods like buckwheat (fapar), Millet (kodo), Himalayan Red Rice (maarsi chamal). Further, with the increase in income, food consumption patterns have changed towards high-value items like fine rice, fast foods, and drinks across income quintiles. It was informed that with the increased income, food consumption patterns have changed in recent years and the majority of the household prefer to have white rice and fast foods over traditional and organic foods as it is linked to social prestige and affluence in these areas. *"One prefers to welcome guests with cold drinks like Coca-cola, white rice over milk, mohi, marsi rice during different occasions such as Dashain just to demonstrate affluence through changes in their lifestyles and dietary practices."* (Members of DCC at Phidim Municipality and Chandanath Municipality).

- Most often in both provinces (Karnali Province and Sudurpaschim Province) rampant sales and distribution of fast-food items have compromised the intake of locally available foods by children and mothers. The food items that have exceeded the expiry date are available in the market and are sold as there are no food inspections even though regulations are in place.

- With the increase in male migration, the proportion of women-headed households has augmented particularly in mountain and hilly regions and more women in these regions are involved in the agriculture sector. This has overburdened women with the workload as a result they can't continue exclusive breastfeeding and provide the appropriate complementary food diverse in nature in the lack of innovative and time-saving agriculture technologies.

E. WASH Sector

Notable progress has been made in the WASH sector in terms of improving the coverage of safe drinking water and improved sanitation and handwashing facilities. The coverage for basic water supply stands at over 90% of the total population, and with the country achieving the Open Defecation Free (ODF) Status in September 2019, the coverage for basic sanitation is nearly one hundred percent (depicted in Table 9). This is a demonstration of concerted efforts to improve the water supply and sanitation

(WASH) situation by formulating and enforcing several WASH policies, guidelines, and acts and of strong leadership of the government and a successful awareness and support campaign.

Table 9: Progress toward access to WASH

Outcome 2: Improved access to and the equitable use of nutrition-sensitive services and improved healthy habits and practices						
Indicators	Target				Achievement by 2019 (NMICS, 2019)	Remarks
	2018	2019	2020	2021		
2.2 Increased % people using safe drinking water	33.7	38.4	43.1	47.8	97%	On track
2.3. Increased % people using improved sanitation facilities that are not shared	95	98	100	100	80%	Off-track
2.4. Increased % of people practicing handwashing with soap and water before feeding baby (0-2 yrs) and after cleaning babies' bottoms	15	20	30	40		NA

Between 2016 and 2019, access to an improved source of drinking water has improved. In 2019, the proportion of HHs using improved sources of drinking water increased to 97 % (NMICS, 2019) from 95% in 2016 (NDHS, 2016) and has surpassed the milestone set for 2019 and 2021. However, during the review period, the target for access to improved sanitation facilities has not been met and falls behind by an 18-point percentage in 2019 (NMICS, 2019).

Access to improved drinking water varies by province, place of residence, and wealth quintile. At the provincial level, of those with access to an improved drinking water source, only forty percent of the households in Karnali Province and sixty percent HHs in Sudurpaschim Province have a drinking water source within their premises in 2019. Disparities in access to improved drinking water by income level were also reported by NMICS 2019, with 92% of HHs in the lowest wealth quintile category having access to improved sources of drinking water compared to nearly universal access (99%) among HHs from the highest wealth quintile category. Further, less than fifty percent of the HHs in the lowest wealth quintile had improved drinking water sources within their premises compared to nearly ninety percent of HHs in the highest wealth quintile category.

According to NMICS 2019, at the subnational level, water quality (assessed in terms of the presence of E. coli in the water per 100mL) was the worst in Bagmati Province (93.9% HHs) followed by Karnali Province (89.1%) and Sudur Paschim Province (83.2%) and in rural areas (81.8) compared to urban areas (72.1%).

Treatment of drinking water: Overall, there is an improvement in the use of appropriate water treatment practices- an increment of 4 percentage points from 20% in 2016 (NDHS, 2016) to 24% in 2019 (NMICS, 2019). At the provincial level, the lowest proportion of HHs in Madhesh Province (4.1%) uses appropriate treatment methods followed by Sudurpaschim Province (6.9%) and Karnali Province (9.2%). Appropriate treatment of water is found to be least common in HH heads with no education (12.3 %) and HH from the lowest wealth category (12.3%) compared to HH with the head of the family with higher education (53.9%) and from highest wealth quintile category (50.5%) respectively.

Handwashing Facilities: Handwashing facilities were observed at 86.4 % of HHs in 2019 compared to 80.9%- a nearly 6-point percentage increase from 2016. In 2016, of those HHs where handwashing facilities were observed, 47.1% HHs had handwashing facilities with water and soap available which has nearly doubled by 2019 (80.7%) (Refer to Table 10). The percentage of household members with handwashing facilities where water and soap were present has increased in 2019 compared to 2016, however, it remains lower in rural areas, Karnali Province, and among HHs from the lowest wealth quintile.

Table 10 Percentage of HH members with Handwashing facilities with water and soap

Background Characteristics	NDHS 2016	NMICS 2019
Residence		
Urban	57.4	85.6
Rural	30.7	70.7
Province		
Bagmati Province	63.5	88.2
Karnali Province	25.9	55.2
Wealth Quintile		
Lowest	16.7	49.8
Richest	86.1	93
National	47.1	80.7

The increase in access to safe drinking water and improved handwashing behavior was also affirmed during focus discussions with women having children under five. However, as claimed by the FGD participants, not all HHs members have water and soap present at their hand-washing station at HH. This is also revealed by the data from NMICS 2019.

Use of basic sanitation services: Nepal appears to inch gradually towards SDG targets related to universal access to sanitation. The overall percentage of HHs using improved toilet facilities that are non-shared has increased substantially from 62% in 2016 to 80% in 2019.

Despite the impressive household coverage of improved toilet facilities and a high level of awareness of the importance of hygiene and knowledge of the importance of handwashing at critical times (as noted during the field mission), it was observed that mothers and caretakers still do not wash their hands during critical times. This malpractice demonstrates attitudinal problems and signals the need for a social behavior change (SBC) approach to desired behavior change.

WASH services at Health Institutions: The availability of WASH amenities at health facilities (HFs) have improved (sanitation from 82 percent in 2015 to 89 per cent in 2021 and improved water sources from 81 per cent to 94 per cent) (Nepal Health Facility Survey, 2021). However, the functionality and conditions of these amenities were poor (at the places visited) in terms of cleanliness, maintenance, availability of regular supply of running water and sanitation supplies, client friendliness. During the field visit, WASH services- a prerequisite for quality care- in the HFs visited were sub-standard. The majority of the HFs had inadequate water supply and unhygienic sanitation facilities with few even lacking functional handwashing facilities (with water and soap and/or alcohol-based hand rub) accessible to PLW and caretakers visiting the HFs. None of the HFs visited had sex-separated toilets with menstrual hygiene facilities. In addition, none of the HFs visited across all eight palika had handwashing and toilet facility accessible to children and people with limited mobility.

F. Social Protection Sector

The coverage of Child Cash Grant (CCG) has increased gradually from 14 districts in 2076/2077 to 25 in 2077/2078 (Refer to Annex 1-Table 22) and the cash amount paid is also increased from Nrs. 400 to Nrs. 532 during the same period. In addition, the duration of cash transfers through the bank by the local government has been reduced from 4 months to 3 months. So, as of 2077/78 (2020/21), a total of Nrs. 1596 (@Rs.532 each month) is paid to mothers of eligible children by the local government every three months.

During the field mission, it was found that there is widespread awareness about CCG among mothers. Most of the recipients (mothers) of a child cash grant from the palika visited reported using the cash received to meet basic household needs and for buying food and clothes for their children. Further, the evaluation conducted in Nepal to assess the impact of the CCG program20 has also revealed the improvement in food availability, health services-seeking behavior, and WASH outcomes. However, despite the awareness of the program among the mothers, coverage was relatively low among the marginalized community either due to delayed or no birth registration.

Impact of COVID-19 on nutritional services and food security:
The COVID-19 pandemic severely affected the livelihoods of vulnerable populations, particularly in remote areas where agriculture is the primary source of income. It was found that household food insecurity increased due to the COVID-19 pandemic since HH income was adversely affected due to the lockdown The finding is consistent with a survey carried out by WFP in April 2020 that reported that household incomes were negatively affected by the COVID-19 pandemic across all provinces, as illustrated in Figure 17. This may have led to the deepening of pre-existing vulnerabilities. This raises concerns about households' ability to access food, and their overall capacity to withstand further shocks and precarious conditions.

[20] Renzaho, A., Chen, W., Rijal, S., Dahal, P., Chikazaza, I. R., Dhakal, T., & Chitekwe, S. (2019). The impact of unconditional child cash grant on child malnutrition and its immediate and underlying causes in five districts of the Karnali Zone, Nepal–A trend analysis. Archives of Public Health, 77(1), 1-18.

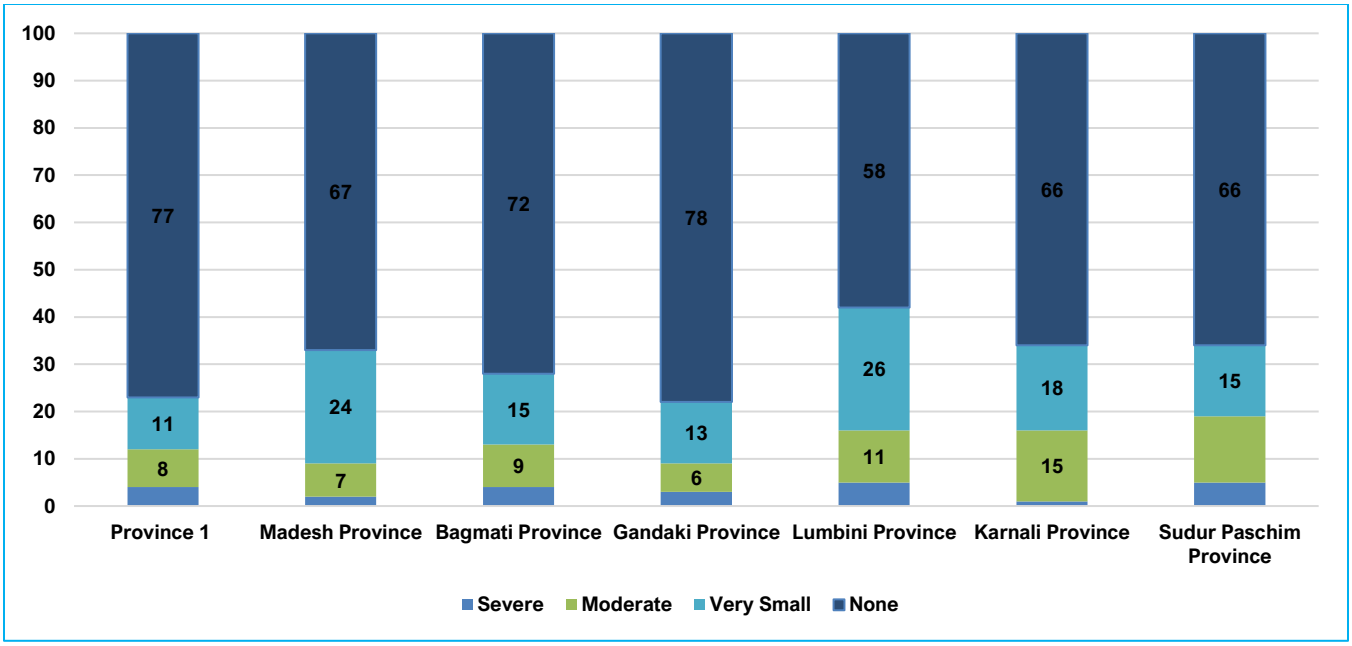


Figure 17 Households reporting a reduction in income due to COVID-19 (By Province) (Source: Fill the Nutrient Gap Nepal-Summary Report, 2021)

During the field visits, a few mothers whose children were admitted to NRH due to severe malnutrition said that the lockdown imposed by the government to combat the spread of COVID-19 caused a sharp decline in the income of the household as they and their partners could not go to work for a daily wage. This adversely affected the availability and affordability of nutritious food for their children. In addition, a few of the women during the NRH visit and group discussion reported interruptions in accessing the health facilities for nutrition services.

During COVID-19, the mid-day meal program, iron, and folic acid supplementation, and deworming tablet distribution program were disrupted, as a result, children were unable to receive mid-day meals and adolescent girls could not receive iron and deworming tablets. Many of the chiefs of health facilities reported interruptions in the supply of the IFA and deworming tablets at schools and presented challenges in the conduction of these programs due to school closures. This in turn could have adversely affected the nutritional status of children and adolescents. Furthermore, the closure of schools has the potential to affect the schooling of girls more significantly compared to boys as girls are more likely to be forced into early marriage and pushing them into the vicious cycle of intergenerational malnutrition.

4.6 Progress against outcome 3: Enabling policy environment, institutional framework, and nutrition governance

This section of the report includes the findings based on the assessment of the constitutional provisions, prevailing government policies, development plans, periodic plans, sectoral plans and policies, and their alignment with the MSNP-II. It also analyses the enabling policy environment for the implementation of the MSNP-II, including policy coherence and harmonization across the three tiers of government. Furthermore, it also outlines institutional arrangements, and nutritional governance mechanisms established to support the smooth functioning of MSNP.

MSNP interventions have been successful in creating the enabling environment for nutrition and have been able to achieve Output 3.1; Output 3.2 and Output 3.3. MSNP-II has been included in the policies and plans of the federal, provincial, and local governments (Details in Table 24). The institutional mechanism and nutrition governance structures are in place and are functional at all levels of government from the federal to the local level with the lead role taken by NPC (Details in Subsection II)

Progress towards Output 3.1: MSNP-II included in local, provincial, and federal government policies and plans

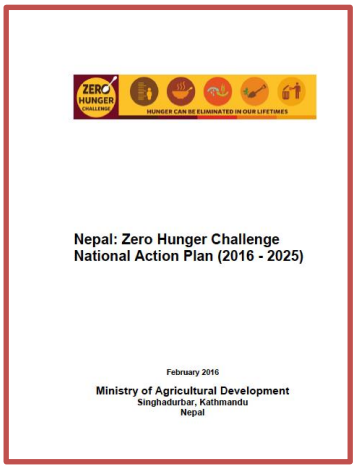
I. Alignment of MSNP with national, sectoral policies and mainstreaming of nutrition in policies and plans at the federal level

The Constitution of Nepal 2015 has given recognition to food security by guaranteeing food sovereignty as a basic human right and has explicitly recognized the right to food, and other food-related provisions in articles 36 and 42. In addition to this, to support the commitment to MSNP-II several national policies, and sectoral development plans have been formulated by the government including inter alia, the current Fifteen Plan (2019/20-2023/24), Nepal Health Policy (2019), Nepal Health Sector Strategy – Action Plan (2016-2021), National Nutrition Strategy 2077, The Right to Food and Food Sovereignty Act, 2075 (2018); Public Health Service Act, 2075 (2018) Public Health Service Regulations 2077 (2020). In line with MSNP, sectoral ministries and the local and provincial government has been proactive in formulating policies and strategies for nutrition and food security. The sectoral policies, strategies, and programs have been formulated putting greater emphasis on nutrition and food security and are considered key enablers for guiding the implementation of nutrition interventions (Refer to Annex 3- Table 24).

A few of the sectoral policies and plans are described briefly that are explicitly aligned with MSNP:
National Health Policy 2071 envisages fighting against malnutrition and improving nutrition through the effective promotion of quality nutritious foods generated locally.

National Nutrition Strategy 2077 envisions addressing all forms of malnutrition by implementing nutrition-specific and sensitive interventions through the health sector that provides strategic and programmatic directions for nutrition interventions in Nepal through the health sector.

Multi-Sector Action Plan for Prevention and Control of NCD (2021-2025) has included various interventions to promote the intake of healthy diets and reduce the risk of diet-related NCDs, promote the production of locally available foods, and formulate regulations related to Salt-Intake and Breast-milk substitute and identified indicators to monitor the progress and outcome achieved by the respective interventions.



Zero Hunger Challenge National Action Plan (2016 - 2025): The outcomes envisaged align with MSNP in this action plan. The plan has placed greater emphasis on universal access to nutritious food for expectant and lactating mothers and children under two. In particular, it gives priority to G1000- days, supported by sustainable nutrition-sensitive health care, water, sanitation, education, and specific nutrition interventions that enable the empowerment of women, as encouraged within MSNP-II. It also aims to eliminate wasting and being underweight among children below five years of age. Further, this plan has also prioritized the actions to overcome chronic energy deficiency (CED) among women of reproductive age (WRA) with emphasis on the intake of micronutrients.

Agriculture Development Strategy (2015-2035) The ADS is aligned with MSNP and remains coherent with the SDG target for nutrition and food security that seeks to "end hunger, achieve food security and improve nutrition and promote sustainable agriculture."

National Climate Change Policy 2076 (2019): National Climate Change 2076 (2019) policy envisages the adoption of a climate-friendly agriculture system to improve food security, nutrition, and livelihoods thereby supporting the vision and goal of MSNP-II. The strategy envisaged in the National Climate Change Policy 2076 to support the results of MSNP for instance is the development of crop-diversified kitchen gardens or home gardens at the household level in rural areas aiming to ensure nutrition security.

National Education Policy 2076 (2019): Under Policy 10.1. of the National Education Policy 2076 (Section 10.1.8) provides for the provision of establishing and operationalizing a Child Development and Care Center within or outside the school premises with the investment from the guardian for the care, nutrition, and health development of children under five. As per the policy (Section 10.3.3), children enrolled in early childhood development classes will be provided with hygiene, care, meals and other facilities and support required.
School sector Development Plan (2016/17-2022/23) is aligned with MSNP-II, as it has envisioned increasing knowledge on food, nutrition, and health in students and communities and has focused on instituting and scaling up school health and nutrition programs (midday meals) in areas of poverty and food insecurity as well as included activities to ensure gender-segregated and disabled-friendly WASH facilities in the school.

GoN is promoting a "one tap, one toilet for every household" policy and has been promoting hand-washing facilities in public spaces including in health service points and schools, and is mainstreamed with MSNP-II. The Nepal Water Supply, Sanitation and Hygiene Sectoral Development Plan (2016-2030) has recognized MSNP and has explicitly mentioned implementing sectoral actions to contribute to achieving MSNP objectives through the provision of safe WASH facilities acknowledging safe drinking water as one of the vital components of nutrition.

Guidelines for Local Level Program Planning 2078 (2021): Constitutional provisions generally require the federal government to share responsibility for planning in varying measures with its political subdivisions. Under the federal governance mechanism, local governments have delegated tasks related to people's welfare such as health care, education, housing environmental protection among others. The "Guidelines for Local Level Program Planning 2078" developed by the National Planning Commission guides preparing development plans for the provincial and local level planning entities. This guideline ensures that decentralized development plans including MSNP are well linked to the overall National development strategic direction as well as to the sector development goals and also ensure intra-agency and inter-agency synergies and linkages in the local government planning process.

Provincial and Local-level plans and policies in line with MSNP-II
The subnational policies (provincial and local levels) have recognized the pivotal importance of maternal and child nutrition. The local and provincial governments have forwarded their policies and commitments aligning with MSNP which is reflected in the annual work plan and budget of the local government. A few of them are explained below:

Health Policy 2076 of Karnali Province has envisaged a scale-up of the access and use of locally produced nutritious food to improve the nutritional status of the people of the province. The policy has recognized MSNP and provisioned to scale up the nutrition program

effectively across the province. The provisions related to strengthening the integrated management of SAM, management of NRH, production of locally available indigenous food, and mid-day meal program including the school WASH program have been made in the policy. Similarly, the Gandaki Province Council of Ministers has approved the Right to Food and Food Sovereignty Act (RTF) 2018 Procedural Guideline[21]. Likewise, the First Five Year Plan (2076/077-2080/081) of Karnali Province has included nutrition services and the total cost estimated for the program is NPR million 150,000.

The Policy, plan, and Budget of Dipayal Municipality of 2021/222 have aligned MSNP-II and provisioned the following strategies:

- **The policy proposes to allocate the necessary budget and plans for health and nutrition programs targeting G1000 days women and continue the interventions/ activities to declare nutrition-friendly ward**
- **The policy envisages declaring the palika as malnutrition-free and nutrition-friendly in the next five years by giving due priority to the implementation of MSNP.**

The Jorayal Rural Municipality of Doti district has included MSNP in its annual work plan and budget and allocated a budget from internal resources for its implementation.

- **A total budget of NPR 700,000 is allocated for MSNP. The program to reduce malnutrition and increase awareness of nutritious food intake including the Vice-chairperson souvenir program *(upaadhyax koseli karyakram)* targeted at G1000 women is continued.**

Likewise, Chandannath Municipality of Jumla district has acknowledged the MSNP and mainstreamed MSNP interventions in the annual policies and budget for the fiscal year 2077/2078 (2020/2021). Similarly, the annual policies and budget for the fiscal year 2075/2076 of Durgabhagwati Rural Municipality of Rautahat district have recognized MSNP and are envisioned to promote the MSNP.

To conclude, nutrition in particular MSNP is mainstreamed in sectoral policies, plans, and provincial and local levels plans (those visited during MTR). The mainstreaming of MSNP into local government's annual and periodic plan has allowed for the effective leveraging of resources and block-grant received from the federal government to scale up MSNP intervention at palika level. Several key policies emphasize the GoN's commitment to addressing all forms of malnutrition and providing an enabling environment for the implementation of MSNP interventions. Many respondents (government and non-government stakeholders) perceived these policies and plans positively. Consistent advocacy and follow-up with local leaders and officials of the palika by MSNP coordinators and MSNP volunteers has hugely contributed to mainstreaming MSNP in local levels' policies and plans. However, the depth of the importance given to MSNP varied across the palika. In the palika visits, the level of awareness and the engagement of the Mayor/Chairperson and or bureaucratic leadership such as CAO, HC, or the focal person of the MSNP at the local level was fundamental in the process of mainstreaming the policies and leveraging of resources for MSNP.

Despite the ongoing process of mainstreaming the MSNP in provincial and local level plans, challenges remain. Many respondents from the federal level pointed out that those policies and plans are not supported by adequate financial resources and implementation mechanisms at sub-national levels. Resource constraints and capacity gaps especially at the local level impair low budget allocation and budget execution for MSNP. Further, harmonization and integration of sectoral policies were highlighted as challenging tasks. MTR findings revealed that cross-sectoral integration and convergence are not adequately achieved at the implementation level. Some of the key informants from sectoral ministries and DPs echoed each other's thoughts that policies and plans are good and strong policies are in place, however, their implementation is weak.

Progress toward Output 3.2 and Output 3.3

- **Output 3.2: MSNP governance mechanism instituted and strengthened at federal, provincial, and local levels) and**
- **Output 3.3 (MSNP institutional mechanisms established and functional at the federal government level)**

II. Institutional Framework, Nutrition Governance, and management:

The MSNP intervention has been successful in establishing a formal government-led multi-sector and multi-stakeholder nutritional governance structure at all levels of the government from the federal to local level up to the ward level. At the apex level, High-Level Nutrition and Food Security Steering Committee are established and functional under the chairmanship of Hon. Vice-Chairman of the National Planning Commission (NPC) to provide high-level guidance and endorse policies and programs related to nutrition and food security. Likewise, at the federal level, the National Nutrition and Food Security Coordination Committee (NNFSCC) is established for national-level coordination for the implementation of MSNP-II and is chaired by Hon. Member, Health and Nutrition Sector, of NPC. National Nutrition and Food Security Secretariat (NNFSS) under NPC exist at the national level for supporting the high-level steering and coordination committee, particularly in strengthening advocacy efforts, coordination, and communication across the sectoral ministries and at all levels of government.

At subnational levels, seven Provincial Level Nutrition and Food Security Steering Committees (PLNFSSC), 720 Local Level Nutrition and Food Security Steering Committees, and 4494 Ward-Level Nutrition and Food Security Steering Committees are established. Besides, there are 77 District Coordination Committees (DCC) to coordinate and monitor MSNP intervention at the local level where it is implemented.

During the field assessment, it was noted that multi-sectoral engagement has not been adequately achieved despite the establishment of nutrition governance structures and mechanisms indicating that establishing nutrition governance structures at all levels of government is crucial for multisectoral interventions but not sufficient to initiate adequate intersectoral actions. To attain the meaningful engagement of multi-layer multistakeholder engagement there should be shared priorities, funding, targets, and mutual accountability across the sectors and at levels of government. Most of the members of the provincial-level nutrition and food security steering and district coordination committee members showed their concerns over the poor coordination with the province during the planning, implementation, and monitoring of the activities related to nutrition and food security.

---

[21] **WFP Nepal Country Brief 2022 (https://docs.wfp.org/api/documents/WFP 0000137787/download/?_ga=2.113548227.599535800.1649668557-1055501472.1562658913)**

Article 232 (1) of the Constitution of Nepal states that the relations between the federal, provincial, and local levels shall be based on the principles of cooperation, co-existence, and coordination. However, during the field mission, it was noted that the allocation of functions and the formal mechanism to facilitate coordination and communication across the federal, provincial, and local governments and government entities has not been stated explicitly. This inadequacy in clarity of roles and functions across the tiers and entities of government has created a vacuum in decision- making which in turn has resulted in confusion, miscommunication, and mistrust.

"Local government is ill-informed of works from the province, for instance, WASH projects at school, infrastructure work or any other IG support provided to a specific group at the particular ward from the provincial governments as no consultations are done with Mayor/Chairperson of the palika while selecting those interventions at specific sites and targets (schools, wards, groups). The decision is made solely by the provincial government without or in some cases minimal consultation with the local government. Much of this work and support from the provincial government are granted based on political affiliation. It's only during the financial clearance that local government gets informed about the work being done by the provincial government" **- (Participant from LLNFSSC at Hilihang Rural Municipality, Panchthar and Madhavnarayan Municipality, Rautahat).**

To the worse, one of the Chairperson from Guthichaur Municipality even shared that, ***"though my son is in provincial government however I am barely informed or aware of work being done in my palika from provincial government's end."***

One of the member during interaction with LLNFSSC at Chandanath Municipality said that, " ……..*the major issue under the federated governance system is that we (local government and provincial government together with district structure) are not able to accept each other existence and a result there is minimal coordination and consultation while developing annual plans and budgets with District Coordination Committee and Provincial Government…. Neither we (LG) nor they (District and PGs) feel accountable to each other for any intended*

The issues surrounding the hierarchy, power struggles at different levels and among different actors, and the communication and coordination between the three tiers of government regarding the functional division of power and authorities were identified with the federal transformation. For instance, local governments have seen provincial governments as a threat to exercise the given constitutional powers[22]. In some cases, tensions between elected leaders at local governments and their party command regarding the mobilization of local governments' resources have also been observed. This has adversely affected the functioning of different nutrition governance structures and mechanisms including the monitoring of MSNP interventions at local levels from the District Coordination Committee (DCC) and Provincial Governments (PGs).

Institutional and Human Resource Capacity:

The autonomous local levels' responsibilities are challenged by insufficient supervision, expertise, and inadequate resources. Field visits and interviews revealed that virtually all the local government-visited nutrition-capacity domains (perception of the nutrition situation of the municipality, information systems, etc.) require considerable strengthening. It was witnessed that local government has limited technical and managerial capacity to comply with the increased roles and responsibilities and perform the operational responsibilities and this has been engendering the bottlenecks in the effective implementation of MSNP interventions. The newly created staff position in local government under the social development section particularly health and education have often been insufficient to perform tasks specifically technical functions assigned to them. Besides the capacity issues of existing human resources, there are human resource constraints at local levels, with many lacking enough key staff from key sectors such as agriculture, education, and WASH. For instance, in the absence of the dedicated staff, the existing officials are provided with additional responsibilities (for instance Health Coordinator is assigned to oversee either the WASH sector or the Education sector if the post of WASH Officer or Education Officer is vacant, CAO also pursues the function of agriculture sector) which amplify the workload and reduced the efficiency of existing key officials at the palika. The findings from the field regarding human resource constraints are further validated by the study conducted by Pokhrel et. al (2009) that reported the lack of trained public health nutritionists and academic centers providing formal nutrition training in Nepal.[23] Regarding human resource management, another key concern that was reported by all the Women and Children Officers (WCOs) at palika regarding their limited role and least mobilization and involvement in MSNP and other programs under the federated context. One of the WCOs from Guthichaur Municipality said, ***'…. issues of maternal and child nutrition revolve primarily around women and children, but we (WCOs) are least consulted in the planning and implementation process of MSNP at local levels.'*** **Further, she reiterated the concerns of all the WCOs visited during the review that the women and children section at palika is the most neglected unit and allocated a minimal budget for the implementation of the interventions.**

Management issues:

It was witnessed that frequent transfer of the staff from the federal to the local level affected the timeliness and overall implementation of the activities. Frequent changes in institutions and transfers of officials particularly the focal persons at the federal level and chief administrative officers and health coordinators at the local level hampered the implementation of the MSNP intervention. This is because of low institutional memory as at government institutions there are limited practices of documenting and sharing the functions during handover to help the predecessors better understand the background, progress, and constraints involved with the job. With the frequent change in the focal person, members of nutrition and food security at steering at all levels, MSNP coordinators and MSNP volunteers must start the orientation and advocacy from scratch to make these focal persons understand the gravity of the issues that in turn delay the planning and budgeting at the local level.

---

[22] **Bhattarai, P. (2019). The new federal structure in Nepal: Challenges and opportunities for quality governance. EDP Network. Kathmandu Nepal: Centre for Social Change.**

23 Pokharel, R. K., Houston, R., Harvey, P., Bishwakarma, R., Adhikari, J., & Pant, K. (2009). Nepal nutrition assessment and gap analysis final report. Kathmandu: Child Health Division, Ministry of Health and Population, Federal Democratic Republic of Nepal.

Co-ordination, Complementarity, and cross-linkages between sectoral ministries and the relevant Development Partners (DPs):
The majority of key informants from sectoral ministries and developmental partners acknowledged that there exists a certain level of coordination between six different sectoral ministries involved in MSNP-II implementation. However, they pointed out that the coordination is limited to a formal meeting conducted occasionally at the federal level. The extent of coordination is not to extent that could lead to joint planning and resource allocation and mobilization and shared accountability to achieve the desired common goals of better nutritional outcomes. Most of the key informants, particularly from developmental partners, appreciated the proactive and stewardship role MoFAGA and MoHP have taken to guide the implementation of nutrition-sensitive and specific interventions respectively, however, they also flagged their concerns about the inadequate coordination among these ministries as well. During the review, it was found the nutritional governance structure exists, and principally there are cross-linkages between these structures and the sectoral ministries but in the real sense, these governance structures and sectoral ministries are not sufficiently cross-linked to promote shared accountability.

As envisioned in MSNP, the integrated perspectives, comprehensive approach, and integrated actions such as kitchen gardening, maternal health services, and social protection schemes are not reflected at the HH level. This is partly due to inadequate technical expertise to develop an integrated action plan and adopt a multi-sectoral approach at the local level. However, inadequacy in the multi-sectoral approach is not only due to limited resources or lack of knowledge about its significance but is predominantly due to the 'silos mentality' of the sectors and developmental partners. This is consistent with the findings of the study conducted by Kennedy et al. 2016 that indicated a lack of effective coordination across the sectors and between the government officials at the provincial and local levels as a key concern for the effective implementation of MSNP. The dominating nature of the sectoral (silos) working mentality acts as a key challenge for the implementation and coordination of MSNP. For instance, the health sector is involved in implementing different nutrition-specific interventions such as IYCF practices from their side while agriculture and education sectors implement nutrition-sensitive interventions in their priority areas in their way with limited coordination and consultation with cross-sectoral units causing a gap in multidisciplinary knowledge and resource gap. Neither the health sector is worried about the education sector nor the agriculture sector and vice versa. This general lack of functional coordination from the federal to the local level between different sectors, mentioned by the majority of the key informants and members of the nutrition and food security steering committee, has compromised the synergistic effect of the multi-sectoral intervention on the nutritional outcomes of children and women.

Alignment and complementarity of MSNP with sector ministries programs and development partners' projects:
Key informants from DPs reported some ongoing projects such as 'SUAAHARA' that have adopted multi-sectoral approaches to address malnutrition in Nepal are aligned partially with MSNP-II. Few members of LLNFSSC from the municipalities visited acknowledged 'SUAAHARA' as a multisector project for nutrition. Respondents of the KIIs from the EDPs mentioned that a few other USAID-funded projects are related to Nutrition and Food Security such as Feed the Future Nepal Knowledge-Based Integrated Sustainable Agriculture in Nepal (KISAN) II Project (2015-2019) implemented in 25 districts, Swachchhata (Health and Hygiene) project (2016-2021) led by SNV in 5 districts; Knowledge-based Integrated Sustainable Agriculture in Nepal (KISAN II) (2017-2022) implemented in 24 districts by Winrock International; Nepal Seed and Fertilizer Project (2016-2022) implemented by International Maize and Wheat Improvement Center (CIMMYT). However, the alignment of these projects with MSNP-II and whether they are contributing to achieving the nutrition-sensitive outcomes of the MSNP-II remains largely unclear. Resource mainstreaming and weak coordination with the local government was highlighted as key operational challenges of these project to ensure alignment and integration with MSNP to intensify the efforts. For instance, some respondents from LLNFSSC at Phidim Municipality showed their deep concerns over weak coordination of DPs working in nutrition with local government." It was learned that institutional and bureaucratic barriers, for instance, separate funding mechanisms, different working discourses, and different government institutions prevent partnerships and cooperation. Similarly, government-led projects, particularly by the Ministry of Agriculture and

5 CHAPTER FIVE: REVIEW, MONITORING AND EVALUATION

In this chapter, a summary of the existing monitoring and evaluation mechanism to monitor MSNP interventions at the implementation level coupled with the limitations and gaps in the existing monitoring mechanism based on the field experience is explained.

Sectoral ministries and departments perform their M&E functions to monitor performance and progress on MSNP interventions with information obtained from MISs. Some of these are the Ministry of Health and Population (with its HMIS), the Ministry of Federal Affairs and General Administration (with its Web-based reporting system and population and district poverty monitoring and analysis systems), the Ministry of Education, Science and Technology (with its EMIS) and the Ministry of Water Supply (with its N-WASH). Furthermore, annual reports are produced using the data from the routine management information system. Moreover, periodic reviews are done at the federal level by the MoFAGA of nutrition-sensitive interventions and by the MoHP of nutrition-specific interventions. Besides, the nutrition and food security steering committee at all levels of government reviews the progress during the meetings. However, in the review meetings, achievement against the target set for the particular period for individual sectors is least discussed, instead, meetings are more focused on the activities completed in a particular duration. Moreover, it was noted that the verification of data from the routine information system to ensure its accuracy and completeness is barely done.

Reporting and documentation
Though local governments are responsible for reporting on the physical and financial progress of MSNP-II on a quarterly and annual basis to district coordination committees, provincial level, and federal level sectoral ministries and the sectoral are required to

prepare the integrated reports to document the implementation status of MSNP-II and submit to NPC in the prescribed format[24], in the real world, this not happening adequately and promptly. MSNP volunteers at the local level and the Provincial MSNP Coordinators in the province document, record, and report the progress on nutrition-sensitive MSNP-II interventions to MoFAGA. While reports of nutrition-specific interventions are submitted to MoHP through their own regular HMIS recording and reporting system. Besides, this information and reports are not shared and submitted to sectoral ministries – a concern that was strongly placed by the focal person of the sectoral ministries particularly MoWCSC, MoALD, and MoWS.

Issues and challenges from the field visits and interviews with KIs at the federal level:

Monitoring: During the field assessment, it was observed that members of PLNFSSC and LLNFSSC including DCC were involved in the monitoring of MSNP interventions. Most of the *palikas* such as Durgabhagwati RM and Jorayal Municipality showed their concerns and dissatisfaction over the limited monitoring visits from provincial and federal government officials of the relevant sectors. Moreover, it was observed that even the local government is least involved in the monitoring of interventions and its result. For instance, while interviewing with the Chief of the HFs, the majority of them reported receiving limited facilitative and supportive supervision visits from local government authorities. In addition, interactions with members of the nutrition and food security steering committee in the province and consultation with key informants raised the concerns of accountability of local government toward monitoring and review of the MSNP interventions. On top, the field experience showed that even the limited program monitoring in most cases was done without proper costed M&E plans or monitoring tools and was limited to completing the ritual process and barely submitting a few pages of report of monitoring visits. Besides, minimal monitoring visits, documentation of the M&E visits were found to be weak. Moreover, most of the respondents reported that the feedback mechanisms are inadequate at the local level through which progress can be compared against the agreed targets to provide positive feedback and follow up on the corrective actions recommended during the monitoring visits. In line with the existing mechanism, all the LGs visited report to the provincial and federal governments. However, these LGs rarely receive feedback about their performance, and the report submitted. The MTR review findings corroborate the findings from the MSNP evaluation, which reported that the functionality of the existing monitoring and reporting mechanism of MSNP is weak.

M&E Function of District Coordination Committee (DCC): In line with roles and functions envisaged in Article 220 Sub Article (7) of the Constitution of Nepal, DCC has been assigned duties to conduct monitoring of MSNP interventions at local levels and coordinate within provinces. The majority of the DCC members from all the four districts visited stated that they are least involved and coordinated during the planning and implementation of MSNP interventions at local levels. However, DCC has not been able to begin the monitoring in any meaningful sense as they are least knowledgeable about how to conduct effective monitoring and or do it with some sense of authority. On top, they do not have enough resources, particularly financial resources, to perform their M&E and coordination functions.

It is quite challenging for DCCs to work without clear procedures, directives, and standards that could enable them to work with *palikas* within the districts. The absence of clear guidelines to coordinate and monitor the works at the local level has caused disillusionment not only on the part of the DCC but even LG has no clear clue on how to work with DCCs under the existing constitutional regime. Thus, given the nature of their work and under the current context of constitutional disillusionment and power dynamics between LG and DCC, a legal regime needs to be created, developed, and consolidated and DCC needs to be empowered with clear-cut jurisdictions to perform M&E functions if GoN aspires to make good use of this structure. This finding is further authenticated by the findings from the MSNP evaluation that found that there is a lack of clarity on who should monitor and of adequate capacity and personnel to perform these functions.

Lack of integrated information management system to track progress on MSNP indicators: There is a common results framework developed for MSNP-II, however, during the interviews and field mission it was noted the MSNP Result framework is barely referred to by the sectors to measure the progress against the results and keep track of the results. Sectoral ministries have their information system, to perform situation analysis and monitor the implementation of their sectoral programs. As a result, information is dispersed around different sectoral ministries and departments making it difficult to monitor the progress and track the progress of different performance indicators of each sector. For instance, MoHP has its information system (Health Management Information System – HMIS) with limited access that provides information on nutrition-specific interventions and MoFAGA has a Web-Based Reporting System (WBRS) that provides information on nutrition-sensitive interventions under EU support. Similarly, MoEST has EMIS that provides information on Mid-day meals and enrollment rates, MoALD has its information system that collects information on crop production and productivity while Child Cash Grant Information is required to be collected from the Ministry of Home Affairs/ MoWCSC. To collect data and track progress from multiple information systems and periodic reports from different sectoral ministries and agencies is exhausting and a considerable amount of time is required to collect, analyze, and interpret data using disparate MIS systems and platforms. Alignment of information about MSNP is yet to be achieved. Besides, insufficient institutional structure or resources have further constrained the monitoring of the MSNP interventions, which was highlighted by most of the DCC members from all the four districts visited. Moreover, development partners and I/NGOs have their own data management systems which are not linked or integrated with the existing information system of sectoral ministries making it difficult for the government to track the progress made by projects supported by DPs. In addition, there is either no reporting or ad-hoc reporting of the progress from the DPs and I/NGOs to the sectoral ministries.

Equity components in the information management system: The existing routine monitoring, and reporting do not strongly include disaggregation for assessing inequalities. The equity analysis is extremely limited to provincial-level disaggregation and there is no disaggregation based on child-level characteristics in HMIS and WBRS. The analysis of inequalities based on gender, economic status, place of residence, and ethnicity, is quite limited. In addition, there is a lack of an effective nutrition monitoring and surveillance system for the early detection and management of nutritional-related issues. The feedback system is nearly missing in the current context.

---

[24] Multi-sector Nutrition Plan-II (2018-2022)

Limited use of data for review and planning: **The MTR findings indicate that the HFs and *palika*s visited are least likely to use HMIS and WBRS information data or refer to an annual report published by the sectoral ministries for their planning and budgeting. This was also evident in the comments shared during the interviews and interactions with PLNFSSC and key informants from the federal level. This is because the system is suffering from a shortage of skilled technical human resources resulting in deficiencies in data analysis, interpretation, and decision-making. The review of indicators, monitoring of progress and performance, and use of data for planning and projection of nutritional targets are least likely done even at the federal level besides the local level. Even though HF staff and MSNP Volunteers had received e-reporting training, still they are unable to put this learning into practice either due to insufficient skills to perform the duty or due to poor internet services at HF and *palikas*.**

6 CHAPTER SIX: FINANCIAL ANALYSIS

The review was conducted to understand the leveraging of resources for MSNP (from domestic public funding and support from development partners) including the trend for budget allocation and expenditure for four years from Fiscal Year (FY) 2018/19 to FY 2021/22. The review referred to the data shared by MoFAGA and MoHP and reviewed the Web-based Reporting System (WBRS) and MSNP-II document for financial analysis.

The total estimated budget for MSNP-II (2018-2022) is NPR million 48,901 and the government was expected to progressively increase the budget share from 47 percent in 2018 to 69 percent in 2022. Contrary to the expectation to gradually increase the budget share from the government end, until this current fiscal year FY 2021/2022, only thirty-one percent of the budget for MSNP is funded through government sources. MSNP II has spelled out the contribution of 60% from the government and 40% from development partners. However, the assurance of government and development partners is yet to be materialized.

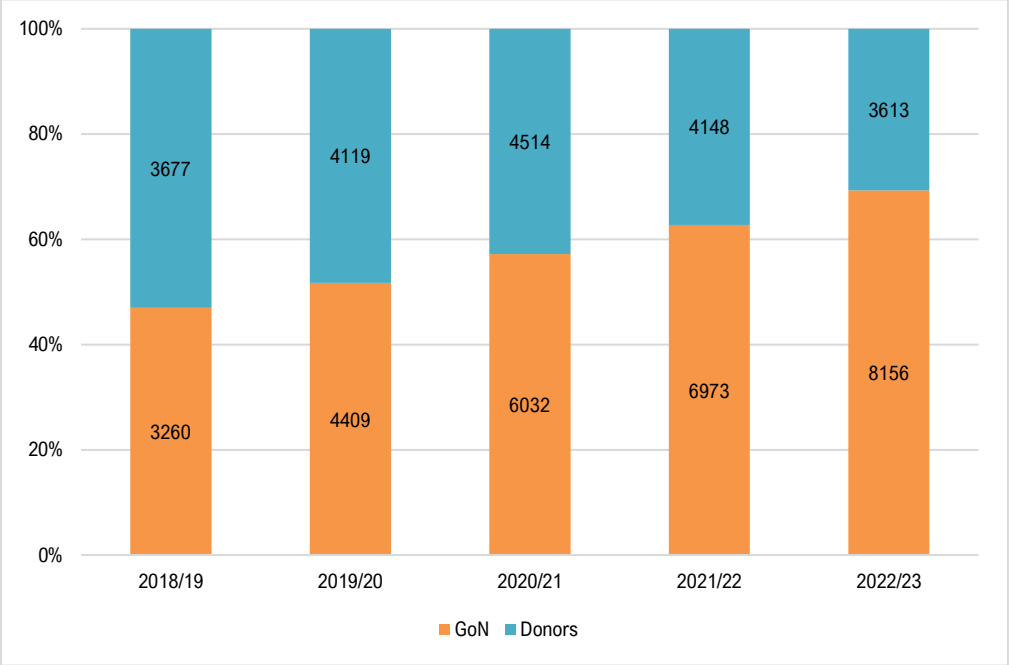


Figure 18 Financing of MSNP between GoN and Donors between (2018/2019 to 2022/2023) [Source: MSNP-II (2018-2022)]

5.1 Overview of budget allocations and expenditures:

Nepal's consolidated (all tiers of government- Federal, Provincial and local) budget expenditures (of conditional grants) for nutrition-sensitive interventions have risen between 2018 (2075/76) and 2021 2078/79) from the Nepalese Rupee (NPR) million 413,504 in FY 2018/19 to an NPR 1.5 billion in FY 2021/22. Over the same period, the value of nutrition-specific expenditures (federal level) rose by 565 percent – NPR million 30,580 to NPR million 203,466–from 2018/19 to 2020/21 (Source: Nutrition Section, DoHS). ***Note: the budget allocated for nutrition-sensitive interventions doesn't fully reflect the government's allocations for nutrition and food security as the analysis is based on the data available from MoFAGA for EU budget-supported activities allocated to provincial and local governments as a conditional grant.***

The total actual consolidated budget allocated for nutrition-specific interventions has increased nearly 8-fold in the past 3.10 years from NPR million 203,900 in 2018/19 to NPR 1.6 billion in 2021/2022. During the same period, the consolidated budget allocated for nutrition-sensitive interventions quadrupled -from NPR million 413,504 in 2018/2019 to NPR 1.5 billion in 2021/2022 (Refer to Annex-1; Table 26). Despite the substantial increment in the budget, there still exists a huge difference (NPR million 432,273) between the actual and the estimated figure (Table 11).

Table 11:% of resource allocation by sector Till FY 2021/2022 (2078/2079) (Source: Web-based Reporting System, MoFAGA)

Source	Budget Allocated (in thousands)	
GoN	17,627	
Developmental Partners	39,100	
Total	56,727	
Estimated Cost for MSNP-II	Budget Allocated	Budget Difference
489,000	56,727**	432,273

*** The budget amount doesn't contain the amount allocated by sectoral ministries and direct budget support of other DPs.***

The Government has initiated the implementation of federalism through administrative restructuring and fiscal budgeting. The devolution of large responsibilities to local government has been translated into the higher transfer to them with the change in the federal structure for implementing the MSNP interventions. In the current fiscal year FY 2021/2022, of the total budget of NPR 1.5 billion allocated for MSNP as a conditional grant, more than ninety percent (94%) was disbursed to local levels (demonstrated in Figure 19).

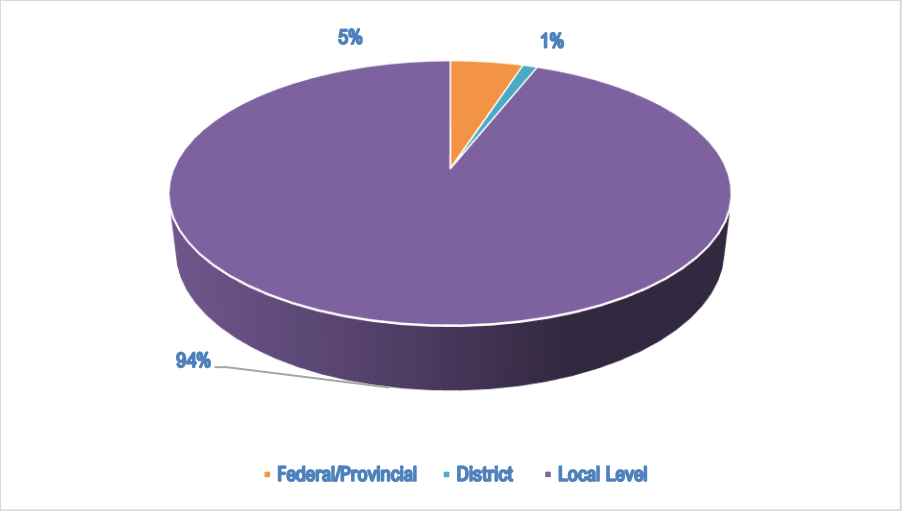


Figure 19: Disbursement of budget for MSNP by governance unit

The local government was found to complement the earmarked funding received from the federal government with their resources from revenue sharing mechanisms, equalization, special grants, or their local resources. The data on the local governments' allocations and expenditures suggests the overall priority of MSNP at local levels. Local governments have allocated their resources for MSNP – outside grants from the federal government and EU grants – represented 32% (2018/2019) and 13% (2021/2022) of the total actual budget allocated for MSNP. Most of the participants mentioned concerted advocacy efforts of the MSNP Coordinators and Volunteers as well as sensitization of the political leaders and policymakers on the significance of "Nutrition and Food Security" at the local and provincial level as a reason for an increased financial contribution from the "palika" in these years.

There has been a steady increment in the budget allocation and expenditure from the local government for MSNP intervention. The budget allocation has risen to NPR 866,541,000 in 2021/2022 from NPR 161,900,000 in 2018/2019 – a huge increment of 435 percent for nutrition-specific interventions. However, during this period between 2018 to 2021, a fluctuation in budget allocations was observed at the local level for MSNP (particularly nutrition sensitive) (illustrated in Fig 20). Moreover, between 2018 to 2021, MSNP and nutrition components have been explicitly addressed in the budget speech every year- demonstrating the government's commitment to achieving better nutrition outcomes for human capital development.

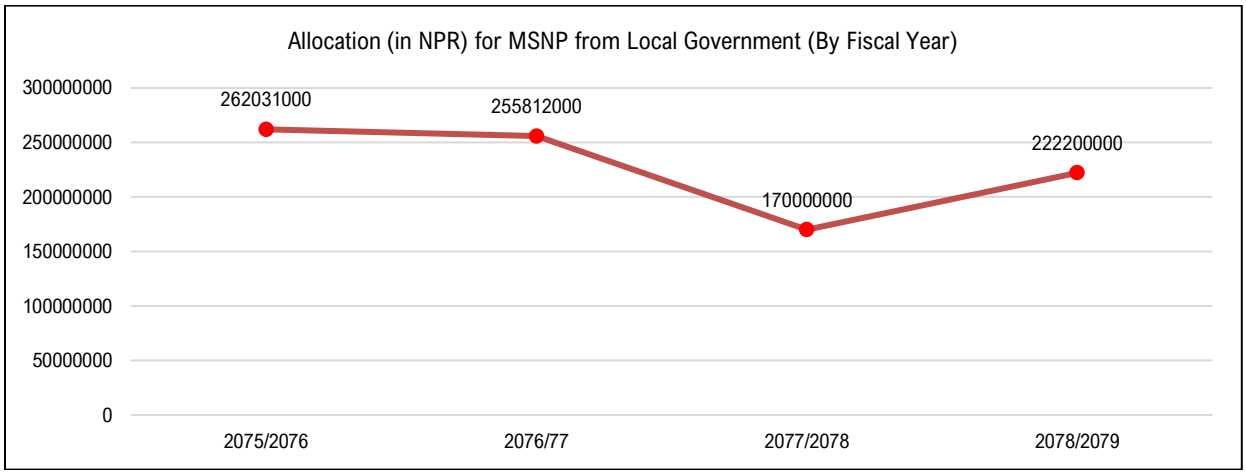


Figure 20: Budget Allocation for MSNP from Local Government (By Fiscal Year)

Special grants for MSNP:

The Federal Government has a provision to transfer financial resources to the provincial and local government in four forms Equalization, Conditional, Counterpart, and Special Grants (Article 60 of the Constitution) to carry out different economic and social activities. Of these four different forms of fiscal transfer, GoN through NPC provides special grants to subnational governments on an equitable basis for programs and activities aligned with MSNP. Table 12 below illustrates the special grants provided to local government and provincial government for the fiscal year 2076/77 (2019/2020) and 2078/79 (2021/2022). There has been a substantial increase in the amount allocated to the local government for MSNP in the form of special grants from NPR. 23 million in FY 2076/77 (2019/2020) to NPR. 347 million in FY 2078/79 (2021/2022).

Table 12: Special Grants allocated to state government

Province/Fiscal Year	Total Budget Allocation to Local government for MSNP-related activities			Total Budget Allocation to Provincial Government for MSNP-related activities	
	FY 2076/77 (2019/2020) (NPR 100,000)	FY 2077/78 (2020/2021) (NPR 100,000)	FY 2078/79 (2021/2022) (NPR 100,000)	FY 2077/78 (2020/2021) (NPR 100,000)	FY 2078/79 (2021/2022) (NPR 100,000)
Province 1			292		415
Madhesh Province	50	620	2217	2000	
Bagmati Province	50		42		
Gandaki Province		25	416	4000	332
Lumbini Province	50	160	108		
Karnali Province		680	126		
Sudurpaschim Province	85	410	275		
Total	235	1895	3476	6000	747

Source: National Planning Commission (https://npc.gov.np/np/category/other_major_reports?page=3)

Allocative Efficiency:

The subnational analysis demonstrated that the current allocation of funding across seven different provinces is equitable in relation to nutrition investments as the volumes of financing to provinces in the fiscal year 2076/2077 is proportionate to the burden of malnutrition (Refer to Table No 13). For instance, per child allocation is higher in the Karnali province (i.e., NPR 1308 - higher than the mean allocation per child-NPR 384) as it has a higher prevalence of stunting, while allocation per child is lower in Gandaki Province (i.e., NPR 266) as it has lowest stunting prevalence compared to other provinces. This is indicative of the equitable distribution of financial resources across the provinces. Further, it signals that the current nutrition investment is responding to the need and is important to maintain an equitable allocation in the future for substantial improvement in nutritional status.

Table 13: Allocation per child (By Province)

	FY 2076/77 (2019/20)						
Province/FY	Budget Allocated (in NPR)	Under 5 children	Stunting	Total No. of Stunted Child	Allocation (NPR)	Median Difference	Mean Difference
Province 1	47748000	496934	25%	124234	384	0	-184
Madhesh	238440000	629490	34%	214027	1114	730	545
Bagmati		647368	23%	148895	0		
Gandaki	15430000	252307	23%	58031	266	-118	-303
Lumbini	61123000	511668	36%	184200	332	-53	-237
Karnali	114392000	182248	48%	87479	1308	923	739
Sudurpaschim	91623000	293876	41%	120489	760	376	192
Median Allocation (NPR)					384		
Mean Allocation (NPR)					569		

Issues and challenges indicated from field visits and interactions with the nutrition and food security steering committee

- During the interactions with members of LLNFSSC, it was indicated that there were issues of underspending conditional grants for MSNP within the stipulated time mainly because of delays in fund flow from the federal government and ambiguity in the program implementation guidelines. Moreover, it was learned that a few "palikas" delayed their assemblies and, as a result, the conditional grant could not be transferred promptly to the respective "palikas" which affected the burn rate of the budget.
- It was extremely arduous to collect and track the budget allocations and expenditures from the federal, provincial, and local levels. It was mainly because of the absence of a nutrition budget code and budget headings for nutrition programs in the sectoral ministries' annual plans and budgets.
- It was found that a multitude of disparate "mini" financial management information systems and accounting platforms of different sectoral ministries such as Line Ministry Budget Information System (LMBIS) and Transaction Accounting and Budget Control System (TABUCS) used by the federal government; PLMBIS used by the provincial government and Sub-national Treasury Regulatory Application (SuTRA) used by local government exists with either complete absence or limited linkages between these various systems. This lack of an integrated modern financial management system further limited to track of detailed information on budgeting and expenditure.
- Since most of the expenditures at local levels are controlled through central releases of grants (particularly conditional), it is not clear if there is full autonomy at the local levels in designing, implementing, and monitoring programs that are driven by local government context-specific evidence and risk-informed decisions.
- It has been envisioned that MSNP-II grants will be allocated to local governments based on fixed criteria including the percentage of children with malnutrition, causes of malnutrition, the status of nutrition and food security, geographical remoteness, and availability of local resources. However, as per the current practices, the budget allocation to the local government is done based on the Human Development Index (HDI), geographical area, and population density of the respective districts and local levels
- MSNP has envisioned those donors and international agency who wish to channel their support through development partners (DPs) should first get an endorsement from the HLNFSSC. In addition, donors are required to submit proposals to the NPC stating total amounts, budget code, and mode (lump sum or installments), however, this has not been happening yet. DPs, for instance, USAID and International non-government organizations such as Hellen Keller International (HKI), Save the Children, ACF, FAO working in the nutrition and food security sectors are yet to channel their support as per the provision detailed in MSNP.

7 CHAPTER SEVEN: GENERAL ISSUES, CONSTRAINTS AND CHALLENGES

General Issues and constraints:

- **There is an inadequate human resource for nutrition programs which acts as a critical barrier to implementing existing nutrition interventions. A few challenges highlighted by key informants from the health sector, development partners and CSOs, and the respondents of the health facilities were:**
    - **The limited number of technical staff allocated to serve the nutrition functions at the nutrition section within the Department of Health Service (DoHS) at the federal level.**
    - **At the subnational level, there is no dedicated staff to oversee the implementation of nutrition-specific interventions**
- **The current MSNP intervention particularly nutrition-specific interventions have little or no focus on nutrition issues pertaining to adolescent girls.**
- **Current interventions primarily focus on the supplementation of micronutrients such as Vitamin A, Iodine, IFA, and MNPs *(Baalvita)* with little attention to food-based approaches including food diversity.**
- **The prioritization of interventions in any context should be based on a robust situational analysis supported by strong evidence. However, no such situation analysis is carried out at the local level to prioritize the interventions and plan context-specific interventions to address the nutritional needs of the municipality.**
- **During the field assessment and key informant interviews with developmental partners, concerns regarding the engagement and participation in the formulation process of MSNP were noted. The members of the provincial and local level nutrition and food security steering committee shared that they have not been sufficiently involved in the formulation process. In addition, DPs expressed their willingness for more meaningful engagement, participation, and collaboration with the government (particularly NPCs and sectoral ministries) in the formulation of MSNP-III compared to previous years.**
- **The focal person of the sectoral ministries is least aware of the MSNP and have a limited understanding of multisector approaches to nutrition among the focal person of the key sectors particularly WASH, education, women, children, and senior citizen. This in turn has affected their engagement in MSNP and accountability towards MSNP results. There is limited transdisciplinary knowledge among a focal person of the sector at the provincial and the local level. In addition, there are inadequate knowledge-sharing platforms that have been creating systematic barriers to the effective implementation of MSNP interventions in an integrated manner.**
- **Private sector engagement is provisioned in MSNP-II, however, meaning engagement in a way that the private sector in partnership with the government could bring tangible results in nutrition and food security is inadequate. There are no specific performance indicators included in MSNP to measure the contribution of the private sector in addressing malnutrition and food insecurity issues. *"The involvement of the private sector is limited to attending a few meetings at NPC and most often even the members representing the private sector attending those meetings are not in a decision-making role and hence have limited authority to make decisions on the behalf of the private sector and reinforce the decisions made in those meetings for the private sector."* -One of the KI from Private Sector. There are limited private sector engagement opportunities in the absence of incentives that attract these entities to invest in the nutrition and food security sectors. Without incentives in the form of tax exemptions and tax subsidies from the government, the private sector is least likely to be encouraged to invest in nutrition.**

8 CHAPTER EIGHT: CONCLUSIONS, LESSON AND RECOMMENDATION

8.1 Conclusions:

MTR revealed mixed progress in MSNP outcomes since its implementation in 2014. The indicators of child nutrition (stunting, wasting, and underweight) have improved significantly in intervention areas compared to non-intervention areas between 2014 and 2020 with the implementation of MSNP. The improved nutrition knowledge and outcome indicate that MSNP interventions are making a difference. At the output levels, coverage of most of the nutrition-specific and sensitive interventions has improved between the review period (January 2018 to October 2021). Notable progress has been achieved in terms of increasing the coverage of Vitamin A, Universal Salt Iodization, Child Cash Grants, IMAM program, CB-IMCI programs, and improvement in the utilization of maternal health services. Similarly, an increase in access to drinking water and improved sanitation facilities, in the enrollment rate in ECED/PPE has been noted. In addition, MTR demonstrated some promising progress through the implementation of MSNP in terms of creating an enabling environment for nutrition through the establishment of a nutrition governance structure and coordination mechanism at all three tiers of government. In terms of food security, improvement in GHI has been noted indicating the shift toward food security.

Establishment of nutrition governance structure and mechanism, mainstreaming of MSNP into subnational policies, plans, and budget, resource allocation for MSNP by local government and ownership of the program at the local level, strong leadership of NPC and sectoral ministries particularly MoFAGA and MoHP and bureaucratic leaders at the local level, political commitment following the continued technical support and advocacy from MSNP coordinators have been critical for the success of MSNP.

Despite the improvement across the nutrition indicators and increase in coverage of MSNP interventions, MSNP targets for reducing different forms of malnutrition have not been achieved. Further, Nepal is off-track to achieve the WHA 2025 and SDG 2030 targets. Though there is some progress in equity with the implementation of MSNP, still deep inequalities exist within the country as the rate of decline in malnutrition indicators is not uniform across the nation even though MSNP is guided by the principles of equity and inclusion. The data reviewed explicitly demonstrated the disparities in nutrition outcomes by age and sex of children, geographical location (the provinces, ecological region, urban and rural areas), economic status (wealth quintile), education level, and ethnicity of mothers. Moreover, the least attention has been given to adolescent nutrition in terms of programming and investment. Closely associated with issues of malnutrition is food insecurity. In Nepal, part of the country has witnessed a decline in food production and extreme weather conditions which is affecting food security. Further, it is evident that the COVID-19 pandemic is having serious consequences on food security and child nutrition, especially among women and children from marginalized and disadvantaged groups.

It is clear from the MTR that to meet commitments (national and global), efforts must be intensified and streamlined, and additional efforts are needed to maintain and accelerate improvements. The MTR findings underscore the need for targeted interventions to reach disadvantaged, marginalized, and vulnerable populations to achieve the MSNP and global targets. Based on the positive contribution of the MSNP to improving the maternal and child nutrition MSNP and as per the recommendations received from all the respondents including target beneficiaries from federal to local levels visited during the review, it has been learned that MSNP should be continued and the next phase of MSNP should be formulated. Rather than quantum transformation, targeted and tailored interventions, capacity development of local government for effective monitoring and data use for decision making and planning, increased ownership at local levels, and better resource mobilization followed by stronger coordination across the sectors and with DPs are required.

8.2 Lessons:

- **Success in implementing the MSNP rests, first and foremost, on achieving political commitment, proactive leadership at the local level, and mobilizing indispensable financial and trained human resources.**
- **Political readiness and awareness of political and bureaucratic leaders including the Chief Administrative Officer are key for the successful and effective implementation of MSNP and for mainstreaming MSNP policies and plans into the local level's annual plans and budget.**
- **Joint Monitoring involving the relevant sectors and DPs in coordination with NPC, along with the integrated management information systems of key sectors is an essential component of effective MSNP operationalization. A sustainable system for recording and verifying coverage is crucial for targeted intervention and approach.**
- **For integrated nutrition to be embedded into a multi-sectoral program successfully communication and coordination among officials working in different units at the local level are key.**
- **Strong political commitment, conducive policy environment, functional institutional arrangements, and rationale resource allocation when promoted together and working towards the same direction progress towards achieving the results expedite.**
- **Nutrition capacity development, especially at the local level and at peripheral service delivery institutions, is critical for the effective implementation of multisectoral approaches.**
- **Without incentives in the form of tax subsidies and tax exemptions, pulling the private sector for the production and distribution of quality nutritious food is tasking.**

8.3 Recommendations

Findings and Recommendations:

Findings	Recommendations
Health Sector	
• Wasting has changed a little over time between 2014 to 2019. • MTR findings revealed that the prevalence of both stunting and wasting was highest among children below 6 months of age. The highest rates of wasting at an early age indicate a poor start to life that arises from factors like low birth weight, poor nutritional status of the mother, adolescent pregnancy, poor hygiene practices, and exposure to infections. • Moreover, stunting prevalence increased substantially with growing age among children below five years of age.	• Adolescent maternal nutrition should be given priority as the interventions aimed at improving the nutritional status of children cannot bring the intended results unless the nutritional status of these groups of mothers is addressed. • Interventions to improve ANC and support mothers to improve their nutritional status before and during pregnancy, and guide and encourage mothers to exclusive breastfeeding should be effectively implemented. An adolescent pregnant mother should be given particular attention. In addition, effective implementation of interventions to prevent early child marriage and early childbearing should be ensured. • Adequate access to WASH and hygiene knowledge and practices should be ensured and measures to control and prevent episodes of diarrhea and worm infestation should be strengthened. • Greater emphasis should be placed on improving the knowledge and behavior of the mothers and caregivers including fathers and ensuring access to health services for the management of infections and acute malnutrition. To combat wasting, priority should be given to addressing the level of food insecurity, mostly focusing on household access, affordability, and utilization of food and targeting the mothers from the lowest wealth quintile, where the severity of food insecurity is high. Social protection approaches need to be scaled up and targeted to the most vulnerable.
• There exist wide disparities in nutritional outcomes based on the location of residence (urban/rural), gender, ethnicity, socio-economic status, and a host of other factors. • National surveys (NDHS 2016 and NMICS 2019) including the MSNP evaluation 2019 revealed that the prevalence of stunting and wasting was higher among the children from the poorest quintile household compared with those from the richest quintile demonstrating that children from poorer households are still missed. The rural-urban coverage gap has also not narrowed over time.	• Differential outcomes across the socio-economic background indicate that the equity of the program should be improved. Moreover, to improve equitable access (particularly among socially excluded women) a system-wide focus that integrates gender equality and social inclusion (GESI) into existing interventions is needed. • Specific nutritional support programs targeting particular geographic territories to intervene in the worsening situation of malnutrition among these groups should be developed. To this end, equally important is to examine and identify who is vulnerable to marginalization and exclusion so that interventions reach out to those who are in real need. Moreover, not just targeted interventions, but also the effective management of these interventions in the context of translating policies into practice should be aimed. • To overcome the specific challenges faced in attaining better nutrition outcomes in these areas and specific groups and communities' innovative approaches should be developed and tested and the small survey approach should be resurrected to measure the effectiveness of approaches adopted.

Findings	Recommendations
Health Sector	
Exclusive Breast Feeding	
• A decline in Exclusive Breastfeeding (EBF) practices has been observed between 2016 and 2019 requiring urgent action. Preference for bottle-feeding over EBF was noted particularly in women in urban areas (as these women are increasingly joining the formal workforce) and women in informal work such as agriculture in rural areas.	• Awareness creation about the risk of pre-lacteal feeding, bottle-feeding, and the benefits of EBF should be emphasized through the Social Behavior Change (SBC) approach considering prevailing social, cultural, and environmental circumstances, and other structural determinants of EBF practices. • Fathers and caregivers need to be engaged and supported to help them know about the recommended period of exclusive breastfeeding. Where fathers are concerned, research shows that breastfeeding is enhanced by the support and companionship they provide as family providers and caregivers. • An optimum enabling environment at the workplace for instance paid maternity leave, part-time work arrangements, facilities for expressing and storing breast milk, and breastfeeding breaks should be ensured. • Access to antenatal care services and institutional delivery should be increased. The counseling skills of the service providers should be enhanced through formal training, onsite mentoring, and supportive supervision. Strict follow-up on the use of skills learned should be done. • Legislation and regulations for the marketing of breastmilk substitutes such as • "Breast Milk Substitute Act and Regulation" should be reinforced effectively. • Besides, the Promotion of EBF, early initiation of breastfeeding, and extended breastfeeding should be duly promoted.
• Optimal breastfeeding and IYCF practices for children living with special needs have not been addressed	• Children in extraordinary circumstances, for example, orphans and children in foster care, children born to adolescent mothers, mothers suffering from physical or mental disabilities, or otherwise marginalized populations- extra attention should be provided.
Growth Monitoring and Promotion • Growth Monitoring and Promotion (GMP) has continued to be low in Nepal.	• During local-level review meetings, discussion on GMP data should be made and action plans should be developed, and actions taken should be reviewed and appraised in the subsequent meetings of LLNFSSC. • Service providers should raise awareness among the mothers about the significance of monitoring child growth and linking GMP with child development and should engage with fathers and caregivers during counseling. • GMP should be integrated with immunization, Vitamin A distribution, MNP distribution, and Super cereal distribution to improve the average number of visits to GMP.
Growth Monitoring and Promotion	
• Inconsistencies in the plotting of the GMP chart and recording of GMP were observed.	• Training and onsite coaching should be provided to health workers to enhance their knowledge and skills to accurately measure, plot, and interpret the GMP chart. Supportive supervision to deliver GMP should be emphasized and ensured by the municipality.
• On an annual basis, approximately 15 % of the children are missed by the Vitamin A supplementation program which represents the poorest of the poor families, mothers with no education, and residents of rural areas and selected ecological regions.	• Efforts to ensure universal and equitable coverage of the Vitamin A program should be made.
Management of SAM cases • Poor functioning of OTC centers due to HR and logistic constraints.	• Outpatient Treatment Centers (OTCs) should be strengthened both in terms of trained HR and logistic supplies.

	• All health facilities should provide treatment services for children who are acutely malnourished (wasted)

Findings	Recommendations
Health Sector	
Getting treatment from OTC and NRH for acute malnutrition is appropriate to prevent imminent death but is not sufficient as the treated child returns to food-insecure households from an impoverished community without other complementary interventions.	SAM treatment should be coupled with development support and social protection services (also recommended by one of the key informants from the Foreign Commonwealth Development Office) to the family that can be sustained in the longer-term leading to improvement in their circumstances.
Universal coverage of IDD has been achieved. However, issues of excessive iodine in salt, and intake of processed food with high salt intake were noted during the MTR.	The success achieved in reducing IDD should be sustained and future challenges such as managing the iodine content in iodized salt to address excessive iodine in salt, regulating the use of iodized salt in processed foods, strengthening the national and provincial level coordination structure to improve iodized salt coverage in hard-to-reach areas should be addressed.
Anemia prevalence among women and children has persisted high reflecting IFA distribution and deworming are not sufficient to address the issue of anemia among women and adolescents.	• Besides IFA distribution, particular attention should be given to increasing awareness about the benefits of iron-tablet intake and promoting the practices of intake of iron-rich locally available nutritious food. • Harmful practices such as menstrual seclusion and early child marriage and childbearing and food taboos such as avoiding the intake of specific food such as meat and milk during menstruation and pregnancy should be eliminated by engaging in closing with the community, female adolescents, and schoolteachers. • The distribution of deworming tablets should be complemented by action should be taken to address sanitation and hygiene factors. • School Health and Nutrition Programs should be strengthened and the nutrition intervention targeting school-aged children and adolescents (micronutrient supplementation, dietary practices, physical activity) should be effectively implemented using platforms such as schools, HFs, and child-clubs.
• Sustaining adherence to IFA intake and MNP over time is found challenging.	• To improve adherence to MNP intake, a culturally appropriate social behavior change communication approach should be developed focusing on the context-specific knowledge, attitudes, and behaviors around complementary feeding that might impact intake and adherence. Formative research may help to identify ways of improving adherence to IFA and MNP. • Regular and uninterrupted supply of MNPs, effective and trusted communication channels, along with more thorough dissemination of the knowledge of MNPs to mothers and caregivers should be ensured, to improve coverage as well as compliance with the recommended doses of MNPs.
• Adolescent nutrition has been given little attention in terms of program planning and investment.	• Particular focus and greater investment should be made to address the nutritional needs of this critical and unique group population. To understand the situation of adolescent nutrition and enable targeted evidence-based interventions, the mechanism to generate and analyze disaggregated data on nutrition status and outcomes among these groups should be strengthened.

• Policies and programs targeting adolescent nutrition are relatively new and coverage of programs targeted at adolescents (such as IFA supplementation and deworming) is low.	The existing interventions aimed at adolescent girls' nutrition need to be further strengthened and intensified. The minimum package including both nutrition-specific and sensitive interventions should be developed and implemented in an integrated way targeting adolescents. The minimum package could include improving access to reproductive health services; increasing the coverage of interventions designed to increase school attendance; strengthening and intensifying the IFA distribution and deworming program delivered though schools and HFs.
Dietary patterns and lifestyles among urban well-off are changing increasing the risk of diet related NCDs.	• Nutrition education including diet counseling should be provided through school-based platforms, adolescent youth clubs/peer education, and technology-based platforms. • Peer models to equip adolescents with nutrition-related knowledge and skills to improve adolescents' self-efficacy should be used. • Urban well-off adolescents anticipate the patterns of the future. Since these privileged youth are a reference group for other adolescents, they should also be targeted by health and nutrition promotion activities.

Findings	Recommendations
Agriculture Sector	
• Improved food security measured by Global Hunger Index (GHI)- an incremental gain in the overall food security score. • In 2000, Nepal's GHI score was also in the alarming category, but between 2000 and 2021, Nepal experienced an impressive decline in GHI score, dropping from 37.4 points in 2000 to 19.4 points in 2021 which is considered a moderate category. • Notable growth in livestock production and cereals and pulses production has been reported during the review period.	• Interventions to make the country self-sufficient in the production of cereals, rice, egg, and potatoes should be prioritized. Production-based agriculture interventions should be promoted.
One-time distribution of eggs and poultry items in a year on a rotation basis and inadequate monitoring from the local government of the utilization of agriculture inputs appear to have minimal impact on increasing livestock production and food diversity at the household level.	• Instead of distributing agriculture and livestock commodities, initiatives to enhance the livelihood of women and uplift their economic status such as providing life skills training or supporting them in establishing a small business are highly recommended. • It was recommended that the local government should provide the farmland on lease to the marginalized and disadvantaged groups who are landless for agriculture purposes rather than just providing a limited size of the food basket.
Demographic shifts including a rise in single female-headed households and male migration have forced women to get involved in agriculture which has increased their workload. In addition, these women have limited knowledge and skills in farming.	• The local government should improve the capacity of small-scale farmers, by ensuring their access to training, information, and agriculture technologies that improve the efficiency of crop and livestock production and reduces their workload
Small-scale farmers are least encouraged to produce locally available indigenous food because of lower crop yields.	• Interventions to conserve the traditional plant genetic resources and increase the productivity and extension of local and indigenous crops and breeds, particularly by establishing community seed banks at palika level, precise fertilizer management, and integrated pest management technologies should be strengthened and scaled up. • Farm subsidies in the form of fertilizers, credit, irrigation, and crop insurance should be provided to small-scale farmers particularly women to encourage the production of local and indigenous crops.

Limited access of small-scale food producers to the local market.	• Initiatives that increase access to the local market should be strengthened. • Transportation subsidies in close collaboration with the Government of Nepal for food should be provided to rural districts like Humla that lack road connectivity.
Nepal is currently facing the impact of climate change on crop yields.	• Training on sustainable and climate-resilient agricultural practices and timely supervision and the follow-up of the skills learned during the training should be planned. • The Agriculture Knowledge Center could be developed as coordinating bodies and representatives of both central and provincial governments to lead and backstop the agriculture functions for achieving national priority. • Recommendations for expanding crop rotation and reintegrating livestock into the crop production system to address the impact of climate change were received.

• Findings	• Recommendations
Social Protection Sector	
• Child Cash Grants have been found effective delivery mechanisms to improve child nutrition, but the coverage among the marginalized community is still low.	• An awareness program regarding timely birth registration to get benefitted from the CCG program should be done targeting mothers from socially marginalized groups, pregnant women, and mothers with children under 1 year of age. Greater efforts should be made to reach out to disadvantaged groups and FCHVs and MSNP volunteers can be mobilized for this purpose. • The distribution of CCG should be complemented by capacity building and behavior change interventions. Greater emphasis should be placed on the use of CCG to buy nutritious foods to optimize its impact on child nutrition. • The suggestion of introducing conditionalities for child cash distribution for instance conditional on regular or quarterly visits to a health facility for child growth monitoring and promotion.
• The amount given to each household is fixed and not adjusted by the size of the household or the number of malnourished children	• Increase the grant to ≥ 20% of the household expenditure. (Based on the recommendation from a study conducted by Andre et. al (2019) in Nepal to evaluate the impact of an unconditional child cash grant)
Women and Children Sector	
• Current interventions under MSNP such as community-level awareness programs aimed at reducing and ultimately eliminating child marriage is inadequate to address age-old tradition and custom of early child marriage (ECM). Still over one-third of the women get married before the age of 18 years.	• To address the issues of early child marriage and teenage childbearing, comprehensive, specific information on local risk and protective factors should be gathered and context-specific measures should be developed taking into account the community's or household's socioeconomic conditions and gender norms. • Education, in particular, female education should be given high priority to prevent ECM. Besides, educating girls, child clubs and youth clubs should be mobilized to make their peers self-reliant and empowered to prevent ECM rather than the advocacy campaign and street drama on a sporadic basis.

• Data has revealed that women are more likely to marry at a younger age compared to men and illiterate women are at a higher risk of getting married early.	• The interventions to address the rights of girls to equality of participation in secondary and post-secondary education, with pathways to income-generating work should be considered. The program should be focused to enroll and retain the girls in schools. • Adolescent boys and girls should be empowered to avoid early marriage by equipping them with knowledge of their rights (particularly sexual and reproductive health rights) and ensuring the availability of support of peer groups of other empowered adolescents that would help them to have more control over their own lives and prospects. • Even if adolescents get married early (before 18 years), they should be informed to delay pregnancy by using appropriate FP services. Health facilities should provide special attention and educate and counsel young married women about delaying childbirth by using contraceptives and improving their feeding practices to improve their nutritional outcomes • Parents and community leaders should be educated about the negative consequences of child marriage to inspire them to change their views, speak up for girls' rights, and encourage others to do the same. Further, the family should be educated about the health and economic productivity of enabling young women to delay marriage and childbearing beyond adolescence to strive to eliminate ECM from society. • Religious and traditional leaders, political leaders, and the media in the areas of gender-based violence and the rights of children/women who can influence families and dissuade parents from marrying off their girls too early should be mobilized. • Legal systems should be strengthened to protect the rights of adolescent girls and boys and services to help adolescents at risk or affected by child marriage should be strengthened.
Findings	**Recommendations**
Women and Children Sector	
• *Chhaupadi* has deeply ingrained superstitions associated with menstruation and remains widespread in the western part of Nepal. Adolescent girls and women are excluded from various activities social gatherings, visiting temples, staying away from school, eating and sleeping separately) during menstruation and the proportion of women experiencing menstrual seclusion varies by age, province, wealth quintile and education status.	• Multilevel intervention includes adequate financing, monitoring, and accountability system from federal, provincial, and local up to community level and multisectoral interventions (for instance interventions that support social justice; promote literacy and empowerment among young girls and women; a program that promotes menstrual health and hygiene) is required to address the issue of menstrual seclusion. • Adolescent girls should be empowered to manage their sexual and reproductive health issues through a peer-to-peer approach among others. A consistent, empowering program that provides accurate information and challenges negative associations and social practices should be effectively implemented. To this end, the school setting could be an ideal intervention setting for providing information. • Family members (including the older generation), female teachers, youths (including boys) and religious leaders, and gatekeepers of the community should be engaged to develop context-specific interventions to eradicate this deadly practice, besides social campaigns and legal protection measures.
WASH Sector	

• Open Defecation Free (ODF) status has been achieved across the nation and access to improved sanitation facilities and drinking water has been improved. However, sanitation and hand hygiene practices were found to be poor despite being knowledgeable about washing hands with soap and water during critical times. Poor hygiene practices during handling of foods and breastfeeding have been reported (Only 7.3% washed their hands after handling their child's faces *(Tech Paper Nepal ODF V9 April 19).*	• The sanitation social movement and the total sanitation concept should be scaled-up to sustain the gains. • The local government should continue to monitor the sanitation facilities at HH and institutional levels in their respective areas to maintain the ODF status. Further, hygiene and sanitation behavior change interventions should be continuously reinforced to sustain ODF status. • Awareness about the benefits of washing hands with soap at key times should be improved and measures to improve the practice of washing hands with soap should be further taken.
• Access to basic drinking water (76% of HHs) has improved, however, only one-fourth (24%) of households in Nepal uses appropriate water treatment method, and this varies by province, place of residence (urban vs. rural), wealth quintile, educational status of head of HHs. Moreover, only basic water supply coverage has increased, with the least emphasis on quality. In addition, there is geographical heterogeneity and inequality in access to safely managed water across the province, wealth quintile, and ecological region. • Contamination of drinking water at the source and the household level with E. coli has been reported high (96%- in the poorest households and 65% in the richest households)- NMICS 2019.	• More attention in terms of resource prioritization (increase funding in rural areas) should be provided in the areas with inequitable access to safely managed drinking water and improved sanitation facilities to ensure the availability and accessibility of clean water and sanitation to unreached areas • Water regulatory bodies should be strengthened, water safety plans should be implemented to improve water quality. Specific plans such as conducting microbial water quality tests for sustainable services for both water and sanitation at local levels should be reinforced. •
• WASH facilities and services at health facilities Fs visited were poor and inadequate (in terms of cleanliness and supply of running water and sanitation supplies) and were not gender, children, and disabled-friendly.	• Interventions to improve WASH infrastructures and services at schools and HFs should be planned through intersectoral coordination. Gender-friendly, child-friendly, and disabled-friendly WASH facilities should be ensured and continued monitoring should be undertaken by the local government.
Findings	**Recommendations**
Education Sector	
Reports have shown that school mid-day meal has been able to improve the enrollment and retention rate.	• The local government (particularly ward-level NFSSC) should monitor the school's mid-day meal program periodically to ensure the implementation of the program as per the guidelines developed by MoEST. • School Mid-day Meal Program should be complemented by School Nurse Program services at the local level to identify under-nourished, normal, and over-nourished children as evidence have shown the impact of school mid-day meal in terms of retention and educational achievement is even more persuasive when accompanied by complementary actions such as deworming and micronutrient fortification or supplementation[25].

25 Bundy, D. A. (2009). Rethinking school feeding: social safety nets, child development, and the education sector. world bank publications.

	• Besides strengthening the school mid-meal program, Early Childhood Development program, and School Health and Nutrition Program should be strengthened and integration across these programs should be ensured to intensify and complement the efforts. • Interventions such as providing orientation to parents on nutrition, establishing a school garden, ensuring provision of clean water, separate toilet and handwashing facilities for girls and boys, and ensuring that children in schools receive deworming tablets and nutrition education from the school health nurse or the health workers from nearby health facilities on a periodic interval should be considered and should be effectively monitored.
• Concerns about the distribution of unhealthy food such as noodles, and biscuits as meals were raised in a few of the palika visited together with some of the respondents from the federal level.	• The composition of meals provided should be improved, use of locally produced and available food should be promoted as a school meal.
• Data suggest there is a gender imbalance in ECDC/PPE enrollment rate across all the social strata.	• The local government needs to revisit its approach to ensure equitable access to ECED/PPE and achieve gender balance in coordination with MoEST.
• The retention rate is still low i.e., 68.7%.	• More attention, particularly among disadvantaged areas, should be paid and the program should be strengthened to increase the completion and retention rate.

Findings	Recommendations
Local Governance	
• MTR findings underscored the fundamental role that good governance plays in promoting child nutrition and growth.	• The next phase of MSNP should strongly consider the interventions to strengthen the nutrition governance mechanism at all levels and make the institutions empowered. Previous studies have reported that better nutrition governance is positively associated with nutrition outcomes in children over 2 years of age.
Findings	**Recommendations**
Local Governance	
Institutional and HR Capacity The autonomous local levels' responsibilities are challenged by insufficient supervision, expertise, resources, and ambiguity in roles across three tiers of government. The local government has limited technical and managerial capacity to comply with the increased roles and responsibilities and perform the operational responsibilities and this has been engendering the bottlenecks in the effective implementation of MSNP interventions. Besides the capacity issues of existing human resources, there are human resource constraints at local levels, with many lacking enough key staff from the key sectors.	• Capacity need assessment should be conducted to develop local institutional capacity to improve their capability to effectively plan and enhance decision-making efficiency to implement the policies. • The provincial government and district-based offices such as Health Office, Education Development and Coordination Unit, and Agriculture Knowledge Center can play an important intermediary role in the areas of institutional and capacity development at local levels, but roles need to be defined explicitly and need to be formalized to allow the envisioned coordination, cooperation, and coexistence for undertaking shared responsibilities across the tiers of government. In addition, municipalities need to be allocated adequate qualified and trained human resources to implement activities to achieve the intended results.

• A considerable amount of work needs to be done to ensure local governments have the requisite capacity to mobilize more resources and manage the MSNP better.	• Nutrition capacity needs should be strengthened in the local government mechanisms supporting the MSNP. • The main actors particularly individuals from WASH, women and children, agriculture and livestock, and education sectors involved in the food and nutrition security committees should be provided 2-3 rounds of special orientation on nutrition and the MSNP. Such training should deal with all forms of malnutrition from a life course perspective and communicate the concepts of duty bearers and rights holders, and the obligation of duty bearers to safeguard nutrition and food-security-related rights. • Two to three rounds of orientation should be provided to the local politicians to raise their awareness of the importance of investing in nutrition and addressing the malnutrition issues and improving the likelihood of approval of the budget for MSNP estimated by the local level NFSSC. These training and orientation should be conducted before drafting the local-level annual work plan and budget.
• There is inadequate coordination between sectors and across the three levels of government.	• The roles and responsibilities and lines of accountability of the sectoral ministries and government institutions need to be clarified for multisectoral work. The avenues and aspects of sectoral coordination and integration at all levels of government particularly at local levels and across institutions should be defined. • Efforts should be made to link existing FCHV's work with MSNP Volunteers from the LG.
• Capacity constraints particularly at the sub-national levels continue to impede the effective implementation of MSNP. • The facilitation, field mobilization, planning, and reporting skills of MSNP volunteers are weak. Provincial MSNP Coordinators have to oversee the implementation of nearly 80-100 palika and are stationed in the province making it difficult to provide technical assistance and monitor the activities at local levels that are miles away and scattered.	• Capacity needs assessment and capacity enhancement programs especially at mid-level decision-makers and at the implementation level should be planned and promoted. • More investment in capacity development in terms of planning, monitoring, documenting, reporting, and facilitating including boosting the motivation of MSNP volunteers should be made as part of technical assistance to local government. Field mobilization of MSNP should be increased particularly among the most vulnerable and marginalized communities. • HR planning and forecasting should be done to bring technical assistance closest possible at local levels.
• Establishing nutrition governance structures at all levels of government is crucial for multisectoral interventions but not sufficient to initiate adequate intersectoral actions. • Coordination between six different sectoral ministries is limited to a formal meeting conducted occasionally at the federal level. The extent of coordination is not to extent that could lead to joint planning and resource allocation and mobilization and shared accountability to achieve the desired common goals of better nutritional outcomes.	• To attain the meaningful engagement of multi-layer multistakeholder engagement there should be shared priorities, funding, targets, and mutual accountability across the sectors and at levels of government.

Findings	Recommendations
Local Governance	
Alignment and Integration It is difficult to authenticate the alignment and contribution made by different individual projects in achieving the goal and outcome of MSNP in the absence of a minimum package for MSNP.	• The minimum package for MSNP should be defined and developed to outline what interventions are in line with MSNP and what interventions constitute MSNP. This will allow tracking the contribution of different projects related to nutrition and food security in achieving the outcomes of MSNP
Resource Allocation	• More concerted and rigorous advocacy should be done with subnational governments, particularly with local governments for internal resource mobilization for MSNP.

There is an upward and increasing trend of domestic resource mobilization for MSNP, which is very encouraging, however, the share of fund allocation from the government's end stills remains low.	• An equity-sensitive approach that combines not only an innovative approach to reach the most vulnerable group, but also commits to making better use of existing resources should be ensured. • Shift from a traditional incremental line-item-based budgeting system to a Goal-oriented performance-based or program-based budgeting system should be made to improve efficiency and accountability toward the results. Developing and institutionalizing a Performance-Based Grant[26] could be a key step to this end and devising a mechanism to monitor the process of implementation by the nutrition and food security steering committee could enhance the allocative efficiency.
Engagement with sub-national government and DPs	
The limited engagement of Development Partners (DPs) and sub-national government in the formulation of MSNP affects the accountability and ownership of the plan.	• Engagement of all levels of government, sectors relevant development partners including the community in the design and implementation of multi-sectoral responses should be ensured
• There are multiple stakeholders and projects in place claiming to work to achieve the outcome envisioned by MSNP.	• Necessary steps should be taken to mainstream and synchronize their efforts for accelerating the actions to achieve the intended results and avoid duplication of efforts and resources. Further, a minimum package to ascertain what is MSNP should be endorsed to facilitate the alignment and mainstreaming of efforts of developmental partners. • Fostering meaningful partnerships at the local level among the DPs and local levels for streamlining the efforts to address malnutrition and food insecurity based on their strength and expertise is recommended. The local government and DPs/CSOs should be engaged in the initial stage of drafting the strategic planning as well as during the implementation and most importantly during monitoring of the implementation.
MTR findings indicated that sufficient integration and coordination between health, WASH, and education interventions, policy, and implementation has not been achieved at the local level revealing missed opportunities for effective and sustainable behavior change.	Integration of different sectors should be ensured at the local level to address the issue of malnutrition. As suggested by most DPs, MSNP interventions (nutrition-specific and sensitive) of different sectors should be delivered as an integrated package at the household level rather than delivering vertical programs from each sector in silos.
Limited understanding of multisector approaches among the focal person of the key sectors at all levels of government particularly WASH, education, women, children, and senior citizens were observed. This in turn has affected their engagement in MSNP and their accountability towards the results of MSNP.	The understanding of the essence of the multisectoral approach for addressing the issue of malnutrition among the policymakers and the implementing authorities should be improved and the transdisciplinary collaboration between multi-stakeholders across the formulation and implementation process should be strengthened to bring greater success compared to the current achievement.
Findings	**Recommendations**
Review, Monitoring, Reporting and Evaluation	
• The functionality of the monitoring and reporting mechanism of MSNP-II is weak.	• A robust and integrated program MEAL system should be developed with feedback mechanisms through which progress can be compared against the agreed targets. The MEAL system should detail clear roles and responsibilities for monitoring and reporting for the various government agencies. • Besides instituting and strengthening M&E infrastructure and processes, continuous capacity building of staff tasked to implement M&E should be planned and implemented to strengthen their M&E knowledge and skills.

[26] Performance Based Grant: The actual funds in the form of conditional grants/special grants released based on the achievement of agreed key performance indicators (KPIs) target milestones.

	• Performance summaries should be regularly sent by palika and should be reviewed, and feedback should be provided to palika during periodic review meetings conducted by sectoral ministries/departments and the nutrition and food security steering committee at all levels.
• There exists a disparate information management system across the different sectoral ministries such as HMIS (Health sector), WBRS (Local Governance Sector), EMIS (Education Sector), and N-WASH (WASH Sector). A considerable amount of time is required to collect data, track progress from multiple information systems from different sectoral ministries and thereafter analyze and interpret data using disparate MIS systems and platforms which is exhausting. • The existing information systems seem to serve central functions more than the local government systems. Furthermore, the various information systems are not considered suitable for guiding local government decisions for effective planning and monitoring of MSNP.	• Develop and strengthen integrated information and mutual accountability platform built around a multi-stakeholder, government-led cycle of planning, monitoring, and learning. • A list of key MSNP input, output, outcome, and impact indicators needs to be constructed for each municipality (rural/urban) referring to the M&E framework to serve local government decision-making and help identify bottlenecks that limit program impact. • The local Level Nutrition and Food Security Steering Committee (LLNFSSC) needs to develop data-driven annual plans and budgets for the municipality. Local problem assessment and solution development should be encouraged in these processes.
• Limited use of data for planning, budgeting, setting nutrition-related targets and designing the interventions. •	• The use of data generated from information management systems (and from sectoral MISs) in the policymaking and decision-making process and prioritization of nutrition services particularly at the local level should be promoted. • Continuous utilization of data to focus on vulnerable children, adolescents, and women and to ensure accountability at all levels for change should be done
• There is a lack of disaggregated data on most of the nutritional indicators in the existing information system.	• A mechanism to collect better and more granular data on time should be developed and strengthened
• Information on the alignment of developmental partners' activities with MSNP is lacking.	• There is a need to improve the practice of the sharing of data on the progress of the activity aligned with MSNP.
	• Accountability at local levels and among the key actors engaged in the delivery of nutrition-specific and sensitive services should be improved. To this end, a range of options could be considered such as using a dashboard at *palika* office to inform the community about the nutrition status and food security situation of the palika by displaying progress on different indicators of nutrition and food security. Besides, for improved accountability, leadership and management should use M& E tools to assess the progress and address the bottlenecks on time. In addition, the functionality of the feedback mechanism should be strengthened for critical and timely feedback to the local government from the provincial and federal governments.
• Data verification to validate the accuracy and completeness of data is least likely observed at all levels of government.	• To strengthen data quality and reporting, the local government should ensure that those involved with recording and reporting have received proper training and are skilled. Routine Data Quality Assessment should be mandated at HF and palika levels. Regular mentoring and periodic refresher training should be planned to strengthen their skills in recording and reporting and smooth internet connections should be ensured. The data of WBRS maintained on the web should be made accessible to the public and relevant stakeholders.

Findings	Recommendations
Other Recommendations	

The traditional Behavior Change Communication approach and interventions facilitating behavior change have placed more emphasis on communication approaches and there is top-down sharing of the information at the individual, family, and community levels for intended behavior change.	• **As dietary choices and other eating-related behaviors are often strongly tied to cultural and social norms, thus, there is a need to move away from top-down information sharing and towards ensuring that messages are tailored by considering local beliefs and cultural context. For this, Social Behavior Change Communication (SBCC) approaches are critical. The social and cultural norms and harmful practices that adversely affect the feeding and care practices during pregnancy, lactation, and complementary should be identified and feeding behaviors that have an impact on the intended nutrition outcome should be prioritized and the most important modifiable factors that influence the priority nutrition behaviors should be addressed using SBCC approach.** • **The content of the communication tool for desired behavior change should be specific to the local context and target group for whom it is intended to improve knowledge and practices related to nutritious food intake and feeding practices.**
Limited engagement of the Private sector • **Meaningful engagement of the private sector in the agriculture sector, safe and nutritious food production and distribution is constrained by the lack of a conducive policy environment.** • **There are limited private sector engagement opportunities without encouraging incentives that could attract these entities to invest in the nutrition and food security sectors.** • **The private sector is willing to widen its investments in the areas of nutrition and food security particularly in ensuring food supplies in remote areas, partnering for innovative agriculture and food fortification.**	• **Private sector engagement (PSE) should be sought by creating a supportive policy environment and PSE in nutrition should expand and go beyond corporate social responsibility and actions from food companies. The avenues for increased private sector investment through public-private partnerships in this area should be explored.** • **In the context where private sectors are interested in partnering with the government to deliver products and services, public-private dialogue should be increased to discuss the role and engagement of private sector in addressing nutrition priorities, potentially through policies and/or programs that incentivize the service provisions of private sectors particularly in hard-to-reach and food insecure areas.** • **Without the incentives in the form tax exemptions and tax subsidies from the government, the private sector is least likely to be encouraged to invest in nutrition. The incentives for private providers to engage in expanding access to affordable and nutritious foods for excluded populations should be strengthened.** • **Women's businesses and female entrepreneurs in the food supply chain should be supported by providing tax incentives.**
• **Markets and private sector entities have largely been contributing to overnutrition, pushing a certain group of populations to consume unhealthy foods using effective yet harmful marketing strategies – and especially targeting children and adolescents.**	• **The capacity of the government should be strengthened to regulate and partner with the private sector aligning with MSNP's goals and objectives.** • **The private sector should support governments to develop and enforce regulations on harmful business practices linked to malnutrition, for instance, inappropriate marketing of breastmilk substitutes and complementary foods for children below 2 years of age; and aggressive marketing of unhealthy foods targeting children including in school settings**

Strengths and Limitations of the Review:

This review covers the best documented and most accessible experiences and review of data from sectoral information systems and annual reports. Cooperation and prioritization of this task by many stakeholders enabled the completion of the iterative process. The breadth of experience and expertise amongst the participants provided unique contextual information and insights for the development and implementation of multisector approaches in Nepal. Few limitations are acknowledged and are worth noting.

- **Each KI and member of the nutrition and food security steering committee and FGD participants may not have authentically shared their experiences, particularly if the experience deviates from socially accepted norms. However, the findings remain valid and are still useful for understanding culture and key behaviors and beliefs related to review in this context.**
- **Although widely used in qualitative research, a purposive technique was used for the selection of province, district, and municipality which might have influenced the findings. The findings from the qualitative study might not be considered representative of other program districts of Nepal because only four districts and eight local levels were selected from four different provinces.**
- **Nutritional and WASH practices of mothers were self-reported and changes in behavior were not closely observed, which may have resulted in over-or under-reporting. For instance, it is conceivable that mothers might have under-or over-reported their dietary consumption patterns and either over-or underestimated their consumption of healthy foods, such as fruits and vegetables.**
- **It was difficult and time consuming to access the information system of different sectors, which in turn took longer than planned to carry out the data analysis.**
- **Analysis from equity perspectives was limited because of the unavailability of disaggregated data in the routine information systems a report of sectors.**
- **One of the limitations of this review is that information on budget allocations for nutrition intervention, does not capture the total allocation from different sectoral ministries and only represents the allocations by MoFAGA through EU-budget support. Allocations of different sectoral ministries are embedded in larger programs that do not have disaggregated budget line items or budget codes for nutrition making it harder to record the total allocation for nutrition.**

References:

1. Adato, M., & Bassett, L. (2009). Social protection to support vulnerable children and families: the potential of cash transfers to protect education, health and nutrition. AIDS care, 21(sup1), 60-75.
2. Bhandari, S., Thorne-Lyman, A. L., Shrestha, B., Neupane, S., Nonyane, B. A. S., Manohar, S., ... & West, K. P. (2019). Determinants of infant breastfeeding practices in Nepal: a national study. International breastfeeding journal, 14(1), 1-17.
3. Behzadifar, M., Saki, M., Behzadifar, M., Mardani, M., Yari, F., Ebrahimzadeh, F., ... & Bragazzi, N. L. (2019). Prevalence of exclusive breastfeeding practice in the first six months of life and its determinants in Iran: a systematic review and meta-analysis. BMC pediatrics, 19(1), 1-10.
4. Central Bureau of Statistics (CBS),2020. *Nepal Multiple Indicator Cluster Survey 2019,Survey Findings Report*. Kathmandu, Nepal: Central Bureau of Statistics and UNICEF Nepal.
5. Chowdhury, M. R. K., Khan, M. M. H., Khan, H. T., Rahman, M. S., Islam, M. R., Islam, M. M., & Billah, B. (2020). Prevalence and risk factors of childhood anemia in Nepal: A multilevel analysis. Plos one, 15(10), e0239409.
6. Dahal, G. (2021). Role of District Co-ordination Committee in Nepalese Federalism. *International Scholars Journal of Arts and Social Science Research, 4(1),* 182-189.
7. Grellety, E., Babakazo, P., Bangana, A., Mwamba, G., Lezama, I., Zagre, N. M., & Ategbo, E. A. (2017). Effects of unconditional cash transfers on the outcome of treatment for severe acute malnutrition (SAM): a cluster-randomised trial in the Democratic Republic of the Congo. BMC medicine, 15(1), 1-19.
8. Ghimire, U., & Vatsa, R. (2021). Spatial distribution of various forms of malnutrition among reproductive age women in Nepal: A Bayesian geoadditive quantile regression approach. SSM-Population Health, 14, 100781.
9. Government of Nepal NPC. Nepal Multidimensional Poverty Index. Singha Durbar: Oxford Poverty and Human Development Initiative (OPHI), University of Oxford; 2018.
10. Harding, K. L., Aguayo, V. M., Namirembe, G., & Webb, P. (2018). Determinants of anemia among women and children in Nepal and Pakistan: An analysis of recent national survey data. Maternal & child nutrition, 14, e12478.
11. Kennedy, E., Fekadu, H., Ghosh, S., Baral, K., Davis, D., Sapkota, D., & Webb, P. (2016). Implementing multisector nutrition programs in Ethiopia and Nepal: challenges and opportunities from a stakeholder perspective. Food and nutrition bulletin, 37(4_suppl), S115-S123.
12. Khanal, V., Adhikari, M., & Karkee, R. (2014). Low compliance with iron-folate supplementation among postpartum mothers of Nepal: An analysis of Nepal Demographic and Health Survey 2011. *Journal of Community Health*, 39(3), 606– 613. https://doi.org/10.1007/s10900-013-9806-6
13. Lawson, T. M. (2012). Impact of school feeding programs on educational, nutritional, and agricultural development goals: a systematic review of literature.
14. Leroy, J. L., Ruel, M., & Verhofstadt, E. (2009). The impact of conditional cash transfer programmes on child nutrition: a review of evidence using a programme theory framework. Journal of development effectiveness, 1(2), 103-129.
15. Pradhan, R., Wynter, K., & Fisher, J. (2018). Factors associated with pregnancy among married adolescents in Nepal: secondary analysis of the National demographic and health surveys from 2001 to 2011. International journal of environmental research and public health, 15(2), 229.
16. Pollifrone, M. M., Cunningham, K., Pandey Rana, P., Philbin, M. M., Manandhar, S., Lamsal, K. P., ... & Deuja, V. (2020). Barriers and facilitators to growth monitoring and promotion in Nepal: Household, health worker and female community health volunteer perceptions. Maternal & Child Nutrition, 16(4), e12999.
17. Merttens, F., Hurrell, A., Marzi, M., Attah, R., Farhat, M., Kardan, A., & MacAuslan, I. (2013). Kenya hunger safety net programme monitoring and evaluation component. Impact Evluation Final Report. Oxford Policy Management.
18. Miller, C., Tsoka, M., & Reichert, K. (2008). Impact evaluation report external evaluation of the Mchinji Social Cash Transfer pilot.
19. Ministry of Health and Population, Nepal; New ERA; UNICEF; EU; USAID; and CDC. 2018. *Nepal National Micronutrient Status Survey, 2016. Kathmandu, Nepal: Ministry of Health and Population,Nepal*
20. Ministry of Health, Nepal; New ERA; and ICF. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu,Nepal: Ministry of Health, Nepal.
21. Nepal Indigenous Disabled Association (NIDA), National Indigenous Disabled Women Association Nepal (NIDWAN), & Asia Indigenous Peoples Pact (AIPP). (2018). Reply from Indigenous Persons with Disabilities Organizations to the List of Issues in relation to the initial Report of Nepal. NIDA, NIDWAN, & AIPP.
22. Nepali, S., Simkhada, P., & Davies, I. G. (2020). Association between wasting and food insecurity among children under five years: findings from Nepal demographic health survey 2016. BMC Public Health, 20(1), 1-7
23. NPC and WFP (2021), Fill the Nutrient Gap Nepal - Summary Report
24. Ngum Chi Watts, M. C., Liamputtong, P., & Mcmichael, C. (2015). Early motherhood: a qualitative study exploring the experiences of African Australian teenage mothers in greater Melbourne, Australia. BMC public health, 15(1), 1-11.
25. Ruducha, J., Bhatia, A., Mann, C., & Torlesse, H. (2022). Multisectoral nutrition planning in Nepal: evidence from an organizational network analysis. Maternal & child nutrition, 18, e13112.
26. Schauer, C., Sunley, N., Hubbell Melgarejo, C., Nyhus Dhillon, C., Roca, C., Tapia, G., ... & DW Klemm, R. (2017). Experiences and lessons learned for planning and supply of micronutrient powders interventions. Maternal & Child Nutrition, 13, e12494.
27. Seidenfeld, D., Handa, S., Tembo, G., Michelo, S., Harland Scott, C., & Prencipe, L. (2014). The impact of an unconditional cash transfer on food security and nutrition: the Zambia Child Grant Programme.
28. Singh, D.R., Sunuwar, D.R., Adhikari, B., Szabo, S., & Padmadas, S.S. (2020). The perils of COVID-19 in Nepal: Implications for population health and nutritional status. Journal of Global Health, 10:1, 1-4.
29. Shrestha, R. M., Ghimire, M., Shakya, P., Ayer, R., Dhital, R., & Jimba, M. (2019). School health and nutrition program implementation, impact, and challenges in schools of Nepal: Stakeholders' perceptions. Tropical Medicine and Health, 47(1), 1-11.
30. Sunuwar, D. R., Singh, D. R., Adhikari, B., Shrestha, S., & Pradhan, P. M. S. (2021). Factors affecting anaemia among women of reproductive age in Nepal: a multilevel and spatial analysis. BMJ open, 11(3), e041982.
31. Temesgen, H., Negesse, A., Woyraw, W., Getaneh, T., & Yigizaw, M. (2018). Prelacteal feeding and associated factors in Ethiopia: systematic review and meta-analysis. International breastfeeding journal, 13(1), 1-12.
32. Thakuri, D. S., Thapa, R. K., Singh, S., Khanal, G. N., & Khatri, R. B. (2021). A harmful religio-cultural practice (Chhaupadi) during menstruation among adolescent girls in Nepal: Prevalence and policies for eradication. PloS one, 16(9), e0256968.
33. Thapa, S., & Aro, A. R. (2021). 'Menstruation means impurity': multilevel interventions are needed to break the menstrual taboo in Nepal. BMC Women's Health, 21(1), 1-5.
34. UNICEF, T. (2013). Capacity Building To Strengthen Local Government and Community Participation in Multisectoral Nutrition Programs in Nepal. Multisectoral Nutrition Programs in Nepal.
35. Wemakor, A., Garti, H., Azongo, T., Garti, H., & Atosona, A. (2018). Young maternal age is a risk factor for child undernutrition in Tamale Metropolis, Ghana. BMC research notes, 11(1), 1-5.

36. WHO. Global Nutrition Targets 2025: Stunting Policy Brief (WHO/NMH/NHD/14.3). Geneva: World Health Organization; 2014.

Annex

Annex 1: Additional tables and figures

Table 14. SWOT analysis of MSNP-II

Strengths	Challenges/ Weakness
A government-led national plan for nutrition and food security is in place and implemented A formal government-led multi-stakeholder national coordination mechanism and governance mechanism exists for sector planning and review at the national and sub-national level Ownership of the program at levels of government Technical support and assistance from EU/UNICEF Strong leadership of NPC and facilitation of MoFAGA and MoHP Alignment of MSNP into sectoral plans and policies at the federal and sub-national level Upward and increasing trend of resource allocation from the local government from their internal resources	Substantial gaps in financing and advanced skills necessary to achieve these targets Institutional and HR capacity at the local level Weak Monitoring and Reporting system Lack of nutrition budget code to track the budget and expenditure Lack of integrated Nutrition Information System Coordination among the sectors and across the three tiers of government along with DPs
Opportunities	**Threats**
Continued national prioritization and international support More prioritization and enabling environment to loop-in private sector financing	COVID-19 pandemic has created an unprecedented impact on the national economy and strained the health system. A considerable shortfall in the mobilization of financial resources

Table 15 List of places visited during field mission for MTR

Name of the Province	Ecological Region	Name of district	Name of the municipalities	Nature of the municipalities	Duration of the implementation by MTR
Madhesh Province	Terai	Rautahat	Durgabhagwati	Rural	Since FY 2015/2016 (6 years)
			Madhavnarayan	Urban	
	Terai	Parsa	Parsagadhi Municipality	Urban (For pretest)	Since FY 2014/2015 (7 years)
Province 1	Hilly	Pancthar	Phidim Municipality	Urban	Since FY 2015/2016 (6 years)
			Hilihang	Rural	
Sudur Paschim Province	Hilly	Doti	Dipayal Municipality	Urban	Since FY 2016/2017 (5 years)
			Jorayal Municipality	Rural	
Karnali Province	Mountain	Jumla	Chandanath Municipality	Rural	FY 2014/2015 (7 years)
			Guthichaur Municipality	Urban	
	Mountain	Mugu	Chhayanath Rara	Urban	FY 2016/2017(5 years)

Table 16 Coverage of MSNP (By Province and District)

SN	Province	Total District	Full Package		Partial Package		Total Program Coverage	
			District	Local Level	District	Local Level	District	Local Level
1.	Province 1	14	3	26	11	111	14	137
2	Madhesh Province	8	8	136	0	0	8	136
3	Bagmati Province	13	3	30	6	61	9	91
4	Gandaki Province	11	1	8	9	72	10	80
5	Lumbini Province	12	6	47	6	62	12	109
6	Karnali Province	10	9	70	1	9	10	79
7	Sudur Paschim Province	9	7	66	2	22	9	88
	Total	77	37	383	35	337	72	720

Table 17 Coverage of Nutrition specific Programs run by MoHP 2075/2076- 2078/2079 (2018/2019- 2021/2022)

Coverage (by district) of different program under nutrition specific interventions:	2078/2079
1. MIYCN	77
2. Growth Monitoring and Promotion	77
3. Prevention and control of Iron Deficiency Anemia (IDA)	77
4. Prevention, Control and Treatment of Vitamin A deficiency (VAD)	77
5. Prevention of Iodine Deficiency Disorders (IDD)	77
6. Control of Parasitic Infestation by deworming	77
7. CB-IMNCI	77
8. Adolescent IFA	77
9. School Health and Nutrition Program	77
10. Maternal Health (ANC, Institutional Delivery, PNC)	77
Scale-up programmes:	77
11. Integrated Management of Acute Malnutrition (IMAM)	70
12. Integrated IYCF and Baal-vita community Promotion Program (IYCF-MNP)	70 districts
13. Maternal and Child Health Nutrition (MCHN) Program– (Two different approach has been adopted): *Of the 11 program districts, in 6 districts fortified super flour is distributed while in remaining 5 district only behavior change communication (BCC) activities is being conducted.*	11 (Mugu, Kalikot, Humla, Jumla, Dolpa, Solukhumbu)-6 (Siraha, Saptari, Jhapa, Morang,Sunsari): 5
14. Comprehensive Nutrition Specific Intervention (CNSI) packages:	70
15. Mother Baby Friendly Hospital (MBFHI) Initiative	15 Hospitals
At piloting phase 16. MAM management program	1 (Siraha)
17. Family MUAC: 4 districts	4 Panchthar, Saptari, Kavre and Jumla)

Table 18: Trend of Nutrition Service Coverage between Fiscal Years 2075/76 to 2077/78 at national Level.

The data for FY 2075/2076, 2076/77, 2077/78 was obtained from Annual report of Department of Health Services and while data for FY 2078/2079 was extracted from HMIS.

Indicators	NDHS 2016	NMICS 2019	% Improvement	2075/2076 (2018/2019)	2076/2077 (2019/2020)	2077/2078 (2020/2021)	% Change	2078/2079 (2021/2022)
Growth Monitoring and Promotion								
Percentage of new-born with low birth weight				12	13	11	-8	12
Average number of growth monitoring visit per child (0-23) months				3	3	3	0	3
Percent of the children age 0-23 months were registered for growth monitoring (New)				71	65	73	3	52
From these 2.8 % of the children were reported as underweight				4	3	3	-25	4
Percentage of children were exclusively breastfed				33	30	37	12	27
Percentage of newborns who initiated breastfeeding within 1 hour of birth				24	16	16	-33	13
Breastfeeding								
Early Initiation of BF	55	41.7	-24	23.5	16.1	15.7	-33	13.4
Exclusive Breastfeeding	66	62.1	-6					
Bottle feeding	13	23	77					
IYCF indicators (6-23 months)								
Complementary Feeding								
Introduction to CF (6-8 months) Percentage of children (6-8 month) registered for growth monitoring who receive solid, semi solid or soft foods				33	30	36	8	27
Minimum Meal Frequency (MMF)	71	68.9	-3					
Minimum Dietary Diversity (MDD)	47	39.7	-16					
Minimum Acceptable Diet (MAD	36	30.4	-16					
Micronutrient supplementation								
IFA Supplementation (180 days) pregnant women (180+ IFA PW)				50.6	44	44.8	-11	28.6
45 days PP IFA				38.8	37.6	40.7	5	24.7

Table 19: Nutrition Specific Indicators (Coverage and Progress)- Between 2075/2076- 2078/2079

Indicators	NDHS 2016	NMICS 2019	% Improvement	2075/2076	2076/2077	2077/2078	% change	2078/2079
Vitamin-A								
Vitamin (6-11 months)				85	91	NA		

Vitamin (12-59 months)				80	84	83	4	47
Vitamin (6-59 months)				80	85	83	4	48
PP Vit-A Supplementation				65	57	61	-6	38
Deworming								
Deworming (12-59 months)				82	85	84	2	94
Deworming (PW)				61	59	59	-3	36
MNP Districts				46	46	53		61
MNP 1st				51	33	30	-41	14
MNP All				7	6	5	-29	2
IMAM Districts				56	56	64		65
SAM Cure Rate (0-59 months)				75	76	75	0	71
SAM cases diagnosed				12139	6567	7112	-41	9576
Defaulter				20	24	13	-35	13
IMICI								
Incidence of diarrhea (per 1000)				397.3	349.6	338.8	-15	186.1
Treatment of Diarrhea (Zinc+ORS) [% of under 5 children with diarrhoea treated with ORS and Zinc]	10	28.9	189	95.5	94.8	96.2	1	94.4
Case Fatality Rate [Diarrhea case fatality rate among children under five years (per 1000) < 1				0.1653	0.2349	0.1567	-5	0.2147
Feeding during Illness [continued feeding and oral rehydration therapy]	61	62.4	2					
HH Iodized Salt	95%							
School Aged Children (SAC)			314 ug/L					
Women of reproductive age (WRA) [In the Terai region, the mUIC among			286 ug/L					
Early childbearing (Percentage of women age 20-24 years who have had a live birth before age 18)		13.8						

Table 20: Indicators of Maternal Health Care Service utilization (Coverage and Progress)- Between 2075/2076- 2078/2079

Indicators	NDHS 2016	NMICS 2019	% Improvement	2075/2076	2076/2077	2077/2078	% change	2078/2079
ANC								

Percentage of pregnant women who had 1st ANC checkup				60	58	59	-2	37
Percentage of pregnant women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th month)				56	53	55	-2	43
Percentage of institutional deliveries				63	66	65	3	45
Skilled Attendant at delivery				60	63	61	2	42
PNC								
Percentage of women who had 3 PNC check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery)				16	19	25	56	22
Contraceptive prevalence rate (unadjusted) among women of reproductive age (WRA)	53	46.7	-12	38	35	36	-5	35

Table 21: Gross enrolment ratio in ECED/PPE by gender and province (2019-20)

Province/Gender	Gross enrolment ratio in ECED/PPE by gender and province (2019-20)					
	GER					
	Girls	Boys	Grand Total	Girls (%)	Boys (%)	Total (%)
Province 1	94227	107962	202189	99.7	102.4	101.1
Madhesh Province	75270	88260	163530	51.5	53.5	52.6
Bagmati Province	102290	123128	225418	106.1	109.5	108
Gandaki Province	46550	56056	102606	102.8	104.2	103.5
Lumbini Province	102039	123114	225153	98.3	102	100.3
Karnal Province	32429	34895	67324	72.1	71.1	71.6
Sudur Paschim Province	55340	64001	119341	84.1	84.1	84.1
National	508145	597416	1105561	85.1	87.5	86.4

AGRICULTURE SECTOR:

Table 22: % of production and productivity of crops and livestock

% of production and productivity	Baseline		2018/2019				Yield (Mt./Ha.)	2019/2020				Yield (Mt./Ha.)	Change (%) Between 2018 and 2019		Remarks	
													(Area)	Change		
	Area	Production	Area (ha)		Production (ton)			Area (1000 ha)		Production (1000 ton)				(Production)		
			T	A	T	A		T	A	T	A					
															Area	Production
Cereals	3306000	8614000	3,405,000	3,450,163	9,515,000	10,685,550	3.1	3371000	3,421,389	9,750,000	10,935,664	3.2	-0.83	2.34	On track	On track
Pulses	342000	316000	349,000	331,740	329,000	381,987	1.15	353000	340,692	335,000	404,210	1.19	2.7	5.82	Off track	On track
Vegetables	280000	3819000	315,000	297,195	4,413,000	4,271,270	14.37	328000	281,132	4,678,000	3,962,383	14.09	-5.4	-7.23	Off track	Off Track
Potatoes	190000	2551000	210,000	193997	2,976,000	3,112,947	16.05	218000	188098	3214000	3131830	16.65	-3.04	0.61	Off track	Off Track
Fish		48000			57,000	91,832				57000	97271					On track
Fruits		992000		120028	1181000	1,178,352	9.82		119,025	1,181,000	1,249,764	10.5	-0.84	6.06		On track

Source: Reports of Ministry of Agriculture and Livestock

Table 23:Percentage of production and productivity of Livestock commodities:

% of production and productivity	Baseline	2018/2019		2019/2020	
		Target	A	T	A
Milk (1,000 tonnes)	1954, ooo	2031000	2,168,434	2296000	2,302,000
Meat (1,000 tonnes)	332, ooo	344,000	357,082	379000	552,156
Eggs ('000 number)	135,ooo	135,000	1,549,689	145000	1,620,000

Source: Reports of Ministry of Agriculture and Livestock

Table 24: District with full coverage of CCG

Child Cash Grants districts covering all children under 5 years	Name of districts	Total no. of districts
FY 2076/77	Siraha, Sarlahi, Mahottari, Rautahat, Kalikot, Jajarkot, Jumla, Dolpa, Mugu, Humla, Achham, Doti Bajhang and Bajura	14 districts
FY 2077/78	Rasuwa, Dhanusha, Dailekh, Salyan, Bara, Baitadi, Rukum East, Rukum West, Rolpa, Saptari and Kapilvastu	11 districts
	Total	25 districts

Table 25:List of Government policies and plans to support the commitment of MSNP-II

Guiding policies:	Nutrition Specific	Nutrition-Sensitive
The Constitution of Nepal 2015 15th Periodic National plan (2019/20-2023/24) addressing nutrition and food security Vision 2100 Sustainable Development Goals 2030	• National Health Policy 2076 National Nutrition policy 2004 • National Health Sector Strategy (NHSP) (2015-2020) • Sexual and Reproductive Health (RH) Act, 2018: Ensured maternity protection of 98 days of paid maternity leave • National Nutrition Strategy 2077 • National Adolescent Development and Health Strategy 2075 • Multi-sectoral Action Plan for Prevention and control of NCD (2021-2025): Support implementation of the plans in line with MSNP to promote affordability, availability, and acceptability of healthier food products; Strengthen supportive policies and legislation to promote a healthy diet	Education sector: • National Education Policy 2076 • School Sector Development Plan (2016–2022) • National School Health and Nutrition Strategy 2006 • Free and Compulsory Basic Education Act of 2018 • National Strategy for Early Childhood Development 2077–2088 Agriculture and Livestock Sector: • Agriculture Development Strategy (2015-2035)- prioritizes improved food and nutrition security for the next 20 years. • Zero Hunger Challenge National Action Plan (2016 - 2025): to make Nepal free from hunger and malnutrition by 2025 [100 % Equitable Access to Adequate, Nutritious and Affordable Food All Year Round] • National Climate Change Policy 2076 (holistic policy linking nutrition, food security, and environment) WASH Sector: • Nepal Water Supply, Sanitation and Hygiene Sector Development Plan (SDP) for the period 2016 – 2030- Achieve the goal of universal access to basic WaSH services • National Water Supply and Sanitation Policy 2014 • National Standards on WASH for Health Institutions 2078 • Revised 5-year Joint Action Plan (2014/15-2019/20)- Key document to mainstream SHN in the health and education system. • Water Quality Surveillance Guideline, 2015 Women, Children, and Senior Citizen Sector: • National Gender Equality Policy 2077 Local Governance: Nutrition Friendly Local Governance Guideline 2078: guided by the mandate of MSNP-II to provide technical guidance to local government and relevant stakeholders to make municipality nutrition friendly by 2087

Table 26 Budget Allocation vs. Expenditure for nutrition-sensitive intervention implemented under the EU budget support in the leadership of MoFAGA

Administrative Unit		Budget Allocation 2018/2019 2075/2076	Budget Expenditure	Budget Allocation 2019/2020 2076/2077	Budget Expenditure	Budget Allocation 2020/2021 2077/2078	Budget Expenditure	Budget Allocation 2021/2022 2078/2079	Budget Expenditure
Conditional Grant									
Budget Allocation (Conditional)	Local	368721000	368721000	312944000	312944000	1198563000	1143512174	1444900000	Not Verified (By the end of the review period)
	District DCC	8700000	8700000	0	0	16338000	8503000	16338000	10786000
	Provincial	3000000	3000000	0	0	58500000	32456000	6962000	3,500,000.00
	Federal	33083000	33083000	79296000	79296000	60999000	17325000	65600000	64741000
	Sub-Total	413504000	413504000	392240000	392240000	1334400000	1201796174	1533800000	79027000
	Allocation from Local and Provincial Government from internal resources for MSNP								
Budget Allocation (Internal Resources-subnational government)	Local	262,031,000	218,522,000	255,812,000	234,852,000	170,000,000	155,100,000	222,200,000	
	Provincial	NA		NA		50,000,000		6,900,000	Not reported yet ((By the end of the review period)
Total Budget Allocation vs. Expenditure		675,535,000	632,026,000	648,052,000	627,092,000	1,504,400,000	1,356,896,174	1,762,900,000	
% of allocation from local government for MSNP ((Nutrition sensitive)		39		39		11		13	

Annex 2.1: Programmatic Indicators (Outcome Indicators and Output Indicators):

Nutrition Specific Outcomes	Means of Verification	Responsible
Outcome 1: Improved access to and equitable use of nutrition-specific services		
1.1 % of children aged 6-23 months have a minimum acceptable diet (MAD) (*disaggregated by gender and age)*	NDHS, NMICS	Health
1.2 % of children under 6 months with exclusive breastfeeding	NDHS, NMICS	Health
1.3 % of anaemia among children aged 6-59 months (*disaggregated by gender and age)*	NDHS, NMICS	Health
1.4 % of anaemia among adolescent girls (10-19 years)	NDHS, NMICS	Health
1.5 % of anaemia among WRA (15-49 years)	NDHS, NMICS	Health
1.6 Prevalence of under 5-years old children with diarrhoea in last two weeks (*disaggregated by gender and age)*	NDHS, NMICS	Health
1.7 Mean dietary diversity score among WRA (15-49 years)	NDHS, NMICS	Health
2: Nutrition-sensitive outcome		
2.1 Proportion of population below minimum level of dietary energy consumption	NMICS	Agriculture and Livestock
2.2 % people using safe drinking water	NMIP-DWSS	Water and Sanitation
2.3 % people using improved sanitation facilities that are not shared	NMICS	Water and Sanitation
2.4 % of people practicing hand washing with soap and water before feeding baby (0-2 yrs) and after cleaning babies' bottoms	NDHS	Water and Sanitation
2.5 Percentage of women aged 20-24 years who were married or in union before age 18	NDHS	Women, Children and Social Welfare and Health
2.6 Gross enrolment rate (GER) (boys and girls) in early child education and development (ECED)/pre-primary education (PPE)	EMIS	Education
2.7 % of out-of-school children (boys and girls) in basic education	EMIS	Education
2.8 Basic education cycle completion rate (boys and girls)	EMIS	Education
3: Enabling environment outcome		
Outcome 3: Improved policies, plans and multi-sectoral coordination at federal, provincial and local government levels to enhance the nutrition status of all population groups		
3.1. % of farmland owned by women or in joint ownership	ADS	Agriculture and Livestock
3.2. No. of local, provincial and federal government plans that include nutrition and food security programs in line with MSNP-II	Government plans and MSNP-II annual progress report	Local Governance
3.4. Availability of national budget code for nutrition and food security	MoF budget code	NPC
3.5. National Capacity Development Master Plan for implementation of MSNP produced	CapacityDevelopment Plan	NPC, all sectors
3.6. Multi-sector commitment and resources for nutrition increase to at least 3.5% of total budget	MoF red Book	NPC
3.7. Financial resource tracking in place	Financial resource tracking tools	NPC, MoF

Annex 2.5: Features of the full package and partial package intervention areas:

Full Package	Partial Package
• Full participation of all seven sectors (health, education, agriculture development, livestock development, women and children development, WASH and local governance) with the minimum program and an integrated action plan • Integrated planning, implementation, and reporting of 7 sectors • School WASH or Female Cooperative intervention for income generating of poor women at the local level. • Technology-based information management systems established, and reporting ensured • Availability of MSNP Volunteers or MSNP focal person at Local level.	• Formulation of the Nutrition and Food Security Steering Committee • Involvement of at least health or/and governance sector • Preparation of an integrated MSNP action plan • Orientation to mothers and caregivers on utilization of Child Cash Grants. • Ensure linkage of the child grant with Infant and Young Child Feeding (IYCF) interventions. • Technology-based information management systems established, and reporting ensured

• Availability of MSNP Volunteers or MSNP focal person at Local level.	

Annex 2.6: List of sectors-specific MSNP interventions in the full-package districts and *palika.*

Sectors	Interventions
Health Sector	• Capacity building of Health workers and female community health volunteers on IMAM through Comprehensive Nutrition Specific Interventions (CNSI) and scaling up CNSI • Establish and Strengthen OTC and Ready to Use Food (RUTF) transportation at the Local level • Counseling for behavior change on consumption of diversified food among pregnant, lactating women • Supplementation of iron folic acid and deworming tablets as per protocol to Pregnant and lactating women and adolescent girls • Supplementation of deworming tablets for the school children • Counsel to pregnant, lactating women and family members for the early initiation within 1 hour of birth and exclusive breastfeeding for the first six month • Support in Bi-annual supplementation of Vitamin A to 6–59-month children and deworming tablets to 12–59-month children • Celebration of nutrition days; breastfeeding week, Iodine month, nutrition week, etc.)
Education Sector	• Distribution of sanitary pads to Adolescent girls • Form Child clubs at the local level • Distribution of education kit • ECD and literacy class for women/ mothers on nutrition • Orientation/training to education sector staff on mainstreaming nutrition in annual program planning • Mobilization of SMC/PTA/Teachers Association for parent education • Training for students at school on kitchen gardening • Develop a Model kitchen garden at school • Schools with the provision of mid-day meal • School drinking water and sanitation scheme
WASH Sector	• Campaign for total sanitation, • Training/orientation to Adolescent girls on incinerators for management of sanitary pads • Conduct WASH committee meetings • Training/orientation to Household members on water purification methods • Sensitize a student on handwashing during critical situations and drinking water purification • Form and reform WASH-CC • Upgrade WASH facilities in ECDs and schools • Filter/purifier distribution at households

Sectors	Interventions
Agriculture Sector	• Support for Kitchen Garden activities (including promotional activities: pipe motor, micro irrigation) • Distribution of seed packets for kitchen gardening • Distribution of fruit plants • Distribution of Kitchen Garden Kit • Conduct Training for Kitchen gardening, • Conduct Training on Agriculture Gardens, • Conduct Training to Promote Traditional and local food grains including organic farming, • Training/Orientation for Mothers on nutrition, • Conduct Training for students on kitchen gardening at school and home
Livestock Sector Intervention	• Distribution of grass plants or seeds for animal husbandry, • Distribution of Chicken/pigeons/duck/fingerlings, • Distribution of Goats/Pig, • Households benefitted from anti-parasitic medicines for poultry/animals, • Dairy Production and Promotions Training • Training on animal husbandry, • Training for poultry farming on a short scale

Women and Children Sector Intervention	• Grant support to women groups/cooperatives for income generation, • Training/orientation to Members of women federations/ women cooperatives/mothers' group/ women group on nutrition, reproductive health, and safe motherhood, • Training on gender violence to G1000Days mother, • Training/orientation to Adolescent girls on nutrition, • Training/orientation to Adolescent girls on the reduction of child marriage, • Training/orientation to Adolescent girls on reproductive health and menstrual hygiene, • Training/orientation to Adolescents on reproductive health, safe motherhood, and nutrition, • Advocacy, awareness raising against traditional beliefs/culture about menstruation, • Mothers-in-law and daughters-in-law enroll in the interaction program, • Training/orientation to the Out-of-school adolescent girls on life skills and nutrition,
Local Governance Sector	• Formation of MLNFSSC and WLNFSSC, Regular meeting of MLNFSSC and WLNFSSC • Training/Orientation to Political leaders and stakeholders on nutrition and MSNP • Conduct Annual reviews at the district and Local level • Distribution of cash grant to G1000Days mother • Display of hoarding boards/banners on nutrition • Orientation to Household members on IYCF message while receiving child cash grant, • Distribution of child cash grant (except GoN regular program) • Joint visits to monitor MSNP activities • Orientation to Journalists/media persons on nutrition and food security • Publish Posters/pamphlets/calendars on nutrition • Recruit and capacity building of MSNP Volunteers

Annex 2.2: Brief on MSNP Evaluation 2022

Brief on MSNP Evaluation 2022

The evaluation of Nepal's MSNP was undertaken independently by a third party between October 2021 and March 2022 to assess the program's relevance, effectiveness, efficiency, impact, and sustainability of MSNP interventions. The evaluation assessed the contribution of Nepal's MSNP program in improving the nutritional status of children aged under five and women of reproductive ages. The scope of the evaluation was the MSNP program in Nepal to date with a primary focus on MSNP- I (2013-2017) as MSNP-II (2018-2022) is still underway.

The evaluation employed a combination of qualitative and quantitative methods. The quantitative data analysis was based on primary data collected for the 2017 midline and 2019 End-line surveys. The 2014 NMICS was taken for baseline. The purpose of quantitative data analysis was to assess whether the program had made a difference in the prevalence rates of stunting, underweight, and wasting among children aged under five, and in the level of chronic energy deficiency among women (BM1<18.5) in the 28 intervention districts where the program was rolled out in three phases (first phase beginning in 2014/15) during MSNP-I.

Difference-in-differences (DID) model that uses a "before-after and intervention-comparison" evaluation framework to quantify the impact of the program, controlling for fixed effects and other pre-existing differences between the intervention and comparison areas was used for quantitative data analysis. For this evaluation, the intervention/treatment group consisted of 18 districts where the MSNP had been rolled out between 2014 and 2016 in three phases while the control group consisted of a sub-sample of households from MICS 2014 with similar socio-economic characteristics as intervention households.

The qualitative data analysis was based on the data collected through 43 KIIs with various stakeholder groups - 29 in Nepali (with provincial and local level implementers, MSNP Volunteers, and FCHVs and beneficiaries) and 14 in English (with members of NPC, sectoral Ministries, and development partners) was conducted.

Annex 2.3: Data Sources for the Review (Desk Review and secondary data analysis)

S.N.	Methods	Data Source

	Desk Review	• Management information system across different sectors –
		  ○ Health Management Information System
		  ○ Education Information Management System
		  ○ Local Governance (Web-Based Reporting System): With the view to examine the progress and coverage trend vis-à-vis the MSNP-II's result chain and report on progress on most of the nutrition-sensitive interventions particularly supported through EU budget support
		• National, provincial, and local level MSNP-II progress reports and review reports between 2018 to August 2021
		• Nepal Multiple Indicator Cluster Survey (NMICS) 2019
		• Nepal Demographic Health Survey (NDHS) 2016; Nepal Health Facility Survey 2021.
		• Evaluation of Nepal's Multi-Sector Nutrition Plan (MSNP) 2022
		• Department of Health Services' (DoHS) Annual Report from the Ministry of Health and Population including annual reports from sectoral ministries (Education, Agriculture, Livestock, Water Sanitation, and Hygiene, Women, Children, and Social Welfare, Ministry of Federal Affairs and General Administration (MoFAGA)
		• Flash Report of the Education Sector
		• Statistical Information on Nepalese Agriculture – Agriculture Sector
		• Long-term plans, periodic plans, and strategies of the provincial and local levels.
		• Sectoral strategies, plans, and policies: Agriculture Development Strategy (2015-2035)
		• National Health Policy 2019
		• National Nutrition Strategy 2020
		• Nepal Health Sector Strategy
		• Zero Hunger Challenge National Action Plan (2016-2035)
		• Country's commitment to Nutrition for Growth (N4G) 2021
		• UN Food System Summit 2021
		• SUN JAA, reports
		• Partnership for Improved Nutrition (PIN) Evaluation Report
		• Fill the Nutrient Gap Analysis 2021 report
		• SDGs Progress Assessment Report 2016-2019
		• Nepal: Education Sector Analysis 2021
		• Reports and relevant documents and studies from World Food Program (WFP) and (United States Agency for International Development (USAID) funded SUAAHARA projects
		• Some of the relevant literature and publications on the MSNP examine the outcome and effectiveness of different nutrition-sensitive and nutrition-specific interventions in other countries; Documents of monitoring and field visits.

Annex 2.4 Data source for Primary data collection (Qualitative)

S.N.	Methods	Data Source
	Key Informant Interviews	i. Focal person of all the sectoral ministries ii. Focal Person from USAID for SUAAHARA Project iii. Focal Person from World Food Program (WFP) and Food and Agriculture Office iv. Focal persons of the Foreign Commonwealth Development Office (FCDO) v. Focal person of ACF vi. Representatives from the private sectors (Federation of Nepalese Chamber of Commerce & Industries, Baliyo Nepal) vii. Representatives from Civil Society Organization (Civil Society Alliance for Nutrition Nepal – CSANN)
	In-depth Interviews (IDIs)	Chief of the Basic Health Service Center (BHSC)- (Health Post, Primary Health Care Center
	Interactions with the steering committee	• Provincial Level Nutrition and Food Security Steering Committee • Local Level Nutrition and Food Security Steering Committee • Interaction with District Coordination Committee
	Focus Group Discussion (FGDs)	Women who have children under five with different socioeconomic backgrounds.