Multi-Sector Nutrition Plan

(2018–2022)

Approved by the Cabinet Meeting of the Government of Nepal on 19 November 2017

Government of Nepal
National Planning Commission
Singha Durbar, Kathmandu, Nepal
2017

Unofficial Translation

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THE PRIME MINISTER

KATHMANDU
NEPAL

Message from the Prime Minister

Throughout the world, ending malnutrition is taken as a basis for achieving social, economic and human development as well as the Sustainable Development Goals. Studies have shown that the health issues caused by malnutrition are serious, long lasting and irreparable. Approximately 36 percent of Nepalese children suffer from stunting and 10 percent from wasting. Therefore, additional efforts from all relevant stakeholders are essential to achieve the social and human development commitments Nepal has made at regional and international forums.

In this context, under the leadership of the National Planning Commission, and with coordinated support from relevant ministries and development partners, the Multi-Sector Nutrition Plan (MSNP, 2013–2017) has been implemented. It is essential to launch additional efforts targeted to reduce malnutrition in pregnant and lactating mothers, children under the age of two and adolescent girls. Similarly, as a continuation of the current plan, with participation from seven relevant ministries, development partners and other stakeholders, MSNP-II (2018–2022) has been formulated for the upcoming five years. This plan needs to be implemented with priority following the federal structure at all levels – federal, provincial and local, so as to reduce malnutrition which adversely affects social, economic and human development.

The plan has the target of minimizing the adverse effects on human capital and social and economic development by reducing chronic malnutrition from the current 36 percent to 28 percent in the upcoming five years. As per the World Health Assembly global targets, malnutrition needs to be reduced to 24 percent of under-fives by the end of 2025. Similarly, the Sustainable Development Goals target is to reduce the percentage to 15 percent by 2030. In line with this, the plan attempts to build capacity at all levels of government agencies and relevant stakeholders by implementing promotional, preventive and therapeutic measures to reduce the problem of malnutrition in women, children and adolescent girls.

It is essential, with our collective efforts, to reduce malnutrition among women, children and adolescent girls. For this, our additional commitments are essential to achieve the neccessary additional progress while sustaining the achievements made at all levels across the various sectors.

Jay Nepal!
Mangsir, 2074

Sher Bahadur Deuba
Prime Minister and Chairperson
National Planning Commission

VICE-CHAIRMAN

GOVERNMENT OF NEPAL
National Planning Commission
SINGHA DURBAR, KATHMANDU, NEPAL

Message from the Vice Chair

Malnutrition causes 45 percent of all deaths of under 5-year-olds worldwide. Undernutrition hampers their physical, mental and emotional development which in turn adversely affects the overall social, economic and human development of countries.

Approximately 36 percent of Nepal's children suffer from stunting, 10 percent from wasting and almost 53 percent from anaemia. Forty-one percent of women of reproductive age suffer from anaemia and 17 percent from long term energy deficits. These statistics differ by geographical region and social group.

Studies have shown that malnutrition cannot be addressed by the efforts of the nutrition sector alone and hence the first Multi-Sector Nutrition Plan (2013–2017) was formulated and implemented in an integrated and coordinated way between nutrition specific and nutrition sensitive sectors. Taking stock of the achievements under MSNP (2013–17) pointed to the necessity of continuing these efforts and thus MSNP-II (2018-2022) has been conceptualized. This new plan aims to make a crucial contribution to achieve the Sustainable Development Goals related to health and nutrition and to help reap the benefits of the demographic dividend by strengthening the future economically productive population.

To ensure its effective implementation, MSNP-II was formulated by all the concerned ministries and development partners including the ministries of health; agricultural development; livestock development; education; water supply and sanitation; women, children and social welfare; and federal affairs and local development, plus development partner agencies and other stakeholders. The National Planning Commission played the coordinating role.

Strong leadership is needed at the local level, as successful implementation at this level will determine the achievement of the plan's outcomes. In this context, various federal, provincial, local and ward level structures are being established to effectively undertake the plan's programmes and activities.

The NPC will extend various kinds of support, coordination and facilitation to ensure the implementation of this plan at all levels. I expect unified and consolidated support from all relevant stakeholders including all relevant ministries, local governments, development partners, civil society and the private sector.

Swarnim Wagle
Vice Chair
National Planning Commission

MEMBER

GOVERNMENT OF NEPAL
National Planning Commission
SINGHA DURBAR, KATHMANDU, NEPAL

Message from NPC Member

Both undernutrition and overnutrition persist among Nepalese women and children although undernutrition is more common. The problem of undernutrition is specially seen in women of reproductive age and children under the age of five. The main causes of undernutrition are inadequate access to nutritious and diverse food, the poor use of available foods, infectious diseases due to unsafe water and poor hygiene, untimely treatment of diseases, poor use of health services, heavy workloads and poor awareness. Stunting, wasting, under-weight, and maternal and child anaemia are the major problems caused by undernutrition. These problems are found in varying degrees among different social groups, classes and communities, and geographical regions.

From the perspective of nutrition, the period from conception until a child's second birthday are crucial — it is known as the "golden thousand days". During this period, the foods eaten by pregnant women, new mothers and newborns and childcare play a crucial role in growth and development of children. Scientific studies indicate that the problems of undernutrition, such as the breastfeeding of newborns and children, supplementary food, caring habits and behaviour, sanitation, cleanliness, and food security, can be resolved only if programmes are formulated and implemented in a consolidated way with a collective approach.

Under the leadership and coordination of the National Planning Commission (NPC), the ministries of health; agricultural development; livestock development; water and sanitation; education; women, children and social welfare; federal affairs and local development, as well as national and international agencies working on nutrition are applying collaborative efforts through the multisectoral approach to address the problems of malnutrition.

The Sustainable Development Goals for Nepal have targets to reduce stunting to 25 percent, wasting to 4 percent, and anaemia to 10 percent among children under five by the year 2030. Similarly, the government has set a target to reduce anaemia in women of reproductive age to 10 percent on the same timeline.

Considering the research and study findings indicating the need of multisectoral efforts to address malnutrition, the government formulated and implemented the Multi-Sector Nutrition Plan (MSNP) 2013-2017. As the continuation of this plan, MSNP-II (2018-2022) has been formulated and will be expanded throughout the country.

The Multi-Sector Nutrition Plan-II (2018-2022) will be implemented at all three levels of government: federal, provincial and local, with active participation from the relevant sectors with the local level playing a vital role. In this context, in order to identify various activities under the plan and devise a detailed work plan and effectively implement it requires the participation of nutrition and food security committees at state, district, municipality, rural municipality and ward levels. This also requires the technical and financial contribution from development partners.

To conclude, I would like to express my sincere gratitude to the High Level Committee for Nutrition and Food Security formed under the chairmanship of NPC vice-chair for their direction and suggestions in formulating MSNP-II. I would also like to thank the members of the National Nutrition and Food Security Coordination Committee (NNFSCC) for their help and suggestions. I also appreciate the contribution of the ministries, donor agencies and development partners for their contributions to formulating the Multi-Sector Nutrition Plan-II. I also thank all the staff of the National Planning Commission Secretariat, National Nutrition and Food Security Secretariat for helping to produce this new plan.

Prof. Dr. Geeta Bhakta Joshi
Member
National Planning Commission

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Abbreviations

AARR	Average Annual Rate of Reduction
ABPMDD	Agribusiness Promotion and Marketing Development Directorate
ANC	Antenatal Care
AWPB	Annual Workplan and Budget
BMI	Body Mass Index
CLC	Community Learning Centre
CMAM	Community-Based Management of Acute Malnutrition
DFID	Department for International Development (UK Aid)
DFTQC	Department of Food Technology and Quality Control
DoCR	Department of Civil Registration
DoE	Department of Education
DoHS	Department of Health Services
DoLS	Department of Livestock Services
DWC	Department of Women and Children
ECED	Early Childhood Education and Development
EMIS	Education Management Information System
FAO	Food and Agriculture Organization
FCHV	Female Community Health Volunteer
GoN	Government of Nepal
HLNFSSC	High Level Nutrition and Food Security Steering Committee
HMIS	Health Information Management System
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Neonatal and Childhood Illness
ITC	Inpatient Therapeutic Care
IYCF	Infant and Young Child Feeding
JMP	Joint Monitoring Programme
MIYC	Maternal, Infant and Young Child
MIYCN	Maternal, Infant and Young Child Nutrition
MIYCU	Maternal, Infant and Young Child Undernutrition
MNP	Multiple Micronutrient Powder
MoAD	Ministry of Agriculture Development
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoH	Ministry of Health
MoLD	Ministry of Livestock Development
MoWCSW	Ministry of Women, Children and Social Welfare
MoWSS	Ministry of Water Supply and Sanitation
MSNP	Multi-Sector Nutrition Plan
NA	Not Available
NDHS	Nepal Demographic and Health Survey

NFC	Nepal Food Corporation
NLSS	Nepal Living Standards Survey
NMICS	Nepal Multiple Indicator Cluster Survey
NMIP-DWSS	National Management Information Project of the Department of Water Supply and Sewerage
NNFSS	National Nutrition and Food Security Secretariat
NPC	National Planning Commission
NPR	Nepali Rupees
NRH	Nutrition Rehabilitation Home
O&M	Organisation and Management
ODF	Open Defecation Free
OPD	Outpatient Department
ORS	Oral Rehydration Solution
OTC	Outpatient Therapeutic Care
PHC-ORC	Primary Health Care Outreach Clinics
PNC	Post-Natal Care
PPE	Pre-Primary Education
ReSoMal	Rehydration Solution for Malnutrition
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goal
SUN	Scaling Up Nutrition
ToT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WCF	Ward Citizens Forum
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
WRA	Women of Reproductive Age

Executive Summary

Multi-Sector Nutrition Plan-II (2018–2022)

Nepal has made strong efforts to address the problem of malnutrition. The Government of Nepal has recognized the need of multi-sectoral efforts to improve the nutrition of its citizens. It developed the first Multi-Sector Nutrition Plan, which was implemented from 2013 led by the National Planning Commission. The second Multi-sector Nutrition Plan (2018/19–2022/23) has been designed as a continuation of MSNP (2013–17).

Nepal has made remarkable progress in the field of nutrition. According to the regular Nepal demographic health surveys (NDHSs), stunting among under-five years children has reduced from 57 percent in 2001 to 35.8 percent in 2016. The process of stunting starts at conception, accelerates until two years of age, and is then irreversible. Therefore, nutrition needs to be improved among mothers and potential mothers (i.e. during adolescence and pregnancy) and when children are under two years of age.

Overweight and obesity is an emerging problem due to excessive intake of high amounts of fat, sugar and salt and inactive lifestyles. This is leading to a growing incidence of high blood pressure, diabetes and other non-communicable diseases.

The undernutrition problems of stunting, wasting and low weight in children contribute to 52 percent of child mortality in Nepal. And those who survive usually have limited intellectual growth and cognitive development that affects their education.

The World Bank estimates that undernutrition causes losses of up to 3 percent of economic development. Thus, improving nutrition is a precondition to break the cycle of poverty and for sustainable economic development.

Major causes of chronic malnutrition in Nepal are poor feeding and care practices, insufficient nutrient intake, and high rates of infection and teenage pregnancy. The Nepal Demographic Health Survey, 2016 reported that only 50 percent of babies were breastfed within one hour of birth. Although, the exclusive breastfeeding rate of newborns up to six months of age is 66 percent, only 17 percent of 6–8 months old babies were found receiving minimum acceptable diets while only 35 percent of children aged 6-23 months received minimum acceptable diets. Despite improvements in complementary feeding, families and fathers play little part in promoting this.

According to the Nepal Multiple Indicator Cluster Survey, 2014, 20 percent of children under 5 years of age had recently suffered from fever and 12 percent from diarrhoeal disease. These infections lead to malnourishment and the death of young children. According to the 2016 NDHS, 17 percent of women of reproductive age and 30 percent of adolescent girls had chronic energy deficiency (BMI less than 18.5kg/m^2), while 44 percent of adolescent girls were anaemic. Pregnancy in these conditions results in low birth weight babies, a cycle that repeats from mother to child and onwards. Maternal and infant infections are also common problems as are intestinal parasites. Other problems that contribute to malnutrition are that 13 percent of women of reproductive age smoke, while 40 forty percent of women suffer from indirect smoking, and 75 percent are exposed to smoke pollution from solid fuel cooking stoves.

According to the Nepal Multiple Indicator Cluster Survey, 2014, 48 percent of women aged 20-49 years were first married or in union before age 20 and so teenage pregnancies are common. And 16 percent of women delivered a baby before their eighteenth birthdays. In such cases, maternal care practices tend to be poor. The heavy workloads of many women after delivery is another problem.

Access to and the use of health services has improved. The 2016 NDHS reported 53 percent of married women aged 15-49 years using modern

According to the regular Nepal demographic health surveys (NDHSs), stunting among under-five years children has reduced from 57 percent in 2001 to 35.8 percent in 2016. The process of stunting starts at conception, accelerates until two years of age, and is then irreversible.

The underlying causes of malnutrition have diminished. Now, only 21.6 percent of the population live below the poverty line. It however remains challenging to provide enough food in food deficit districts year-round to attain the SDG of zero poverty and hunger.

family planning methods. Maternal care practices have also improved with 84 percent of pregnant women having at least one antenatal or postnatal checkup. Fifty-eight percent of pregnant women used the services of a skilled birth attendant for their deliveries.

According to the Nepal Multiple Indicator Cluster Survey, 2014, 93 percent of households used a source of safe drinking water. However only half of the population used toilet facilities while less care was taken for the safe management of cow dung and manure, which creates a polluting environment and spreads disease and parasites. This indicates that personal hygiene and sanitation is still poor in many households.

Although the literacy rate among young women has reached more than 88.6 percent, women's voices are not adequately heard and they play little part in decision-making. Gender discrimination and social exclusion persist, although they are being addressed in many programmes of the government and its development partners.

The underlying causes of malnutrition have diminished. Now, only 21.6 percent of the population live below the poverty line. It however remains challenging to provide enough food in food deficit districts year-round to attain the SDG of zero poverty and hunger. But at the basic level of causality there have been overwhelming improvements in infrastructure including roads, schools and health facilities.

According to the Global Nutrition Report, 2016, scaling up nutrition investments is a high-impact, high-return proposition, with a benefit-cost ratio of 16:1 and a compound rate of return of more than 10 percent. The costs of neglecting nutrition are high, causing economic losses of around 10 percent of gross domestic product.

The design of this Multi-Sector Nutrition Plan-II (2018/19–2022/23) addresses the achievement of the World Health Assembly global targets for 2025, the Sustainable Development Goals for 2030 and nutrition deprivation and causality analysis in Nepal. This plan addresses lessons

learned from MSNP (2013–17). Nutrition related cultural trends, habits, weaknesses in the nutrition sector, gaps and the problems of under-nutrition and over-nutrition have also been analysed. The plan's logical framework leads on from its theory of change. This plan covers concepts and experiences shared by the related sectoral ministries.

This final draft of MSNP-II was discussed in the National Nutrition and Food Security Coordination Committee and then submitted to the High Level Nutrition and Food Security Steering Committee for endorsement. The endorsed document from the HLNFSSC was approved by the Council of Ministers in November 2017.

The implementation of MSNP (2013–17) started with the aim of enhancing nutrition to remove it as an impeding factor for human development and for overall socioeconomic development. The new plan continues the MSNP (2013–17) interventions. The goal for the next five years is "Improved maternal, adolescents and child nutrition'" which will be achieved by taking to scale nutrition specific and sensitive interventions and by improving the nutrition enabling environment.

The nutrition specific interventions will be largely delivered through the health sector, and the nutrition sensitive interventions mainly by the education, agriculture, livestock, water and sanitation, women and children sectors in collaboration with local governments. All these interventions will aim to improve the status of nutritional as measured against the incidence of stunting and wasting among under 5-year-olds and low birth weight babies. The plan also aims to reduce chronic energy deficiency among women. The expectation is also to reduce the proportion of mothes and children who are overweight.

The implementation of MSNP (2013–17) started in 2013 with the aim of enhancing nutrition to remove it as an impeding factor for human development and for overall socioeconomic development. The new plan continues the MSNP (2013–17) interventions.

Table A: Goal, outcomes and outputs of MSNP-II

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

OUTCOME 1: IMPROVED ACCESS TO AND EQUITABLE USE OF NUTRITION-SPECIFIC SERVICES

Output 1.1: Enhanced nutrition status of women of reproductive age including adolescents

Output 1.2: Improved infant and young child nutrition and care practices

Output 1.3: Improved maternal, infant and young child micronutrient status

Output 1.4: Improved management of severe and moderate acute malnutrition

Output 1.5: Enhanced preparedness for nutrition in emergency responses

Output 1.6: Capacity built of nutrition-specific sectors

OUTCOME 2: IMPROVED ACCESS TO AND THE EQUITABLE USE OF NUTRITION-SENSITIVE SERVICES AND IMPROVED HEALTHY HABITS AND PRACTICES

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

Output 2.2: Increased physical and economic access to diverse types of food

Output 2.3: Increased access to safe drinking water

Output 2.4: Increased access to safe and sustainable sanitation services

Output 2.5: Improved knowledge of children and mothers and caretakers of under 5-year-old children on health and hygiene

Output 2.6: Targeted groups have access to resources and opportunities that make them self-reliant

Output 2.7: Nutrition component incorporated in women, adolescent girls and child development training packages

Output 2.8: Women, children and out-of-school adolescent girls reached with health and nutrition care practices

Output 2.9: Child care homes comply with minimum standards of nutrition care

Output 2.10: Communities empowered to prevent harmful practices (menstrual seclusion [chhaupadi], food taboos)

Output 2.11: Enhanced enrolment of children in basic education

Output 2.12: Increased adolescent girls' awareness and improved behaviour on nutrition

Output 2.13: Enhanced access to health and reproductive health services

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

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

Output 3.2: MSNP governance mechanism instituted and strengthened at federal, provincial, and local levels

Output 3.3: MSNP institutional mechanisms established and functional at federal government level

Output 3.4: Functional updated information system across all MSNP sectors

Output 3.5: Enhanced capacity of federal, provincial and local level government to plan and implement nutrition programmes

Chapter 1

REVIEW OF MULTI-SECTOR NUTRITION PLAN, 2013–17

Chapter 1

1. Review of Multi-Sector Nutrition Plan (2013–17)

1.1 Background

The Government of Nepal and its development partners are committed to addressing the complex problem of malnutrition. The government's development objectives are outlined in the Constitution of Nepal, the Fourteenth Development Plan and the Sustainable Development Goals (SDGs). Economic growth, employment promotion, poverty alleviation, post-conflict reconstruction, social transformation and human resource development are the government's development priorities.

Improving the nutritional status of its citizens is a major priority of the government. Improving nutrition involves interventions in health and other sectors; thus policies, strategies and plans of the health, agriculture, livestock, water and sanitation sectors emphasise good nutrition and food security.

The government is addressing the complex causes of malnutrition through a multi-sectoral approach. Its first Multi-Sector Nutrition Plan (MSNP, 2013-2017) had the following outcomes:

1. Improved maternal, infant and young child feeding.
2. Increased maternal, infant and young child micro-nutrient status.
3. Improved management of malnutrition in children.

MSNP (2013–17) was implemented through the following nutrition-specific and nutrition-sensitive programmes:

- The 'direct' nutrition-specific interventions targeted individuals and included micronutrient supplements to under 5-year-olds and adolescents and women during pregnancy and lactation, micronutrient fortification (salt iodization and flour fortification), awareness raising and behaviour change communication on optimal infant and young child feeding, and the management of severe acute malnutrition.
- The 'indirect' nutrition-sensitive interventions targeted families and communities including on hygiene and sanitation, with cash and in-kind transfers (including child cash grants), nutritious food and diets, school feeding programmes and parental education.

These programmes (most of which are ongoing) were implemented by government line ministries, principally the Ministry of Health (MoH), Ministry of Agricultural Development (MoAD), Ministry of Livestock Development (MoLD), Ministry of Education (MoE), Ministry of Water Supply and Sanitation (MoWSS), Ministry of Federal Affairs and Local Development (MoFALD), and the Ministry of Women, Children and Social Welfare (MoWCSW). In addition to funding the regular cross-sectoral nutrition programmes nationwide, the government provided additional funding to implement MSNP (2013–17) in 28 priority districts from its own resources and development partner support.

1.2 Introduction

People are malnourished if their diet provides inadequate nutrients for growth and good health or if they are unable to fully use the food they consume due to illness. They are also malnourished if they consume too many calories (overnutrition) (UNICEF 2012).

Malnutrition is caused by poor health, diet, education, access to resources, empowerment and other factors. Good nutrition, i.e. an adequate well-balanced diet, and regular physical activity are the cornerstones of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development and reduced productivity.

The government is addressing the complex causes of malnutrition through a multi-sectoral approach.

Nutritional deficiencies among young children

From the perspective of nutrition, a young child's first 1,000 days (from conception to the second birthday) are critical. Nutrition interventions can have a huge benefit during this period. Subsequent interventions can make a difference, but cannot undo damage related to malnutrition from the first 1,000 days.

and mothers has large economic costs that manifest later in an increased burden of disease and losses of human capital and economic productivity. Undernourished children suffer irreparable intellectual impairment and stunted physical growth. Hungry children make poor and less productive students and often make unhealthy workers. All this results in impoverished families and communities and an overburdened health care system.

Undernourished mothers usually give birth to underweight babies, thus transferring disadvantages to the next generation. From the perspective of nutrition, a young child's first 1,000 days (from conception to the second birthday) are critical. Nutrition interventions can have a huge benefit during this period. Subsequent interventions can make a difference, but cannot undo damage related to malnutrition from the first 1,000 days.

Children's nutrition outcomes are closely related with maternal nutrition. Healthy, well-nourished mothers are more likely to give birth to and nurture healthy children. Accordingly, it is important that adolescent girls, pregnant women and lactating mothers receive the range of nutrition-related services and information they need to support their good nutrition.

1.3 Global Nutrition Initiatives

The main initiatives that guide and promote improved nutrition at the global level are the Scaling Up Nutrition (SUN) Framework, the SDGs and the World Health Assembly's global nutrition targets (2012).

The momentum to improve nutrition accelerated at the global level from 2009 with the initiation of a global collaborative process, the Scaling Up Nutrition (SUN) Framework (scalingupnutrition.org). The SUN framework has been endorsed by over 100 international development institutions working in the field of nutrition including UNICEF, WFP, FAO, WHO, USAID, DFID, DFAT and the World Bank, and by the governments of 59 countries (the movement). The SUN Movement works to build an enabling social, economic and political environment that ensures all children can reach their full potential. The SUN Movement Strategy and Roadmap (2016-2020) (SUN Movement 2016) calls for the following:

1. Expanding and sustaining an enabling political environment.
2. Prioritizing and institutionalizing effective actions that contribute to good nutrition.
3. Implementing effective actions aligned with common results frameworks.
4. Effectively using and significantly increasing financial resources for nutrition.

The SUN framework calls for multi-sectoral approaches to improving nutrition, arguing that the essential complementary approaches of nutrition-specific activities and nutrition-sensitive activities both need scaling up.

Almost all countries signed up to the 2030 Agenda for Sustainable Development committing to comprehensive, integrated and universal transformations, including ending hunger and malnutrition. The agenda focuses on achieving the 17 Sustainable Development Goals by 2030. SDG 2 calls for "Ending hunger, achieving food security and improving nutrition and promoting sustainable agriculture." At least 12 of the 17 SDGs have indicators that are relevant to good nutrition with SDGs 1, 2, 3 and 6 closely related to nutrition. Nepal's enactment of its new 2015 Constitution coincided with the beginning of the SDG period providing the opportunity for the new system of governance to focus on achieving the SDGs.

In 2012, the World Health Assembly (WHA) agreed on the following six global nutrition targets by 2025 (WHO 2012):

- 40 percent reduction in the number of children under-5 who are stunted
- 50 percent reduction of anaemia in women of reproductive age
- 30 percent reduction in low birth weight babies
- no increase in childhood overweight
- increase the rate of exclusive breastfeeding in the first 6 months up to at least 50 percent
- reduce and maintain childhood wasting to less than 5 percent.

The following are other important global commitments signed up to by Nepal:

- In 2013, the World Health Assembly agreed to halt the rise in diabetes and obesity as part

of the adoption of the comprehensive global monitoring framework for the prevention and control of non-communicable diseases WHO 2013).

- Many countries, including Nepal, endorsed the World Health Organisation's Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (MIYCN) in 2012 (WHO 2014).

1.4 Initiatives to Improve Nutrition in Nepal

The government has instituted a number of nutrition-related policies and plans:

The National Nutrition Policy and Strategy, 2004 (CHD 2004) guides nutrition programmes and activities in the health sector. Other relevant policies and plans include the National Health Policy 2015, the Nepal Health Sector Strategy Action Plan (2016-2022) and the Food and Nutrition Security Plan of Action (2014-2024).

The Agriculture Development Strategy, 2015–2035 (MoAD 2015) calls for reducing food-related poverty from 27.6 percent in 2016 to 13 percent in 2026 and 6 percent in 2036. Food and Nutrition Security is one of the strategy's flagship programs.

The Nepal Health Sector Strategy, 2016-2021 (MoHP 2015) recognises nutrition as a multi-sectoral issue and includes related programmes and activities under the following three action areas:

- ***Maintain comprehensive extension and use of services*** — These programmes include distributing Vitamin A capsules to under 5-year-olds and deworming tablets to 1–5 year olds, the distribution and use of zinc tablets for diarrhoea treatment, the distribution of iron folic acid tablets, deworming tablets and vitamin A capsules to pregnant mothers, and the use of iodised salt.
- ***Programmes to scale up*** — These programmes include exclusive breastfeeding after birth, complementary feeding (including breastfeeding after 6 months), providing Baalvita micronutrient powders to 2–23 month olds, handwashing at critical times, the integrated management of severe malnutrition and the production of fortified flour.
- ***Programmes to assess and revise*** — These programmes include maternal and child nutrition improvement related activities, mixing micronutrients in fortified wheat flour and the treatment of child malnutrition.

The Nepal Water Supply, Sanitation and Hygiene Sector Development Plan, 2016-2030 (MSWW 2016) calls for actions that enhance nutrition including frequent handwashing with soap, safe disposal of faeces, the safe handling and treatment of drinking water and regular nail cutting, bathing, and tooth brushing.

And above all, Nepal's new 2015 Constitution grants all citizens the fundamental right to food and basic health care (GoN 2015).

MSNP (2013-17) calls for nutrition-specific and nutrition-sensitive programmes to address undernutrition. The health, education, water and sanitation, agriculture and livestock, local governance and women, children and social welfare sectors have a leading role to play in improving nutrition in Nepal. The interventions implemented by these six sectors in Nepal under MSNP (2013–17) are summarised below.

- **Health —** The wide range of health sector nutrition interventions included maternal infant and young child nutrition, maternal health care, micronutrient supplementation and the fortification of foodstuffs.
- **Education —** Education has a large role to play in improving the nutritional knowledge and behaviour of the future generation. Major MoE nutrition programmes under MSNP (2013–17) were the provision of midday meals in schools, improving water, sanitation and hygiene (WASH) facilities in schools and the inclusion of nutrition topics in curricula.
- **Water and sanitation —** The water and sanitation sector is involved in nutrition by promoting safe drinking water and sanitation, especially as diarrhoea is a major cause of child mortality. The interventions run in the MSNP (2013–17) period were mainly for safe water supplies and improving hygiene and sanitation.
- **Agriculture and livestock —** The development of agriculture and livestock production is crucial for improving nutrition. Interventions were run under MSNP (2013–17) to en-

MSNP (2013-17) called for nutrition-specific and nutrition-sensitive programmes to address undernutrition. The health, education, water and sanitation, agriculture and livestock, local governance and women children and social welfare sectors have a leading role to play in improving nutrition in Nepal.

There has been a large reduction in childhood stunting (short height for age) in Nepal in recent years; reducing from 57 percent of under 5-year-olds in 2001 to 35.8 percent of them in 2016.

hance homestead food and livestock production, to increase the incomes of poor women through credit incentives, and to increase the consumption of micronutrient-rich foods.

- **Women children and social welfare —** During MSNP (2013–17) MoWCSW helped increase the knowledge of children and the mothers and caretakers of young children on hygienic behaviour and empowered communities to address harmful traditional practices such as menstrual seclusion and food taboos.
- **Local governance—** Local governments have a major role to play in improving nutrition including through social mobilization and the administration of cash transfers and social protection. The contributions to improved nutrition by MoFALD and the local bodies under the previous constitution focussed on the 28 MSNP (2013–17) districts. The new federal units of local governance — provinces and the four levels of local government (metropolitan cities, sub-metropolitan cities, urban municipalities and rural municipalities) plus their wards have an important role to play in improving nutrition.

Alongside these sectors, the Nepal Food Corporation and Salt Trading Corporation (under the Ministry of Supplies) supply food to remote districts and distribute iodised salt and are therefore important MSNP-II stakeholders.

1.5 Situation of Nutrition in Nepal

Although there have been significant improvements across the different types of malnutrition (stunting, wasting, underweight, low body mass index, micronutrient deficiency, overweight and obesity), malnutrition continues to constrain human lives and Nepal's socioeconomic development. Malnutrition contributes to more than a third of child mortality in Nepal, and children who survive often lead diminished lives due to impaired cognitive development, reduced economic productivity and the increased risk of malnutrition-related chronic diseases. Overweight and obesity are emerging amongst certain groups.

Nepal made mixed progress on the achievement of the World Health Assembly's global nutrition targets for 2025 between the base year of 2011 and 2016. It must be noted though that Nepal has made great progress on these indicators over the last two decades.

There were small improvements in stunting (WHA target 1), childhood overweight (WHA 4), exclusive breastfeeding (WHA 5) and childhood wasting (WHA 6) (Table 1.1). There was a worsening in the situation of anaemia among women and children and a doubling in the prevalence of low birth weight (although the latter was probably due to the increased number of institutional deliveries meaning it was detected more). The childhood overweight and breastfeeding targets have been achieved and efforts need accelerating to achieve the other targets.

Note that although overweight is only a minor problem amongst children it has become a serious concern among adults with the 2016 NDHS finding that 22.2 percent of women and 17.1 percent of men were overweight (MoH, New ERA and ICF 2017). The highest incidence was in the highest wealth quintile where 45 percent

TABLE 1.1: NEPAL'S STATUS AGAINST GLOBAL NUTRITION TARGETS

	Global nutrition targets for 2025 and 2030	Base year situation	Progress	Nepal's WHA target	Nepal's SDG targets
		2011	2016	2025	2030
1	Achieve 40% reduction in the number of children under-5 who are stunted	40.5%	35.8%	25%	15%
2a	Achieve a 50% reduction of anaemia in women of reproductive age	35%	40.8%	18%	10%
2b	Achieve a 50% reduction of anaemia in children	46.2%	52.7%	23.1%	10%
3	Achieve a 30% reduction in low birth weight	12.1%	24.2%*	8%	–
4	Ensure no increase in childhood overweight	1.4%	1.2%	≤1.4%	–
5	Increase rate of exclusive breastfeeding in first 6 months to at least 50%	69.6%	66.1%	>50%	–
6	Reduce and maintain childhood wasting to less than 5%	10.9%	9.7%	5%	4%

*Source of information: MoH, New ERA and ICF (2017) and *CBS 2015*

of women and a third of men were overweight or obese in 2016.

There has been a large reduction in childhood stunting (short height for age) in Nepal in recent years; reducing from 57 percent of under 5-year-olds in 2001 to 35.8 percent of them in 2016 (MoH, New ERA and ICF 2017). Note that the stunting of under 5-year-olds is recognised as the main indicator of malnutrition and so receives the most coverage here.

However, Nepal has fallen behind on the average annual rate of reduction needed to achieve WHA target 1 of a 40% reduction by 2025 in the number of stunted under 5 year-olds (Figure 1.1). The prevalence of stunting in this age group in the 2011 WHA base year was 40.5 percent, amounting to 1,108,573 stunted children (CBS population projection 2011). To reduce the prevalence by 40 percent entails reaching 24.3 percent by 2025, which means having 661,860 fewer stunted children. The average annual rate of reduction between 2001 and 2016 was 3.09 percent. To reach the WHA target of 24.2 percent therefore requires an average annual rate of reduction from 2016 onwards of 4.26 percent.

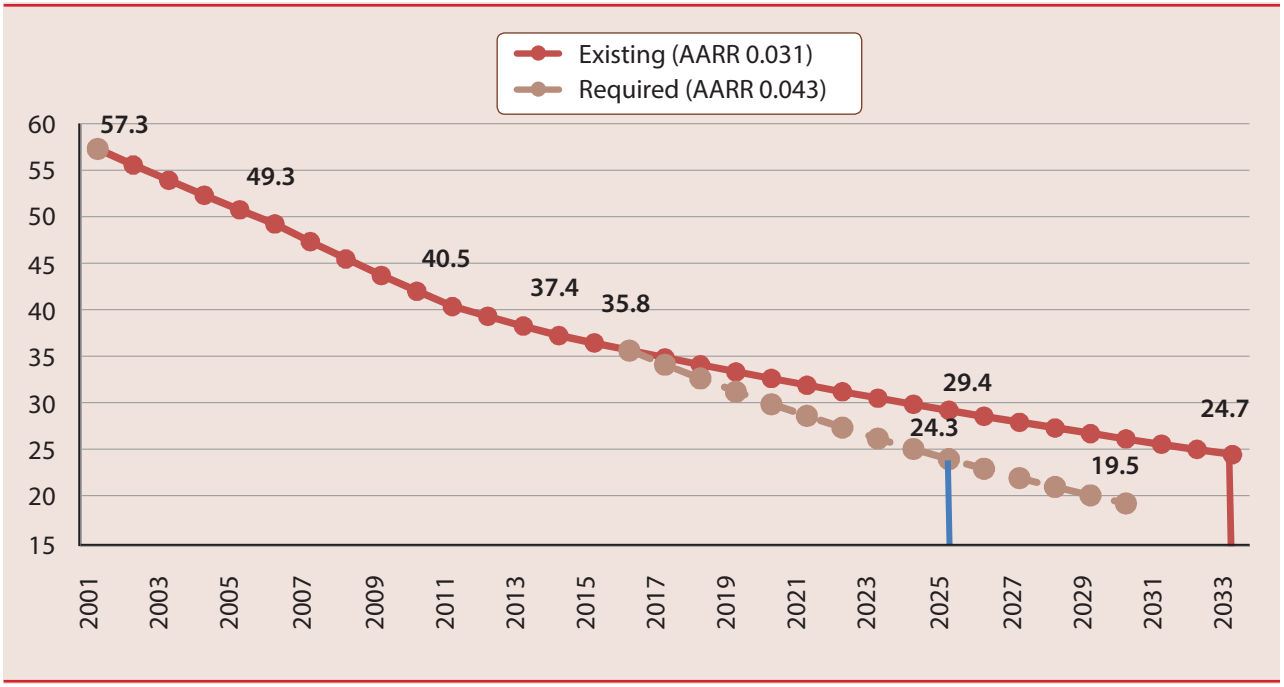
Note that the same kind of trend and disparity analysis was carried out for all six WHA indicators as background analysis for MSNP-II. Only the stunting analysis is included here.

The 2016 NDHS found that 35.8 percent of under-5-year-olds were stunted, although there were considerable variations, as illustrated in Figure 1.2:

- 40.2 percent of children stunted in rural areas compared to only 32.0 percent in urban areas
- Children from the poorest wealth quintile were three times more likely to be stunted (49.2%) than children from the richest quintile (16.5%)
- Children of mothers who were not educated were twice as likely to be stunted (45.7%) as children of educated mothers (22.7%)
- Children below 18 months old were less stunted than older children
- 46.8 percent of children in mountain areas were stunted compared to 36.7 percent in the Tarai plains and 32.3 percent in the hills
- Provinces 2, 5, 6 and 7 had above national average rates of stunting with a very high

However, Nepal has fallen behind on the average annual rate of reduction needed to achieve WHA target 1 of a 40% reduction by 2025.

FIGURE 1.1: NEPAL'S PROGRESS ON WORLD HEALTH ASSEMBLY TARGET 1 (40% REDUCTION IN NUMBER OF STUNTED UNDER 5-YEAR-OLDS)



Note: AARR = average annual rate of reduction

The prevalence of wasting (low weight for height) has fluctuated in recent years in Nepal from 9.6 percent of under 5-year-olds in 2001 to 11.4 percent in 2014 and 9.7 percent in 2016

prevalence in Province 6 (mid-western Nepal) (54.5%), almost double that in Province 4 (28.9%) (Figure 1.3).

The prevalence of wasting (low weight for height) has fluctuated in recent years in Nepal from 9.6 percent of under 5-year-olds in 2001 to 11.4 percent in 2014 and 9.7 percent in 2016 (MoH, New ERA and ICF 2017). Wasting is a measure of acute undernutrition and represents the failure to receive adequate nutrition in the period immediately before the survey.

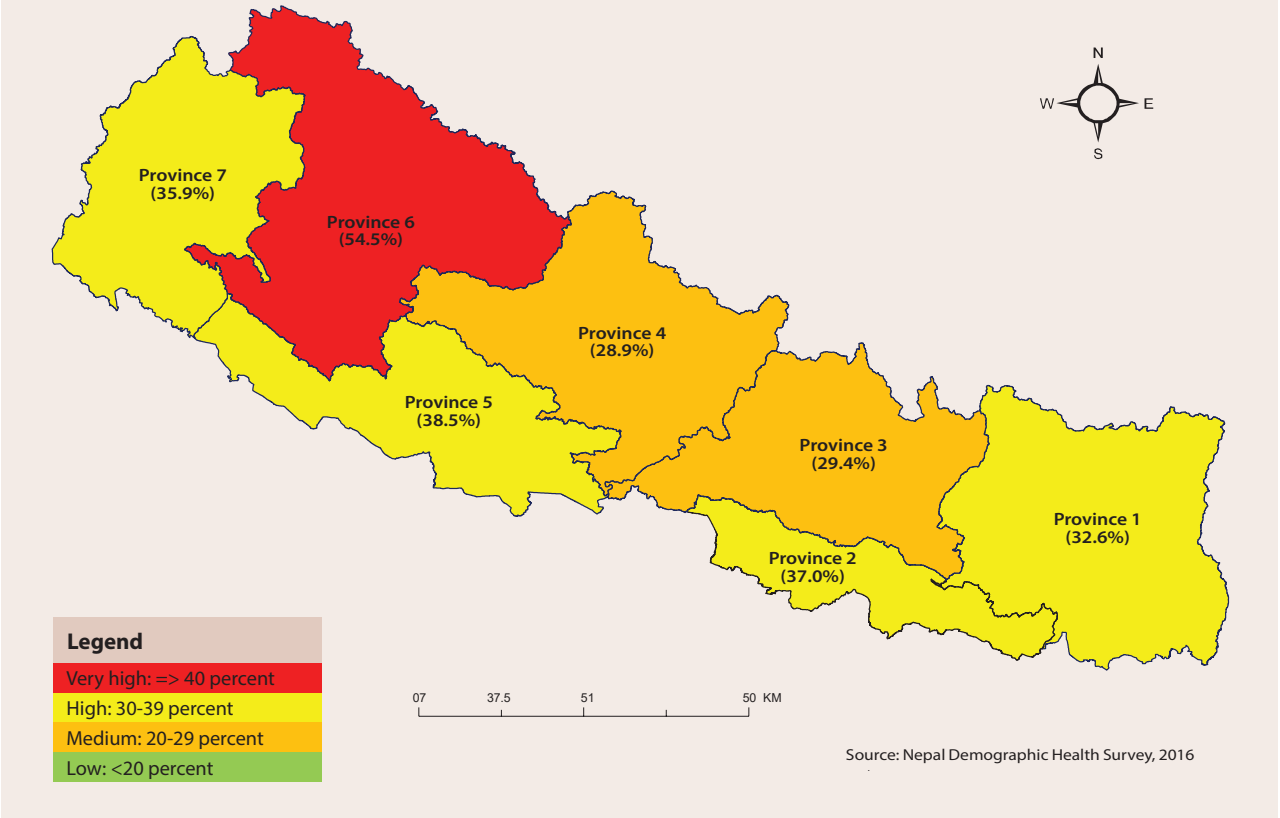
There was little difference in the rate of wasting between boys (9.5%) and girls (9.8%) in 2016 and only a small difference by residence with 10.2 percent of under 5-year-olds wasted in rural areas versus 9.2 percent in urban areas. Children in the Tarai had the highest prevalence of wasting (12%) compared to children in the hills (6.4%) and mountains (6.1%). And the prevalence of wasting among infants aged 0-23 months was almost twice (ranging from 15.2% to 21.3%) that among 48-59 month old infants (6.2%).[1]

1.6 Progress of Nutrition Programmes

In 2017 UNICEF analysed the coverage trends of nutrition specific and sensitive interventions from the MSNP (2013–17) period (and in some cases earlier). This analysis was carried out using sectoral ministry data. Sufficient data was not available to do this analysis for enabling environment interventions. Figures 1.4 and 1.5 show the results of this analysis, with:

- the level of coverage of target groups along the horizontal axis (up to maximum 100% coverage) and associated recommendations
- the progress of coverage of along the vertical

FIGURE 1.2: SEVERITY OF STUNTING IN NEPAL'S PROVINCES BY WHO CATEGORIES



Disclaimers: The map is based on The Constitution of Nepal Published by Government of Nepal, Ministry of Law, Justice and Parliamentary Affairs. Law Book Management Board The boundaries are derived using spatial operation in GIS environment on old ward level administrative data from DoS.

[1] The dataset used for this paragraph includes NDHS 2016, Nepal Multiple Indicator Cluster Survey (NMICS) 2014, Annual Reports of the Department of Health Services for 2012/2013 and 2014/2015, Nepal Health Facility Survey (NHFS) 2015 and other statistics from government ministries.

axis ranging from programmes that have expanded significantly to ones that have shrunk.

The recommendations for the interventions in both graphs for the three levels of coverage are:

- Need scaling up, strengthening or sustaining for positive coverage trend interventions.
- Need attention, reversing negative trend or sustaining for negative trend coverage.

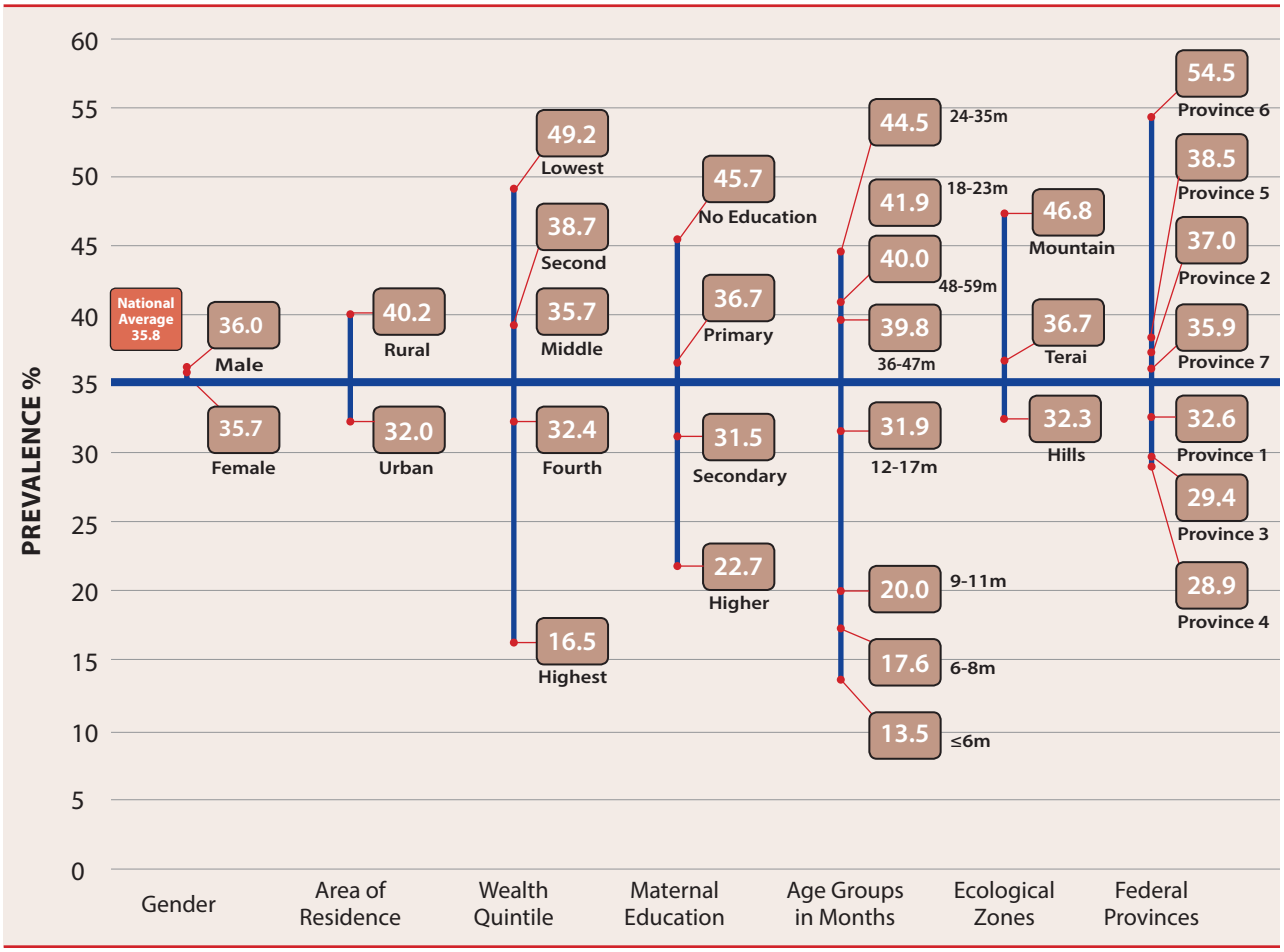
Based on the limited data available for this exercise, Figure 1.4 shows a mixed trend of progress of the nutrition-specific interventions during the MSNP (2013–17) period, with:

- flour fortification being unchanged at 100 percent targeted coverage
- the coverage of the treatment of diarrhoea cases increased by 250 percent, but still only covers about 20 percent of cases
- the proportion of households using iodised salt increased by 50 percent to reach about 80 percent targeted coverage
- exclusive breastfeeding declined to about 56 percent of babies
- the needed financial resources for improving nutrition increased by about 40 percent.

The UNICEF Nepal analysis of the progress of nutrition-sensitive interventions found that 11 of the major selected nutrition sensitive indicators increased their coverage in the MSNP (2013–17) period (Figure 1.5). Only the two married-before-age-18-years indicators had a negative trend. The increases in coverage were for secondary school enrolment, disposal of child faeces, handwashing, and and access to improved sanitation. The most remains to be done on reducing early marriage and installing well-functioning water supply systems, with less than a third of targeted coverage achieved.

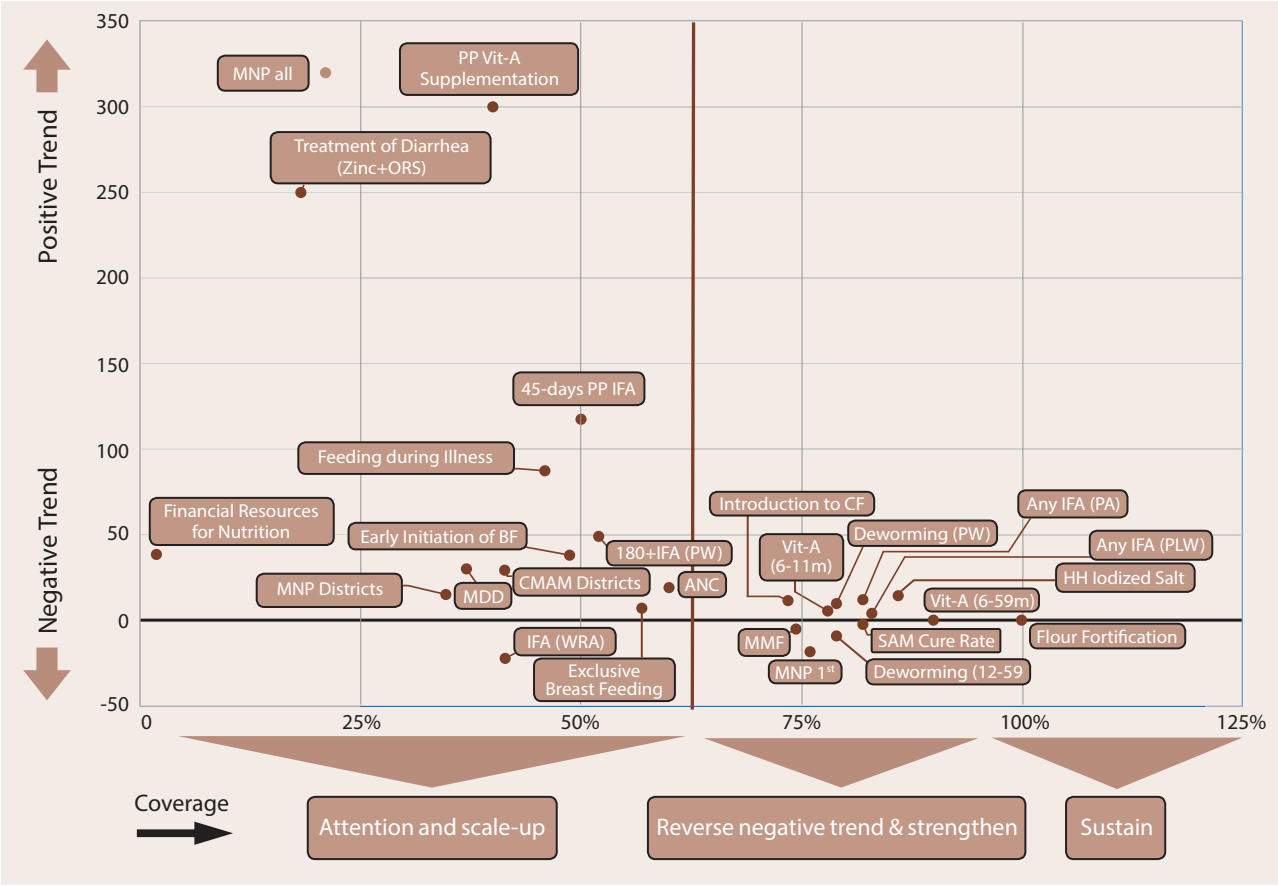
Children in the Tarai had the highest prevalence of wasting (12%) compared to children in the hills (6.4%) and mountains (6.1%).

FIGURE 1.3: DISPARITIES IN STUNTING PREVALENCE AMONG UNDER-5S IN NEPAL IN 2016



Source: MoH, New ERA and ICF 2017

FIGURE 1.4: COVERAGE PROGRESS OF NEPAL'S NUTRITION SPECIFIC INTERVENTIONS IN MSNP (2013–17) PERIOD



Source: DHS MICS 2014, NDHS 2011, NDHS 2006 and MoHP Annual Reports 2009/2010, 2010/2011 and 2014/2015

1.7 Analysis of Causes of Malnutrition in Nepal

The following text discusses the main health-related causes of malnutrition in Nepal.

1) **Causes** — Nepal's population faces a range of nutritional problems from deficits in energy intake to imbalances in the consumption of macro and micronutrients. The causes include imbalanced diets; inadequate family care; poor quality water, sanitation and hygiene; inadequate access to health services; child marriage; women's heavy workloads; women's lack of access to economic resources; gender-based violence and cultural taboos. The problem of excess intake is also surfacing as changing dietary patterns and lifestyles result in overweight and obesity.

2) **Causes of stunting** — The underlying causes of stunting in Nepal are inadequate maternal, infant and young child feeding practices, untreated episodes of acute malnutrition, infections, and micronutrient deficiencies. Exclusive breastfeeding is sufficient for the first six months after birth while the timely introduction of appropriate complementary foods with breastfeeding is essential after six months of age.

The underlying causes of stunting in Nepal are inadequate maternal, infant and young child feeding practices, untreated episodes of acute malnutrition, infections, and micronutrient deficiencies.

Nepal achieved the World Health Assembly target of exclusive breastfeeding of 50 percent of infants in early 2015. However, further efforts are needed to reach the target of the National Infant Young Child Feeding Strategy (CHD 2014) of 80 percent exclusive breastfeeding in the first six months of life by 2020 as in 2016 only 66% of this age group were exclusively breastfed (MoH, New ERA and ICF 2017). The 2016 NDHS found major disparities around this average figure with only 48.6 of female infants exclusively breastfed compared to 63.8 percent of male infants and only 48.3 percent of lowest wealth quintile infants compared to 70.8 percent of infants in the second wealth quintile (MoH, New ERA and ICF 2017).

In terms of the introduction of appropriate complementary foods after six months of age:

- in 2016, only 17 percent of children aged 6–8 months and only 35 percent of children aged 6–23 months had minimum acceptable diets (MoH, New ERA and ICF 2017)
- in 2014, only 17 percent of children aged 6-23 months in the mid-western Tarai had minimum acceptable diet (CBS 2015)
- only 23.5 percent of young children from the middle wealth quintile had at least the minimum acceptable diet compared to 50.2 percent from the richest quintile (CBS 2015).

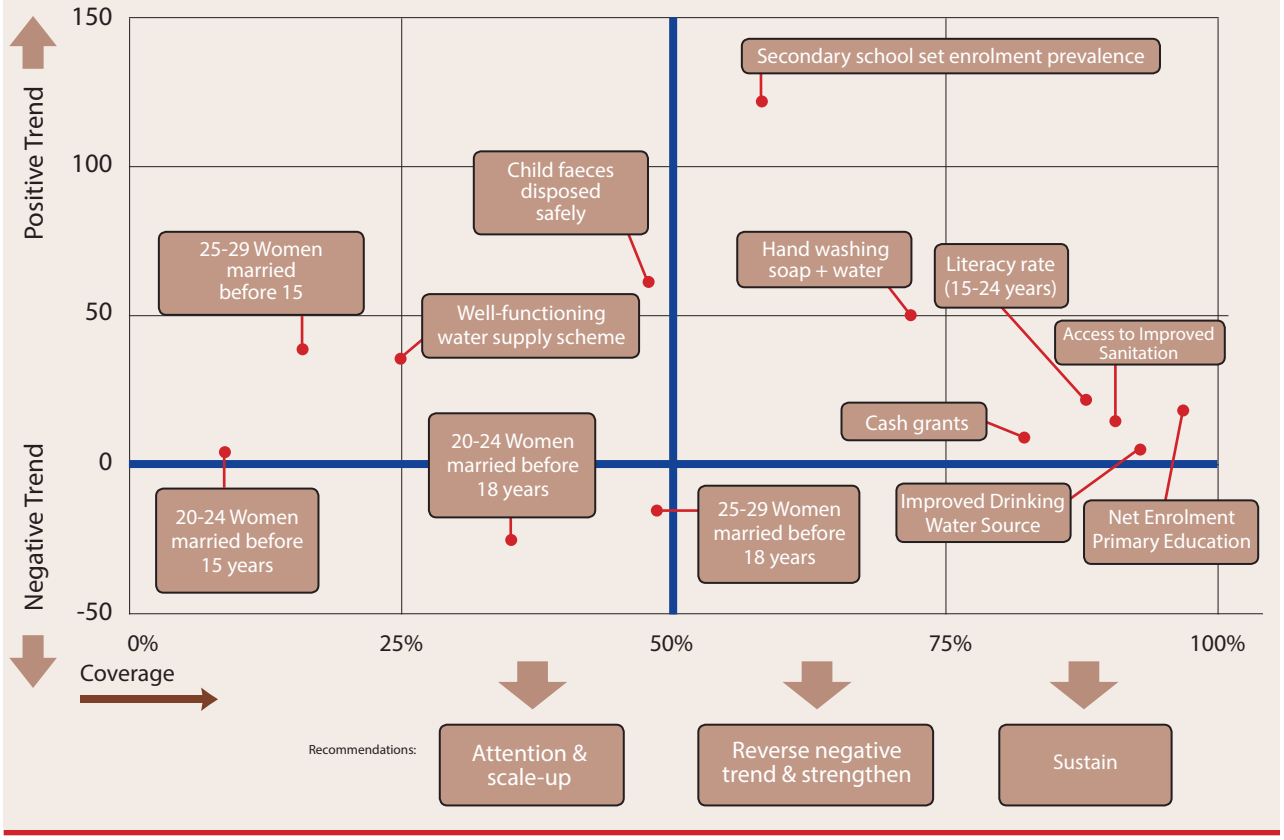
3) **Disease** — In Nepal, maternal and infant infections are common and intestinal parasites are a major public health problem. The 2014 Nepal Multiple Indicator Cluster Survey (NMICS) found that 20.1 percent of under 5-year-olds had suffered fever in the previous two weeks while 12 percent had suffered diarrhoea and 7 percent acute respiratory infections in the same period (CBS 2015). These diseases cause malnutrition and can cause the deaths of young children. A major cause of acute respiratory infection is exposure to indoor air pollution — principally smoke from cooking with firewood and other solid fuels. And, although the prevalence of diarrhoea in young children has decreased over the last decade, only 47 percent of children sought advice and treatment from a health facility or provider (CBS 2015).

4) **Immunisation** — In 2016, only 87 percent of children aged 12–23 months had received all the vaccinations as per the national schedule by their first birthday (MoH, New ERA and ICF 2017). The percentage of non-immunised children reduced to 1 percent in 2016 from 3 percent in 2011.

5) **Adolescent nutrition** — The NDHS 2016 found that many adolescents, and especially adolescent girls, were malnourished, with 30 percent of 15 to 19 year old girls being underweight, while 44 percent of them were anae-

in 2016, only 17 percent of children aged 6–8 months and only 35 percent of children aged 6–23 months had minimum acceptable diets.

FIGURE 1.5: COVERAGE PROGRESS OF NEPAL'S NUTRITION SENSITIVE INTERVENTIONS IN MSNP (2013–17) PERIOD



Although the poverty level reduced from 49 percent in 1992 to 21.6 percent in 2016 (NPC 2016a), certain areas of the country are food insecure and suffer food deficits. The affordability, consumption and absorption of local food is a problem in the Tarai, Mid-West and Far Western regions.

mic (MoH, New ERA and ICF 2017). This means they are poorly prepared for the rigours of motherhood, which often translates into them having low birth weight babies.

6) **Harmful practices** — Maternal and child care is still beset by too frequent pregnancies, inadequate awareness of health services, unsecured deliveries, inappropriate care of babies, and the lack of qualified health workers' in rural areas.

The other factors that compromise health and nutrition are as follows:

7) **Food security** — Although the poverty level reduced from 49 percent in 1992 to 21.6 percent in 2016 (NPC 2016a), certain areas of the country continue to be food insecure and suffer food deficits. The affordability, consumption and absorption of local food is a problem in the Tarai, Mid-West and Far Western regions.

8) **Early marriage** — Teenage marriage is common in Nepal with 48 percent of women aged 20-49 years having first married or been in a union before age 18 years (CBS 2015). This results in almost a quarter of mothers (16 percent) having a live birth before the age of eighteen (CBS 2015). And maternal care practices are often poor with only 57 percent of women having received a health check following delivery or a post-natal care visit within two days of delivery of their most recent live birth (CBS 2015).

9) **Smoke** — The 2016 NDHS found that 13 percent of women smoked while far more were exposed to domestic smoke pollution from the use of solid fuel for cooking inside homes (MoHP, New ERA and ICF 2012).

10) **WASH** — The lack of proper sanitation threatens the health of many people. About half the population still defecate in the open, 27.5 percent of households lack a specific place for hand washing (CBS 2015) and cow manure and dung is often carelessly managed, creating a polluting environment that spreads disease and parasites such as worms.

11) **Traditional harmful practices** — Traditional practices that are harmful to health persist in certain areas and among certain caste groups. This includes adolescent girls and women not being allowed to consume milk, yoghurt or ghee during menstruation. Menstrual seclusion *(chhaupadi)* is still practised in the Mid-West and Far West. And inadequate

menstrual hygiene is commonplace leading to infection and disease, sometimes triggering anaemia, resulting in undernutrition.

12) **Natural disasters** — Nepal's vulnerability to natural disasters was demonstrated by the impact of the 2015 earthquakes that displaced many people from their homes, destroyed crops and disrupted healthy nutrition in thousands of households.

13) **Education and infrastructure** — Large improvements in education and infrastructure have ameliorated major causes of malnutrition. The literacy rate among young women (15-24 years) now stands at 88.6 percent meaning they are more educated and aware about health and nutrition issues. The large improvements in Nepal's road network makes it easier to transport foodstuffs around the country.

1.8 Analysis of Other Issues that Affect Nutrition

Nepal's current situation provides many opportunities and significant challenges to improve nutrition as a key driver of socioeconomic growth. Nepal has seen impressive improvements in recent years on human development, infrastructure, transport networks, communication, social services, the expansion of cooperatives and self-initiated local development. These provide the foundation for many kinds of improvements including for improved nutrition. The major development challenges faced by Nepal include the lack of jobs, reliance on remittance incomes, deep-rooted discrimination, the underdevelopment of agriculture and unplanned urban growth.

1.8.1 ECONOMIC

In 2015, Nepal adopted the ambitious aims of graduating from least developed country status (LDC) to developing country status by 2022, and middle-income country status by 2030 (NPC 2015). To become a developing country Nepal needs to achieve a certain human asset index score. This score is calculated based on (i) percentage of population undernourished; (ii) mortality rate of children under 5-years of age; (iii) gross secondary school enrolment ratio; and (iv) adult literacy rate. These are all affected by nutritional status meaning that good nutrition is a precondition for Nepal to graduate to developing and middle income status. This ambition is a spur for improved nutrition.

The third Nepal Living Standards Survey (NLSS 3) reported a shrinking income gap between the poor and the rich (CBS 2011).

Although the annual income of the poorest 20 percent of the population had increased considerably, poverty persists among a fifth of the population. The rate of joblessness remains high, particularly among women and young people, with youth unemployment being the major cause of the high rate of migration of young people from rural to urban areas and to work abroad. In 2011, 55 percent of households were receiving remittance incomes with an average of $773 per year (CBS 2011). And the trend has increased with remittances accounting for 29.2 percent of gross domestic product in 2014/15.

NLSS 3 found that agricultural development was neglected with the percentage of irrigated land remaining stagnant at 54 percent compared to NLSS 2 in 2003/04 while the percentage of farmers holding less than 0.5 hectares of land had increased.

1.8.2 SOCIAL

NLSS-3 found that people's access to basic facilities had improved. It found that 95 percent of households could reach a primary school and 74 percent a health centre within 30 minutes' travel. It also reported improved access to banking, market centres, paved roads and safe drinking water. The 2016 NDHS found that the use of health services had increased:

- The proportion of married women (15-49 years) using any modern method of contraception increased from 48 percent in 2011 to 53 percent in 2016.
- The proportion of pregnant women receiving at least one antenatal check-up by skilled health personnel increased from 58 percent in 2011 to 84 percent in 2016 with 69 percent of women having received the recommended four antenatal check-ups.
- The percentage of women delivering their babies in a health facility increased from 36 percent in 2011 to 58 percent in 2016 (MoHP, New ERA and ICF 2016).

Nepal has seen impressive improvements in recent years on human development, infrastructure, transport networks, communication, social services, the expansion of cooperatives and self-initiated local development. These provide the foundation for many kinds of improvements including for improved nutrition.

Nepal is instituting a federal system of governance under its 2015 constitution with a three-tiered structure that devolves executive and legislative powers to provincial and local governments.

Job creation and other development efforts are hindered by persistent discriminatory socio-cultural practices that cause the social and economic exclusion of women and people from marginalized groups. The development-related results of gender discrimination and social exclusion vary between Nepal's urban and rural areas and between its regions/provinces. For example, the Mid and Far-western regions ranked the lowest on the Gender Empowerment Measure and the Gender-related Development Index (GDI) (UNDP 2015). It is likely that deep-rooted exclusionary practices will remain in the near future.

1.8.3 POLITICAL

Nepal is instituting a federal system of governance under its 2015 constitution with a three-tiered structure that devolves executive and legislative powers to provincial and local governments (metropolitan cities, sub-metropolitan cities, urban municipalities and rural municipalities). This involves restructuring the civil service and laws to protect and empower women and other traditionally marginalized people. This system of devolved governance provides many opportunities for improving the health and nutritional status of Nepal's people.

1.8.4 DEMOGRAPHY

Nepal has a young population. It is estimated that 44 percent of its 28.4 million people are under 19-years-old. Given current trends, Nepal should be able to benefit from its youth-based demographic dividend until at least 2050 (UNCT Nepal 2017). The rapid demographic changes are due to declining birth and death rates and improved life expectancy. Nepal needs to prepare itself for these changes and invest in today's children so they become more productive on entering the workforce. There is a finite window of opportunity until the proportion of the working-age population starts to decrease. During this time, the proportion of working-age people is high compared to dependent young and old people, which provides favourable conditions for socioeconomic development. This highlights the urgency of investing in children to ensure they are more productive when they enter the workforce. At the same time investments need making to reduce malnutrition and develop human capital focusing on children under-5 and adolescents.

Eighteen percent of Nepal's population live in urban and peri-urban areas with an estimated urban growth rate of 3 percent per year (in 2014)

(Bakrania 2015). However, much of this population growth is amongst the urban poor, who live in unsanitary, overcrowded and unhealthy conditions that especially put mothers and children at risk (HEART 2013).

1.9 Achievements of Multi-Sector Nutrition Plan (2013–17)

MSNP (2013-2017) was implemented from 2014 in 28 districts.[2] It was also partially implemented in other districts with the support of non-government organisations. Its main aim was to reduce chronic malnutrition (stunting) by achieving the following three outcomes that broadly match the nutrition specific, nutrition sensitive and enabling environment outcomes of MSNP-II (see Section 2.1):

1. Improved maternal, infant and young child feeding.
2. Increased maternal, infant and young child micro-nutrient status.
3. Improved management of malnutrition in children.

A) LONG-TERM IMPACT

During the MSNP (2013–17) period chronic malnutrition (stunting) reduced by 12 percent from 40.5 percent in 2011 to 35.8 percent in 2016, which is a great achievement. This achievement was greatly facilitated by the Fourteenth Plan prioritising improved nutrition (NPC 2016b) with a tripling of the budget for nutrition programmes from NPR 5,220 million spent in FY 2013/14 to NPR 19,260 million allocated in 2017/18.

However, much remains to be done as 27 percent of under 5-year-olds remain moderately or severely underweight and 5.4 percent severely underweight. Ten percent are moderately or severely wasted or too thin for their height and 2 percent are severely wasted (MoH, New ERA and ICF 2017).

During the MSNP (2013–17) period chronic malnutrition (stunting) reduced by 12% from 40.5% in 2011 to 35.8% in 2016.

[2] Achham, Baitadi, Bajhang, Bajura, Bara, Bardiya, Dadeldhura, Dailekh, Dhanusha, Dolpa, Doti, Humla, Jajarkot, Jumla, Kalikot, Kapilvastu, Khotang, Mahottari, Mugu, Nawalparasi, Panchthar, Parsa, Rautahat, Rolpa, Rukum, Saptari, Sarlahi and Udayapur

TABLE 1.2: STATUS OF MSNP (2013–17) NUTRITION SPECIFIC INDICATORS

Indicator	Baseline	Progress Status	MSNP target
	2012	2016	2017
Outcome 1: Improved maternal, infant and young child feeding			
1.1. % of children born in last 24 months who were put to the breast within one hour of birth	44.5	55	56
1.2. % of infants 0–5 months of age who received only breast milk during the previous day	70	66	88
1.3. % of infants registered for growth monitoring who reached 6 months in the last month who were exclusively breastfed for the first 6 months	NA	28.5	36
1.4. % of infants registered for growth monitoring who reached 6 months in the last month who were timely initiated complementary feeding at 6 months of age	NA	27.5	34
1.5. % of infants 6–8 months of age surveyed who received solid, semi-solid or soft foods in the previous day	70	73.5	88
1.6. % of children 6-23 months of age who were receiving a minimum acceptable diet (apart from breast milk)	24	36	42
Outcome 2: Increased maternal, infant and young child micro-nutrient status			
2.1. % of children under 5-69 months with anaemia	46	52.7	69
2.2. % of women aged 15-49 years with anaemia	35	40.8	53
2.3. % of women who delivered in previous 6 months who reported consuming all 180 iron folic acid tablets during pregnancy	49.8	42	75
2.4. % of women surveyed who delivered in previous 6 months who reported consuming anthelminthics during pregnancy	55.1	70	83
2.5. % of women who delivered in previous 6 months who reported consuming all 45 tablets of iron folic acid postpartum	55.6	45	83
2.6. No. of students in grades 1-10 in private and public schools who received deworming tablets in previous six months (1,000s)	1,919	1,636	2,581
2.7. % of households where adequately iodized (>15ppm) salt was present	80	95	>95
2.8. % of children aged 6-23 months surveyed who consumed multiple micronutrient powder (MNP) in previous 7 days	NA	78.8	80
2.9. % of children under-5 who had diarrhoea in two weeks preceding the survey	14	8	7
2.10. % of children under-5 who had symptoms of acute respiratory infections in two weeks preceding the survey	5	6.7	3
2.11. % of children aged 6-59 months who received vitamin A supplements in previous six months	90.4	90.3	>95
2.12. % of children aged 12-59 months who received antihelminthics in previous six months	83.7	79	>95
2.13. % of women reporting receiving vitamin A supplementation within 6 weeks following a live birth in previous three years	40.3	49.1	60
Outcome 3: Improved management of malnutrition in children			
3.1. % of cases of severe acute malnutrition discharged who recovered	89	84	>75
3.2. % of cases of severe acute malnutrition discharged who defaulted	4.8	9	<15
3.3. % of cases of severe acute malnutrition discharged who died	1.3	0	<10
3.4 % of children aged 0-23 months underweight among those registered for growth monitoring	3	3.3	12
3.5. No. of children under-5 with severe acute malnutrition registered	6,646	11,517	8,308

Source: MoH, New ERA and ICF 2017; DoHS 2016

Note: All Outcome 1 and Outcome 2.1 to 2.5 targets were based on the WHA targets (2012–2025). Since 2017 is about midway to 2025, it was assumed that the target for 2017 would be half the WHA target for most of the indicators. The outcome 3 targets were based on the minimum standard in humanitarian response (SPHERE Standard).

B) PROGRESS AGAINST NUTRITION SPECIFIC OUTCOME

Although good progress was made against many of the MSNP (2013–17) targets, only the following five had been achieved or almost achieved by 2016: immediate breastfeeding (target 1.1), the presence of adequately iodized salt (2.7), the consumption of MNP (2.8), children who suffered diarrhoea (2.9) and deaths among discharged severe acute malnutrition cases (3.3) (Table 1.2).

There has been progress on mitigating micronutrient deficiencies (vitamin A, iron and iodine) of essential dietary components (USAID nd), although a below average proportion of households use iodized salts, vitamin A supplementation and iron supplementation in the hills and mountain regions of the Mid-west (CBS 2015). In 2014, 81.5 percent of households nationwide were using adequately iodized salt (15 parts per million), which is less than the targeted 90 percent (CBS 2015).

Maternal care has improved with increased access to antenatal care with 6% of pregnant women having at least one session with a skilled health worker and 59.5% at least four sessions by any provider (MoH, New ERA and ICF 2017). In 2014, 58 percent of mothers had a post-natal health check-up (CBS 2015).

Two major concerns are the management of diarrhoea and anaemia in children, with the rate of anaemia among 15-59 month olds increasing between 2011 and 2016 (MoH, New ERA and ICF 2017). The recently conducted Nepal Micronutrient Survey hopes to identify the cause of this. Also, see Figure 1.5 for progress of nutrition-sensitive interventions.

C) PROGRESS AGAINST NUTRITION SENSITIVE OUTCOME

Most programmes implemented under MSNP (2013–17) addressed the causes of malnutrition and contributed to improving the nutritional status of all Nepal's women and children. Among the achievements, the 2016 NDHS found that:

- 72.5 percentage of households had specific places for hand washing where water and soap or another cleansing agent was present
- 53 percent of married women of 15-49 years were using family planning methods.

The agriculture sector has added nutrition indicators into its management information system (NEKSAP), which further strengthen monitoring and evaluation. And with support from UNICEF, bottom-up planning has been started in both nutrition specific and nutrition sensitive areas. Also, See Figure 1.5 for progress of nutrition-sensitive interventions.

D) PROGRESS AGAINST ENABLING ENVIRONMENT OUTCOME

MSNP (2013–17) activities strengthened the enabling environment for nutrition. An MSNP institutional mechanism is now in place with the lead role taken by the National Planning Commission (NPC). A High-Level Nutrition and Food Security Steering Committee and a National Nutrition and Food Security Coordination Committee were formed in 2011. District level nutrition and food security steering committees were formed in most districts over the course of MSNP. External development partners are supporting the National Nutrition and Food Security Secretariat (NNFSS), which helps NPC manage nutrition-related issues.

The sectoral ministries responsible for health; agriculture; livestock; water and sanitation; education; women, children and social welfare; and local governance implemented MSNP (2013–17). Three technical working groups were formed in 2011/12 to support i) advocacy and communication, ii) capacity development, and iii) monitoring, evaluation and information management. The six sectoral ministries have all included nutrition and food security in their working policies. An M&E framework was used to measure the progress of MSNP.

The programmes under MSNP (2013–17) were implemented in the 28 districts through the Ministry of Health, MoFALD and the other sectoral ministries in coordination with NPC. The government allocated budget to the district level for implementing the plan, which was reflected in district development committees' annual programmes. These funds were spent by sectoral line agencies according to the decisions of district nutrition and food security steering committees.

A range of development partners provided technical and financial support to the government to formulate and implement MSNP (2013–17).

Most programmes implemented under MSNP (2013–17) addressed the causes of malnutrition and contributed to improving the nutritional status of all Nepal's women and children.

The amount allocated for nutrition by the government and its development partners almost tripled over the course of MSNP (2013–17) from NPR 7,210 million ($69 million) in 2013 to NPR 19,241 million ($184.9 million) in 2017.

From 2013, the partners implemented MSNP activities through their projects and programmes. Some worked in the same districts and deciding in which areas they would work. The government and its development partners implemented MSNP in a total of 60 districts. A summary of MSNP (2013–17) programmes and projects supported by donors is given in Annex 2.

1.10 Analysis of Estimated Costs and Expenditure of Multi-Sector Nutrition Plan (2013–17)

The amount allocated for nutrition by the government and its development partners almost tripled over the course of MSNP (2013–17) from NPR 7,210 million ($69 million) in 2013 to NPR 19,241 million ($184.9 million) in 2017. The proportion provided by the government and its development partners varied from year to year with the government overall contributing 46 percent and development partners 54 percent.

Including on and off-budget figures two-thirds of MSNP (2013–17) expenditure came from development partner support. These local budgets were planned by the district nutrition and food security steering committees and were spent through sectoral line agencies to reach the various target groups.

1.11 Key Problems and Challenges

The following were the main issues that hindered the implementation of MSNP (2013–17):

1. **Disparities —** The large disparities in access to adequate nutrition and good quality health care between people living in urban and rural areas and between the wealthiest and poorest people make it difficult for poor rural dwellers to improve their nutritional status.
2. **Quality of services —** Poor quality health care sometimes impedes the delivery of health services to the populations who are most vulnerable to undernutrition.

TABLE 1.3: BUDGET ALLOCATED TO NUTRITION BY GOVERNMENT OF NEPAL AND DEVELOPMENT PARTNERS IN MSNP (2013–17) PERIOD

	GoN	Development partners	Total
2013			
Budget (NPR million)	3,408	3,802	7,210
Proportion	47%	53%	100%
2014			
Budget (NPR million)	3,889	27,094	30,983
Proportion	13%	87%	100%
2015			
Budget (NPR million)	12,717	6,056	18,773
Proportion	68%	32%	100%
2016			
Budget (NPR million)	6,627	5,653	12,281
Proportion	54%	46%	100
2017			
Budget (NPR million)	13,773	5,469	19,241
Proportion	72%	28%	100
Total (2013–2017)			
Budget (NPR million)	40,414	48,074	88,488
Proportion	46%	54%	100%

Source: NPC, Annual Development Programme, Part 1:

3. **Traditional practices —** Erroneous food and social practices in more conservative communities impede the correct intake of nutrients for mothers and children and their care.
4. **Inadequate data —** Inadequate data on the nutritional status of women and children affected the adoption of evidence based planning.
5. **Budgets —** The insufficient and late release of budgets led to inadequate health services and made it difficult to run local nutrition and awareness programmes. This was a cause of the limited progress on increasing awareness and protection for mothers and their children, and ending child marriage and harmful food practices during menstruation and pregnancy.
6. **Assessment of financial investments —** It was difficult to assess the financial investments by the different sectors as their budget and programme codes differed.
7. **Weak institutional structure —** Inadequate personnel, institutional and individual capacity gaps, and rapid staff turnover hindered the implementation of MSNP (2013–17). Existing institutional structures and human resources were not fully mobilised to improve nutrition and food security and there was, in some cases, inadequate coordination between higher and lower authorities. Also, sectoral ministries gave a low priority to nutrition.

1.12 Lessons Learned Implementing MSNP (2013–17)

- More convergence and complementarity are needed while implementing MSNP interventions.
- Improved information management and the sharing of information is needed for the success of the multi-sectoral nutrition approach.
- The MSNP key sectors need to improve ownership, the assignment of roles and responsibilities and the commitment of time and

More convergence and complementarity are needed while implementing MSNP interventions.

The graduation of Nepal from LDC status by 2022 is contingent on improving nutrition.

resources to nutrition as competing priorities and workloads delayed MSNP (2013–17) interventions.

- There needs to be more technical assistance and capacity building support to all MSNP sectors at community and institutional levels.

1.13 The Rationale for MSNP-II

This introductory chapter concludes with a summary of the main reasons for producing the follow-on MSNP-II:

- **Impact of stunting** — In Nepal, one out of three children still suffer from stunting. Stunted children under-5-years-old are less likely to survive their fifth birthdays, and those who survive are unlikely to achieve adequate physical growth and mental and cognitive development. The stunting process occurs from conception to two years of age and is irreversible.
- **Micronutrient deficiency** — Many Nepalis, and especially the most vulnerable and women and children, are affected by micronutrient deficiencies. This increases the risk of mortality in infancy and childhood, impairs cognitive functions and hinders national socioeconomic development.
- **Build on MSNP (2013–17)** — Most of the proposed MSNP-II activities will build on the achievements of MSNP (2013–17)
- **Graduation from LDC status** — The graduation of Nepal from LDC status by 2022 is contingent on improving nutrition. All the criteria needed to graduate (income, human assets index and economy vulnerability index) demand nutrition programmes for children and women in one way or another.
- **Reaping the demographic dividend** — The demographic window of opportunity for Nepal began around 1992 and will start to close around 2047. During this time the number and proportion of working-age population will be high providing very favourable condi-

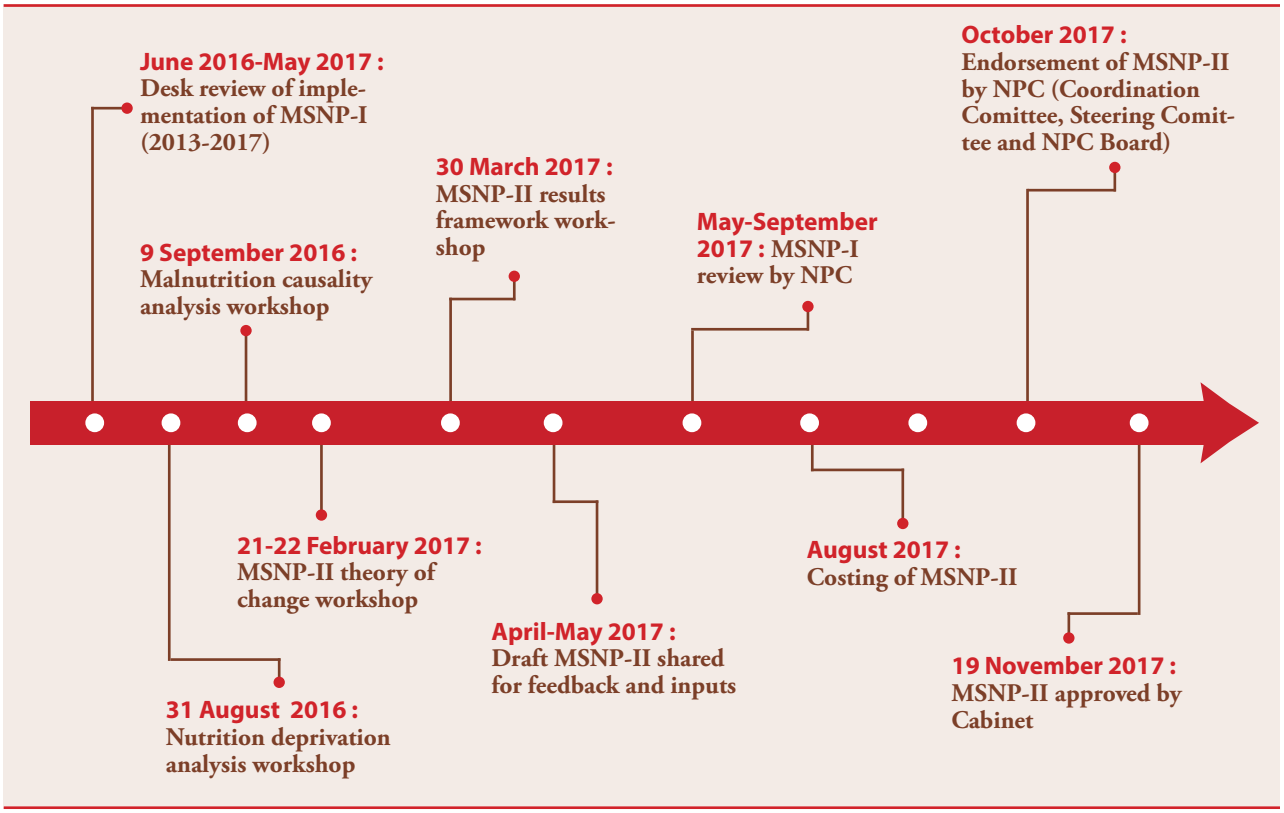
tions for socioeconomic development. To reap this dividend the government must invest in early childhood development, health, nutrition, education, water, sanitation and hygiene, child protection, adolescents' development and social protection.

- **Global development imperatives** — Malnutrition is a major issue to be addressed under the SDGs (2016-2030). These new development goals provide a massive opportunity for the national and international community to upscale nutrition initiatives and secure good nutrition for all. And the Lancet causality framework for maternal and child undernutrition (The Lancet 2013) and the Global Scaling Up Nutrition (SUN) Movement remain key driving forces for improvements worldwide.

Set against this strong rationale, in 2016/17 the National Planning Commission (NPC) formulated the second MSNP (MSNP-II) with support from its development partners to outline a set of core values that reflect the country's social and economic priorities. The plan is based on consultations with a wide range of public and private stakeholders and on the analysis of nutrition deprivations, causality, disparities, inequities, bottlenecks, a desk review, recommendations from the Lancet 2013 series on maternal and child nutrition (The Lancet 2013) and other global and national priorities. Figure 1.6 shows the process undertaken to prepare MSNP-II beginning in June 2016 and concluding with the plan's approval by the Cabinet in November 2017.

Malnutrition is a major issue to be addressed under the SDGs (2016-2030).

FIGURE 1.6: TIMELINE OF PREPARATION OF MSNP-II



Chapter 2

MULTI-SECTOR NUTRITION PLAN-II (2018–2022)

Chapter 2

2. Multi-Sector Nutrition Plan-II (2018–2022)

2.1 Vision

To reduce malnutrition so that it no longer impedes people's potential and performance towards enhanced human capital and overall socioeconomic development.

2.2 Goal

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

2.3 Objectives

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

- 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 behaviour.
- To improve policies, plans and multi-sectoral coordination at federal, provincial and local government levels to create an enabling environment to improve nutrition.

2.4 Strategies

MSNP-II will take the following strategies:

1. Scale up multisector nutrition programmes across Nepal to ensure qualitative, equitable and gender-informed nutrition services for all.
2. Develop positive nutrition behaviour by running advocacy, communication and participation campaigns and through public engagement programmes.
3. Foster cooperation, partnership, coordination and the sharing of lessons learned and best practices on improving nutrition.
4. Promote and use innovative technologies and initiatives for improving nutrition.
5. Internalise and implement nutrition interventions in federal, provincial and local government policies and plans.
6. Strengthen monitoring, evaluation, study and research for evidence-based planning, decision making and implementation.

2.5 Policy-level Principles and Approaches

- **Prevailing government policies and perspective plans —** MSNP-II will be the basis for the implementation of the parts of the Fourteenth Plan (2016/17–2018/19) (NPC 2016b) on improving nutrition. MSNP-II has been designed and will be implemented in compliance with the Constitution of Nepal, 2015 (GoN 2015) and with related regulations.
- **Inclusiveness and gender equity —** Interventions under MSNP-II will promote social inclusion and gender equity especially in the hills and mountains of the Mid-West and Far West and in the central Tarai. MSNP-II will support the socially inclusive, gender sensitive and child-friendly continuum of care.
- **Affirmative action —** Affirmative action policies will be introduced in favour of poor people, women and disadvantaged communities to maximise their participation in, and benefits from, MSNP-II's interventions. The leadership and management skills of women and disadvantaged communities (Dalit, Janajatis [ethnic groups] and others) will be improved. The plan will seek to ensure that their voices are heard in local decision-making processes, including by mainstreaming and institutionalizing their participation in local institutions.
- **Flexible and process-oriented approach —** MSNP-II will translate the government's commitments on improving nutrition, state restructuring and the engagement of line agencies with communities to improve the delivery of public goods and services. The sup-

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

MSNP-II's theory of change helps the different sectors to see their roles in implementing MSNP-II.

port provided to line agencies and local governments will be flexible and process-oriented and will include innovative and context-specific approaches for responsive, inclusive, and accountable governance through participatory development. Procedures for working with communities and targeting the poorest and most disadvantaged people will be rationalised and harmonised.

- **Transparency and accountability —** MSNP-II will be transparent in its operations, budgets, decision making, communications, coordination among line agencies and non-state agencies and in reaching remote areas. It will delineate the roles and responsibilities of all actors and take a systemic approach to increase accountability at all levels.
- **Information and communication —** Behaviour change communication will be organised to raise civic awareness about chronic malnutrition and actions needed to improve maternal and child nutrition, focussing on reaching the most marginalized, poorest segments and taking into account gender related factors. Civil society organisations, parliamentarians, other elected representatives, and decision makers will be mobilised with advocacy activities.

2.6 Theory of Change

Theories of change explain how activities are understood to produce results that contribute to achieving intended impacts. Using this tool sharpens the focus on what needs to be addressed and the changes needed at government, community, family, and individual levels to reduce malnutrition.

MSNP-II's theory of change (Figure 2.1) helps the different sectors to see their roles in implementing MSNP-II. It shows the desired impact of MSNP-II to address the main nutrition-related problems, which range from stunting of under 5-year olds to childhood wasting. Below are the three outcomes of MSNP-II and the intervention areas (outputs) that the five sectors, plus NPC and local governance, need to carry out under to achieve the desired impact.

FIGURE 2.1: MSNP-II'S THEORY OF CHANGE

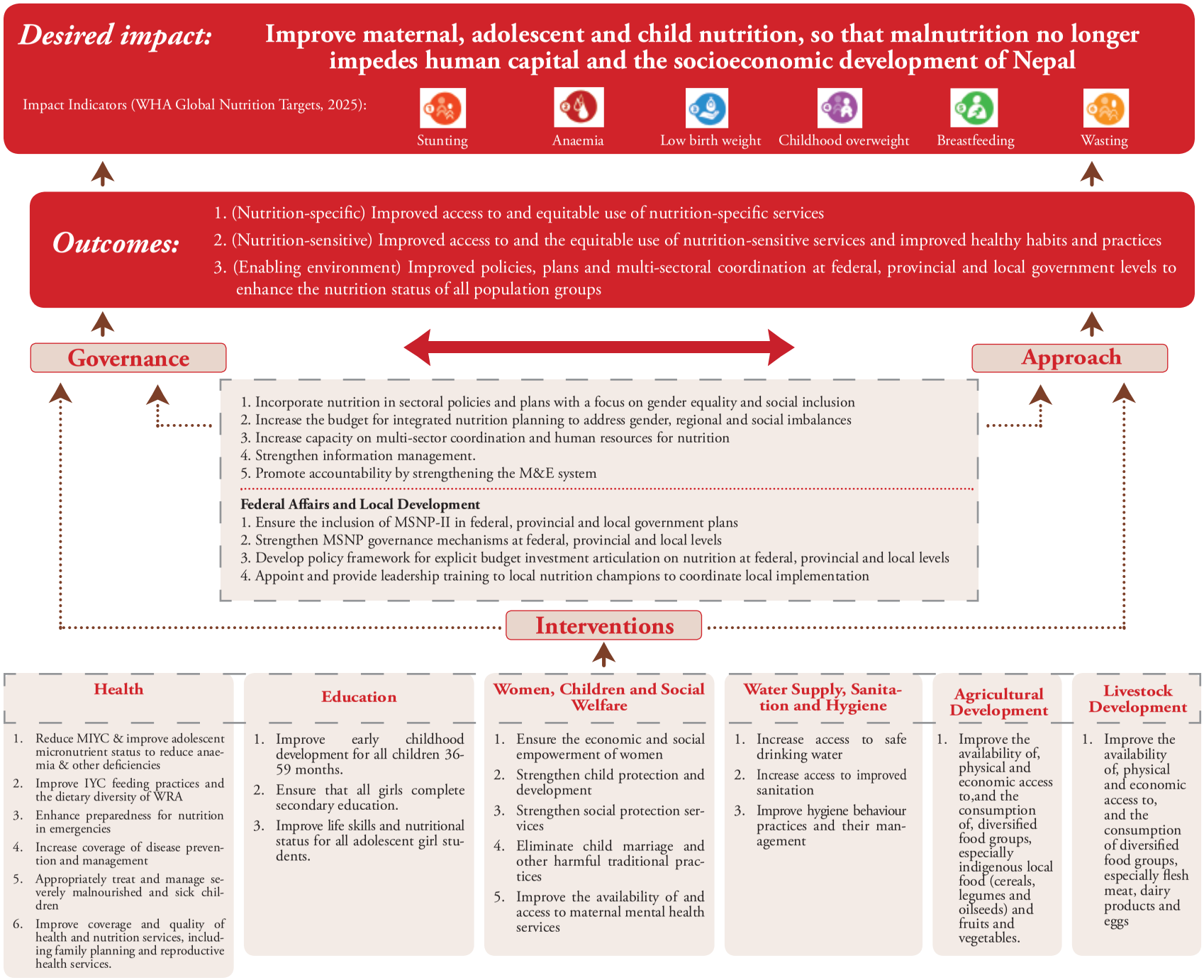



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FIGURE 2.2: MSNP-II RESULTS STRUCTURE — OUTCOME 1 ON NUTRITION SPECIFIC SERVICES

GOAL: IMPROVED MATERNAL, ADOLESCENT AND CHILD NUTRITION BY SCALING UP ESSENTIAL NUTRITION-SPECIFIC AND SENSITIVE INTERVENTIONS AND CREATING AN ENABLING ENVIRONMENT FOR NUTRITION

Outcome 1: Improved access to and equitable use of nutrition-specific

Output 1.1 Enhanced nutrition status of WRA including adolescents

- 1.1.1 Organize and implement fully-nourished villages/ wards including G1000D communication campaign
- 1.1.2 Revitalize School Health and Nutrition Programme including promotion of healthy dietary habits and physical activities
- 1.1.3 Raise awareness and services for healthy timing and spacing of pregnancy
- 1.1.4 Conduct barrier analysis for increased ANC service utilization
- 1.1.5 Integrate and expand adolescent-friendly health and nutrition services

Output 1.2: Improved infant and young child nutrition and care practices

- 1.2.1 Conduct MIYCN counselling at all health sector platforms viz. health mother's group meetings, immunization, ANC, PNC, GMP, PHC-ORC, IMNCI & OPD services
- 1.2.2 Conduct regular growth monitoring counselling at PHC-ORCs and health facilities
- 1.2.3 Disseminate IEC & BCC materials through health facilities, & FCHVs to communities & households regularly
- 1.2.4 Conduct food preparation & cooking demonstrations to prepare local nutritious foods (e.g. nutritious flour/porridge (lito), jaulo/khichadi using local foodstuffs
- 1.2.5 Engage media for documentation and dissemination of MIYCN programme
- 1.2.6 Raise awareness on nutrition including essential newborn care

Output 1.3: Improved MIYC micronutrient status

- 1.3.1 Maintain and sustain routine distribution of Vitamin A capsule and deworming tablets to children under 5 years
- 1.3.2 Increase coverage and compliance of iron folic acid and deworming among pregnancy and post-partum women
- 1.3.3 Scale-up home food fortification with MNP in targeted area
- 1.3.4 Raise awareness to promote household use of two-child-logo iodized salt
- 1.3.5 Raise awareness to promote consumption of roller-mill produced fortified flour and rice
- 1.3.6 Initiate rice fortification in government (NFC) and selected large rice mills.
- 1.3.7 Conduct research to improve compliance of IFA supplementation
- 1.3.8 Conduct barrier analysis on low coverage/ compliance of MNP
- 1.3.9 Procure and supply nutrition commodities for regular and emergency programmes (Vitamin A, IFA, deworming tablets, MNP, RUTF, therapeutic milk, ReSoMal)
- 1.3.10 Scale-up fortified super cereal flour distribution in districts with high prevalence of acute malnutrition to pregnant and lactating women and 6-23 months children under MCHN programme

Output 1.4: Improved management of severe and moderate acute malnutrition

- 1.4.1 Expand and establish OTC and ITC centres for management of severe acute malnutrition in children under 5
- 1.4.2 Scale-up NRH in 50+ bed hospitals
- 1.4.3 Conduct periodic nutrition assessments and counselling at community levels
- 1.4.4 Conduct barrier analysis on services related to SAM management
- 1.4.5 Scale-up and strengthen IMNCI programme
- 1.4.6 Establish and strengthen nutrition information and surveillance system in normal and humanitarian situations

Output 1.5: Enhanced preparedness for nutrition in emergency. responses

- 1.5.1 Establish local level nutrition clusters and conduct quarterly coordination meeting
- 1.5.2 Update and develop nutrition in emergency preparedness for response and contingency planning at local levels.

Output 1.6: Capacity built of nutrition specific sectors

- 1.6.1 Refresher training for HWs & FCHVs at all level on MIYCN package
- 1.6.2 Organize basic training on MIYCN package to newly recruited nutrition supervisors and nutrition officers
- 1.6.3 Organize nutrition champion leadership development events
- 1.6.4 Conduct routine data quality assessments (RDQA) using nutrition programme related HMIS tools

FIGURE 2.3: MSNP-II RESULTS STRUCTURE — OUTCOME 2 ON NUTRITION SENSITIVE SERVICES

GOAL: IMPROVED MATERNAL, ADOLESCENT AND CHILD NUTRITION BY SCALING UP ESSENTIAL NUTRITION-SPECIFIC AND SENSITIVE INTERVENTIONS AND CREATING AN ENABLING ENVIRONMENT FOR NUTRITION

Outcome 2: Improved access to and the equitable use of nutrition-sensitive services and improved healthy habits and practices

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

- 2.1.1 Make available agriculture and livestock inputs (i.e. seeds, fertilizers, breeds) at household and community levels
- 2.1.2 Provide technical support (training, demonstration) to promote production of fruits, vegetables, nutritious roots, cereals and pulses to increase consumption of diversified foods in households
- 2.1.3 Increase production and promote consumption of fresh fruits and green leafy vegetables
- 2.1.4 Build capacity of livestock farmers and entrepreneurs to increase milk, meat and egg production
- 2.1.5 Technical support for micro and alternative small irrigation to produce diversified and micronutrient rich foods
- 2.1.6 Support food producing industries to adopt good manufacturing practices (GMP) and related systems
- 2.1.7 Train agriculture and livestock extension officers and staff on food safety, food processing and nutrition
- 2.1.8 Train farmers on food safety, food processing and nutrition
- 2.1.9 Study and improve local food recipes
- 2.1.10 Update and disseminate food composition tables
- 2.1.11 Disseminate food based dietary guidelines to local governments
- 2.1.12 Develop and multiply BCC materials including audio visuals on food safety, food processing and nutrition

Output 2.2: Increased physical and economic access to diverse types of food

- 2.2.1 Enhance access and utilization of animal source foods
- 2.2.2 Promote and support production and consumption of fish including support to establish community ponds for production and local consumption

Output 2.3: Increased access to safe drinking water

- 2.3.1 Construct and repair water supply schemes in communities and institutions through water safety plans and projects
- 2.3.1 Promote alternative and innovative technologies for supply water
- 2.3.3 Promote household water treatment options

Output 2.4: Increased access to safe and sustainable sanitation services

- 2.4.1 Sensitize communities to raise awareness for construction, maintenance and hygienic use of improved household toilets including safe disposal of child faeces
- 2.4.2 Support and strengthen WASH coordination committees and local government to accelerate ODF campaigns.
- 2.4.3 Support construction and management of child, gender and differently abled friendly toilets including menstrual hygiene management facilities at institutions

Output 2.5: Improved knowledge of children and mothers and caretakers of under 5 children on health and hygiene

- 2.5.1 Construct, establish and promote user friendly hand washing facilities in households and institutions
- 2.5.2 Raise awareness on hand washing at critical times in communities, school children and health workers.
- 2.5.3 Raise awareness on menstrual hygiene management in communities and schools.
- 2.5.4 Raise awareness about food hygiene in communities

Output 2.6: Targeted groups have access to resources and opportunities that make them self-reliant

- 2.6.1 Support community seed banks.
- 2.6.2 Support women and disadvantaged groups to produce and consume animal livestock products.
- 2.6.3 Provide start-up entrepreneurship grants to women cooperatives for social and economic empowerment
- 2.6.4 Provide start-up entrepreneurship grants to women group members for social and economic empowerment.
- 2.6.5 Training and orientations for income generation and business promotion (vegetable & fruit production, animal husbandry, livestock, tailoring)
- 2.6.6 Link the distribution of child protection grants to nutrition in all districts.
- 2.6.7 Include nutrition as a major objective of social protection programmes

Output 2.7: Nutrition component incorporated in women, adolescent girls and child development training packages

- 2.7.1 Integrate nutrition modules in training packages including GBV prevention and response training, leadership, community protection, business development and life skills training.

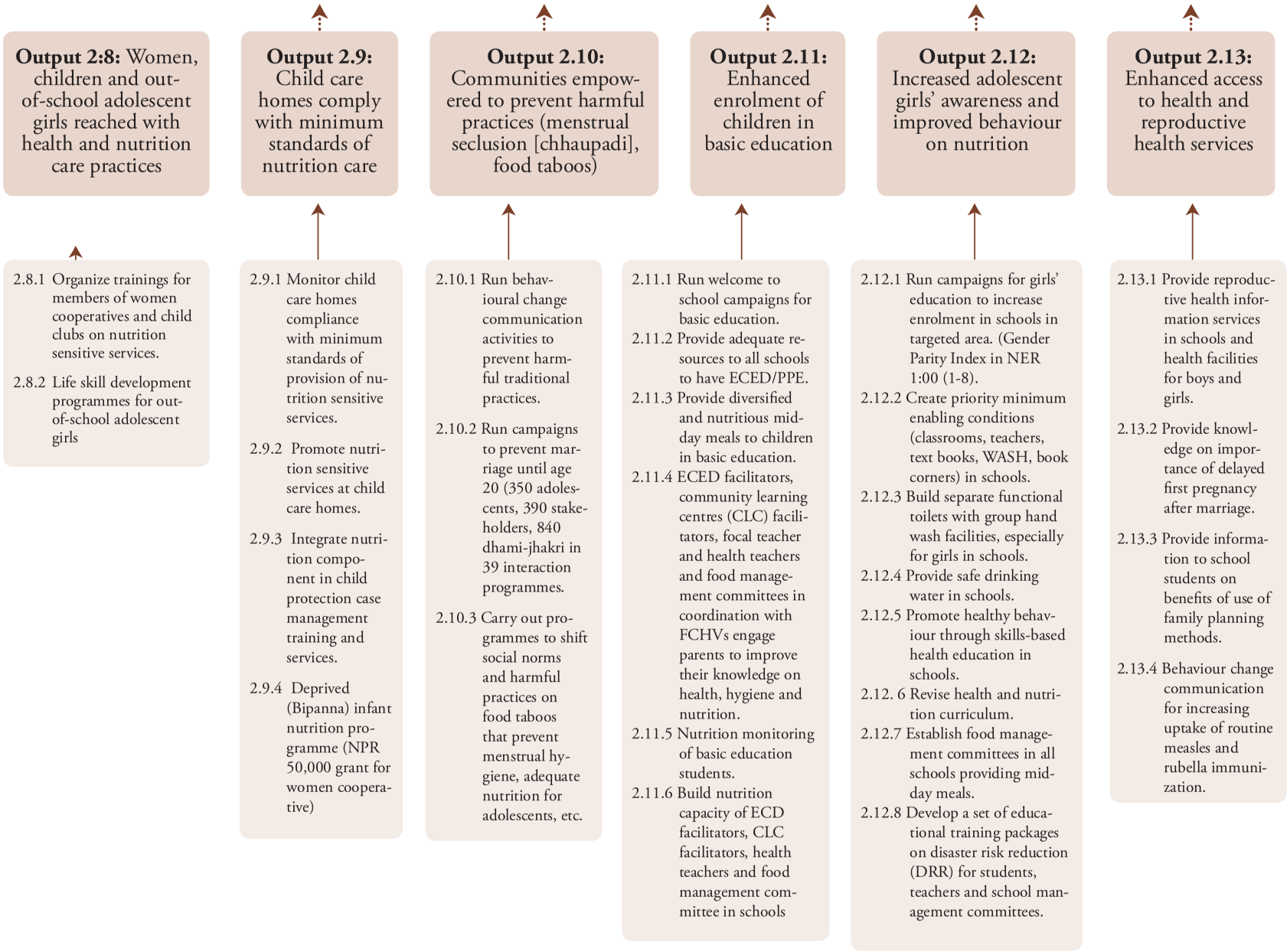
Output 2:8: Women, children and out-of-school adolescent girls reached with health and nutrition care practices
2.8.1 Organize trainings for members of women cooperatives and child clubs on nutrition sensitive services.
2.8.2 Life skill development programmes for out-of-school adolescent girls
Output 2.9: Child care homes comply with minimum standards of nutrition care
2.9.1 Monitor child care homes compliance with minimum standards of provision of nutrition sensitive services.
2.9.2 Promote nutrition sensitive services at child care homes.
2.9.3 Integrate nutrition component in child protection case management training and services.
2.9.4 Deprived (Bipanna) infant nutrition programme (NPR 50,000 grant for women cooperative)
Output 2.10: Communities empowered to prevent harmful practices (menstrual seclusion [chhaupadi], food taboos)
2.10.1 Run behavioural change communication activities to prevent harmful traditional practices.
2.10.2 Run campaigns to prevent marriage until age 20 (350 adolescents, 390 stakeholders, 840 dhami-jhakri in 39 interaction programmes.
2.10.3 Carry out programmes to shift social norms and harmful practices on food taboos that prevent menstrual hygiene, adequate nutrition for adolescents, etc.
Output 2.11: Enhanced enrolment of children in basic education
2.11.1 Run welcome to school campaigns for basic education.
2.11.2 Provide adequate resources to all schools to have ECED/PPE.
2.11.3 Provide diversified and nutritious mid-day meals to children in basic education.
2.11.4 ECED facilitators, community learning centres (CLC) facilitators, focal teacher and health teachers and food management committees in coordination with FCHVs engage parents to improve their knowledge on health, hygiene and nutrition.
2.11.5 Nutrition monitoring of basic education students.
2.11.6 Build nutrition capacity of ECD facilitators, CLC facilitators, health teachers and food management committee in schools
Output 2.12: Increased adolescent girls' awareness and improved behaviour on nutrition
2.12.1 Run campaigns for girls' education to increase enrolment in schools in targeted area. (Gender Parity Index in NER 1:00 (1-8).
2.12.2 Create priority minimum enabling conditions (classrooms, teachers, text books, WASH, book corners) in schools.
2.12.3 Build separate functional toilets with group hand wash facilities, especially for girls in schools.
2.12.4 Provide safe drinking water in schools.
2.12.5 Promote healthy behaviour through skills-based health education in schools.
2.12. 6 Revise health and nutrition curriculum.
2.12.7 Establish food management committees in all schools providing mid-day meals.
2.12.8 Develop a set of educational training packages on disaster risk reduction (DRR) for students, teachers and school management committees.
Output 2.13: Enhanced access to health and reproductive health services
2.13.1 Provide reproductive health information services in schools and health facilities for boys and girls.
2.13.2 Provide knowledge on importance of delayed first pregnancy after marriage.
2.13.3 Provide information to school students on benefits of use of family planning methods.
2.13.4 Behaviour change communication for increasing uptake of routine measles and rubella immunization.

FIGURE 2.4: MSNP-II RESULTS STRUCTURE — OUTCOME 3 ON THE ENABLING ENVIRONMENT

GOAL: IMPROVED MATERNAL, ADOLESCENT AND CHILD NUTRITION BY SCALING UP ESSENTIAL NUTRITION-SPECIFIC AND SENSITIVE INTERVENTIONS AND CREATING AN ENABLING ENVIRONMENT FOR NUTRITION

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.

Output 3.1 MSNP-II included in local, provincial and federal government policies and plans	**Output 3.2:** MSNP governance mechanism strengthened at federal, provincial, and local levels	**Output 3.3:** MSNP-II institutional mechanisms functional at federal government level	**Output 3.4:** Functional updated information management system across all MSNP-II sectors	**Output 3.5:** Enhanced capacity of federal, provincial and local government to plan & implement nutrition programmes
3.1.1 Incorporate MSNP-II in federal plans and polices	3.2.1 Organise High Level Nutrition and Food Security Steering Committee (HLNFSS) meetings twice a year.	3.3.1 Strengthen National Nutrition and Food Security Secretariat at NPC.	3.4.1 Update MSNP information portal and make it functional.	3.5.1 Develop national capacity building master plan for MSNP-II.
3.1.2 Incorporate MSNP-II in provincial level plans and policies	3.2.2 Organise National Nutrition and Food Security Coordination Committee meetings quarterly.	3.3.2 Carry out organization & management survey on including NNFSS in NPC.	3.4.2 Link and update nutrition information at central level (HMIS, EMIS, WASH, agriculture, livestock and local governance).	3.5.2 Implement capacity development master plan at all levels.
3.1.3 Incorporate MSNP-II in local government plans and planning processes	3.2.3 Send circular and facilitate formation of nutrition and food security steering committee in provinces.	3.3.3 Facilitate endorsement of the O&M survey report.	3.4.3 Provide training on web-based MSNP reporting system at federal and province level.	
3.1.4 Organize joint annual review meetings among MSNP-II sector ministries at federal level	3.2.4 Form nutrition and food security steering committees at province level	3.3.4 Recruit staff for NFSS as per approved organogram.	3.4.4 Document & disseminate good practices, lessons learned and case studies.	
3.1.5 Advocacy meetings for increasing nutrition budget (at least 3.5% of total) at federal and province levels		3.2.5 Organise nutrition and food security steering committee meetings twice a year at province level.	3.4.5 Develop and review monitoring and evaluation framework for all MSNP sectors at federal level.	
3.1.6 Develop nutrition budget code		3.2.6 Form nutrition and food security coordination committees at province level.	3.4.6 Develop and review monitoring and evaluation framework for all MSNP sectors at province level.	
		3.2.7 Organise nutrition and food security coordination committee meetings quarterly at province level.	3.4.7 Ensure development of monitoring and evaluation framework for all MSNP sectors at local level.	
		3.2.8 Appoint nutrition focal persons for all sectoral ministries at province level.		
		3.2.9 Organise thematic technical working group meetings at federal level quarterly.		
		3.2.10 Form nutrition and food steering committees at local governments level and meet regularly.		
		3.2.11 Form nutrition and food steering committee and regular meetings at ward level in MSNP local governments.		
		3.2.12 Facilitate to assign coordinators (existing staff or outsourced) at local governments to oversee MSNP-II interventions.		

2.7 Results Framework of MSNP-II (2018–22)

Based on the theory of change, MSNP-II aims to achieve the following three outcomes:

1. **Improved access to and the equitable use of nutrition-specific services.**
2. **Improved access to and the equitable use of nutrition-sensitive services and improved healthy habits and practices.**
3. **Improved policies, plans and multi-sectoral coordination at federal, provincial and local government levels to enhance the nutrition status of all population groups.**

Outcome 1: Improved equitable utilization of nutrition specific services.

The outputs under this outcome address the immediate causes of malnutrition. The health sector is responsible for achieving the following six outputs and implementing the associated 33 key activities (see Figure 2.2):

OUTPUT 1.1: ENHANCED NUTRITION STATUS OF WRA INCLUDING ADOLESCENTS

Key interventions:

1.1.1 Organize and implement fully-nourished village/ward including Golden 1000 Days communication campaign.

1.1.2 Revitalize School Health and Nutrition/ Weekly Iron Folic Acid Supplementation programme including promoting healthy dietary habits and physical activities.

1.1.3 Raise awareness and services for healthy timing and spacing of pregnancy and increase access to and utilisation of family planning tools.

1.1.4 Conduct barrier analysis for increased ANC services utilization.

1.1.5 Integrate and expand adolescent-friendly health and nutrition services.

OUTPUT 1.2: IMPROVED INFANT AND YOUNG CHILD NUTRITION AND CARE PRACTICES

Key interventions:

1.2.1 Conduct maternal, infant, young child and newborn (MIYCN) counselling at all health sector platforms viz. health mother's group meetings, immunization, ANC, PNC, growth monitoring, PHC-ORC, IMNCI and OPD services.

1.2.2 Conduct regular growth monitoring counselling at PHC-ORCs and health facilities.

1.2.3 Disseminate IEC and BCC materials through health facilities and FCHVs to communities and households regularly.

1.2.4 Conduct food preparation and cooking demonstrations on preparing local nutritious foods (e.g. nutritious flour/porridge (lito), jaulo/khichadi using locally available food products.

1.2.5 Engage media for documentation and dissemination of MIYCN programme.

1.2.6 Raise awareness on nutrition including on essential newborn care.

OUTPUT 1.3: IMPROVED MIYC MICRONUTRIENT STATUS

Key interventions:

1.3.1 Maintain and sustain routine distribution of Vitamin A capsules to children under 5 years and deworming tablets to children of 1-5 years.

1.3.2 Increase coverage and compliance of iron folic acid and de-worming among women during pregnancy and post-partum.

1.3.3 Scale-up home fortification with MNP in targeted areas.

1.3.4 Raise awareness to promote household use of two-child-logo iodized salt.

1.3.5 Raise awareness to promote consumption of national roller-mill produced fortified flour.

1.3.6 Initiate fortification process in production of national roller mills and in foods supplied by Nepal Food Corporation.

1.3.7 Conduct qualitative study for improved compliance of IFA supplementation.

1.3.8 Conduct barrier analysis for low coverage and compliance of MNP.

1.3.9 Procure and supply nutrition commodities for regular and emergency programmes (VAC, IFA, deworming tablets, MNPs, RUTF, therapeutic milk, ReSoMal).

OUTPUT 1.4: IMPROVED MANAGEMENT OF SEVERE AND MODERATE ACUTE MALNUTRITION

Key interventions:

1.4.1 Expand and establish OTC and ITC to manage severe acute malnutrition in children under 5 years.

1.4.2 Scale-up nutrition rehabilitation homes (NRHs) in 50+ bed hospitals.

1.4.3 Conduct periodic nutrition assessments and counselling at community level.

1.4.4 Conduct barrier analysis to identify barriers to seek services related to SAM management.

1.4.5 Scale-up and strengthen IMNCI programme.

1.4.6 Establish and strengthen nutrition information and surveillance system in normal and humanitarian situations.

OUTPUT 1.5: ENHANCED PREPAREDNESS FOR NUTRITION IN EMERGENCY RESPONSES

Key interventions:

1.5.1 Establish local nutrition clusters and conduct quarterly coordination meetings at local levels.

1.5.2 Update and develop nutrition in emergency preparedness for response and contingency plans at local levels.

OUTPUT 1.6: BUILT CAPACITY OF NUTRITION SPECIFIC SECTORS

The aim of this output is to implement the capacity development measures recommended in the capacity development plan that will be implemented by the nutrition specific sector.

Key activities:

1.6.1 Conduct refresher training for health workers and FCHVs at all level on the MIYCN package.

1.6.2 Organize basic training on the MIYCN package to newly recruited nutrition supervisors and nutrition officers.

1.6.3 Organize nutrition champion leadership development events.

1.6.4 Conduct routine data quality assessment (RDQA) for nutrition programme related HMIS tools.

Outcome 2: Improved access to and equitable utilisation of nutrition sensitive services and improved healthy habits-practices.

The outputs under this outcome address the basic causes of malnutrition. These outputs are clustered under nutrition sensitive elements. Health, agriculture, livestock, WASH, education women and children, and local governance will be responsible to attain this outcome. There are 13 outputs and 59 key activities under this outcome (see Figure 2.3).

OUTPUT 2.1: INCREASED AVAILABILITY AND CONSUMPTION OF SAFE AND NUTRITIOUS FOODS

The following key interventions will be implemented by the agriculture and livestock sector:

2.1.1 Make available agriculture and livestock inputs (i.e. seeds, fertilizers, breeds) including at households and community levels.

2.1.2 Provide technical support (training, demonstrations) to promote the production of fruits, vegetables, nutritious roots, cereals and pulses to improve the consumption of diversified foods at household level.

2.1.3 Increase production and promote consumption of fresh fruits and green leafy vegetables.

2.1.4 Build capacity of livestock farmers and entrepreneurs to increase milk, meat and egg production.

2.1.5 Provide technical support for micro and alternative small irrigation to produce diversified and micronutrient rich foods.

2.1.6 Technical support to food processing industries on good manufacturing practices and quality promotion measures through training, workshops and observation.

2.1.7 Training on food safety, food processing and nutrition to farmers.

2.1.8 Study and improve local food recipes.

2.1.9 Update the food composition table.

2.1.10 Update and disseminate the food composition table.

2.1.11 Update and disseminate food-based dietary guidelines in local governments.

2.1.12 Develop and multiply BCC materials including audiovisuals on food safety, food processing and nutrition.

OUTPUT 2.2: INCREASED PHYSICAL AND ECONOMIC ACCESS TO DIVERSIFIED FOOD

The following key interventions will implemented by the agriculture and livestock sector:

2.2.1 Enhance access to and use of animal product foods.

a) Establish livestock and food markets.

b) Distribute chilling vats to dairies.

c) Raise awareness about consumption of livestock related foodstuff.

2.2.2 Promote and support production and consumption of fish including support for establishing community ponds.

OUTPUT 2.3: INCREASED ACCESS TO SAFE DRINKING WATER

The following key interventions will be implemented by the water and sanitation sector:

2.3.1 Construct and repair water supply schemes in communities and institutions ensuring water safety plan.

2.3.2 Promote alternative and innovative technologies for providing water supplies.

2.3.3 Promote household water treatment options.

OUTPUT 2.4: INCREASED ACCESS TO SAFE AND SUSTAINABLE SANITATION SERVICES

The following key interventions will be implemented by the water and sanitation sector:

2.4.1 Sensitize communities to raise awareness for construction, maintenance and hygienic use of improved household toilet including the safe disposal of child faeces.

2.4.2 Support and strengthen WASH coordination committees, and local government to accelerate ODF campaigns.

2.4.3 Support for construction and management of CGD friendly toilet facilities including menstrual hygiene management facilities at institutions.

2.4.4 Support to construct safe food hygiene facilities (silauta covers, dish drying racks).

OUTPUT 2.5: IMPROVED KNOWLEDGE ON HYGIENIC BEHAVIOUR OF CHILDREN AND MOTHER AND CARETAKERS OF UNDER 5 CHILDREN

The water and sanitation sector is responsible for implementing the following key activities.

2.5.1 Construct, establish and promote user-friendly hand washing facilities in households and institutions.

2.5.2 Raise awareness on hand washing at critical times to communities, school children and health workers.

2.5.3 Raise awareness on menstrual hygiene management in communities and schools.

2.5.4 Raise awareness to promote safe food hygiene at community level.

OUTPUT 2.6: TARGETED GROUPS HAVE ACCESS TO RESOURCES AND OPPORTUNITIES THAT ARE ESSENTIAL FOR MAKING THEM SELF-RELIANT

All the plan's sectors will be responsible to attain this results, particularly the women and children, agriculture and livestock sectors. The key interventions under this output are the following:

2.6.1 Support community seed banks.

2.6.2 Support women and disadvantaged group participation in producing and marketing safe and nutritious food. Raise awareness to increase consumption of these foods.

2.6.3 Provide start-up entrepreneurship grants to women group members for social and economic empowerment.

2.6.4 Provide basic entrepreneurship training to women entrepreneurs groups for the socio-economic empowerment of women.

2.6.5 Provide training and orientation for IGA and business promotion (vegetable, fruits, production, animal husbandry, livestock lining with agricultural sector, tailoring).

2.6.6 Link child protection grants to child nutrition in all districts (including distribution).

2.6.7 Include nutrition as a major objective of the Social Protection Programme.

OUTPUT 2.7: NUTRITION COMPONENT INCORPORATED IN WOMEN, ADOLESCENT GIRLS AND CHILD DEVELOPMENT TRAINING PACKAGES

The women and children sector will be responsible to coordinate and attain this result and carry out the following activity:

2.7.1 Integrate nutrition module in existing training packages: Gender based violence prevention and response training, leadership, community protection, business development and life skills training.

OUTPUT 2.8: WOMEN, CHILDREN AND OUT OF SCHOOL ADOLESCENT GIRLS REACHED WITH HEALTH AND NUTRITION CARE PRACTICES

The women and children sector is responsible to coordinate and attain this result and carry out the following activities:

2.8.1 Training members of women cooperatives and child clubs on nutrition sensitive services:

a) Leadership development
b) Gender based violence management
c) Social protection
d) Entrepreneurship development
e) Reproductive health
f) Gender based violence management (male and female participation).

2.8.2 Life skill development programmes to adolescent girls in and out of school:

a) Menstrual hygiene management
b) Gender violence management, women trafficking orientation to adolescent girls.
c) Life skill development training to adolescent girls.
d) Nutrition and child care related training to child club and village child protection committees.

OUTPUT 2.9: CHILD CARE HOMES COMPLY WITH MINIMUM STANDARDS OF NUTRITION CARE SERVICES

The women and children sector will be responsible to coordinate and attain this result and carry out the following activities:

2.9.1 Monitor child care homes for compliance with minimum standards of nutrition sensitive services.

2.9.2 Promote nutrition sensitive services at child care homes.

2.9.3 Integrate nutrition component in child protection case management training and services.

2.9.4 Deprived (bipanna) infant nutrition programme grant for women cooperatives.

OUTPUT 2.10: COMMUNITIES EMPOWERED TO ADDRESS HARMFUL PRACTICES

The women and children sector will be responsible to coordinate and carry out the following activities:

2.10.1 Conduct behavioural change communication activities to prevent harmful traditional practices.

2.10.2 Run campaigns to prevent child marriage.

2.10.3 Carry out programmes to shift social norms and harmful practices on food taboos preventing adequate nutrition for adolescents, menstrual seclusion, etc.

OUTPUT 2.11: ENHANCED ENROLMENT OF CHILDREN IN BASIC EDUCATION

The education sector will be responsible to attain this result and carry out the following activities:

2.11.1 Run welcome to school campaigns for basic education students.

2.11.2 Provide adequate resources to all schools to have ECED/pre-primary education (PPE).

2.11.3 Provide diversified and nutritious midday meals and other nutrition services to children in basic education.

2.11.4 Increase knowledge of ECED facilitators, community learning centre (CLC) facilitators, focal teacher, health teachers and food management committees in coordination with FCHVs to activate them on health, hygiene and nutrition.

2.11.5 Carry out nutrition monitoring of basic education children.

2.11.6 Build nutrition capacity of ECD facilitators, CLC facilitators, health teachers and food management committees.

2.11.7 Prepare study materials and demonstrate them to CLC facilitators, focal teachers, health teachers and food management committees on regular dietary (food, vegetable and fruits) calendar.

OUTPUT 2.12: INCREASED ADOLESCENT GIRLS' AWARENESS AND BEHAVIOURS IN NUTRITION

The education sector will be responsible to carry out the following activities.

2.12.1 Run campaigns for girls education to increase their enrolment in schools in targeted areas.

2.12.2 Create priority minimum enabling conditions (class room, teacher, text book, WASH, book corners) in schools.

2.12.3 Construct separate toilets with group hand wash facility especially for girls in schools.

2.12.4 Provide safe drinking water in schools.

2.12.5 Promote healthy behaviours through skills-based health education in schools.

2.12.6 Revise health and nutrition curriculum.

2.12.7 Establish food management committees in all schools providing midday meals.

2.12.8 Develop educational training packages on DRR for students, teachers and school management committees (SMCs).

OUTPUT 2.13 PROMOTE ACCESS TO HEALTH AND REPRODUCTIVE HEALTH SERVICES

The health sector will be responsible to acarry out the following activities:

2.13.1 Provide reproductive health and nutrition information services at schools and health facilities to provide access to boys and girls.

2.13.2 Provide knowledge on the importance of delayed first pregnancy after marriage (if married before 20 years).

2.13.3 Raise knowledge of students at community schools on benefits of family planning methods.

2.13.4 Run behaviour change communication programmes for improving routine measles and rubella immunization.

Outcome 3: Improved policies, plans and multi-sectoral coordination at federal, provincial and local government levels to create enabling environment to improve nutrition status

Outcome 3 is the enabling environment outcome. This outcome aims to increase multi-sectoral commitment and resources for nutrition, strengthen nutritional information management and data analysis and establish protocol for nutrition profiles (as the basis for planning) at federal, provincial and local government levels. The NPC, NPC, MoFALD and other sector ministries will be responsible for the accomplishment of the following 5 outputs and 31 key activities (see Figure 2.4).

OUTPUT 3.1: MSNP INCLUDED IN LOCAL, PROVINCIAL AND FEDERAL GOVERNMENTS' POLICIES AND PLANS

The NPC, MoFALD, MoF and other sectoral ministries will be responsible for the accomplishment of the following key activities:

3.1.1 Incorporate MSNP-II in federal sectoral plans and polices.

a) Update MSNP in the policy, long-term plan and strategies of federal level sector ministries in line with MSNP-II.

b) Provide guidelines from NPC to incorporate MSNP-II activities in the annual programme and budget of sectoral ministries.

c) Monitor to ensure incorporation of MSNP -II activities in the annual programmes and budgets of sectoral ministries.

3.1.2 Incorporate MSNP-II in province level plans and policies.

a) Organise workshops at provincial level to provide advocacy and counselling on MSNP-II.

b) Send circular to all provicncial governments to incorporate nutrition in their relevant policies, long-term plans and strategies in line with MSNP-II.

3.1.3 Incorporate MSNP-II in local governments' plans and planning processes.

3.1.4 Organize joint annual review meeting among MSNP-II sectoral ministries at federal level.

3.1.5 Advocacy meeting for budget increment at federal, province and local government level.

a) Conduct advocacy meetings with federal and provincial level parliamentarians to arrange resources and allocation of adequate budget for the implementation of MSNP-II.

b) Conduct advocacy meetings with MoF at federal and provincial levels to arrange resources and allocation of adequate budget for implementing MSNP-II.

c) Conduct advocacy and counselling with educational agencies, private sector, entrepreneurs etc. to arrange adequate resources for the implementation of MSNP-II.

d) Conduct advocacy and counselling with NGOs and civil society organisations to arrange adequate resources for the implementation of MSNP-II.

3.1.6 Develop a nutrition budget code.

OUTPUT 3.2: MSNP GOVERNANCE MECHANISM STRENGTHENED AT FEDERAL, PROVINCIAL, AND LOCAL LEVEL

The NPC, MoFALD and other sectoral ministries will be responsible for implementing the folllowing activities:

3.2.1 Organise High Level Nutrition and Food Security Steering Committee (HLNFSS) meeting twice a year.

3.2.2 Organise Nutrition and Food Security Coordination Committee meetings in every trimester.

3.2.3 Send circular and facilitate formation of nutrition and food security steering committees at province level.

3.2.4 Form nutrition and food security steering committees at provincial level.

3.2.5 Organise nutrition and food security steering committee meetings at provincial level twice a year.

3.2.6 Form nutrition and food security coordination committee at provincial level.

3.2.7 Organise nutrition and food security coordination committee meetings in every trimester.

3.2.8 Assign a focal person for MSNP-II in provincial level sectoral ministries.

3.2.9 Organise thematic technical working group meetings at federal level each quarter.

3.2.10 Ensure formation of nutrition and food security steering committees and their regular meetings at local government level.

3.2.11 Ensure formation of nutrition and food security steering committees and regular meeting at ward level in MSNP implemented local government areas.

3.2.12 Assign coordinators (from existing staff or outsourced) in local governments.

OUTPUT 3.3: MSNP INSTITUTIONAL MECHANISMS FUNCTIONAL AT FEDERAL GOVERNMENT LEVEL.

NPC will be responsible to attain this result and carry out the following activities:

3.3.1 Strengthen the National Nutrition and Food Security Secretariat at NPC.

3.3.2 Conduct O&M survey to establish NNFSSC within NPC.

3.3.3 Establish NNFSSC within NPC and recruit staff as per approved organogram.

OUTPUT 3.4: STRENGTHENED INTEGRATED INFORMATION MANAGEMENT SYSTEM ACROSS THE SECTORS IN LINE WITH MSNP-II.

NPC, MoFALD and other sector ministries will be responsible to attain this result and carry out the following activities:

3.4.1 Update the MSNP information portal (www.nnfssp.gov.np) and all relevant sector ministries information on the portal.

3.4.2 Link and update the nutrition information management system of sectoral ministries with the MSNP information portal at the central level.

3.4.3 Provide training on web-based MSNP reporting system to MSNP related staff at federal and province levels.

3.4.4 Document and disseminate good practices, lessons learned and case studies through the MSNP portal.

3.4.5 Update the existing MSNP M&E framework used at federal level.

3.4.6 Facilitate preparation of MSNP M&E framework development and implementation at the provincial level.

3.4.7 Facilitate MSNP M&E framework development at local level and ensure its implementation.

OUTPUT 3.5: ENHANCED CAPACITY OF FEDERAL, PROVINCE AND LOCAL LEVEL GOVERNMENT TO PLAN AND IMPLEMENT NUTRITION PROGRAMME.

NPC and all MSNP-II sectors will be responsible to attain this output and carry out the following activities:

3.5.1 Develop capacity building master plan for the implementation of MSNP-II

3.5.2 Build capacity of relevant staff at federal, provincial and local government level as per the capacity development master plan.

a) Prepare training manual for the implementation of MSNP-II.

b) Provide ToT to implement MSNP-II at federal level.

The full MSNP-II results framework is given in Annex 1 including the goal and outcome level indicators with annual targets for 2018 to 2022, the means of verification and the responsible sectors; the output level indicators and the key activities. The outcomes, outputs and key activities are also presented graphically in Figures 2.2, 2.3 and 2.4.

Chapter 3

IMPLEMENTATION OF MSNP-II (2018–2022)

Chapter 3

3. Implementation of MSNP-II (2018–2022)

3.1 Implementation Arrangements

The key sectors for implementing MSNP-II are health, education, agriculture, livestock, water and sanitation, women, children and social welfare and federal affairs and local development. The finance, communication, commerce and supply sectors are also partners. NPC will lead the coordination with and between these sectors and facilitate the implementation of MSNP-II.

MSNP-II will be scaled up across the country to address malnutrition and will be rolled out to all local governments. It will initially be rolled out in the areas of greatest need — the remote and severe food deficit areas in the Mid-West and Far Western hills and mountains and in the mid-Tarai. The Local Government Operation Act, 2074 (GoN 2017) gives additional guidelines on implementing this plan at the local level.

The arrangements for implementing MSNP-II will be as follows:

a) **Planning and budgeting —** MSNP-II will be incorporated in provincial and local government policies and plans. Annual programmes and budget will be prepared in line with MSNP-II in all seven provinces and all local governments. Budgetary arrangements will be ensured for this purpose.

b) **Institutional strengthening and human resources management —** Necessary human resources will be assigned for managing nutrition programmes at all levels of involved ministries and focal persons will be assigned at all levels to strengthen institutional, organisational and human resource capacities for implementing the plan at all levels and sectors linked to nutrition. The capacity of these officials will be developed.

c) **Coordination and management —** The coordination and management of MSNP-II will be the responsibility of NPC at the federal level and the entities responsible for planning at provincial and municipality levels. Committees will be formed and made functional to give technical guidance on MSNP-II related functions (see Section 3.6). These committees will coordinate vertically and horizontally with the line agencies to implement MSNP-II.

d) **Information and Communication —** Behaviour change communication will be organised to raise civic awareness about the major problem of chronic malnutrition and the actions needed to improve maternal and child nutrition, thus ensuring equity, and facilitating access to information, to promoting behaviour change, with a focus on reaching the most marginalized and poorest segments of the population, and taking into account gender related factors. The mobilization of civil society organisations, parliamentarians, other elected representatives, and decision making authorities for advocacy activities will accelerate this process.

3.2 Target Groups and Prioritization

As already mentioned, MSNP-II will initially be rolled out in the areas of greatest need — the remote and severe food deficit areas in the Mid-West and Far Western hills and mountains and in the mid-Tarai.

Although MSNP-II will benefit a wide range of people, it's main focus will be on the following two groups:

- Nutritional investments are most effective and yield the greatest returns in the window of opportunity of the 1,000 days from conception. Therefore, women of reproductive age, adolescent girls and under-3-year olds will receive greater attention. Mothers, adolescents, infants' grandmothers and husbands of pregnant women will also be targeted.

MSNP-II will be scaled up across the country to address malnutrition and will be rolled out to all local governments. MSNP-II will initially be rolled out in the areas of greatest need.

The huge amount needed to scale up nutrition programmes nationally will be provided by the government and development partners.

- Pocket areas and communities that suffer higher levels of deprivation or are vulnerable to undernutrition will be prioritised. As many of the causes of undernutrition are related with feeding and care practices and socio-cultural traditions, MSNP-II will address the needs of all citizens including males and females of all ages, castes, ethnicities, religions and geographical areas.

Information, communication and education programmes will target all people nationwide. Other interventions will gradually be geared up to meet the needs of all citizens.

3.3 Financial Management

At the beginning of MSNP-II, in coordination with the Ministry of Finance, the NPC will develop a programme and financial planning framework with well-defined budget lines. The NPC will coordinate, facilitate, guide and monitor implementation.

The huge amount needed to scale up nutrition programmes nationally will be provided by the government and development partners. Implementation will follow the financial administration rules and regulations with auditing carried out by the Office of the Auditor General. The Ministry of Finance will maintain updated records of off-budget grants received from development partners.

Donors and international agencies who wish to channel their support through development partners should first get endorsement from the HLNFSSC. Donors should submit proposals to the NPC stating total amounts, budget code and mode (lump sum or instalments).

All support received to implement MSNP-II, including from the government, foreign grants and the private sector will be entered into the government's Budget Management Information System and Financial Management Information System.

MSNP-II grants will be allocated to local governments based on fixed criteria including percentage of children with malnutrition, causes of malnutrition, status of nutrition and food security, geographical remoteness and availability of local resources. Nutrition analysis in local governments will also cover the nutrition status of pregnant women, mothers and adolescents.

Also, provincial and local governments will contribute at least 15 percent of their internal resources (revenue) and grants for improving the nutrition of women and children.

NPC will assess the funds spent on implementing MSNP-II separately for nutrition specific, nutrition sensitive and enabling environment activities. It will coordinate the ratio of expenditure and issue guidance and directives for needed changes.

Various government ministries and agencies and non-government agencies were involved in implementing MSNP (2013–17). It was difficult to assess the financial investments made as budget and programme codes differed. The NPC will thus coordinate with the Ministry of Finance to implement a separate nutrition budget code. This will help in the preparation of the Medium Term Expenditure Framework, and the monitoring and evaluation of expenditure on nutrition including the allocation of budgets for MSNP-II's programme, and budget preparation by provinces and local governments.

3.4 Estimated Costs

The estimated cost of implementing MSNP-II is NPR 48,901 million ($470 million at exchange rate of NPR 104.04). The budget is segregated thus:

- By seven sectors plus NPC ,with the Ministry of Education needing the most funds (35% of total) followed by the Ministry of Health (25%) (Table 3.1).
- By nutrition specific and nutrition sensitive programming with nutrition sensitive programming accounting for 76 percent of estimated costs (Table 3.2).
- The proportion of funding provided by the government is planned to increase from 47 percent in 2018 to 69 percent in the final year of MSNP-II, with the government providing 59 percent of funds and development partners 41 percent (Table 3.3).

These estimates are based on 2017/18 fixed cost prices, the present or past unit cost of planned activities, existing fixed rates of the government,

TABLE 3.1: ESTIMATED NPC AND SECTORAL MINISTRY COSTS OF IMPLEMENTING MNSP-II (NPR MILLION)

NPC/sectoral ministries	2018	2019	2020	2021	2022	Total	%
Health	2,223	2,403	2,615	2,497	2,464	12,202	25%
Education	3,428	3,434	3,444	3,455	3,467	17,228	35%
Agricultural development	1,652	1,728	1,812	1,900	2,006	9,098	19
Livestock development	101	87	108	96	118	510	1%
Drinking water and sanitation	568	1,021	1,865	2151	2,431	8,036	16%
Women, children and social welfare	188	196	211	223	235	1,053	2%
Local governance	42	78	91	97	104	412	1%
NPC	55	76	75	79	77	362	1%
Total	**6,937**	**7,704**	**8,900**	**9,178**	**9,559**	**48,901**	**100%**

TABLE 3.2: ESTIMATED NUTRITION-SPECIFIC AND NUTRITION-SENSITIVE COSTS OF IMPLEMENTING MNSP-2 (NPR MILLION)

Programmes	2018	2019	2020	2021	2022	Total	
Nutrition sensitive	6,111	6,709	7,717	8,122	8,562	37,211	76%
Nutrition specific	2,146	2,314	2,504	2,376	2,340	11,680	24%
Total	**8,256**	**9,023**	**10,221**	**10,498**	**10,902**	**48,901**	**100%**

TABLE 3.3: ESTIMATED COSTS OF MSNP-II BY SOURCES OF FUNDS

	GoN	Development partners	Total
2018			
Budget (NPR million)	3,260	3,677	6,937
Percentage	47%	53%	100%
2019			
Budget (NPR million)	4,409	4,119	8,528
Percentage	52%	48%	100%
2020			
Budget (NPR million)	6,032	4,514	10,546
Percentage	57%	43%	100%
2021			
Budget (NPR million)	6,973	4,148	11,121
Percentage	63%	37%	100%
2022			
Budget (NPR million)	8,156	3,613	11,769
Percentage	69%	31%	100%
Total			
Budget (NPR million)	28,830	20,071	48,901
Percentage	59%	41%	100%

MSNP-II will be implemented from Nepali FY 2075/76 to 2079/80 (mid-July 2018 to mid-July 2022).

national and international costs and discussions with the concerned line ministries.

The annual financial tracking of nutrition-related expenditure carried out by the NPC covers all of the nutrition-related programmes in the government's AWPB. The programmes proposed under MSNP-II do not necessarily cover all nutrition-related programmes and therefore the proposed above budget is less than the figures in NPC's annual financial tracking exercises.

3.5 Duration of MSNP-II

MSNP-II will be implemented from Nepali FY 2075/76 to 2079/80 (mid-July 2018 to mid-July 2022).

3.6 MSNP Committees

Two existing high-level committees will govern the implementation of MSNP-II at the national level. The High Level Nutrition and Food Security Steering Committee (HLNFSSC) (see composition in Table 3.4) is the highest level governing body and will provide high level guidance and endorse policies and programmes. Its roles and responsibilities are as follows:

a) Formulate and endorse macro level policies and strategies on nutrition and food security.
b) Ensure necessary resources for MSNP-II.
c) Make policy decisions on foreign grant needs and development partner support for MSNP-II.
d) Advocate and counsel on nutrition and food security related issues at national and international conferences, workshops, and meetings on behalf of the country.
e) Review MSNP-II's progress and evaluate its performance and effects.
f) Coordinate about MSNP-II with sectoral ministries at federal level.
g) Provide guidelines and directives to the Federal Level Nutrition and Food Security Steering Committee.

The National Nutrition and Food Security Coordination Committee (NNFSCC) (Table 3.5) will be responsible for national level coordination of the implementation of MSNP-II. Its roles and responsibilities oare as follows:

a) Implement MSNP-II related national policies and strategies
b) Arrange budget for federal level sectoral ministries to implement MSNP-II.
c) Implement decisions of the HLNFSSC.
d) Provide guidelines and directives to provincial level NFSSCs.
e) Facilitate the formation and operation of provincial and local government nutrition and food security steering committees.
f) Form federal level technical groups and determine their roles and responsibilities for implementing MSNP-II.
g) Review progress of MSNP-II at province and local government levels.
h) Form technical working groups for MSNP-II at the federal level.
i) Coordinate and perform other functions to implement, monitor, review and evaluate MSNP-II at the federal level.
j) Provide guidelines to NNFSS and responsible NPC divisions.

New committees will be formed as the main bodies for overseeing the implementation of MSNP-II in provinces, local governments and wards. District coordination committees will also be formed.

Provincial nutrition and food security steering committees (PLNFSSC) (Table 3.6) will have the following responsibilities:

a) Formulate provincial level policies and strategies on nutrition and food security that comply with HLNFSSC and NNFSCC federal level policies.
b) Identify available resources for MSNP-II and ensure necessary resources for its implementation at provincial and local government levels.
c) Advocate and guide on nutrition and food security at national level conferences, workshops and meetings on behalf of provinces
d) Review MSNP-II progress and evaluate its performances and effects at the local level.
e) Provide guidelines and directives to provincial level sectoral ministries and agencies on implementing MSNP-II.
f) Facilitate the formation and operation of local government nutrition and food security steering committees.
g) Review performance of local nutrition and food security steering committees.

TABLE 3.4: COMPOSITION OF HIGH LEVEL NUTRITION AND FOOD SECURITY STEERING COMMITTEE (HLNFSSC)

Office holders	Position on committee
Hon. Vice Chairman, National Planning Commission (NPC)	Chairperson
Hon. Member, Health and Nutrition, NPC	Co-chair
Hon. members NPC (agriculture, livestock development, WASH, women children and social welfare, education, federal affairs and local development, communication, commerce and supplies)	Members
Secretaries of federal ministries of health, agriculture development, livestock development, drinking water and sanitation, women children and social welfare, education, federal affairs and local development, communication, commerce and supplies	Members
Nutrition and food security experts (4, nominated by the Chair)	Members
Member Secretary, National Planning Commission	Member Secretary
Joint Secretary, Social Development Division, NPC	Joint Member Secretary

TABLE 3.5: COMPOSITION OF NATIONAL NUTRITION AND FOOD SECURITY COORDINATION COMMITTEE (NNFSCC)

Office holders	Position on committee
Hon. Member, Health and Nutrition Sector, NPC	Coordinator
Hon. NPC members responsible for health, agriculture, livestock, WASH, women children and social welfare, education, federal affairs and local development, communication, commerce and supplies.	Members
Chiefs of the Policy Planning and International Cooperation Division, the Budget and Programme Division and Nutrition Division from the federal ministries of health, agriculture, livestock, drinking water and sanitation, women, children and social welfare, education, federal affairs and local development, communication, commerce and supplies.	Members
Director generals of federal departments of health, agriculture development, livestock development, drinking water and sanitation, women, children and social welfare, education, federal affairs and local development	Members
Executive Director, Nepal Health Research Council	Member
Two nutrition and food security experts (nominated by the Coordinator)	Members
Representative of civil society network working on nutrition and food security	Member
Representative responsible for health and nutrition from FNCCI or other representative body	Member
Joint Secretary, Social Development Division, NPC	Member Secretary

TABLE 3.6: COMPOSITION OF PROVINCIAL NUTRITION AND FOOD SECURITY STEERING COMMITTEES (PLNFSSC)

Office holders	Position on committee
Chief of body responsible for provincial level planning	Chair
Chief of agencies responsible for health, agriculture development, livestock development, drinking water and sanitation, women children and social welfare, education, federal affairs and local development, finance, communication, commerce and supplies in the province	Members
Two local nutrition and food security experts	Members
Development partners working in the nutrition and food security sector in the province.	Can be invited to meetings as per need

MSNP-II will be implemented by government agencies, national and international NGOs, private sector agencies and community and civil society organisations.

h) Regularly submit MSNP progress report to National Nutrition and Food Security Coordination Committee.

District coordination committees will carry out monitoring and coordination within provinces by carrying out the following responsibilities:

a) Conduct MSNP-II monitoring in local governments where it is implemented.
b) Coordinate with provinces and between local governments.
c) Facilitate the incorporation of MSNP-II in local governments' long-term, periodic and annual programmes.
d) Advocacy and guidance on nutrition and food security at local conferences, workshops, and meetings on behalf of provincial governments.
e) Review MSNP-II progress and evaluate its performance and effects at the local level.

Local government nutrition and food security steering committees will be formed in metropolitan cities, sub-metropolitan cities, urban municipalities and rural municipalities (Table 3.7). They will have the following responsibilities:

a) Formulate local government policies and strategies on nutrition and food security that comply with federal and provincial policies.
b) Identify resources for MSNP-II and ensure necessary resources for its implementation.
c) Incorporate MSNP-II activities in long-term, periodic and annual programmes of local governments.
d) Advocate and counsel on nutrition and food security at national conferences, workshops, and meetings.
e) Facilitate the formation of ward level nutrition and food security steering committees, review their progress and provide guidelines and directives.
f) Review MSNP-II related performance of ward level nutrition and food security steering committees and provide directions for improvement.
g) Regularly submit MSNP-II progress reports to district coordination committee and province level nutrition and food security coordination committees.

Ward-level nutrition and food security steering committees (Table 3.8) will have the following responsibilities:

a) Identify nutrition programmes in a participatory way and submit for support to local government councils.
b) Identify local nutrition deficient communities.
c) Assess needs of nutrition deficient communities and support prioritization of programmes for them with their participation.
d) Mobilise communities to run nutrition specific and sensitive campaigns.
e) Assign NGOs and other agencies to monitor local nutrition programmes and report findings to the committee.

3.7 Power to Frame Guidelines

The NPC may frame guidelines and issue directives to provincial and local levels to implement MSNP-II.

3.8 National Nutrition and Food Security Secretariat

A National Nutrition and Food Security Secretariat (NNFSS) will be established under the NPC Secretariat to provide technical and managerial support to the national committees (HL-NFSSC and NNFSCC) for the smooth operation of MSNP-II. The organogram and staffing of the secretariat will be as assigned by NPC.

3.9 Responsibilities of Private, Non-government and Academic Sectors

MSNP-II will be implemented by government agencies, national and international NGOs, private sector agencies and community and civil society organisations. The plan will be implemented through the coordinated efforts of national and international agencies, professional bodies, civil society and academia. At the local level, the range of stakeholders will be involved in formulating policies, and planning, implementing and monitoring nutrition and food security programmes.

Civil society organisations, the private sector and other stakeholders will participate in nutrition and food security-related advocacy and communication. Their cooperation will also be sought for the organisation of nutrition-related public hearings and grievance handling. Public-private-partnerships will help implement MSNP-II with NPC responsible for coordinating this process.

TABLE 3.7: COMPOSITION OF LOCAL GOVERNMENT NUTRITION AND FOOD SECURITY STEERING COMMITTEES

Office holders	Position on committee
Chief of local government authority	Chair
Deputy chief of local government	Deputy chair
All ward chairpersons of local government	Members
Woman member of local government designated by the chair	Member
Dalit woman member of local government designated by the chair	Member
Coordinator designated for planning and implementation of nutrition and food security programmes	Member
Section chiefs of health, agriculture, livestock development, WASH, women, children and social welfare, education, federal affairs and local development, communication, finance, commerce and supplies and documentation and information section of local government	Members
Programme officer of social development section of local government	Member
President of local chambers of commerce and industry	Member
President of local NGO federation	Member
Executive officer of local government or a designated officer	Member Secretary
Executive member who looks after the social sector or executive woman member	Coordinator
Nutrition and food security experts from local government and development partners.	Can be invited as per need

TABLE 3.8: COMPOSITION OF WARD-LEVEL NUTRITION AND FOOD SECURITY STEERING COMMITTEES

Office holders	Position on committee
Ward chair	Chair
Female ward member	Member
Unit chiefs of health, agriculture, livestock development, WASH, women children and social welfare, education, federal affairs and local development, communication, commerce and supplies unit in the ward (if any)	Members
Local female teacher	Member
Representative of an NGO working in the ward	Member
Coordinator of ward citizens forum	Member
One local female community health volunteer (FCHV)	Member
Representative of a local school management committee	Member
Representative of a local health service management committee	Member
Ward secretary	Member Secretary

Status and progress information will be regularly posted on the nutrition and food security web portal (http://www.nnfsp.gov.np)

3.10 Capacity Development

The capacity of staff and officials involved in implementing MSNP-II will be developed including their knowledge and skills on nutrition and food security, documentation and reporting, information dissemination and training skills.

3.11 Review, Monitoring and Evaluation

A) NEED AND PROCESS

The review, monitoring and evaluation of MSNP-II will assess progress of MSNP-II programmes principally in terms of the attainment of outcomes and outputs and impact on target groups. Annex 1 lists the indicators for measuring progress against the annual targets.

A monitoring and evaluation framework will be prepared as per the National Monitoring and Evaluation Guidelines to measure programme delivery and sectoral performance. Information will be collected on all indicators. The capacity of stakeholders will be developed at all levels to monitor the achievement of results.

Nutrition improvements will indirectly help to achieve all 17 SDGs, particularly SDGs 2 and 3.

B) REGULAR MONITORING AND REVIEW

Much of the data for measuring the indicators will come from regular national surveys including the Nepal Demographic and Health Survey, the Nepal Multiple Indicators Cluster Survey, and Nepal Living Standards Surveys. The periodic reports of government agencies will be another important source of information and means of verification. Further surveys may be carried out to gather data not available from existing surveys. Capacity will be built to carry out monitoring.

C) STUDIES, RESEARCH AND EVALUATION

Applied and action research will be carried out to identify and address bottlenecks to implementing MSNP-II.

Status and progress information will be regularly posted on the nutrition and food security web portal (http://www.nnfsp.gov.np). Relevant policy making-related information will also be posted here.

Consultations will be held with NPC's Monitoring and Evaluation Division to guide decisions on monitoring, review and evaluation. A Technical Working Group for monitoring and evaluating MSNP-II will be formed under the joint secretary of NPC's Social Development Division to supervise MSNP-II's management information system. Each involved sectoral ministry will nominate an M&E focal person to this TWG who will be responsible for updating their ministry's progress.

3.12 Documentation and Reporting

Local governments will be responsible for reporting on the physical and financial progress of MSNP-II to district coordination committees, provincial level and federal level sectoral ministries. Local governments will submit four monthly and annual physical progress reports and statements of expenditure to their district coordination committees and sectoral ministries at provincial and national levels. The sectoral ministries will prepare integrated reports for submission to NPC and will document the implementation status of MSNP-II and update physical and financial progress reports in the prescribed format.

Annexes

Annex 1: Multi-sector Nutrition Plan-II (2018-2022) Results Framework

Goal and Outcome Indicators

Results chain	Result indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Goal (Impact)									
Improved maternal, adolescent and child nutrition by scaling up essential nutrition-specific and sensitive interventions and creating an enabling environment for nutrition	1. Prevalence of stunting among under 5 years children reduced	35.8 NDHS 2016	34	31	31	29	28	NDHS, NMICS	Health
	2. Prevalence of wasting among under 5-year-old children reduced	9.7 NDHS 2016	9.5	8	8	7	7	NDHS, NMICS	Health
	3. Prevalence of low birth weight reduced	24 NMICS 2014	20	17	13	11	10	NDHS, NMICS	Health
	4. % reduction in children under-5 with overweight and obesity	2.1 NDHS 2016	2	1.9	1.7	1.6	1.4	NDHS, NMICS	Health
	5. % reduction in overweight and obese women of reproductive age (WRA)	22 NDHSS 2016	22	21	20	19	18	NDHS, NMICS	Health
	6. % of women with chronic energy deficiency (measured as body mass index) reduced	17 NDHS 2016					12	NDHS, NMICS	Health
Outcomes									
1: Nutrition specific outcome									
Outcome 1: Improved access to and equitable use of nutrition-specific services	1.1. Increased % of children aged 6-23 months having minimum acceptable diet	35 NDHS 2016	40	45	50	55	60	NDHS, NMICS	Health
	1.2. Increased % of children under 6 months with exclusive breastfeeding	66 NDHS 2016	68	70	74	77	80	NDHS, NMICS	Health
	1.3. Reduced % of anaemia among children aged 6-59 months	52.7 NDHS 2016	40	37	33	30	28	NDHS, NMICS	Health
	1.4. Reduced % of anaemia among adolescent girls (10-19 years)	39 NDHS 2016			20		25	NDHS, NMICS	Health

Results chain	Result indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Outcome 1: Improved access to and equitable use of nutrition-specific services	1.5. Reduced % of anaemia among WRA (15-49 years)	40.8 NDHS 2016			26		24	NDHS, NMICS	Health
	1.6. Reduced prevalence of under 5-years old children with diarrhoea in last two weeks	14% NDHS 2016			10%		7%	NDHS, NMICS	Health
	1.7. Mean dietary diversity score among WRA (15-49 years)	TBD NDHS 2016					TBD	NDHS, NMICS	Health
2: Nutrition-sensitive outcome									
Outcome 2: Improved access to and the equitable use of nutrition-sensitive services and improved healthy habits and practices	2.1. Reduced proportion of population below minimum level of dietary energy consumption	22.8 NMICS 2014	17	15.5	14	12.5	11	SDG status reports, NMICS	Agriculture and livestock
	2.2. Increased % people using safe drinking water	15 JMP 2017	33.7	38.4	43.1	47.8	52.5	Joint Monitoring Programme (JMP)	WASH
	2.3. Increased % people using improved sanitation facilities that are not shared	92.6 toilet coverage: 2017 NMIP-DWSS, 2017	95	98	100	100	100	NMICS & NMIP-DWSS	Water and sanitation
	2.4. Increased % of people practising hand washing with soap and water before feeding baby (0-2 yrs) and after cleaning babies' bottoms	Knowledge 6 and 5.5 NMICS 2014	15	20	30	40	50	NMICS	Water and sanitation
	2.5. Percentage of women aged 20-24 years who were married or in union before age 18	40.7% NDHS 2011	5% reduction per year					NDHS	Women, Children and Social Welfare and Health
	2.6. Increased gross enrolment rate (GER) (boys and girls) in early child education and development (ECED)/pre-primary education (PPE)	81 (81.2, 80.9)	82.6 (82.8, 82.5)	84.3 (84.5, 84.2)	86 (86.2, 85.9)	87.7 (87.9, 87.6)	89.4 (89.4, 89.5)	Education Management Information System (EMIS)	Education
	2.7. Decreased % of out-of-school children (boys and girls) in basic education	10.6 (10.8, 10.4)	9.06 (9.2, 9.8)	7.5 (7.6, 7.3)	6.0 (6.1, 5.8)	4.5 (4.6, 4.6)	3.0 (3.1, 2.0)	EMIS	Education
	2.8. Increased basic education cycle completion rate (boys and girls)	69.6 (68.8, 70.5)	72.4 (71.6,73.4)	75.4 (74.5, 76.4)	78.5 (77.6, 79.5)	81.7 (80.8, 82.8)	85.0 (84.1, 86.1)	EMIS	Education

Results chain	Result indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
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 farm land owned by women or in joint ownership	10 (2010)	12	13	15	18	21	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	30 districts	299 local governments	60 districts	753 local governments	753 local governments	753 local governments	Government plans and MSNP-II annual progress reports	Local Governance
	3.3. Availability of national MSNP-II document	MSNP-I	1	-	-	-	-	MSNP-II doc	NPC
	3.4. Availability of national budget code for nutrition and food security	0	1	-	-	-	-	MoF budget code	NPC, MoF
	3.5. National Capacity Development Master Plan for implementation of MSNP-II Produced	0	1	-	-	-	-	Capacity Development Plan	NPC, all sectors
	3.6. Multi-sector commitment and resources for nutrition increase to at least 3.5% of total government budget	1.08	1.5	2	2.5	3	3.5	MoF red Book	NPC
	3.7. Financial resource tracking in place	1	1	1	1	1	1	Financial resource tracking tools	NPC, MoF

Output Indicators

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Nutrition specific outputs									
Outcome 1: Improved access to and equitable use of nutrition-specific services									
Output 1.1: Enhanced nutrition status of WRA including adolescents	Median age at first birth among WRA (15-49 years)	17 NDHS 2016					20	NDHS	Health
	% of institutional delivery	57 NDHS 2016			65		70	NDHS, NMICS	Health
	% getting a postnatal check-up for essential newborn care and services within 24 hours of delivery	57 NDHS 2016					75	NDHS	Health
Output 1.2: Improved infant and young child nutrition and care practices	% of newborns initiating breastfeeding within one hour of birth	55 NDHS 2016					80	NDHS, NMICS	Health
	Proportion of infants 6–8 months of age receiving solid, semi-solid or soft foods	73.5 NMICS 2014					95	NDHS, NMICS	Health
	% of children aged 0-59 months who received more frequent feeding (breast milk and appropriate food) during episodes of diarrhoea	29 NDHS 2016					50	NDHS, NMICS	Health
Output 1.3: Improved maternal, infant and young child (MIYC) micronutrient status	% of children aged 6–59 months who received Vitamin A capsule in last six months	86 NDHS 2016					95	NDHS, NMICS	Health
	% of children aged 12-59 months who received deworming tablet in last six months	83 NDHS 2016					90	NDHS, NMICS	Health
	% of pregnant and lactating women who took 180 + IFA tablets	42 NDHS 2016	65				>80	NDHS, NMICS	Health
	% of pregnant women who received deworming tablets	55 NDHS 2016					80	NDHS HMIS	Health

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
	% of school age children who received deworming tablet increased	65 HMIS					80	HMIS	Health
	% of households using adequately iodized salt	82 NMICS 2014					>90	NDHS, NMICS	Health
	% of adolescent girls (10-19 years) who received weekly IFA tablet supplements	5					50	HMIS	Health
	% of children aged 6-23 months who received micronutrient powder (MNP)	5 HMIS					20	HMIS	Health
	% of children who received ORS and zinc during diarrhoea	18 NMICS 2014					50	NDHS, NMICS	Health
Output 1.4: Improved management of severe and moderate acute malnutrition	No. of local governments with integrated management of acute malnutrition (IMAM) programme	35 districts					520 local governments	HMIS	Health
	Percentage of children aged 6-59 months identified with severe acute malnutrition (SAM) against total estimation of SAM	NA					>90	NDHS	Health
	% of children aged 6-59 months with acute malnutrition treated among identified cases	70					90	HMIS	Health
	No. of local government bodies with IMNCI programme implemented	55 districts					753 local governments	HMIS	Health
Output 1.5: Enhanced preparedness for nutrition in emergency responses	No. of local governments with nutrition emergency preparedness and response or contingency plan	50					500 local governments	Contingency plans and preparedness plan	Health
Output 1.6: Capacity built of nutrition specific sectors	No. of capacity development measures recommended in the capacity development plan implemented by nutrition specific sector	NA					>90	HMIS	Health

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
NUTRITION SENSITIVE OUTPUTS									
Outcome 2: Improved access to and the equitable use of nutrition-sensitive services and improved healthy habits and practices									
Agriculture and livestock									
Output 2.1: Increased availability and consumption of safe and nutritious foods	% of production and productivity of crops and livestock:								
	1. Cereals: area (1,000 ha)	3306	3405	3371	3303	3270	3188	Annual report of MoAD	Agriculture
	2. Cereals: production (1,000 tonnes)	8614	9515	9750	9414	9697	9987		Agriculture
	3. Pulses: area (1,000 ha)	342	349	353	356	360	363		Agriculture
	4. Pulses: production (1,000 tonnes)	316	329	335	342	349	356		Agriculture
	5. Vegetables: area (1,000 ha)	280	315	328	341	354	369		Agriculture
	6. Vegetables : production (1,000 tonnes)	3819	4413	4678	4959	5256	5572		Agriculture
	7. Potatoes: area (1,000 ha)	190	210	218	227	236	246		Agriculture
	8. Potato: production (1,000 tonnes)	2551	2976	3214	3471	3749	4049		Agriculture
	9. Fish: production (1,000 tonnes)	48	57	60	63	66	69		Agriculture
	10. Fruits: production (1,000 tonnes)	992 (2014)	1181	1252	1327	1407	1492		Agriculture
	Year round irrigation (%)	18 (2010)	22	25	30	35	45	ADS annual reports	Agriculture
	Per capita food grain production (kg)	341 (2014)	381	391	401	411	422	SDG progress report	Agriculture
	Decreased incidence of sub-standard food in the market (%)	12 DFTQC	11	10	9	8	7	Annual report of DFTQC	Agriculture and Livestock
	Households with minimum dietary diversity (%)	10.5 AHSIII 2014/15	13	15	18	20	23	Annual household survey (CBS)	Agriculture and Livestock
	% of production and productivity of crops and livestock:								
	Milk (1,000 tonnes)	1,954	2031	2296	2594	2776	2942	Annual report of MoLD	Livestock
	Meat (1,000 tonnes)	332	344	379	417	438	460		Livestock
	Eggs (1,000 tonnes)	135	135	145	157	168	178		Livestock

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Output 2.2: Increased physical and economic access to diverse types of foods	Improved access to updated agriculture marketing information							ABPMDD report	
	Publish agriculture marketing information bulletin	1	1	1	1	1	1		Agriculture
	Update website and app related to agriculture marketing information system	1	1	1	1	1	1		Agriculture
	Households raising livestock	NA							
Water, Supply and Sanitation									
Output 2.3: Increased access to safe drinking water	% households using improved drinking water facilities	93.3 NMIP 2017	95	98	100	100	100	NMIP-DWSS	Water Supply and Sanitation
	% households with piped water supply in dwelling yard	26 NMIP 2017	25	32	40	45	50	NMIP-DWSS	Water Supply and Sanitation
	% households adopted water treatment option	22.4 NMICS 2014	30	52.15	58.1	64.05	70	NMICS	Water Supply and Sanitation
	% households with Escherichia coli (E. coli) risk level in household water of ≥ 1 colony forming unit (cfu)/100ml	82.2 NMIP 2017	60	50	30	20	10	NMIP-DWSS	Water Supply and Sanitation
Output 2.4: Increased access to safe and sustainable sanitation services	% households having toilets (sanitation coverage)	87.27 NMIP-DWSS 2016	98	99	100	100	100	NMIP/DWSS	Water Supply and Sanitation
	% of children aged 0–2 years whose last stools were disposed of safely (use of toilet, or faeces disposed in toilet)	48 NMICS 2014	52	56	62	66	70	NMICS	Water Supply and Sanitation
	Number of districts declared open defecation free (ODF)	42 districts NMIP-2017	65	77 (753 local governments)	77 (753 local governments)	77 (753 local governments)	77 (753 local governments)	NMIP-DWSS	Water Supply and Sanitation

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Output 2.5: Improved knowledge of children, and mothers and caretakers of under 5-year-olds on health and hygiene	% of mothers and caretakers of under-5 year-old children (households) with knowledge of handwashing before eating	92.2 NMICS 2014	95	96	97	98	100	NMICS	Water Supply and Sanitation
	% of mothers and caretakers of under 5-year-old children (households) with knowledge of handwashing before preparing food	22.2 NMICS 2014	30	40	50	60	70	NMICS	Water Supply and Sanitation
	% of mothers and caretakers of under-5 year-olds (households) with knowledge of handwashing before breastfeeding or feeding babies	6 NMICS 2014	20	30	40	50	60	NMICS	Water Supply and Sanitation
	% of mother and caretakers of under 5-year-olds (households) with knowledge of handwashing after defecation and urinating	86.6 NMICS 2014	88	90	93	96	99	NMICS	Water Supply and Sanitation
	% of mothers and caretakers of under 5 year-olds (households) with knowledge of handwashing after cleaning children's bottoms	5.5 NMICS 2014	15	20	50	70	90	NMICS	Water Supply and Sanitation
	% of mothers and caretakers of under 5 year-olds (households) with knowledge of handwashing after cleaning toilets and potties (after managing waste)	7.7 NMICS 2014	20	30	45	60	75	NMICS	Water Supply and Sanitation
	% of people who wash raw food, vegetables, covers cooked food and sufficiently heat stale food before eating	NA							
Social Protection									
Output 2.6: Targeted groups have access to resources and opportunities that make them self-reliant	No. of women group cooperatives received grants and credit	411	88	90	100	110	120	Annual report of Dept of Women and Children (DWC)	Women, Children and Social Welfare
	No. of community level awareness programmes held on reducing child marriage		900	1,000	1,050	1125	1,200	Annual report of DWC	Women, Children and Social Welfare
	No. of women group, committee, cooperative members with established self-entrepreneurship (start-up grants)	49,385	15,000	12,000	10,000	15,000	17,000	Annual economic survey	Women, Children and Social Welfare

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
	No. of local governments providing child grants to children under 5-years-old	203	203	299	323	347	372	Report of Dept of Civil Registration (DoCR)	Local Governance sector
Maternal Health and Women Empowerment									
Output 2.7: Nutrition component incorporated in women, adolescent girls and child development training packages	No. of training packages with health and nutrition module integrated	2	3	2	1	-	-	Annual reports of DWC	Women, Children and Social Welfare
Output 2:8: Women, children and out of school adolescent girls reached with health and nutrition care practices	No. of out-of-school adolescent girls reached with health and nutrition care practices information through life skills training	NA	3,700	3,750	3,800	3,825	3,900	Annual reports of DWC	Women, Children and Social Welfare
	No. of women group, committee, cooperative members reached with health and nutrition care information through women social and economic development training	NA	15,000	12,000	10,000	15,000	17,000	Annual reports of DWC	Women, Children and Social Welfare
Output 2.9: Child care homes comply with minimum standards of nutrition care	No. of child care homes that comply with minimum nutrition care services	103	47	25	30	35	40	Annual reports of DWC	Women, Children and Social Welfare
Output 2.10: Communities empowered to prevent harmful practices	No. of communities and rural municipalities declared chhaupadi free	15 VDCs (declared as menstrual seclusion shed [*chhaupadi goth*] free)	6	7	8	9	10	Annual reports of DWC	Women, Children and Social Welfare

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Early Childhood Development and Classroom Education									
Output 2.11: Enhanced enrolment of children in basic education	Number of children in basic education receiving midday meals	612,000 student	612,000	612,000	612,000	612,000	612,000	EMIS	Education
Output 2.12: Increased adolescent girls' awareness and improved behaviour on nutrition	Number of schools using nutrition-sensitive literacy materials							Annual report of Department of Education (DoE)	Education
Health and Family Planning Services									
Output 2.13: Enhanced access to health and reproductive health services	Proportion of women (15-49 years) using any contraceptive method	53 NDHS 2016					60	NDHS	Health
	% of children receiving complete immunization within one year	78 NDHS 2016					≥ 90	NDHS, NMICS	Health
Enabling environment outputs									
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									
Output 3.1: MSNP-II included in local, provincial and federal government policies and plans	No. of sectoral ministries' plans that include nutrition and food security in line with MSNP-II	7	7	7	7	7	7	AWPB of Sectoral Ministries	NPC, Sectoral Ministries
	No. of provincial government's plans including nutrition and food security in line with MSNP-II	Not applicable	7	7	7	7	7	AWPB of province government	NPC, Sectoral Ministries
	No. of local governments incorporated nutrition related targets and indicators in their plans and programmes	30 districts (selected wards of 194 local governments)	308 (30 districts)	308 (30 districts)	332 (33 districts	356 (37 districts)	381 (39 districts)	AWPBs of local governments	Local Governance
	No. of provinces with MSNP-II institutional arrangement set up and functional	Not applicable	5	6	7	7	7	Meeting minutes	Local Governance
	No. of provinces allocated resources as required for MSNP-II	Not applicable	7	7	7	7	7	Annual budgets and plans at province	Local Governance
	No. of local governments allocated resources as required for MSNP-II	Not applicable	308	308	332	356	381	Annual budgets and plans of local governments	Local Governance

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
Output 3.2: MSNP governance mechanism instituted and strengthened at federal, provincial, and local levels	No. of meetings of High Level Nutrition and Food Security Steering Committee conducted a year at federal level	1	2	2	2	2	2	Meeting minutes	NPC
	No. of quarterly Nutrition and Food Security Coordination Committee meetings conducted at federal level	1	4	4	4	4	4	Meeting minutes	NPC
	Nutrition and food security steering committees formed at province level	Not applicable	7	-	-	-	-	Meeting minutes	NPC, Local governance
	No. provinces holding nutrition and food security steering committee meetings twice a year	Not applicable	7	7	7	7	7	Meeting minutes	NPC, Local governance
	No. provinces forming nutrition and food security coordination committees	Not applicable	7	-	-	-	-	Meeting minutes	NPC, Local governance
	No. of provinces conducted nutrition and food security coordination committee meetings quarterly	Not applicable	7	7	7	7	7	Meeting minutes	NPC, Local governance
	MSNP-II focal point/unit identified in all relevant sectors at province level	Not applicable	7	7	7	7	7	Decision letter for MSNP focal point/unit	Local Governance
	No. of local units (districts and local governments) with MSNP institutional arrangements	30 districts (308 local governments)	308 local governments (30 districts)	308 (30 districts	332 (33 districts)	356 (37 districts)	381 (39 districts)	Meeting minutes	Local Governance
	No. of local governments conducted nutrition and food security steering committee meeting at least twice a year	30 districts (308 local governments)	308 (30 districts)	308 (30 districts)	332 (33 districts)	356 (37 districts)	381 (39 districts)	30 districts (308 local governments)	Local Governance
	No. of local governments assigned a coordinator (from existing staff or outsourced) to oversee MSNP-II interventions	30 districts (308 local governments)	308 (30 districts)	308 (30 districts)	332 (33 districts)	356 (37 districts)	381 (39 districts)	Letters	Local Governance
	No. of wards with ward level nutrition and food security steering committees	2,749	2,749	2749	2,941	3,133	3,514	Meeting minutes	Local Government

Results	Indicators	Baseline	Targets					Means of verification	Responsible sector
			2018	2019	2020	2021	2022		
	No. wards conducted ward level nutrition and food security steering committee at least twice a year	2,749	2,749	2,749	2,941	3,133	3,514	Meeting minutes	Local Government
Output 3.3: MSNP institutional mechanisms functional at federal government level	National Nutrition and Food Security Secretariat (NNFSS) institutionalized and functional at NPC	1	1	1	1	1	1	F	NPC
	Organization and management survey for NNFSS completed and approved by NPC Board	0	1	-	-	-	-	NPC organogram	NPC
	Number of sanctioned staff positions filled at NNFSS	1 (Fulfilled from external sources)	-	1	-	-	-	Contract letters	NPC
Output 3.4: Functional updated information system across all MSNP-II sectors	MSNP-II M&E framework developed or updated for all sectors and implemented at federal, provincial and local levels	1	1	1	1	1	1	M&E framework for MSNP-II	NPC, sectors, Local Governance
	Web-based reporting system linked with MSNP-II M&E plan at all levels	7 sectors	7	7	7	7	7	NPC's web based system	NPC & sectors
	NNFSS portal updated each quarter	4	4	4	4	4	4	NNFSS portal	NPC
	No. of sectoral reports updated on NNFSS portal as per M&E plan each quarter	0	4	4	4	4	4	NNFSS portal	NPC, all sectors
Output 3.5: Enhanced capacity of federal, provincial and local level government to plan and implement nutrition programmes	National Capacity Development Master Plan for implementation of MSNP-II developed	0	1	1	1	1	1	Capacity development plan	NPC, all sectors
	MSNP-II Capacity Development Master Plan implemented at federal level	0	1	1	1	1	1	Sectoral training reports	NPC, all sectors
	MSNP-II Capacity Development Master Plan implemented at provincial level	0	7	7	7	7	7	Sectoral training reports	NPC, all sectors

Key Activities

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
OUTPUT 1									
Nutrition sensitive activities									
Output 1.1: Enhanced nutrition status of WRA including adolescents									
1.1.1 Organize and implement fully-nourished villages/wards including Golden 1000 Days communication campaign	Village	NA					300 villages	Annual reports of DoHS	Health
1.1.2 Revitalize School Health and Nutrition Programme including promotion of healthy dietary habits and physical activity	Local governments	77 districts					350 local governments	Annual reports of DoHS	Health
1.1.3 Raise awareness and services for healthy timing and spacing of pregnancy.	Local governments	77 districts					753 local governments	Annual reports of DoHS	Health
1.1.4 Conduct barrier analysis for increasing ANC service utilization	Province	NA					7 (1 in each province)	Annual reports of DoHS	Health
1.1.5 Integrate and expand adolescent-friendly health and nutrition services	Local governments	NA					372 local governments	Annual reports of DoHS	Health
Output 1.2: Improved maternal, infant and young child nutrition and care practices									
1.2.1 Conduct maternal, infant and young child nutrition (MIYCN) counselling on all health sector platforms viz. health mother's group meetings, immunization, ANC, PNC, growth monitoring (GMP), PHC-ORC, IMNCI and OPD	Local governments	NA					372 local governments	Annual reports of DoHS	Health
1.2.2 Conduct regular growth monitoring counselling at PHC-ORCs and health facilities	Local governments	NA					372 local governments	Annual report of DoHS	Health
1.2.3 Disseminate IEC and BCC materials in line with Food Based Dietary Guidelines through health facilities, FCHVs to communities and households regularly.	Local governments	NA					753 local governments	Annual report of DoHS	Health
1.2.4 Conduct food preparation and cooking demonstrations to prepare local nutritious foods (e.g. nutritious flour/porridge (lito), jaulo and khichadi using local foodstuffs	Local governments	NA					753 local governments	Annual report of DoHS	Health

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
1.2.5 Engage media for documentation and dissemination of MIYCN programme	Event	NA					7 (1 in all 7)	Annual report of DoHS	Health
1.2.6 Raise awareness on nutrition including essential newborn care	Local governments	NA					753 local governments	Annual report of DoHS	Health
Output 1.3: Improved MIYC micronutrient status									
1.3.1 Maintain and sustain routine distribution of Vitamin A capsules and deworming tablets to children under 5	Local governments	77 districts					753 local governments	Annual report of DoHS	Health
1.3.2 Increase coverage and compliance of iron folic acid and deworming among pregnant and post-partum women	Local governments	77 districts					753 local governments	Annual report of DoHS	Health
1.3.3 Scale-up home food fortification with multiple micronutrient powder (MNP) in targeted areas	Local governments	30 districts	34 districts	45 districts	55 districts	753 local governments	753 local governments	Annual reports of DoHS	Health
1.3.4 Raise awareness to promote household use of two-child-logo iodized salt	Local governments	77 districts					753 local governments	Annual reports of DoHS	Health
1.3.5 Raise awareness to promote consumption of national roller-mill fortified flour and rice	Local governments	NA					372 local governments	Annual reports of DoHS	Health and agriculture
1.3.6 Initiate rice fortification in government (NFC) and selected big rice producing mills	Roller mills	NA		1	2	2	2	Annual reports of DFTQC	Agriculture, health, supplies
1.3.7 Conduct research to improve use of iron-folic acid (IFA) supplementation	Province						7	Annual reports	
1.3.8 Conduct barrier analysis on low coverage/ compliance of MNP	Event per province	NA					7 (1 in all 7 province)	Annual reports of DoHS	Health
1.3.9 Procure and supply nutrition commodities for regular and emergency programs (VAC, IFA, deworming tablets, MNPs, RUTF, therapeutic milk, ReSoMal)	Percentage	100					100	Annual reports of DoHS	Health

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
1.3.10 Scale-up fortified super cereal flour distribution in selected districts with high prevalence of acute malnutrition to pregnant and lactating women and 6-23 months children under MCHN programme	Districts	6	6	6	8	9	9	Annual reports of DoHS	Health
Output 1.4: Improved management of severe and moderate acute malnutrition									
1.4.1 Expand and establish OTC and ITC centres for management of severe acute malnutrition in children under 5 years	Local governments	32 districts					753 local governments	Annual reports of DoHS	Health
1.4.2 Scale-up nutrition rehabilitation homes (NRH) in 50+ bed hospitals	Local governments	43 hospitals					372 local governments	Annual reports of DoHS	Health
1.4.3 Conduct periodic nutrition assessments and counselling at community level	Local governments	NA					372 local governments	Annual reports of DoHS	Health
1.4.4 Conduct barrier analysis on services related to SAM management	Province	NA					7 province	Annual reports of DoHS	Health
1.4.5 Scale-up and strengthen IMNCI programme	Local governments	77 districts					753 local governments	Annual reports of DoHS	Health
1.4.6 Establish and strengthen nutrition information and surveillance system in normal and humanitarian situations	Province	2 districts					7 provinces	Annual reports of DoHS	Health
Output 1.5: Enhanced preparedness for nutrition in emergency responses									
1.5.1 Establish local nutrition clusters and conduct quarterly coordination meeting at local levels	Province	77 districts					7 provinces	Annual reports of DoHS	Health
1.5.2 Update and develop nutrition in emergency preparedness for response and contingency planning at local levels	Provinces and local governments	77 districts					7 provinces and 372 local governments	Annual reports of DoHS	Health
Output 1.6: Built capacity of nutrition specific sector									
1.6.1 Conduct refresher training to health workers and FCHVs at all levels on MIYCN package	Local governments	77 districts					753	Annual reports of DoHS	Health
1.6.2 Organize basic training on MIYCN package to newly recruited nutrition supervisors and nutrition officers	Local governments	NA					753 local governments	Annual reports of DoHS	Health

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
1.6.3 Organize nutrition champion leadership development events	Province	NA					7 provinces	Annual reports of DoHS	Health
1.6.4 Conduct routine data quality assessment (RDQA) using nutrition programme-related HMIS tools	Local governments	NA					372 local governments	Annual reports of DoHS	Health

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
OUTPUT 2									
Agriculture and Livestock									
Output 2.1: Increased availability and consumption of safe and nutritious food									
2.1.1 Make available agriculture and livestock inputs (i.e. seeds, fertilizers, breeds) at household and community levels									
Improved seeds (increase by 10%) (in 1,000 tonnes)	1,000 tonnes	9,540 (2014)	12,698	13,968	15,364	16,901	18,591	MoAD's annual reports	Agriculture
Fertilizers (increase use by 5% annually) (in 1,000 tonnes)	1,000 tonnes	298,677 (2014)	345,756	363,044	381,196	400,256	420,269	MoAD's annual reports	Agriculture
Breeds (no. of artificial inseminations)	Breeds	450,000	500,000	525,000	550,000	600,000	650,000	MoAD's annual reports	Livestock
2.1.2 Provide technical support (training, demonstration) to promote production of fruits, vegetables, nutritious roots, cereals and pulses to increase consumption of diversified foods in households									Agriculture
Cereals (1,000 tonnes)	1,000 tonnes	8,614 (2014)	9,515	9,705	9,414	9,697	9,987	MoAD's annual reports	
Pulses (1,000 tonnes)	1,000 tonnes	316 (2014)	329	335	342	349	356		
Fruits (1,000 tonnes)	1,000 tonnes	992 (2014)	1181	1,252	1,327	1,407	1,492		
Vegetables (1,000 tonnes)	1,000 tonnes	3,819 (2014)	4413	4,678	4,959	5,256	5,572		
Potato (1,000 tonnes)	1,000 tonnes	190	210	218	227	236	246		

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
2.1.3 Increase production and promote consumption of fresh fruits and green leafy vegetables		Refer to c. and d. of activity 2.1.2						MoAD's annual reports	Agriculture
2.1.4 Build capacity of livestock farmers and entrepreneurs to increase milk, meat and egg production	Person	13,000	15,000	17,000	19,000	22,000	25,000	Annual reports of MoLD	Livestock
2.1.5 Technical support for micro and alternative small irrigation to produce diversified and micronutrient rich foods	% of crop land in year round irrigation	18 (2010)	22	25	30	35	45	ADS	Agriculture
2.1.6 Support food producing industries to adopt good manufacturing practices and related systems	Industry	NA	10	10	10	10	10	Reports of DFTQC	Agriculture and Livestock
2.1.7 Train agriculture and livestock extension officers and staff on food safety, food processing and nutrition	Event	NA	100	100	100	100	100	Reports of DFTQC	Agriculture and Livestock
2.1.8 Train farmers on food safety, food processing and nutrition	Person	NA	1,000	1,000	1,000	1,000	1,000	Reports of DoA & DoLS	Agriculture and Livestock
.9 Study and improve local food recipes	Event	NA	5	5	5	5	5	Reports of DFTQC	Agriculture and Livestock
2.1.10 Update and disseminate food composition tables a) Analyse food samples b) Data compilation and publication of updated food composition table	Piece	Existing	300	300	300	300	300	Reports of DFTQC	Agriculture and Livestock
2.1.11 Disseminate food based dietary guidelines to local governments	Piece	NA	300	300	300	300	300	Reports of DFTQC	Agriculture and Livestock
2.1.12 Develop and multiply BCC materials including audio visuals on food safety, food processing and nutrition	Piece	NA	5	5	5	5	5	Reports of DFTQC	Agriculture and Livestock
Output 2.2: Increased physical and economic access to diversified food									
2.2.1 Enhance access and utilization of animal source foods									
a) Open market establishments	No. of markets	3	5	6	7	7	7	Annual reports of MoLD	Livestock
b) Chilling vat distribution	Number	20	40	60	70	100	110		
c) Awareness programmes to use safe animal products (events)	Event	20	40	50	70	90	120		

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
2.2.2 Promote and support production and consumption of fish including support to establish community ponds for production and local consumption	1,000 tonnes	48	57	60	63	66	69	Annual reports of MoAD	Agriculture
Water Supply and Sanitation									
Output 2.3: Increased access to safe drinking water									
2.3.1 Construct and repair water supply schemes in communities and institutions through water safety plans and projects	Percentage	6					100	DWSS	Water Supply and Sanitation
2.3.1 Promote alternative and innovative technologies for supply water	Percentage	0.4					2.5	NMIP-DWSS	Water Supply and Sanitation
2.3.3 Promote household water treatment options	Percentage	NA					25	NMIP-DWSS	Water Supply and Sanitation
Output 2.4: Increased access to safe and sustainable sanitation services									
2.4.1 Raise community awareness on construction, maintenance and hygienic use of improved household toilets including safe disposal of child faeces	Percentage	NA					100	NMIP-DWSS	Water Supply and Sanitation
2.4.2 Support and strengthen WASH coordination committees and local government to accelerate ODF campaigns.	Percentage						100	NMIP-DWSS	Water Supply and Sanitation
2.4.3 Support construction and management of child, gender and differently abled friendly toilets including menstrual hygiene management facilities at institutions	Percentage	NA			20		35	WASH Sector Development Plan	Water Supply and Sanitation
22.4.4 Safe and hygenic food safety practices such as covering stone mixture, drying utensils etc	Percentage	NA			20		35	WASH Sector Development Plan	Water Supply and Sanitation
Output 2.5: Promoted hygiene behaviour practices and its management									
2.5.1 Construct, establish and promote user friendly hand washing facilities in households and institutions	Percentage	NA					100	DWSS	Water Supply and Sanitation
2.5.2 Raise awareness on hand washing at critical times in communities, school children and health workers		NA						Data from DoE and DoHS	Water Supply and Sanitation
2.5.3 Raise awareness on menstrual hygiene management in communities and schools	Percentage	NA					100	DWSS	Water Supply and Sanitation
2.5.4 Raise awareness about food hygiene in communities		NA						DWSS	Water Supply and Sanitation

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
Social Protection									
Output 2.6: Targeted groups have access to resources and opportunities that are essential for making them self-reliant.									
2.6.1 Support community seed banks	Seed bank	15 (2016)	17	19	21	23	25	Annual report of MoAD	Agriculture
2.6.2 Support women and disadvantaged groups to produce and consume animal livestock products	District	NA	20	25	30	32	35	Annual report of MoLD	Livestock
2.6.3 Provide start-up entrepreneurship grants to women cooperatives for social and economic empowerment (NPR 150,000 to 450,000)	Women cooperative	411	88	90	100	110	120	Annual reports of DWC	Women, Children and Social Welfare
2.6.4 Provide start-up entrepreneurship grants to women group members for social and economic empowerment (NPR 3500–7500)	Members of women cooperatives	49,385	15,000	12,000	10,000	15,000	17,000	Draft 73/74 Annual Economic Survey	Women, Children and Social Welfare
2.6.5 Training and orientations for income generation and business promotion (vegetable & fruit production, animal husbandry, livestock, tailoring, etc.)	Persons/no. of trainings	163,959	1,500	1,600	1,750	1,900	2,000	Annual reports of DWC	Women, Children and Social Welfare
2.6.6 Link the distribution of child protection grants to nutrition in all districts	Local governments	203 local governments	203	299	323	347	372	Reports of DoCR	Local Governance
2.6.7 Include nutrition as a major objective of social protection programmes	Local governments	203 local governments	203	299	323	347	372	Reports of DoCR	Local Governance
Maternal Health and Women Empowerment									
Output 2.7: Nutrition component incorporated in women, adolescent girls and child development training packages									
2.7.1 Integrate nutrition modules in training packages including gender based violence prevention and response training, leadership, community protection, business development and life skills training	Module	2	3	2	1	0	0	Annual reports of DWC	Women, Children and Social Welfare

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
Output 2.8: Women, children and out of school adolescent girls reached with health and nutrition care practices									
2.8.1 Organize trainings for women cooperatives and child clubs on nutrition sensitive services:									
Leadership training	Person	37,632	3,760	3,800	3,825	3,850	3,900	Annual reports of DWC	Women, Children and Social Welfare
Gender based violence prevention and response training	Cooperative		36	40	42	45	50		
Community protection training	Cooperative		32	40	42	45	50		
Business development trainings	Person	48,300	28,300	38,200	51,600	62,000	73,000		
Reproductive health training	Person	121,513	1980	2,000	2,050	2,150	2,200		
Gender development training (co-development)	Person	2,850	2,900	2,950	3,000	3,100	3,200		
2.8.2 Life skill development programmes for out-of-school adolescent girls:									
Menstrual hygiene training	Person		240	500	700	900	1,000	Annual reports of DWC	Women, Children and Social Welfare
Knowledge and awareness raising initiatives for adolescent girls (vulnerable districts for gender-based violence and girl trafficking)	Person		3,700	3,850	4,000	4,200	4,500	Annual reports of DWC	
General life skill development training	Person,	5,120	2,800	3,000	3,200	3,300	3,500	Annual reports of DWC	
Organize training to child clubs and village child protection committees (VCPC) on nutrition care								Annual reports of DWC	
Output 2.9: Child care homes comply with minimum standards of nutrition care services.									
2.9.1 Monitor child care homes compliance with minimum standards of provision of nutrition sensitive services	Child Care Home	103	47	25	35	40	45	Annual reports of DWC	Women, Children and Social Welfare
	Child Care Home	103	103	100	105	110	120	Annual report of DWC	
2.9.2 Promote nutrition sensitive services at child care homes	Child Care Home	NA	50	100	100	100	100	Annual reports of DWC	
2.9.3 Integrate nutrition component in child protection case management training and services	Training Package	NA	1					Annual reports of DWC	
2.9.4 Deprived (Bipanna) infant nutrition programme (NPR 50,000 grant for women cooperatives)	Cooperative	36	40	50	55	60	70	Annual reports of DWC	

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
Output 2.10: Communities empowered to prevent harmful practices									
2.10.1 Run behaviour change communication activities to end harmful traditional practices	Event	NA	900	1,000	1,150	1,200	1,500	Annual report of DWC	Women, Children and Social Welfare
2.10.2 Run campaigns to prevent marriage until age 20 (350 adolescents, 390 stakeholders, 840 dhami-jhakri in 39 interaction programmes)	Event	5,000	2750	3,000	3,200	3,500	4,000	Annual report of DWC	
2.10.3 Programmes to shift social norms and harmful practices on food taboos that prevent menstrual hygiene, adequate nutrition for adolescents, etc.	Event	300	300	400	450	500	550	Annual report of DWC	
Early Childhood Development and Classroom Education									
Output 2.11 Enhanced enrolment of children in basic education.									
2.11.1 Run welcome to school campaigns for basic education	School	29,207	29,307	29,407	29,507	29,607	29,707	Annual reports of DoE	Education
2.11.2 Provide adequate resources to all schools to have ECED/PPE	School	25,000	25,500	26,000	27,000	28,000	29,000	Annual reports of DoE	Education
2.11.3 Provide diversified and nutritious midday meals to children in basic education	Student	612,000	612,000	612,000	612,000	612,000	612,000	Annual reports of DoE	Education
2.11.4 ECED facilitators, community learning centres (CLC) facilitators, focal teacher and health teachers and food management committees in coordination with FCHVs engage parents to improve their knowledge of health, hygiene and nutrition	District	12	12	12	12	12	12	Annual reports of DoE	Education
2.11.5 Nutrition monitoring of basic education students	District	12	57	57	57	57	57	Annual reports of DoE	Education
2.11.6 Build nutrition capacity of ECD facilitators, CLC facilitators, health teachers and food management committee in schools	District	12	12	12	12	12	12	Annual reports of DoE	Education
Output 2.12: Increased adolescent girls' awareness and behaviours in nutrition									
2.12.1 Run campaigns to increase girls' enrolment in schools in targeted areas	School	29,207	29,307	29,407	29,507	29,607	29,707	EMIS	Education
2.12.2 Create priority minimum enabling conditions (classrooms, teachers, text books, WASH, book corners) in schools	School	NA	All schools	All schools	All schools	All schools	All schools	EMIS	Education
2.12.3 Build separate functional toilets with group hand wash facilities, especially for girls in schools	School	67	72	77	82	87	92	EMIS	Education

Key activities	Unit	Situation in 2017	Target					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
2.12.4 Provide safe drinking water in schools	School	80	85	90	95	100	100	EMIS	Education
2.12.5 Promote healthy behaviour through skills-based health education in schools	School	NA	35,222	35,300	35,400	35,500	35,600	EMIS	Education
2.12.6 Revise health and nutrition curriculum	Class	NA	Class 1-3	Classes 4-5	Classes 6-8	Classes 9-10	Classes 11-12	Annual reports of DoE	Education
2.12.7 Establish food management committees in all schools providing midday meals	District	12	57	57	57	57	57	Annual reports of DoE	Education
2.12.8 Develop a set of educational training packages on disaster risk reduction (DRR) for students, teachers and school management committees	Training package	NA	1					Annual reports of DoE	Education
Health and Family Planning Services									
Output 2.13 Promote access to health and reproductive health services.									
2.13.1 Provide reproductive health information services in schools and health facilities for boys and girls	Public school	77 districts					>75% of public schools	Annual reports of DoHS	Health
2.13.2 Provide knowledge on importance of delayed first pregnancy after marriage	Public school	77 districts					>75% of public schools	Annual reports of DoHS	Health
2.13.3 Provide information to school students on benefits of use of family planning methods	Public school	77 districts					>75% of public schools	Annual reports of DoHS	Health
2.13.4 Behaviour change communication for increasing uptake of routine measles and rubella immunization	Local governments	77 districts					753	Annual reports of DoHS	Health

Key activities	Unit	Situation in 2017	Targets					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
OUTPUT 3									
Enabling environment activities									
Output 3.1: MSNP included in local, provincial and federal government's policies and plans.									
3.1.1 Incorporate MSNP-II in federal plans and polices								Sectoral policies and plans	NPC, Sectors
a) Develop and update sectoral policies, long-term plans and strategies at federal level	Ministry	7	7	7	7	7	7	Sectoral policies and plans	NPC, Sectors
b) Directives from NPC to sectors at federal level to incorporate nutrition specific and sensitive activities in AWPBs in line with MSNP-II	Event	1	1	1	1	1	1	Directives	NPC
c) Ensure nutrition specific and sensitive activities are incorporated in annual work plans and budgets of all sectors at federal level in line with MSNP-II	Ministry	7	7	7	7	7	7	AWPBs of sectors	NPC
3.1.2 Incorporate MSNP-II in provincial level plans and policies									
a) Advocacy workshop on MSNP-II in all provinces	Event	NA	7	7	7	7	7	Workshop Reports	NPC
b) Send circular to all provincial governments to incorporate nutrition in their relevant policies, long-term plans and strategies in line with MSNP	Event	NA	1	1	1	1	1	Polices and plans of provinces	NPC, Local Governance, Finance
c) Coordinate and facilitate with local government sector at federal level (MoFALD) to develop MSNP-II policy, long-term plan and strategy at local levels	Event	NA	2	2	2	2	2	Coordination meetings	NPC
3.1.3 Incorporate MSNP-II in local government plans and planning processes	Local governments	28 districts (194 local governments)	203	299	323	347	372	AWPBs of local governments	Local Governance sector
3.1.4 Organize joint annual review meetings among MSNP-II sector ministries at federal level	Event	0	1	1	1	1	1	Reports of review meeting	NPC
3.1.5 Advocacy meetings for increasing nutrition budget (at least 3.5% of total) at federal and province levels									
a) Advocacy meetings with parliamentarian at federal and province levels	Event	0	8	8	8	8	8	Meeting reports	NPC, sectors
b) Advocacy meetings with ministry of finance at federal and province levels	Event	0	2	2	2	2	2	Meeting reports	NPC, sectors

Key activities	Unit	Situation in 2017	Targets					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
c) Advocacy meetings with groups, educational institutes, private sector and industries	Event	0	2	2	2	2	2	Meeting reports	NPC
d) Advocacy meetings with civil society organizations and NGOs	Event	1	2	2	2	2	2	Meeting reports	NPC
3.1.6 Develop nutrition budget code	Event	0	1	-	-	-	-	Red book	NPC, MoF
Output 3.2: MSNP governance mechanism strengthened at federal, provincial and local level									
3.2.1 Organise High Level Nutrition and Food Security Steering Committee (HLNFSS) meetings twice a year	Event	2	2	2	2	2	2	Meeting minutes	NPC
3.2.2 Organise National Nutrition and Food Security Coordination Committee meetings quarterly	Event	4	4	4	4	4	4	Meeting minutes	NPC
3.2.3 Send circular and facilitate formation of nutrition and food security steering committee in provinces	Event	NA	7	-	-	-	-	Meeting minutes	NPC
3.2.4 Form nutrition and food security steering committees at province level	Province	NA	7	-	-	-	-	Meeting minutes	NPC, Local Governance
3.2.5 Organise nutrition and food security steering committee meetings twice a year at province level	Event	NA	14	14	14	14	14	Meeting minutes	NPC, Local Governance
3.2.8 Appoint nutrition focal persons for all sectoral ministries at province level	Province	NA	7	-	-	-	-	Decision letters	Local Governance
3.2.9 Organise thematic technical working group (TWG) meetings at federal level quarterly. Thematic groups: a) Capacity Building b) Advocacy and communication c) M&E	Event	3 TWGs	12	12	12	12	12	Meeting minutes	NPC
3.2.10 Form nutrition and food steering committees at local governments level and meet regularly	Local governments	30 district	203	299	323	347	372	Reports from local governments	Local Governance
3.2.11 Form nutrition and food steering committee and regular meetings at ward level in MSNP local governments	Wards	VDC level	0	914	1350	1450	1600	Report from local governments	Local Governance
3.2.12 Facilitate to assign coordinators (existing staff or outsourced) at local governments to oversee MSNP-II interventions	Local governments	30 district	203	299	323	347	372	Reports from local governments	Local Governance

Key activities	Unit	Situation in 2017	Targets					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
Output 3.3 MSNP institutional mechanisms functional at federal government level									
3.3.1 Strengthen National Nutrition and Food Security Secretariat at NPC	Event	1	1	1	1	1	1	NNFSS	NPC
3.3.2 Carry out organization and management survey on including NNFSS within NPC	Event	0	1					O&M survey report	NPC
3.3.3 Facilitate endorsement of the O&M survey report	Event	0	1					NPC organogram	NPC
3.3.4 Recruit staff for NFSS as per approved organogram	Event	0	0	1	1	1	1	Annual reports	NPC
Output 3.4: Functional updated information system across the sectors.									
3.4.1 Update MSNP information portal and make it functional	Event	1	1	1	1	1	1	Access to updated MSNP portal	NPC
3.4.2 Link and update nutrition information at central level (HMIS, EMIS, WASH, agriculture, livestock and local governance)	Event	1	1	1	1	1	1	Linkage of nutrition information with all sectors	NPC All sectors
3.4.3 Provide training on web-based MSNP reporting system at federal and province level	Event	0	-	1			-	Use of web-based MSNP reporting system	NPC
3.4.4 Document and disseminate good practices, lessons learned and case studies	Event	1	1	1	1	1	1	Report	Local Governance
3.4.5 Develop and review monitoring and evaluation framework for all MSNP sectors at federal level	Event	1	1	1	1	1	1	MSNP-II M&E framework	NPC, sectors
3.4.6 Develop and review monitoring and evaluation framework for all MSNP sectors at province level	Province	NA	7	7	7	7	7	MSNP-II M&E framework	NPC, sectors
3.4.7 Develop monitoring and evaluation framework for all MSNP sectors at local level	Local governments	30 districts	203	299	323	347	372	MSNP-II M&E framework	NPC, local governance, sectors
Output 3.5: Enhanced capacity of federal, province and local level government to plan and implement nutrition program									
3.5.1 Develop national capacity building master plan for MSNP-II	Event	0	1	-	-	-	-	Capacity development master plan document	NPC, Sectors
3.5.2 Implement capacity development master plan at all levels.									
a) Develop training package	Event	0	1	-	-	-	-	Training package	NPC, sectors

Key activities	Unit	Situation in 2017	Targets					Means of verification	Responsible sectors
			2018	2019	2020	2021	2022		
b) Conduct master training of trainers (MToT) on MSNP-II	Event		1	1	1	1	1	MToT report	NPC
3.5.2 (continued): Capacity development measures from sectors									
Agriculture and Livestock Development									
Capacity development training, interactions, exposure visits: a) Central level — 10 persons b) Provincial level — 35 persons c) Local level — 1,488 (agriculture and livestock sector human resources)	Person	NA	1,523	-	1,523	-	1,523	Training reports	Agriculture and Livestock Sector
d) Conduct training and demonstrations on improved recipes	Event	NA	7	7	7	7	7	Training reports	Agriculture and Livestock Sector
e) Establish and strengthen food processing, food safety and nutrition regulation and extension services at local level	Local governments	NA	753	753	753	753	753	Annual report of MoAD	Agriculture and Livestock Sector
Local Governance									
a) Build capacity for in-service nutrition specific and nutrition sensitive training to nutrition stakeholders at federal, provincial, village council, local government and community levels	Local governments	30 Districts	1 federal, 5 province, 203 Local governments	1 federal, 5 province, 299 Local governments	1 federal, 7 province, 323 Local governments	1 federal, 7 province, 347 Local governments	1 federal, 7 province, 372 Local governments	Periodic report of local governments	Local Governance
b) Develop integrated package for Golden 1000 days households — orientation, training	Event	NA	1						NPC, Local Governance
c) Sensitize stakeholders on MSNP-II	Person	N/A	4,500	8,970	9,780	10,500	11,400	Periodic reports of local governments	Local Governance
NPC									
a) Prepare MSNP-II capacity development plan	Event	0	1	-	-	-	-	Capacity development master plan	NPC, sectors
b) Prepare advocacy and communication strategy	Event	1	1					Strategy document	Sectors
c) Train M&E focal person on information system	Event		1	1	1	1	1	Training Report	NPC

ANNEX 2:

MSNP (2013–17) Related Programmes and Projects Supported by Development Partners

Nepal's development partners implemented the following programmes and projects under MSNP (2013–17) with some of them carrying on into the MSNP-II period:

Period	Project	Description
October 2012 to March 2017	Sunaula Hazar Din (Golden Thousand Days)	This project was funded by the World Bank and implemented by the Ministry of Federal Affairs and Local Development (MoFALD). Programmes were conducted in 15 districts to prevent malnutrition in the crucial first 1,000 days from conception until children's second birthday (= 270 days + 365 days + 365 days = 1,000 days).
2011 to 2016 (Suaahara-1) 2016 to 2021 (Suaahara-2)	Suaahara Project	This integrated nutrition programme is implemented with USAID funding in partnership with stakeholders to improve the nutritional status of women and children in 40 districts. The project is a major initiative under MSNP (2013–17) and MSNP-II. The second phase is being rolled out in coordination with the National Planning Commission and relevant federal ministries; and will be rolled out in coordination with provincial planning units, provincial ministries and local governments once they are established. Its activities address the first thousand days from conception to two years of age focussing on infants and women and adolescent girls as the people mainly responsible for caring for infants. It integrates health, nutrition, WASH, agriculture and food security activities.
2013 to 2018	Agriculture and Food Security Project	This World Bank funded project is being implemented by the Ministry of Agricultural Development and the Ministry of Livestock Development in coordination with the Ministry of Health in 18 districts. It aims to improve the nutritional status and food security of targeted groups by increasing the productivity of agriculture and livestock production and improving the availability of and access to nutritional food and nutrition-related behaviour.
2013 to 2016	KISAN: Knowledge-based Integrated Sustainable Agriculture and Nutrition	The KISAN project was implemented by the ministries of agricultural and livestock development and the health ministry with funding from USAID. It ran in 16 districts of the Mid-West and Far Western regions –the areas most severely affected by food insecurity, hunger and inadequate nutrition. The project improved food security and increased incomes through integrated agriculture activities and was implemented as part of USAID's Feed the Future initiative.
2014–2019	SABAL: Sustainable Action for Resilience and Food Security	This project is being implemented in 11 hill and mountain districts of the eastern and central regions with support from USAID. It is being implemented by the Ministry of Agricultural Development, the Ministry of Federal Affairs and Local Development, the Ministry of Health and local NGO partners.
2016–2019	Partnership for Improved Nutrition (Poshan Ko Laagi Haatemalo)	With financial aid from the European Union channelled via UNICEF, and additional funding from UNICEF, this project is conducting nutrition specific programmes through the Ministry of Health and nutrition sensitive programmes through MoFALD in 28 districts in coordination with relevant ministries following MSNP (2013–17) guidelines.
2014-2017	Food for Education	Supported by the World Food Programme and implemented by the Ministry of Education, this programme is improving the nutritional status of students in 10 hill and mountain districts of Far Western and Mid-Western Nepal. It aims to bring quantitative and qualitative improvements in primary education, increase school admission rates for girls, and achieve sustainable improvements in the food security of marginalized community, especially women and children.
2013–2016	Multi-partner Trust Fund	Nepal received a Multi-partner Trust Fund grant from the SUN Movement Secretariat to expand the availability of nutrition-related services. The Civil Society Alliance of Nepal allocated funds to its members to run advocacy and capacity building activities that facilitated the implementation of MSNP (2013–17).
2013–2016	REACH: Renewed Efforts Against Child Hunger and Undernutrition	The REACH project helped establish the National Nutrition and Food Security Secretariat in the initial phase of MSNP (2013–17) to coordinate capacity building at central and district levels. This project has also helped to manage information related to nutrition and food security by developing the Nepal Nutrition and Food Security Portal.

ANNEX 3:

Commitments For Implementing MSNP

September 2012 Kathmandu
Declaration of Commitments

For an accelerated improvement in maternal and child nutrition in Nepal

We, the Nepal Government, UN agencies, development partners and members of civil society and the private sector, meeting today, the 17 September 2012, in the National Nutrition and Food Security Coordination Meeting, whose objective is to achieve a national consensus on the scaling up of the multi-sector action plan for the reduction of chronic malnutrition in Nepal,

Recognizing that chronic malnutrition is the main problem affecting the nutrition of Nepali children especially during the first 1,000 days of life (from conception up to two year of age) and that its resolution requires a multi-sector approach,

Concerned that malnutrition is responsible for more than a third of child mortality, and for derailing socio-economic development of the affected families, communities, and ultimately the country, and impacting negatively on achievement of the all the Millennium Development Goals,

Recalling and reaffirming the commitment during the World Food Summit, held in Rome in 1996, to reduce the number of undernourished people by 50 per cent by the year 2015,

Recognizing that poverty reduction is a Government priority and that there is a strong link between poverty reduction, food insecurity and nutrition and chronic malnutrition,

Taking into account the opportunities that present themselves, notably: the national political engagement, cost effective interventions based on scientific evidence, global initiatives on Scaling Up of Nutrition (SUN) and Renewed Efforts Against Child Hunger and Under-nutrition (REACH), with Nepal having made commitment to be an 'early riser' SUN country under the leadership of His Excellency the Prime Minister of Nepal as a member of the SUN Lead Group, and to introduce REACH in the country with the involvement of national and international partners,

Recognizing that the right to adequate food and nutrition is a fundamental human right,

We commit ourselves and strive to:

- Contribute to the implementation of actions defined in multi-sector nutrition plan of action for the improvement of maternal and child nutrition and the reduction of chronic malnutrition;
- Develop advocacy, communication, and social mobilization actions to raise awareness of the various sectors and the general public, about the significant problem of chronic malnutrition and actions needed to improve maternal and child nutrition, accessible to everyone, especially during the first 1,000 days of life, ensuring equity, and facilitating access to information, to promoting behaviour change, with a focus to reach the most marginalized, poorest segments of the population, and taking into account gender related factors;
- Strengthen the institutional, organization and human resource capacity for the implementation of the plan at all levels and in different sectors linked to nutrition;
- Support the inter-sector coordination body at all the key levels (national, district, and VDC) in all its dimension so that through functional coordination mechanisms are implemented and effective action to improve the nutritional status of women and children, ensuring complementarity and strengthening synergies between the different actors;
- Enhance the multi-sector nutrition information, knowledge management, surveillance systems, monitoring and evaluation of prog-

ress with links to existing early warning systems; and

- Mobilize support nationally and internationally to ensure the large-scale implementation of interventions and nutrition programs to address both the immediate, underlying and basic social and economic determinants of maternal and under-nutrition.

We, the Nepal Government, UN agencies, development partners and members of civil society and the private sector, by this we approve the contents of this **"Declaration of Commitment for an Accelerated Improvement in Maternal and Child Nutrition in Nepal."**

Kathmandu, September 2012

Mr. Deependra Bahadur Kshetry
Hon. Vice Chair, National Planning Commission

Mr. Krishna Hari Baskota
Secretary, Ministry of Finance

(For)

Mr. Balananda Paudel
Secretary, Ministry of Women, Children, & Social Welfare

(For)

Mr. Suresh Man Shrestha
Secretary, Ministry of Education

Dr. Praveen Mishra
Secretary, Ministry of Health and Population

Ms. Hanaa Singer, Representative UNICEF
On Behalf of UN REACH Partners
(FAO, UNICEF, WFP, WHO)

(For)

Mr. Suraj Vaidya
Chair, Federation of Nepalese Chambers of Commerce and Industries (FNCCI)

Prof. Dr. Shiba Kumar Rai
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Country SUN Focal Point - Nepal

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ANNEX 4:

CONTRIBUTORS TO MULTISECTOR NUTRITION PLAN-II (2018-2022)

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