CAPACITY BUILDING TO STRENGTHEN LOCAL GOVERNMENT AND COMMUNITY PARTICIPATION IN

MULTISECTORAL NUTRITION PROGRAMS IN NEPAL



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Acronyms

ANM	Auxiliary Nurse Midwife
APM	All Party Mechamism
CACs	Citizens' Awareness Centres
CAP	Community Action Processes
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CB-IMCI	Community Based Integrated Management of Childhood Illness
CBO	Community Based Organization
CRC	Convention on the Rights of the Child
DACAW	Decentralized Action for Children and Women
DDC	District Development Committee
ECD	Early Child Development
FCHV	Female Community Health Volunteers
GoN	The Government of Nepal
HDI	Human Development Index
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic, Social and Cultural Rights
JP	Joint Programme
JT/A	Junior Technician/Junior Technician Assistant
LGCDP	Local Government and Community Development Project
LSGA	Local Self-Government Act
MCU	Maternal and Child Undernutrition
MDG	Millennium Development Goal
MIYCF	Maternal Infant and Young Child Feeding
MoAD	Ministry of Agriculture and Development
MoE	Ministry of Education
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MoUD	Ministry of Urban Development
MSNP	Multisectoral Nutrition Plan
MWCSW	Ministry of Women, Child and Social Welfare
NFHP	Nepal Family Health Program
NFSSC	Nutrition and Food Security Steering Committee
NNFSSC	National Nutrition and Food Security Steering Committee
NPC	National Planning Commission
PMAS	Poverty Monitoring and Analysis System
SM	Social Mobilizers
VDC	Village Development Committee
WASH	Water, Sanitation and Hygiene
WCFs	Ward Citizens Forums
UNDP	United Nations Development Program
UNICEF	United Nations Children Emergency Fund
USAID	United States Agency for International Development

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Executive Summary

The Government of Nepal (GoN) is committed to scaling up a set of evidence-based nutrition interventions through its Multisectoral Nutrition Plan (MSNP) to reduce the inter generational transmission of stunting. The MSNP was developed by the National Planning Commission (NPC) in close collaboration with the five Ministries involved in its delivery, namely the Ministry of Agriculture Development (MoAD), the Ministry of Health and Population (MoHP), the Ministry of Education (MoE), the Ministry of Urban Development (MoUD), and the Ministry of Federal Affairs and Local Development (MoFALD). Because the MSNP emphasizes decentralized implementation,a critical first step in implementing the MSNP is to determine what nutrition capacity exists in relevant sectors and what capacity must be developed. The purpose of this paper is to assess capacity-building needs to improve nutrition at the local government and community level and to recommend how to strengthen local capacity further.

The authors' assessment considered organizational and system constraints as well as individual level factors. A system-level analysis included a desk review to understand relevant nutrition programs, policy, and legal frameworks from the sectoral perspective of local and national government, as well as from that of civil society and nongovernment organizations. An analysis of organizational issues—done by desk analysis as well as through individual interviews—examined how information was used for decision making at all levels, as well as the ratios and relationships between different levels of workers and households. Individual level analysis was accomplished by interviewing all the principal actors involved in nutrition-related activities at local government and community levels in two districts, in the Hills and the Terai. Responses to the interview questions for eight "nutrition in development" capacity-building domains were ranked from 1 (very narrow) to 5 (broad/good).

Field interviews revealed that virtually all the local government and community nutrition-capacity domains require considerable strengthening. The three narrowest or most restricted domains, with 85 to 92 percent of interviews recording a score of 2 or less, were those of the perception of the problem, the development pathway, and resource mobilization. Communication was the widest domain, with 53 percent scoring 3 or more (mean or fair), mainly because of the presence of television in many households and posters and pamphlets that the majority had seen. The intermediate scoring domains included management/organization, workforce skills and training, information systems, and infrastructure/ equipment with between 69 and 78 percent getting a score of 2 or less.

Changing the very narrow perception of the nutrition situation held by the majority of the actors interviewed will require a concerted effort. Most of the actors involved in nutrition-related activities do not think malnutrition is a problem, and the few that do, consider the problem to be severe malnutrition caused only by a poor diet. Changing this narrow perception will require a variety of specifically developed

training, management, and communication strategies. All these activities should be developed by joint donor programs to support Nepal's Local Government and Community Development Project (LGCDP) coordinated by the Ministry of Federal Affairs and Local Development (MoFALD).

Broadening the narrow nutrition development pathway of most of the actors involved will require a gradual shift from traditional welfare-type passive recipient/actor mode of treating nutrition problems to a more active participation in managing community resources for prevention, based on local problem assessments. Much still remains to be done to strengthen the capacity of local government to mobilize more resources and to manage the MSNP better. To this end, the Nutrition and Food Security Steering Committee (NFSSC) needs to develop annual district food and nutrition security plans and budgets, which draw on, include, and support the village-level food and nutrition security plans.

Nutrition capacity needs to be strengthened in the local government mechanisms supporting the MSNP. A nutrition professional needs to act as a "focal point" in the District Development Committee (DDC) to support the NFSSC and provide oversight and facilitate multiple ongoing nutrition-related activities in a "bottom-up" fashion in the selected district. The main actors involved in the food and nutrition security committees need to receive a training course/ orientation. The individual sectoral workers in health, agriculture, and education, especially will also need some special orientation in nutrition and the MSNP. Such trainings should deal with all forms of malnutrition from a life course perspective and be human rights based, communicating the concepts of duty bearers and rights holders, and the obligation of duty bearers to "respect," "protect," and "fulfill" such rights.

The current Poverty Monitoring and Analysis System (PMAS) seems to serve central functions more than local government ones. Furthermore, the various information systems are not suitable for guiding local government decisions to accelerate stunting reduction through the MNSP. A list of key MSNP input, output, outcome, and impact indicators needs to be constructed to serve local government decision making and help identify bottlenecks limiting program impact. District authorities need to be held accountable for achieving specific time-bound MSNP outcome and impact targets by publishing quarterly reports on progress made towards achieving annual planning objectives.

Broader nutrition concerns, and especially those related to stunting reduction, need to be integrated as appropriate into the existing IEC activities, which are ongoing in the LGCDP districts supported by the Joint Program (JP). Holding an orientation on stunting reduction should be considered for journalists, especially with regard to rights violations associated with stunting whether the Convention on the Rights of the Child (CRC),or the Convention on the Elimination of Discrimination against Women (CEDAW). Citizens' Awareness Centres (CACs) and Ward Citizens Forums (WCFs) also offer an important opportunity to widen the common faulty perception of nutrition and to begin monitoring how and whether progress is being made in their district and village nutrition and food security plans and whether maternal and child undernutrition rates are improving.

1 Introduction

In the last few decades, child stunting rates in Nepal have declined considerably. Nevertheless, continued reductions have slowed more recently and some 41percent of young children continue to be stunted[2]. Recognizing stunting's negative impact on human capital development, the Government of Nepal (GoN) is committed to scaling up a multisectoral set of evidence-based nutrition interventions to improve maternal and child nutrition. The Multisectoral Nutrition Plan (MSNP)[3] was developed by the National Planning Commission (NPC) in close collaboration with the five Ministries involved in its delivery, namely the Ministry of Agriculture Development (MoAD), the Ministry of Health and Population (MoHP), the Ministry of Education (MoE), Ministry of Urban Development (MoUD), and the Ministry of Federal Affairs and Local Development (MoFALD). The MSNP emphasizes decentralized implementation, initially in twelve selected districts by 2014, before gradually scaling up interventions to all 75 districts by 2016. An important first step in MSNP's development was the strengthening of the national nutrition architecture by creating a National Nutrition and Food Security Steering Committee (NNFSSC) in the National Planning Commission (NPC).

The MSNP's overarching objective is to reduce the intergenerational transmission of growth failure or stunting. Each sector involved in the MSNP has agreed to achieve a strategic objective and set of results. The MoHP is responsible for improving maternal, infant and young child micronutrient status and feeding patterns, as well as the treatment of severe acute malnutrition and diarrhea. The MoE has committed to improving the nutritional status,awareness, and behaviors of adolescent girls, as well as their secondary school completion rates. The MoAD has committed to increasing household income and their consumption of animal foods, as well as reducing the workload of poor young mothers and adolescent girls and improving the home environment (e.g. household smoke). The MoUD will aim to reduce episodes of diarrhea among mothers, infants, and young children by ensuring use of improved sanitation facilities, soap for handwashing, and the use of treated drinking water. The MoFALD has committed to increasing the level of local resources mobilized and improving local coordination among sectors, as well

[2] MOHP, New Era, ICF International Inc., 2012. Nepal demographic and health survey 2011. Kathmandu, Nepal: Ministry of Health and Population, New Era, and ICF International, Calverton MD.

[3] Government of Nepal 2012. Multi-sectoral Nutrition Plan for accelerating the reduction of maternal and child undernutrition in Nepal. Kathmandu: National Planning Commission.

as directing social protection measures towards accelerating stunting reduction. Each of these ministries will be scaling up their own sectoral programs independent of the MSNP. Those sectoral efforts lie outside of the immediate remit of MSNP, which is focused on building capacity at local government and community levels to united these efforts and ensure their local relevance and articulation.

Experience has shown that nutrition capacity, especially at the peripheral level, is critical for developing multisectoral approaches. [4][5] The lack of trained public health nutritionists and academic centers providing formal nutrition training in Nepal is well recognized.[6] To date,the MoHP has developed and implemented most nutrition actions through the Nepal Family Health Program (NFHP) and especially through the Female Community Health Volunteers (FCHV). However, a recent evaluation of the NFHP pointed to the potential danger of the FCHVs becoming overloaded by unreasonable demands for a cadre of volunteer workers.[7] How can other sectors, beyond health,become involved with the FCHVs in a local government-led MSNP, without compromising the efforts of these volunteers? This needs to be considered carefully. A critical next step towards building nutrition capacity in Nepal is to determine what capacity exists and what must be developed in relevant sectors. Some recommendations for the health sector have already been made. [8]

4 Nishida C, Shrimpton R, Darnton-Hill I. 2009. Landscape Analysis on countries' readiness to accelerate action in nutrition. SCN News. 37: 4-9.

5 Pelletier DL, Frongillo EA, Gervais S, Hoey L, Menon P, Ngo T, Stoltzfus RJ, Ahmed AM, Ahmed T.2012. Nutrition agenda setting, policy formulation and implementation: lessons from the Mainstreaming Nutrition Initiative.Health Policy Plan. 27(1): 19-31.

6 Pokharel RJ, Houston R, Harvey P, Bishwakarma R, Adhikari J, Pani KD, Gartoula R. 2009. Nepal Nutrition Assessment and Gap Analysis. Kathmandu: MOHP.

7 Riggs-Perla J, Adhikari M, Adhikari RK, Armbruster D, Paudel D, Prasia D, Pokhrel S. 2011. Nepal Family Health Program (NFHP) II Evaluation. Kathmandu: USAID.

8 Spiro D, Devkota M, Rana P P and Blechyden K. 2010. National Health Sector Support Program Capacity Assessment for Nutrition. Kathmandu: Helen Keller International.

2 Objective

The objective of the capacity assessment is to identify existing capacity and gaps in local government and community structures and recommend ways to strengthen them to accelerate the reduction of maternal and child undernutrition (MCU). This exercise complements a nutrition capacity assessment conducted at the national and district levels. Any proposal for strengthening community and local government nutrition capacity is expected to be incorporated into a future national nutrition capacity development plan once the national and district level nutrition capacity development needs are finalized.

3 Methodology

For capacity building to be successful and sustainable,the nutrition capacity assessment must consider organizational and system constraints, not just stand-alone issues at each level.[9] The authors conducted a system-level analysis by reviewing available official government documents obtained in country, as well as those found through an internet search. The aim of the desk review was to understand the program, policy, and legal frameworks relevant to nutrition from the local and national governments' sectoral perspective, as well as from that of civil society and nongovernmental organizations (NGOs). These perspectives include, for example, government commitments to ensuring basic human socioeconomic and cultural rights,providing basic services, and achieving the Millennium Development Goals (MDGs), which are affirmed in the Constitution and national laws, as well as in sectoral policy and budget documents. Organizational issues were drawn out through desk analysis and individual interviews. The authors also investigated the issues of coverage and intensity for the various nutrition interventions by interviewing community workers, recognizing that high coverage of insufficient intensity is ineffective and an investment loss. [10]

The framework used to assess community and local government capacity to accelerate the reduction of mother and child undernutrition at the individual level in Nepal draws on the logic of various frameworks described in the literature. The Landscape Analysis methodology used an analytical framework with indicators to assess the ability to act, which is capacity, as well as those for willingness to act, which is more related to the existence of policies and programs.[11] However, some modifications to this framework were needed because nutrition capacity beyond the health sector was examined, including local government and community nutrition needs, especially. A recent review of community capacity building proposed a series of domains to help organize such efforts.[12] Similar domains previously have been used to rank the magnitude of community involvement and management efforts on a continuum from passive receipts of welfare benefits to active participation in, and management of local government and community-led efforts to resolve nutrition problems. [13]

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[9] Shrimpton R, Hughes R, Recine E, Mason J, Sanders, D, Marks G, and Margetts B. 2013 Nutrition capacity development: a practice framework. Accepted for publication in the Journal of Public Health Nutrition.

[10] Mason JB, Sanders D, Musgrove P, Soekirman, and Galloway R. 2006. Community Health and Nutrition Programs. Chapter 56 in Disease Control Priorities in Developing Countries. 2nd edition.

[11] Jamison DT, Breman JG, Measham AR, et al., editors. Washington (DC): World Bank.

[12] Chopra M, Pelletier D, Witten C, Dieterich M.2009. Assessing countries' readiness: Methodology for in-depth country assessment. SCN News 37: 17-22.

[13] Liberato SC, Brimblecombe J, Ritchie J, Ferguson M, Coveney J. 2011. Measuring capacity building in communities: a review of the literature. BMC Public Health 11: 850.

The framework used in this assessment, as shown in Table 1 (see Annex 1), includes eight "nutrition in development" capacity-building domains: (1) Perception of the nutrition situation; (2) Development pathway; (3) Resource mobilization; (4) Management/organization; (5) Human workforce training/ skills development; (6) Information systems; (7) Communications; and (8) Infrastructure/ equipment. Each domain is ranked by the degree of autonomy and local government and community empowerment by the way the various activities are being carried out, and/or as they are perceived to be carried out by the interviewees. The observations in each cell of the table provide the indicative basis for the scoring for each of these domains, from being very narrow (score 1) to being very wide (score 5). To use the Landscape Assessment instrument at the district and community levels, the authors adapted it to fit the eight domains in Table 1, adding questions as necessary. The structured questionnaires developed to collect stakeholder information are included in Annex 3. Kapil Ghimire translated the questionnaires into Nepali. They were tested all the team members during a trial run in the outskirts of Kathmandu in early June 2012.

Data collection was carried out in July and August 2012 in two of the six districts selected to begin implementing the MSNP. The two survey districts were chosen deliberately to represent two extremes of program implementation in Nepal, with Parsa being on the Terai and Achham in the Hills. Access and availability of facilities are generally better in the flat plains of the Terai than in the Hills and Mountains. To assess individual local government and community nutrition capacity-building needs, the principal actors involved in nutrition-related activities and forums were interviewed. Actors interviewed are involved at all levels, e.g., district, village, and ward/community, as shown in the programmatic model in Figure 1 (see Annex 1).Where possible and appropriate, interviewees included representatives of each of the involved Ministries from the district and village levels, i.e., MoFALD, NPC, MoHP, MoAD, MoUD, MoE, as well as community members. Interviews were "one-on-one" for the district and village officials, whereas group interviews were held with community members. Those that implement nutrition interventions also had their knowledge tested with regard to their technical understanding.

Shikha Basnet and Usha Gautam conducted the interviews in Nepali in the two districts. The questionnaires were reviewed and summarized each day then translated and transcribed into English by Patrick Olsen. The translation and transcription into English was done on a daily basis and any questions were resolved immediately. Following each district visit, a feedback session was held with district officials led by Kapil Ghimire, in which the survey's preliminary summary findings were communicated as well as the next likely steps. The scores were then applied to each set of questionnaires independently, using the assessment framework. Any questions and/or divergences were discussed and resolved immediately. Roger Shrimpton analyzed the collected data and wrote the first draft. The draft report was presented at a Nepal Nutrition and Food Security Coordination Committee (NNFSCC) nutrition stakeholders meeting in November 2012. Comments and suggestions were incorporated into the draft. The subsequent draft was peer reviewed as part of the World Bank's regular quality assurance processes.

14 Shrimpton, R. 1995. Community participation in food and nutrition programmes: An analysis of recent government experiences. In Child growth and nutrition in developing countries. Eds: P. Pinstrup Andersen, D. Pelletier, and H. Alderman .Ithaca, N.Y., U.S.A.: Cornell University Press.

15 WHO 2012. Landscape analysis on countries´ readiness to accelerate action in nutrition: Country assessment tools. Geneva: WHO.

4 Results

The results are explained in two sections, one related to the field interviews from the two districts, and the second related to the desk review. Both sections present information concerning factors that need to be considered to strengthen nutrition capacity in local government and community level actors, be it at the individual, organizational or system level. The field interviews provide data primarily on the individual level issues whereas the desk review data concerns the organizational and system level issues.

4.1. Field Interviews

Sixty interviews were carried out in two districts:34 were in Parsa and 26 in Achham, as summarized in Table 2 (see Annex 2). More sector officials were present and available for interviews at the District and the Village Council levels in Parsa (9 and 19) than in Achham (4 and 16). The interviews with community groups were of similar numbers (3) in each Village Development Committee (VDC), representing mothers groups, farmers groups, and Ward Citizens Forums. One of the mothers groups in Achham had never met before. Despite the highly negative answers to all the questions, the scores were included in the analysis.

Perception of the nutrition situation. For the majority of the local government officials and community groups, the perception of the nutrition situation is quite narrow. Very few of those interviewed (3.5%) seemed to understand that the full spectrum of malnutrition includes stunting, micronutrient deficiencies, and/or obesity(see Table 3). Of those interviewed, 85 percent thought malnutrition was a problem only when prompted. Those prompted, considered malnutrition to be just underweight and/or severe malnutrition, and largely a problem linked to poverty and/or poor food habits. Government officials had a slightly broader perception of the nutrition problem than the community groups, especially the Parsa officials. Perhaps most surprising, a quarter of the community groups interviewed thought that malnutrition was not a problem in their communities at all, even after prompting. Among those interviewed, no consistent pattern of comprehension existed of malnutrition's full range of immediate, underlying, and basic causes, or of the nature of its life course. Since the interviewees had no common understanding of the extent of the problem of malnutrition, cataloging these responses would not provide usable data.

Development pathway. The development pathway of the majority of actors involved is quite narrow, as shown in Table 4. The development pathway concept concerns the existence of a shared vision with clear common goals and objectives that preferably are based on some form of local problem assessment. Two-thirds of interviewees found that local actors did not report having any nutrition-related goals, and/or that their goals and activities were largely imposed from outside with no local problem assessment, analysis, and action choice. In another third, some effort was made to consult local opinion, but activities being promoted/carried out were still largely those imposed externally. Furthermore, there was no difference in these findings between districts, government officials, and community groups.

Mobilization of resources. The extent of resource mobilization practiced by almost all of those interviewed is very narrow, as shown in Table 5. Almost 70 percent of interviewees felt that resources available to deal with nutrition problems were inadequate, even though when first asked,the majority did not think that nutrition problems existed. After prompting, however, they recognized that severe malnutrition exists and consider resources insufficient after all. They were also unaware, or did not think that community members contribute any fees for services, and/or they were not receiving any supplies/resources from the central level. Only at the Parsa District did the majority of government officials (51%) recognize that resources were available from the central level, although they were still considered insufficient. The officials also felt they had little or no control over these resources. Despite recognizing that resources were insufficient, there was very little evidence of local fund raising through payment of fees for services and/or through social mobilization efforts with a nutritional objective.

Management/organization. The management and organizational aspects of the great majority of those interviewed was found to be very narrow, as shown in Table 6. Almost 60 percent of the interviewees had not discussed their work plan formulation with a supervisor and/or with a local committee that they report to/work with,and had not consulted with those members of their community and/or their clientele about the work they do, including prior year planning or period progress review. This result also was found among all of the community groups. The most empowered management/organizational arrangements were seen at the VDC level and in Parsa especially, where a third scored their management/organizational arrangements above three, i.e., they were "fair" or better, in that there was some discussion with a higher level of authority in developing their work plans.

Human workforce training/ skills development. As shown in Table 7, the great majority of those interviewed (75%) felt that human resources were inadequate in terms of nutrition, and that there was little or no nutrition training, even in the health sector, with no training plan for nutrition and with no in-service training and supervisory follow up. This situation was considered to be more the case in Achham (88%) than Parsa (65%), and more so at the community (100%) and village (74%) levels than the district level (54%).

Information systems. The use of information for nutrition decision making seems to be either non-existent and/or highly centralized,as is shown in Table 8. Half of those interviewed did not know what nutrition indicators were, and therefore did not use them locally for decision making or send them to anybody, and so had never had any feedback. This was less the case in Parsa (44%) than Achham (61%), and less the case at district (30%) than village (51%) levels than community (75%) level. Getting meaningful feedback on nutrition indicators sent to another level was extremely rare (2%) and limited to a VDC staff person in Parsa. Some interviewees did report feedback, but related to format rather than content, and therefore this was not included in these results.

Communication. There were considerable differences in the communication domain across the two districts, as is shown in Table 9. Whereas in Achham, the majority (81%) of those interviewed thought that most community members had no home television, in Parsa most interviewees (71%) thought that most homes had a TV. Most people (85%) reported that the only communication materials they had seen were posters and pamphlets. Very few (8%) reported having seen or heard nutrition related radio messages or TV spots, and the few were all in Parsa. A full third of community groups reported never having seen any communication materials of any sort, with no difference across the districts.

Infrastructure/equipment. There were considerable differences across districts in the availability of infrastructure and equipment, as shown in Table 10. All community and local government actors (100%) in Achham had little or no equipment, except perhaps their own mobile phone (77%). This was only the case for about a half (56%) of those interviewed in Parsa, of which only 18 percent did not have their own mobile phone, which was more the case at the community level, where almost 60 percent of the groups said the majority did not have a mobile phone. Computers and means of public transport were much more uncommon, especially in Achham (0%) but less so in Parsa (25%).

4.2 Desk Analysis

A system level analysis reveals that the government's commitment to improving the nutrition situation of its people is strong. Nepal has made great strides in improving the population's nutrition despite the enormous challenges facing the country. Nepal has ratified almost all human rights instruments including the International Convention on Civil and Political Rights (ICCPR), the International Convention on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC).Furthermore,Nepal has shown slow but continuous progress incorporating human rights into the Constitution and into the nation's laws over the last three decades. [15]

[15] Khatiwada PP. 2012. Nepal: Domestication of Treaties. What about implementation? Kathmandu: Human Rights Alliance.

Nepal's main legal document is the Constitution of 1990. The population's fundamental rights incorporated in it are mainly from the ICCPR, such as the Right to Life, the Right to Freedom, and the Right to Equality, among others. Some provisions of the CEDAW related to equality of women are linked to the Right to Equality. Very few ESC rights were enshrined in the 1990 Constitution. It was only the interim Constitution of 2007 that included the Right to Health, the Right to Social Security, the Right to Employment, as well as the Right to Food, among others. The 2011 draft Constitution gave continuity to these ESC rights and included those of the CRC.

Nepal is one of 189 countries committed to achieving the MDGs, a pledge renewed in its current Three-Year Plan (2010–2013). Nations aspiring to the MDGs pledged at the turn of the millennium to halve from 1990 levels the proportion of their population affected by many deprivations by 2015. Nepal has achieved remarkable progress in its MDGs, with the prospects of achieving the targets of all of the goals except some of the MDG1 poverty targets and the MDG7 environment goals. The nutrition MDG1 sub-target,for which Nepal is on track,is the reduction of young child underweight from 60 percent in 1990 to 30 percent in 2015. Despite being on track for achieving the nutrition MDG1 sub-target, Nepal's child stunting rate remained high at 41 percent in 2011.

The populations' socioeconomic and cultural conditions represent a system-level factor that strongly influences capacity-development activities. Nepal, with a per capita income of about $750, is one of the poorest countries in the world. It is passing through a momentous and prolonged political transition following a ten-year violent conflict that ended in 2006. According to the 2011 Human Development Report,[16] Nepal's Human Development Index (HDI) is 0.458, ranking it 157 out of 187 countries with comparable data. Only 59 percent of adults are literate and just 60 percent of students finish primary school, with little gender difference in completion rates. Nepal's wide range of physical and social diversity, including its marked spatial variation in resources, has created and perpetuated the differences in the living conditions of its population.[17] The country has 103 caste and ethnic groups speaking 92 languages. Cultural diversity is one of Nepal's national treasures, and caste, ethnicity, language, and religion remain the major sources of cultural identity. These same factors, however, are the major sources of inequality and exclusion amongst Nepali people. The caste and ethnic differences result from the norms and socially defined practices of dominant caste groups that together have defined the degree and form of these discriminatory practices. Perhaps the most important of these cultural practices, with regard to nutrition, is the unequal gender relations that stem from traditional socio-cultural structures. Over half of adolescent girls are married before they are eighteen years old,[18] despite the legal age for marriage being 20 years. Another dominant cause of inequality is the caste differentials stipulated by the Muluki Ain (the national code of 1854) that characterizes Dalits as "untouchable,"making their insertion into society extremely difficult.

16 UNDP 2011. Human Development Report 2011 Sustainability and Equity: A Better Future for All. New York: UNDP.

17 UNDP. 2009. Nepal Human Development Report 2009. State Transformation and Human Development. Kathmandu: United Nations Development Program.

18 UNICEF. 2010. Progress for Children No.9 Achieving the MDGs with Equity. New York: UNICEF.

In Nepal, the Local Self-Government Act (LSGA) of 1999 provides the basis for decentralization of governance and community development. The Interim Constitution of Nepal (2007) proposes the future restructuring of the state to promote and institutionalize an inclusive, democratic, and progressive local governance system, maximizing people's participation based on decentralization, devolution of power, and the equitable distribution of resources to local bodies. Although under the LSGA,public service delivery (PSD) at the local level is an important indicator to assess how well the District and Village Councils are functioning, PSD is still very much centrally driven.[19] In the absence of elected local bodies since 2002,a major task of the GoN remains to substantiate the objectives, policies, and principles of the LSGA and to translate the principles of local self-governance into practice by mobilizing local bodies and communities, facilitated and supported by the central line ministries. To this end, the MoFALD has been implementing its Local Governance and Community Development Program (LGCDP) since 2008, with the over arching goal of contributing towards poverty reduction through inclusive, responsive, and accountable local governance and participatory community-led development. [20]

Nepal's development partners have adopted a sector-wide approach to decentralization, which supports the LGCDP through the Joint Program (JP).[21] The overall goal of the JP is to contribute to poverty reduction in Nepal through improved and more inclusive local governance and service delivery. To achieve this goal, the JP supports three main outcomes and eight outputs, including increasing the capacity of citizens, communities, and marginalized groups to assert their rights and hold local government accountable; increasing the capacity of local governments to manage resources and deliver basic services. As part of the JP, UNICEF supports the Decentralized Action for Children and Women (DACAW), which includes supporting local government and communities in at least a quarter of all districts to foster capacity to develop and implement multisectoral plans to improve the conditions of the most disadvantaged women and children. The DACAW plans include many nutrition-related activities. [22]

The organizational aspects of local government and community actors also were analyzed,drawing on information available in the MSNP[23] and LGCDP[24] documentation. The ideal district-level organization for implementing MSNP is shown in Figure 1. The vertical sectors, such as Education, Health, and Agriculture are not shown in Figure 1, as these Sectoral Service Centers are essentially still funded and run by the central government ministries. It is envisaged

[19] Sharma Y and Muwonge A. 2010. An opportunity to improve service delivery in Nepal through local governance. Paper presented at the University of New Mexico,Nepal Study Centre 5th Annual Himalayan Policy Research Conference, held at the University of Madison in Wisconsin.

[20] Government of Nepal. 2008. Local governance and community development program. Kathmandu: Ministry of Local Development.

[21] UNDP 2012. Consolidated annual report on activities implemented under the joint program "support for the Local Governance and Community Development (LGCDP). Kathmandu: UNDP Multi-Partner Trust Fund Office.

[22] UNICEF 2007. Improving lives for children and women in Nepal: Decentralized action for children and women (DACAW). Kathmandu: UNICEF.

[23] Government of Nepal 2012. Multi-sectoral Nutrition Plan for accelerating the reduction of maternal and child undernutrition in Nepal. Kathmandu: National Planning Commission.

[24] Government of Nepal. 2008. Local governance and community development program. Kathmandu: Ministry of Local Development.

that staff from these different sectors will participate in the Nutrition and Food Security Steering Committees (NFSSCs)in the MNSP selected districts. The NFSSCs are being created by modifying the existing Food Security Committees to include actors from all MSNP sectors. It is very much work in progress.

The district and village NFSSCs are tasked with multisectoral coordination, analysis and endorsement of nutrition and food security plans. They also are responsible for reviewing the progress in implementing the plans developed with the block grants released to the district level to implement the locally developed NFSS plans. The district level NFSSC has 13 members, including the DDC Chair, District Health Officer, the Local Development Officer, Chiefs of Line Agencies, NGO representative, as well as local government program officers for social development, planning, among others. The district-level management structure will count on support from the health sector through the district nutrition officer, as well as the political and administrative leadership from the District Council Nutrition Coordinator. The Citizens' Awareness Centre (CAC) at the VDC level and the Ward Citizens Forums (WCF) will be entrusted with raising nutrition awareness through the community-based organizations (CBOs). At the village level, the NFSSC has six members including the VDC Chair, Chiefs of Service Centers, as well as representatives of Health Facility management committee, school management committee, and Ward Citizens Forum.

Below the district and village NFSSC are the various community bodies that are involved in the planning and the implementation of the local NFSS plans at the ward and community levels. The LGCDP has identified social mobilization as the principal means of empowering communities and organizations. The aim of social mobilization is to promote local participation in public affairs, especially by marginalized and disadvantaged groups, to articulate their needs and priorities and to exercise their rights in local government and administration. The Citizens' Awareness Centre(CAC) is a grassroots organization where poor and excluded people of a particular settlement of VDC are brought together to identify, analyze, and take actions on the issues that directly affect them. Currently, there is only one CAC in each VDC and Municipality Ward.

Normally, the number of participants in a CAC will be 20-30 people, but priority will be given to women participants with limited access to information. The CAC meet every week for two hours to discuss different village issues like the underlying causes of poverty, social discrimination, gender, planning process and participation, etc. They also analyze different subjects to understand the local situation. Following the discussions, they prepare an action plan, which may include delegations, campaigns, etc.,to assert their voices and to review their actions and outcomes periodically.

The main purpose of establishing a Citizens' Awareness Centre (CAC) is to empower the poor and excluded through the REFLECT process (empowering and social change approach). The

social mobilizer facilitates the members' education about their rights and supports their actions to ensure their access to services. The CAC helps to capacitate members to advocate and lobby for their rights in the hope that local activism will increase the accountability of the local leaders, and compensate in some way for the lack of local elections.

The Ward Citizen Forum (WCF) is a group of people of a respective ward constituted to discuss the ward's problems, challenges,and issues and inclusively give voice to local bodies and other agencies to demand their needs. In each WCF, there are approximately 25 people representing community organizations, women, child club network, Dalit, indigenous people, ultra poor, the disabled,and well to do families from the Ward. The participants hold regular meetings and identify their needs and priorities by analyzing the local situation. Then they voice local-level priorities to the VDC and other agencies for support. The main purpose for establishing WCFs is to increase participation of community members,especially the poor and excluded, in the planning, implementation, and oversight process of local-level planning.

A variety of community-level workers is each linked to various sectors. For the health sector,there are the Female Community Health Volunteers (FCHVs). In the education sector, there are Early Child Development (ECD) facilitators that are employed by local government at the VDC level. There are also the Social Mobilizers (SM), which are linked to the VDC, and operate in each ward facilitating the work of the Ward Citizens Forum, and the Citizens' Awareness Centres. Paralegal Committees are set up to respond to cases of violence against women, especially in the 23 DACAW/CFLG districts supported by UNICEF. There does not seem to be an estimate of how many social mobilizers (SMs) there are in Nepal. No volunteer community workers exist in the agriculture sector, although there are "lead farmers."

The FCHVs are not strictly "community based," as they report to the nearest Health Post where the Auxiliary Nurse Midwife (ANM) is charged with their supervision. There are estimated to be around 16,500 ANMs in Nepal, and the MoHP employs some 7,400. The ANMs are supposed to work at the Health Post level. If they each supervised FCHVs, the ratio would be about seven FCHVs per ANM. Across Nepal, there are only about 700 Health Posts and 3,200 Sub-Health Posts, or about 4,000 health posts of different sorts. There are about 13 FCHVs per health post, if they all have links to FCHVs. The Ministry of Health and Population created the FCHV program in 1988 to improve community participation and enhance the outreach of health services by local women working voluntarily. The FCHV survey[25] carried out in 2006 estimated some 47,000 FCHVs working in rural Nepal. The ratio of FCHVs to the population in the Terai was 706 in ward-based and 454 in population-based districts, while in the Mountains it was 334 in ward-based and 156 in population-based districts. Assuming an average family size of around six, the average FCHV to family ratio is probably around 26 families in population-based Mountain districts to 118 families in the ward-based Terai districts. In Parsa and Achham, there were nine FCHVs for each

[25] USAID/New Era/ Government of Nepal. 2008. An analytical report on female community health volunteers of selected districts of Nepal. Kathmandu: USAID.

ANM and/or Health Post. Very few of those interviewed in the two districts had any idea what the ratio of population to FCHV was supposed to be. This is not difficult to understand, since the central health sector deals with the FCHV program.

While agricultural sector services diminished severely in the nineties, mainly due to structural adjustment policies, the government is devoting great effort to reconstructing the extension network.[26] Each Agriculture Support Centre aids around 9,000 households; nevertheless,the extension system is estimated to reach less than 15 percent of farm households. While nationally there are some 5,000 Junior Technicians/ Junior Technician Assistants (JT/As), normally just one covers at least two VDCs. The numbers of Farmers Groups working with each JT/A is likely to be quite limited. In Parsa, there are just four Agriculture Support Centers, in Achham there are six.

Early Child Development (ECD) in Nepal has made remarkable advances in the last decades. The primary focus in scaling up ECD activities has been on center-based ECD.[27] ECD facilitators are the teachers/caregivers staffing ECD centers, which are essentially preschool classrooms. Community-based centers are often based near a public school, but they may also be stand-alone facilities in communities that do not have a primary school. The number of public ECD facilities has risen from 5,023 in 2004 to 24,773 in 2009,of which 12,883 are community-based ECD centers, and 11,890 are school-based ECD centers. Each ECD center is staffed by one or two ECD facilitators. Nepal has some 50,000 facilitators, usually young women providing care and instruction for as many as 25 children per center. The number of community-based ECD centers is almost the same in Parsa (103) and Achham (96), while the number of school-based ECD centers is almost double in Parsa (178) compared to Achham (116).

Water Sanitation and Hygiene activities promoted by the MoUD are carried out largely by the DDC and VDC officials of the MoFALD, through the district and village levels water, sanitation and hygiene (WASH) coordinating committees. The main program, "Community Led Total Behavioral Change in Hygiene and Sanitation" is carried out in villages and wards using a very participatory methodology.[28] In theory,local NGOs could hire social mobilizers to facilitate the district and village WASH committees' behavior change communication work. The "Open Defecation Free" (ODF) movement seems to have been a very successful one. Who the facilitators are and how many of them are involved in making villages ODF is less clear, however. The study team was informed that all VDCs in Achham had been certified ODF, whereas none had in Parsa.

26 Adhikari J. 2011.Nepal MSNP Framework for the reduction of chronic malnutrition: Agricultural Sector Interventions. Kathmandu: Helen Keller International.

27 UNICEF 2011. Evaluation of UNICEF's Early Childhood Development Program with Focus on the Government of Netherlands Funding (2008-2010): Nepal Country Case Study Report. New York: UNICEF Evaluation Division.

28 MoUD 2011. Lead TBC Facilitator's Training Manual: Community Led Total Behavioural Change in Hygiene and Sanitation: Kathmandu: MoUD.

5 Discussion

The results of the desk analysis and the field interviews are discussed together to highlight the system and organizational level factors that are influencing the various domains of community and local government nutrition capacity. Many of the findings somewhat overlap since the domains are often interconnected. The discussion is organized according to the assessment framework logic based on the eight "nutrition in development" capacity domains.

Before discussing the strength of the various capacity domains, it is important to consider some of the characteristics of the two districts, since these may help explain some of the differences observed between them. The size of the two districts is similar at 1,353 and 1,692 square kilometers for Parsa and Achham, respectively. However, the population of Parsa, with some 601,000, is more than double that of Achham,with just 257,000 in 2011. The sorts of sectoral programs being implemented in the two districts do not differ, and the MSNP interventions have not yet been initiated. The study team found no evidence of specific support provided for nutrition by any development partners in either of the districts. Parsa district is in the Terai region where most of the senior officers are available because of easy accessibility to Kathmandu. Achham is a remote district in the hilly area of the Midwest region. The retention rate of senior officers is very low, which could be the reason why more district level officials were available for interview in Parsa than in Achham.

5.1. Perception of the nutrition situation

The perception of the nutrition situation is a very narrow for the majority of the actors interviewed. This finding was no surprise considering that no real nutrition training center exists in Nepal. Nutrition is a relatively new science, and it is common for nutrition concepts such as stunting, wasting, and growth faltering to be poorly understood, even among those involved in national development planning.[29] Indeed,a narrow perception of nutrition is found in many other countries, even those that have excellent nutrition training centers,such as Brazil, for example. Perhaps most striking,however,is the common lack of perception of any nutrition problem,even after prompting, and especially among the community groups of these selected districts.

29 Shrimpton R. 2007. Chapter 15. A food and nutrition policy framework to help realize the human right to adequate food- lessons from four country case studies, 387-422. In: Food and Human Rights in Development. Volume II: Evolving issues and emerging applications Barthe Eide W, and Kracht U (Eds). Intersentia: Oxford.

Even at the sectoral level, inadequate fetal and child growth is unacknowledged, and severe child undernutrition is commonly unrecognized, even in health facilities.[30] Child growth monitoring seems minimally practiced even by the FCHVs, except in a few restricted project districts depending on donor support. The Child Health Card, given to all children by the health system, has a growth chart incorporated in it. Each time a child is in contact with the health system, the child is supposed to be weighed and the weight recorded. In 2010, district-level surveys in Divyapuri in the Terai found that just 40 percent of mothers could produce the child health card,[31] as opposed to 52 percent reported for Kanchanpur in 2007, after seven years of project implementation in that district. [32]

To change the narrow perception of the MCU problem among the sectoral actors and communities involved in the selected districts will require a concerted effort with specifically developed training and communication strategies. Perception changing strategies will need to engage local government officials and ensure that local politicians are fully aware of the importance of nutrition strategies to decrease childhood malnutrition and are committed to supporting their implementation.

5.2. Development Pathway

The development pathway domain for nutrition is very unsurprisingly narrow in the selected districts, especially considering that nutrition is unrecognized as a problem. The activities carried out and/or promoted by the FCHVs[33] focus more on health than on nutrition and tend to be more curative than preventive, including: family planning, maternal and new-born care, community-based pneumonia treatment,diarrhea treatments,Vitamin A campaigns, immunization,and community-based treatment of malnutrition with ready to use therapeutic foods. In recent years, the FCHVs assumed the task of weekly home delivery of iron folic acid tablets to encourage mothers to take the supplements during pregnancy with dramatic impact on consumption of tablets as well as improvements in maternal anemia rates. [34]

Having a narrow development pathway is not necessarily negative,as long as some nutrition interventions are being carried out, even in a very top-down fashion. Indeed"top-down" and "bottom-up" approaches, also called "goal-based" and "rights-based" approaches to achieving socioeconomic development, should and must be seen as a continuum. Both approaches should be pursued, and over the medium- to long-term,they can become mutually supportive.[35] A

[30] Riggs-Perla J, Adhikari M, Adhikari RK, Armbruster D, Paudel D, Prasia D, Pokhrel S. 2011. Nepal Family Health Program (NFHP) II Evaluation. Kathmandu: USAID.

[31] Pahari DP, Bastola SP, Paudel R. 2011. Factors affecting retention of child health cards in a rural area. J Nepal Health Res Conc. 19: 154-58.

[32] CARE Nepal 2007. Child Survival Project: Kanchanpur knowledge practice and coverage survey. Kathmandu: CARE Nepal.

[33] USAID/New Era/ Government of Nepal. 2007. An analytical report on national survey of female community health volunteers of Nepal. Kathmandu: USAID.

[34] Pokharel RK, Maharjan MR, Mathema P, Harvey PWJ. 2011. Success in delivering interventions to reduce maternal anemia in Nepal. Washington: A2Z: The USAID Micronutrient and Child Blindness Project.

[35] Shrimpton, R, 2002. "Nutrition in Communities." In: Nutrition: A Foundation for Development. Geneva: ACC/SCN.

diagonal approach that links goal achievement as stepping-stones to the realization of human rights can be engineered with the right sort of facilitation and mobilization. Community capacity can be built gradually to move from the traditional welfare type passive recipient participation towards active management of community resources to achieve better nutrition outcomes for the whole community. [36] [37] Such community-based efforts to strengthen capacity to improve nutrition must recognize the need to involve "beneficiaries" in the processes to improve nutrition and so progressively to realize their rights.[38]

To broaden the development pathway domain, capacity needs to be created to assess the local nutrition situation. Actions chosen at the national level as part of a package of interventions to be accelerated through the MSNP may not be the only ones that are important to address at the local level. Additional interventions may need to be developed to counter local factors. For example,women's smoking recently has been identified as having an important association with stunting in Nepal.[39] Nearly 20 percent of Nepalese women smoke. Household smoke is also very common in rural Nepal. Over half of households use wood fires to cook and warm their chimneyless houses, contributing to many health problems, including most likely low birth weight.[40] [41] These are just two factors that are not addressed in any of the various MSNP sectoral packages that could and should be considered from the local perspective so that interventions are included to mitigate the situation.

Another important consideration is maternal literacy, which seems to have a big influence on stunting reduction in Nepal. No gender gap in adult literacy exists in Nepal, with 60 percent of men and women being literate. Of more concern is the low level of adult education. However,with decentralization and the districts assuming responsibility for delivering education services, there has been a big increase in primary school completion rates, which are now 83 percent for girls and 95 percent for boys. What is most reassuring is that especially improvements in women's education in Nepal seem to be one of the biggest drivers of reduced stunting in the last decade. [42]

Another important component of the development pathway domain is targeting the most "at-risk groups," not only to ensure equity but also to prioritize use of scarce government resources.

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36 Shrimpton, R, 1995. "Community Participation in Food and Nutrition Programs: An Analysis of Governmental Experiences." In: Child Growth and Nutrition in Developing Countries, 243 261. Pinstrup Andersen, P, Pelletier, D, Alderman, H. Cornell University Press. Ithaca.

37 Gillespie S 2001. Strengthening capacity to improve nutrition. FCND discussion paper no 106. Washington: IFPRI.

38 Ismail S, Immink M, Mazar I, Nantel G. 2003. Community-based food and nutrition programmes: What makes them successful? A review and analysis of experience. Rome: FAO.

39 Crum J, Mason J and Hutchinson P 2012 Analysis of trends in nutrition of children and women in Nepal. Final Report. Kathmandu; UNICEF.

40 Dhimal M, Dhakal P, Shrestha N, Baral K, Maskey M. 2010. Environmental Burden of Acute Respiratory Infection and Pneumonia due to Indoor Smoke in Dhading J Nepal Health Res Council 8(16):1-4.

41 Pope DP, Mishra V, Thompson L, Siddiqui AR, Rehfuess EA, Weber M, Bruce NG. 2010. Risk of low birth weight and stillbirth associated with indoor air pollution from solid fuel use in developing countries. Epidemiol Rev. 32(1):70-81.

42 Crum J, Mason J and Hutchinson P. 2012. Analysis of trends in nutrition of children and women in Nepal. Final Report. Kathmandu; UNICEF.

The most vulnerable groups are not just defined by ethnicity, but also by biological risks, with mothers and young children being the most vulnerable. A recent assessment of gender equality and social exclusion in Nepal concluded that while many advances have been made in terms of access to education, for example, many rights violations still prevail, including child marriage and domestic violence, amongst others.[43] Furthermore, women are still poorly represented in the VDCs and DDCs, where the difference between welfare (or needs-based) and rights-based approaches to development are still not widely understood.

Most importantly,the district and village level nutrition and food security committees participating in the MSNP can and must take responsibility for mapping, assessing, discussing, and responding to the prevailing gaps and challenges to food security and nutrition in areas under their jurisdiction.[44] To make this vision a reality, these committees must be the focus of the MNSP local government and community capacity-building efforts.

5.3. Resource Mobilization;

Much remains to be done to strengthen local government development actions in Nepal, especially with regard to managing and mobilizing resources. Even though the responsibility for program planning responsibility was devolved six years ago to the district level, the planning process in the District Agriculture Development Office (DADO), the District Livestock Services Office (DLSO), the District Education Office (DEO), and the District Public Health Office (DPHO) are still based on the ceilings and guidelines received from their respective central departments.[45] In reality, the only thing that has changed since the LGSA is that funds for district level sectoral activities in Education, Agriculture and Health are transferred through the DDC. [46]

Nepal has had some remarkably positive experiences with decentralization in the last decade, especially considering the political uncertainty that has existed. Empirical findings suggest that fiscal decentralization had a significant positive impact on GDP per capita over the period 1995-2009.[47] In the health sector both service users and providers convey a generally positive message about health sector decentralization,[48] and while the health sector itself has had

43 Kelles-Vitainen A, Shrestha A. 2011. Gender equality and social inclusion: promoting the rights of women and the excluded for sustained peace and inclusive development. Kathmandu: UN Resident and Humanitarian Coordinators Office.

44 Helen Keller International, Nepal. 2012. Multi-sectoral governance for food security and nutrition in Nepal. HKI Nutrition Bulletin Issue 5. Kathmandu: Helen Keller International, Nepal.

45 Dhungel ND, Sapkota MR, Haug M, Regmi PP. 2011.Decentralization in Nepal: Laws and Practices. Oslo: Norwegian Institute for Urban and Regional Research.

46 Paudel NR 2006. Critical Assessment of Local Governance System in light of public service delivery at local levelin Nepal. Paper delivered at the Annual Conference of the Network of Asia-Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG) held in Sydney.

47 Khim Lal Devkota KL. 2010. Impact of fiscal decentralization on economic growth of Nepal. Available at URL: http://www.lgcdp.gov.np/home/report/unofficial_reports/Impact%20of%20fiscal%20decentralization%20to%20the%20economic%20growth.pdf (Accessed 05/06/12).

48 Regmi K, Naidoo J, Pilington PA, Greer A. 2009. Decentralization and district health services in Nepal: understanding the views of service users and service providers. J Public Health. 12(3): 406-417

difficulty devolving power to local levels,[49] evidence suggests that increasing efforts from both MoFALD and MoHP, especially in capacity building, are likely to bring positive results.[50]

One potential problem is that user fees have been largely abolished. With the commitment to universal access to health services in the 2007 Constitution, financial barriers to care were removed with two free care policies: one focused on providing curative care at the district level and below and the other on providing free deliveries nationwide (the 'Aama' policy).[51] Despite the commitment to universal access, central funds transferred to districts to fund health facilities are"barely adequate,"yet utilization rates are rising. Dwindling general revenues and staff shortages continue to be a concern at the district level. In order for DDC and VDC to finance improvements, and/or maintain their health facilities, they are dependent on other resources,which must be raised through central or local taxes. Because local taxation is minimal, central-level financing remains the primary source of revenue to fund programs.

The lack of true devolution is also due to the still quite limited capacity in local government offices. However, in addition to staffing problems, many consider the main reason for the poor functioning of the DDCs and VDCs is the dominance of the All Party Mechanisms (APM) and the absence of elected representatives.[52] Many central government block grants provided to DDC and VDC—even those earmarked for children—are diverted most commonly to infrastructure projects. Whilst decentralization holds great promise for improving public service delivery, its realization depends on the design and institutional arrangements governing its implementation. A key feature of successful decentralization is political accountability at local government level.[53] How to address these issues in Nepal will require some consideration.

Although a series of financial incentives for FCHVs have been introduced over the years, implementing them has proven difficult. An FCHV endowment fund was introduced in 48 districts in 2001 to generate local financial support for the volunteers and to ensure that some local funds were available for FCHV support activities. However, a qualitative study conducted in six districts in 2006 found that the endowment fund was not working as expected, as interest generated was too little to be useful, and FCHVs had no access to the principal. Thus in 2008, the MOHP approved a new "FCHV Fund Operational Guideline," providing access to micro-credit funds specifically set aside for FCHVs. Under this model, the government gave each VDC NRs

[49] Dhakal R, Ratanawijitrasin S, Srithamrongsawat S. 2009. Addressing the challenges to health sector decentralization in Nepal: an inquiry into policy and implementation process. Nepal Med Coll J. 11(3):152-157.

[50] USAID 2007. Review of activities undertaken by NFHP and its partners to strengthen partnerships between community and health facilities. Kathmandu: USAID.

[51] Witter S, Khadaka S, Nath H, Tiwari S. 2011. The national free delivery policy in Nepal: early evidence of its effects on health facilities. Health Policy and Planning. 26: ii84-ii91.

[52] Dhungel ND, Sapkota MR, Haug M, Regmi PP. 2011. Decentralization in Nepal: Laws and Practices. Oslo: Norwegian Institute for Urban and Regional Research.

[53] World Bank. 2001. Decentralization and governance: does decentralization improve service delivery? PREMS Notes No.55. Development Economics Vice-presidency and the poverty reduction and economic management network. World Bank, Washington.

50,000, and mandated that any remaining funds from each VDC's Endowment Fund be turned over to the FCHV Fund. From this new FCHV Fund (administered by FCHVs), FCHVs can borrow money for income-generating activities. As of 2012, the MOHP had increased the Fund amount to a total of NRs 80,000 (about US$950) per VDC and provided NRs 100,000(about US$1,180)to each district for the FCHV Fund. The 2008 FCHV survey in selected districts[54] found that only a third or so of FCHVs had received any one of the three types of financial support: money from the endowment fund, cash allowances for attending meetings, or in-kind incentives. Effective use of the FCHV Fund and proper bookkeeping by FCHVs is a challenge for two mains reasons: 1) although money for the FCHV fund has already been allocated to all 75 districts, the FCHVs are still unclear about its proper utilization. Conducting orientation workshops about its effective use in all 75 districts will require ample time and resources. 2) The need for periodic support and supervision on effective bookkeeping is resource and time-intensive. It would seem appropriate in the selected districts to consider how to strengthen linkages between FCHVs and local government by providing support for these sorts of activities, helping local district associations of FCHV to manage these funds better.

In the MSNP, the MoFALD is committed to directing social protection measures towards stunting reduction. In collaboration with the Ministry of Women, Child and Social Welfare (MWCSW) and the Women Development Office, MoFALD is responsible for local delivery of the social security funds, including and especially the cash transfers for disadvantage Dalit families in the Karnali district. It is important to examine whether these funds are being transferred adequately and how to strengthen MoFALD to carry out these activities in a decentralized fashion for the Ministry of Social Security in the other selected districts. A few social security funds are delivered by the MWCSW, while local bodies deliver all cash grants at the district level.

The nutrition and food security steering committee needs to develop annual district food and nutrition security plans, and develop budgets for these. District plans should draw on, include, and provide support to the village level food and nutrition security plans, which should have taken into consideration the results of community-based assessments of their food and nutrition security problems.

5.4. Management/organization

A multitude of community-level actors operates at the ward level and below in Nepal, with links to the various sectoral line ministers. No single analysis has examined the community-level actors,or how they inter-relate. Many of these actors may be the same people doing a multitude of different actions, very often on a voluntary basis. Organizing the relationship and interaction of the various sectoral workers and the community mobilizers and village facilitators need to be constructed to support the delivery of local government-led community-based efforts to

[54] USAID/New Era/ Government of Nepal. 2008. An analytical report on female community health volunteers of selected districts of Nepal. Kathmandu: USAID.

accelerate stunting reduction as part of the MNSP development in selected districts. This requires creating and facilitating district, municipal, and village coordination structures, as stated in the MSNP, including the willingness of the sectoral ministries and their line agencies, and district and village CBOs to work with the local bodies in the design and implementation of the multisectoral nutrition approach in an integrated way.

To broaden the management/organization domain in the selected districts, chains of command need to be shortened and linked to orient the centrally determined activities increasingly to accommodate local needs. The 2008 FCHV survey[55] found that almost 90 percent of FCHVs meet regularly with their supervisor, 80 percent report regularly to their health facility, and 70 percent attend monthly meetings at their health facility,all of which is very positive. However, the FCHVs' orientation is still more curative than preventive and the preventive nutrition actions, such as growth promotion, could be strengthened. There is great concern about "overloading" the FCHVs, but they have reported that their average working hours are about five hours a week and 75 percent would like to spend more time working as FCHVs. Furthermore, 75 percent feel it is a prestigious job, which is valuable to their community. The Decentralized Action for Children and Women (DACAW) could offer an important starting point in this regard. Women's health groups in Nepal have successfully used the Community Action Process (CAP) to promote and develop in DACAW districts has been used successfully by to agree among themselves on how to improve birth outcomes.[56] It would seem appropriate to revisit the DACAW experiences with CAP to improve infant and young child feeding practices, as well as to prevent and treat diarrhea as part of a community-based package for stunting reduction. Some 85 percent of FCHVs report having support from mothers groups, and 68 percent that they help them with their work, albeit most likely this support is for their more curative interventions.

While Nepal will not be promoting community-based child growth monitoring, the health system needs to improve its growth monitoring and to measure the progression of stunting rates in the community. Growth monitoring coverage in Nepal remains low largely due to the unavailability of appropriate measurement tools, the inability to integrate growth monitoring with other related interventions such as maternal, infant, and young child feeding (MIYCF), community-based integrated management of childhood illness (CB-IMCI), and nutrition counseling, as well as poor technical capacity, incomplete reporting, and lack of supportive supervision for health workers.[57] It may be possible to link young child length and weight measurement to the six monthly child health day event when the whole health system and community outreach is mobilized for Vitamin A capsules and deworming. Including anthropometric measures, beyond the MUAC tape, for all children under two years of age would allow biannual tracking of stunting

[55] USAID/New Era/ Government of Nepal. 2008. An analytical report on female community health volunteers of selected districts of Nepal. Kathmandu: USAID.

[56] Morrison J, Tamnag S, Mesko N, Osrin D, Shrestha B, Manandhar M, Manadhar D, Standing H, Costello A. 2005. Women´s health groups to improve perinatal care in rural Nepal. BMC Pregnancy and Childbirth 5:6, 1-12.

[57] WHO. 2009. Regional Workshop on National Nutrition Surveillance. Kathmandu: WHO Regional Office for South East Asia Region.

reduction at the VDC/DDC level. The potential for CACs and WFC and their social mobilizers to use all of this information and mobilize more action is obviously something to explore.

Several new projects already being implemented or in the pipeline offer excellent opportunities for learning how to link existing FCHV work with the CAC and WFC processes and their social mobilizers from local government. The USAID funded "Suaahara" project is being developed through the MoHP in all VDCs for 20 districts. Suaahara is attempting to extend outreach into the community to improve very specific MIYCF behaviors through the health posts including to increase the production and consumption of micronutrient rich foods(plants and animals) through the Agricultural Service Centres and extension services; to improve handwashing, water supply and home hygiene through the WASH sector; and to delay first births and increase birth spacing and improve the community perception of the nutrition problem through social behavior change communication (SBC).Other sectors are involved in Suaahara only in a top-down way at the district level;they could well consider how to use the CACs and WFC to help in these processes.

The World Bank supported "Sunaula Hazar Din" Community Action for Nutrition Project[58] will be implemented though MoFALDin 15 districts. This"Golden First Thousand Days" project will use the CACs and the WCFs to mobilize communities to achieve very specific MIYC targets related to five periods from conception to two years of age, all within a 100- day period. This project is more bottom-up than Suaahara, but still quite top down, as the menu of interventions is largely fixed,although the community is left to decide how to achieve changes in behaviors and practices.

Two more projects in the pipeline will be implemented through the MoAD. One is the World Bank supported National Agriculture and Food Security Project (NAFSP), which will be implemented in 19 Hill and Mountain Districts, and will increase food availability through increased productivity. Nutrition will be improved though increased dietary intake made possible by promoting diversified crops, and improved feeding and caring practices for pregnant and nursing women and their children up to two years of age. The second project is USAID's Feed the Future project, which will be implemented in different districts. It aims to increase agricultural productivity and increase incomes, thereby improving the population's nutrition, increasing trade, and expanding export markets.

5.5. Human workforce nutrition capacity

The majority of the actors interviewed consider the human workforce capacity narrow. To broaden this domain for local government and community capacity building, a training plan should be constructed for the various actors to include more formal training or orientation courses, as well

[58] World Bank. 2012. Sunaula Hazar Din – Community Action for Nutrition Project Appraisal document. Kathmandu: World Bank.

as in-service training through supportive supervision. A short training orientation course needs to be provided for the main actors in the food and nutrition security committees. This training should have a broad orientation, identifying the immediate, underlying, and basic causes of malnutrition,in all of its forms, across the life course. Such training should be human rights based, communicating the concepts of duty bearers and rights holders, and the government obligation to "respect," "protect," and "fulfill" such rights, and fulfill is divided between "facilitate" and "provide." [59] The CRC, CEDAW and the Right to Food[60] all offer important elements for ensuring that fetal and young child growth is protected during the first 1,000 days of life.

Nutrition capacity in the local government supporting mechanisms for MSNP needs to be strengthened. A nutrition professional is needed to act as "focal point" in the DDC to have oversight and be supportive of the multiple nutrition-related activities necessary in the selected district. The training of the DDC nutrition focal point should be oriented to "public nutrition" rather than "public health nutrition."[61] The nutrition focal point's job is to bring the various sectoral efforts together with the bottom-up community aspirations as expressed through participatory planning,and to improve nutrition in the selected district. This district public nutrition focal point will also provide all the back up and support the district nutrition and food security committee will need to be able to function efficiently. The job training for the nutrition focal point ideally would be a Master's of Science in public nutrition from a central institution. Because this will be impossible to achieve in the short term, distance-learning courses need to be constructed so that staff can learn on the job, including periodic short-course training held perhaps at the national level.

The individual sectoral workers,especially those in health, agriculture, and education,will need special orientation on nutrition and the goals of the MSNP, including life course consequences of MCU, the essential package of nutrition interventions, especially for Maternal Infant and Young Child Feeding(MIYCF), as well as for micronutrient deficiencies, and the double burden of malnutrition. This orientation training should be presented collaboratively to the central level of the various sectors but restricted to selected districts. Much of these nutrition aspects are covered in the Suaahara training materials.

5.6. Information systems

The current information systems seem to heavily favor central level decision making and are barely used for local decision making. The current information system for LGCDP is the Poverty Monitoring and Analysis System(PMAS), which was introduced by NPC in 2004, following the formulation of the Poverty Reduction Strategy Paper (PRSP), which coincided with Nepal's tenth

[59] Eide A. 2007. Chapter 6. State Obligations Revisited. 137-158. In: Food and Human Rights in Development. Volume II: Evolving issues and emerging applications Barthe Eide W, and Kracht U (Eds). Intersentia: Oxford.

[60] FAO. 2012. Mainstreaming Right to Food: Fact sheet 1. The Global Strategic Framework for Food Security and Nutrition: A Right to Food Perspective. Rome: FAO.

[61] Mason JB, Habicht JP, Greaves JP, Jonsson U, Kevany J, Martorell R, Rogers B. Public nutrition. Am J Clin Nutr. 1996. 63:399–400.

five-year development plan (2002-2007).[62] The primary objective of PMAS is to coordinate, consolidate, harmonize and analyze data from existing poverty monitoring systems and to communicate results to feedback into the policy process. It seeks to accomplish these objectives through five key functions: Implementation (or input/output) monitoring; Outcome or well-being monitoring; Impact assessment; Poverty management information system; and, Communication/Advocacy. A district PMAS was also designed to facilitate decision making by the DCCs. For example, the block grants for local government in LGCDP are currently prioritized for the neediest VDCs, as judged by a series of indicators, including the percent of households without food for more than three months of the year. A recent analysis of the PMAS information systems concluded that while they may serve the information needs to administer the various programs,they are insufficient to meet the monitoring and evaluation needs of the MNSP or early warning systems.[63] The water and sanitation data, the education data, parts of the agriculture/ food security data, and parts of the health primary data were considered unreliable.

An analysis of local capacity development investment to achieve the MDG targets[64] found that most training activities targeted at local capacity development in Nepal tend to be supply driven rather than demand driven. This is primarily because local government bodies have insufficient resources (human and financial) to run programs on their own, i.e., without support from government and donors, and so tend to take what they can get. However,external support rarely goes beyond transferring knowledge, making little attempt to strengthen systems. Local capacity development should be an integral part of development projects, with strengthening databases for planning, implementation, and monitoring given special consideration. This could involve equipment, for example, as few VDCs have any computers, but should also contemplate training staff members to keep databases updated.

The local government and/or community actors in the two districts have limited knowledge about nutrition indicators and the use of nutrition information for decision making. It would seem appropriate to construct a list of key input, outcome, and impact indicators for the MSNP, and consider how to ensure they are collected, with what periodicity, and at what level of aggregation. This exercise may already have started with work that UNICEF has recently initiated in selected districts, which aims to identify the bottlenecks in the MSNP implementation. [65]

There also seems to be a need to make such nutrition indicator information public. Once key output and impact indicators for stunting reduction in MSNP are agreed upon, a register should be

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62 Pandey PR, Khanal RP, Shrestha RK, Paudyal IP, Sharma HP, Shakya PL, Pandey RR, Awasthi LD, Pokharel KR 2007. Country position paper on managing development results – Nepal. Paper delivered at the RETA 6303 Regional forum on mainstreaming managing for development results. Kathmandu: NPC

63 Vance G. 2012. Review of Information Systems in Nepal: The Multi-Sectoral Nutrition Plan and Early Warning Detection. Kathmandu: UNICEF/ NPC.

64 Poudyal LP. 2008. Local Capacity Development Investments for MDG Localization in Nepal. Kathmandu: UNDP.

65 UNICEF. 2011. Sharpening the focus: Selected innovations and lessons learned from UNICEF-assisted programs 2009-2010. Policy and Practice, December 2011. New York: UNICEF.

constructed to put them on public display in VDC and DDC offices. Such practices were common in Indonesia, for example, where the efforts of the "Posyandu" community-based growth-monitoring program were displayed and updated monthly. The data shows how many children under five existed in the village, how many had a growth chart, how many came to be weighed in the previous month, how many had grown, and how many had lost weight.[66] In Thailand, the district level basic services project that achieved rapid reduction of child malnutrition rates also publicly displayed indicators, including number of babies born, number of assisted deliveries, number of babies weighed at birth, and number of low birth weight babies.[67] Some consideration should be given to trying to portray these indicators in a human rights perspective, indicating not how many subjects had their rights met, i.e.,are growing properly or are not anemic, but how many had their rights violated,i.e., did not grow and/or were anemic. In this respect, it was interesting that not one of those interviewed remembered having had their blood hemoglobin measured, and/or knew their blood hemoglobin level.

5.7. Communications

There is some evidence that communication efforts are already being devoted to improving maternal and child health and somewhat to nutrition issues. These efforts largely are confined to posters and radio messages related either to health issues or to eating properly. Indeed, the FCHV have a distance-radio education program, although only 22 percent of FCHVs listen regularly. Such education would still have relatively little nutrition education and be narrowly focused on severe malnutrition and/or curative interventions. Whether FCHV distance education could be selectively broadened for the selected districts is something that might be considered.

There is a need to see how to integrate broader nutrition concerns and especially those related to stunting reduction, as appropriate into the existing LGCDP - IEC activities, which are ongoing in selected districts. These are related to the LGCDP Output 2 for increased capacity of citizens, communities, and marginalized groups to assert their rights and hold local government accountable. To date, this seems to have largely involved providing journalists from the selected districts with training and orientation. An orientation for journalists on stunting reduction should be considered. Some consideration also should be given to developing public awareness information for dissemination through television, especially for the Terai districts where most houses seem to have a TV. Citizens' awareness forums also offer an opportunity for widening the common perception on nutrition, especially with regard to rights violations, be they CRC, CEDAW, or Right to Food related. The preparation of appropriate media for these forums also should be considered. In more remote areas, where there is little or no TV, such as in Achham, the role of folk media and participatory communication in rural development should be explored. Case

[66] Gillespie S, Mason J and Martorell R. 1996. How Nutrition Improves – Nutrition policy discussion paper No. 15. ACC/SCN STATE–OF–THE–ART SERIES. Geneva: ACC/SCN.

[67] Kachondham, Y., Tontisirin, K. and Winichagoon, P. 1992. Nutrition and Health in Thailand: Trends and Actions, ACC/SCN Country Review. Geneva: ACC/SCN.

studies from India[68] have shown some success in combatting child marriage, which concurrently violates CRC and CEDAW.

5.8. Infrastructure/ equipment

The district and village council equipment and infrastructure need improving if community-based nutrition programs are to be managed locally. Of those interviewed, only schoolteachers seemed to have computers. An analysis of local capacity development investment for the achievement of MDG targets[69] found that most training activities targeted at local capacity development in Nepal are supply driven. This is primarily because local government bodies do not have sufficient human and financial resources to run programs on their own, i.e., without government and donor support. Nonetheless,external support rarely goes beyond transferring knowledge, making little attempt to strengthen systems. Local capacity development should be an integral part of development projects, with special consideration for strengthening databases for planning, implementation, and monitoring.

The potential for using mobile phones seems to be great. Most of those interviewed had mobile phones of their own. Mobile phones are being used to revolutionize the collection of data in many situations and could well be tried in the selected districts. The LGCDP has already provided support for the local bodies to ensure that they have GIS set up. To guide the expansion of the Decentralized Action for Women and Children (DACAW) efforts, UNICEF has helped to conduct a mapping of disadvantaged groups covering 300,000 households in 237 villages and eight municipalities. These efforts need to link mapping to coverage and targeting of community-based nutrition activities, as well as collecting vital statistics from community workers/social mobilizers, and village facilitators by ensuring that they have mobile phones to be able to be part of such a network.

68 Naskar R. 2011. The role of folk media and participatory communication in rural development: na exploratory case study of combatting child marriage in Malda. Global Media Journal – Indian Edition. 2(2): 1-9.

69 Poudyal LP. 2008. Local Capacity Development Investments for MDG Localization in Nepal. Kathmandu: UNDP.

6 Conclusions and Recommendations

Application and replication of the methodology. The successful completion of this innovative semi-quantitative survey was achieved due to a collaborative effort by a multicultural team of professionals. Collecting qualitative information is challenging,[70] especially when data is obtained via translation.[71] By using semi-structured interviews, i.e., by asking a series of specific questions without prompting the interviewee and by following the logic of the assessment framework, the interviewers were able confidently to assess the respondents' knowledge about nutrition research issues. To conduct this qualitative research, interviewers needed to be fluent in Nepali and English and conversant with the nutritional research issues. This methodology permitted the principal investigator to monitor and assist the interviewers as necessary by email and Skype thousands of miles away without influencing the interviews or intimidating the interviewees. The successful implementation of this methodology should encourage others to attempt it in future research projects.

Based on the system and organizational analysis, as well as field interviews carried out with those involved in implementing food and nutrition related activities in the Achham and Parsa Districts, the following series of conclusions and recommendations are made.

Field interviews revealed that virtually all the domains for developing community nutrition capacity require considerable strengthening.

- The three narrowest or most restricted of domains, with 85 to 92% of interviews recording a score of 2 or less, were those of the perception of the problem, the development pathway, and resource mobilization. A score of 1 was considered "nothing or very narrow" and score of 2 was considered "restricted/small."
- Communication was the widest domain with 53% scoring 3 or more (mean or fair) due principally to the presence of television in many households and to the majority seeing posters and pamphlets.
- The intermediate scoring domains included management/organization, workforce skills and training, information systems, and infrastructure/equipment. All had between 69% and 78% of those interviewed, getting a score of 2 or less.

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[70] Dew K. 2007. A health researcher's guide to qualitative methodologies. Aust N Z J Public Health. 31:433-7.

[71] Yu DS, Lee DT, Woo J. 2004. Issues and challenges of instrument translation. West J Nurs Res. 26(3):307-20.

The national nutrition system is very committed, but service delivery remains a challenge. Additional commitment will be required to resolve implementation issues.

- GoN commitment to improving the nutrition situation of its people is strong, with all of the important socioeconomic and cultural rights instruments ratified, including CRC, CEDAW, and Right to Food. Furthermore, these rights have been incorporated into the 2011 draft Constitution and various laws.
- Nepal has achieved remarkable progress in its MDG goals, with the prospects of achieving all targets except some MDG 1 poverty targets and MDG7 environment goals. The nutrition MDG1 sub-target, for which Nepal is on track, is the reduction of young child underweight from 60 percent in 1990 to 30 percent in 2015. Despite being on track for achieving the nutrition MDG1 sub-target, Nepal's child stunting rate remained high at 41 percent in 2011.
- The LSGA of 1999 provides the basis for decentralization of governance and community development, including the delivery of basic services. Without elected local bodies since 2002,however,one of the major tasks of the GoN remains to substantiate the objectives, policies and principles of the LSGA, and to translate the principles of local self-governance into practice.
- Since 2008,MoFALD has implemented its Local Governance and Community Development Program (LGCDP), with the over arching goal of contributing towards poverty reduction through inclusive, responsive, and accountable local governance and participatory community-led development. The donor community supports the LGCDP through the Joint Programme, which has become the sector-wide approach for supporting decentralization, with some 16 donors participating.
- An analysis of the organizational aspects of the most distal workers of the various sectors operating at the district level reveals that considerable effort is required to work towards a more symmetrical approach with mutually supportive lines of command. The relationship between sectoral workers, community volunteers, and local government officials needs to be strengthened.

Based on a these results and conclusions, a series of recommendations are made below. The recommendations are organized in terms of short-, medium-, and long-term perspectives, with the short-term being the highest priority. It is important to realize, however, that the medium- and long-term recommendations require that measures begin to be implemented immediately. Because they will take longer to come to fruition, unless efforts are made to put long-term recommendations in place now, the sustainable and continued functioning of the capacity being created will be threatened.

Short-term recommendations:

1. A training course/orientation needs to be provided for the main actors involved in the nutrition and food security committees in the selected districts. The individual sectoral

workers especially in health, agriculture, and education will also need some special orientation in nutrition and the MSNP. Such training should be human rights based, communicating the concepts of duty bearers and rights holders, and the obligation of duty bearers to progressively "respect," "protect," and "fulfill" such rights, considering the double burden of malnutrition across the life course.

2. A list of key MSNP input, output, outcome, and impact indicators needs to be constructed to serve local government decision making and help identify bottlenecks that limit program impact. The current PMAS information systems seem to serve central functions more than the local government systems. Furthermore, the various information systems are not considered suitable for guiding local government decisions to accelerate stunting reduction through the MNSP.

3. The capacity of local governments to mobilize more resources and to manage them better for MSNP needs to be strengthened. To this end, the food and nutrition security committees needs to develop annual district food and nutrition security plans and budgets, which include, draw from, and provide support to the village-level food and nutrition security plans. Local problem assessment and solution development should be encouraged in these processes. In addition, an orientation/briefing should be provided to the local politicians from the All Party Mechanism (APM) to raise their awareness of the importance of MCU issues and improve the likelihood NFSSC budgets being approved.

4. The linkages between FCHV and local government-led action plans should be strengthened. The DACAW experiences with Community Action Processes (CAP), which is supported by UNICEF in selected districts, should be revisited and built upon as appropriate. Such efforts should explore linking existing FCHV work with the CAP processes in mothers groups, organized by social mobilizers from local government. The focus of all of these efforts is to improve maternal, infant, and youth nutrition, especially targeting the most disadvantaged village households.

Medium-term recommendations:

5. Nutrition capacity in the local government supporting mechanisms for MSNP needs to be strengthened. A nutrition professional is needed to act as a "focal point" in the DCC with oversight and to support the multiple nutrition-related activities in the selected districts, including supporting the district nutrition and food security committee.

6. Changing the very narrow perception of the nutrition situation held by the majority of the actors interviewed will require a concerted effort involving a series of specifically developed training, management, and communication strategies. All these activities should be developed under the umbrella of the JP in support of the LGCDP, and TV should be used to communicate especially with and involve the local Terai communities.

7. Equipment and infrastructure at the district and village council level will need strengthening if community-based nutrition programs are to be managed locally. This should include hardware (computers) as well as software (training) for local government workers, including a place to meet and work. In addition, mobile phone networking and linking of community mobilizers and facilitators must be constructed to update and to share village and district databases continually. Social media also should be used to connect volunteers and local government workers in supportive peer-to-peer networking.

8. District authorities need to be accountable for achieving specific time-bound MSNP outcome and impact targets by publishing quarterly reports on progress made towards achieving annual planning objectives.

Long-term recommendations:

9. Broader nutrition concerns, and especially those related to stunting reduction, need to be integrated appropriately into the existing IEC activities, which are ongoing in the LGCDP districts supported by the JP. Journalists should receive stunting reduction orientation, especially with regard to rights violations associated with stunting be they CRC, CEDAW or Right to Food. Citizens' awareness forums,such as CACs,also offer an important opportunity to widen the common nutrition perceptions, as well as to monitor indicators of rights violations.

10. Broadening the narrow development pathway of most of the actors involved will require a gradual shift from the traditional welfare-type, passive recipient/actor mode of treating nutrition problems to more active participation in the management of community resources for prevention, based on local problem assessments.

Annex 1

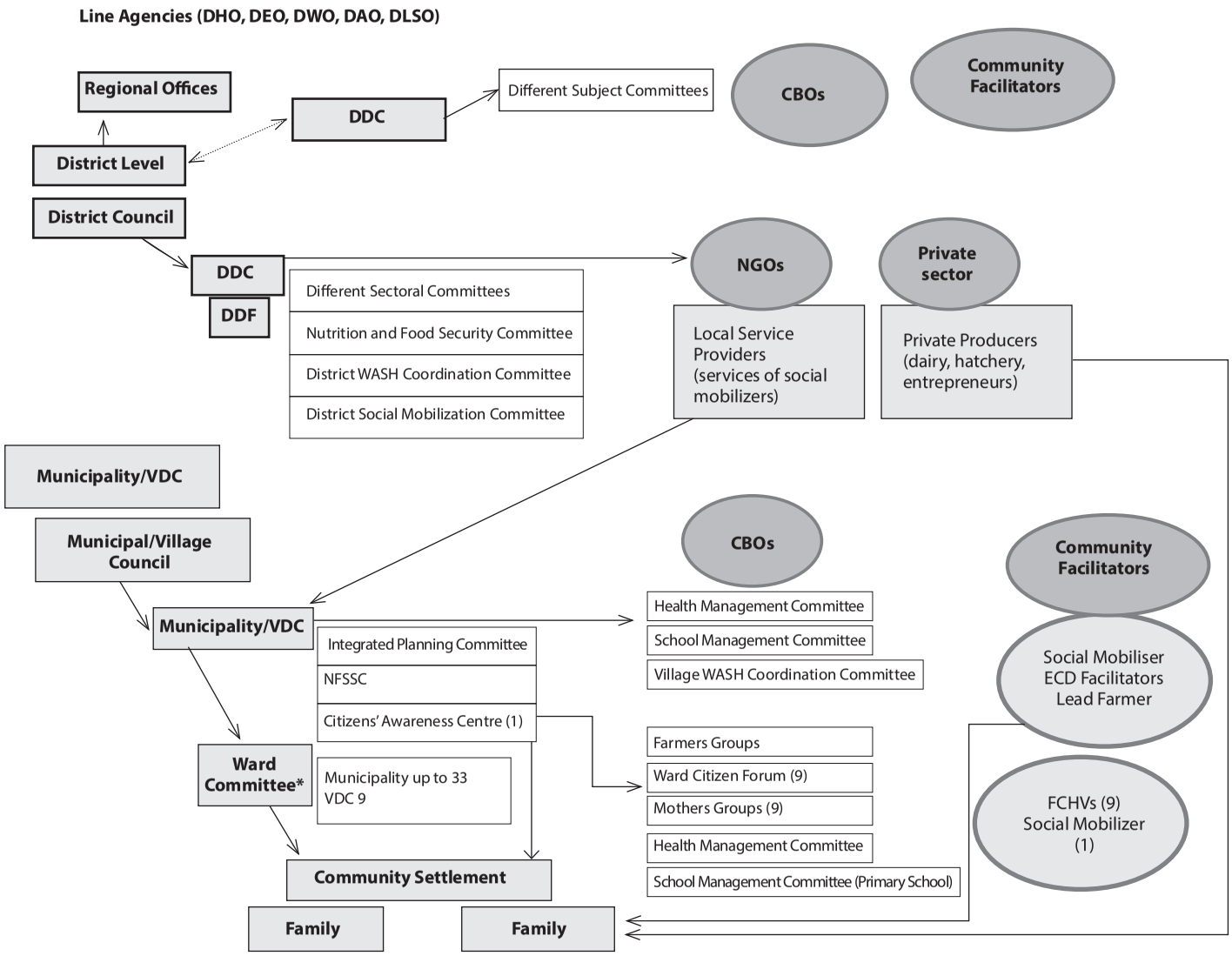
Table 1. Ranking with scores for community and local government nutrition capacity development domains

Domain	Ranks (score)				
	Nothing/ Narrow (1)	Restricted/ Small (2)	Mean/ Fair (3)	Open/ Good (4)	Wide/ Excellent (5)
1. Perception of Nutrition Situation	Has no perception of what malnutrition is (in any form) and does not mention it as a problem, even when prompted.	Does not give malnutrition as a problem until prompted, and then says it is underweight and/ or severe PEM. Not aware of other forms of malnutrition, and/ or thinks causality is predominantly food related.	Thinks malnutrition a problem without prompting, but not aware that various forms of malnutrition exist beyond PEM/underweight and/ or thinks causality is predominantly food related.	Thinks malnutrition is a problem without prompting and aware that various forms of malnutrition exist beyond PEM, such as stunting and micronutrient deficiencies (anemia), but not aware of the full spectrum of immediate underlying and basic causes.	Thinks malnutrition is a problem without prompting and aware of full spectrum of malnutrition (severe PEM, wasting, stunting, micronutrient deficiencies, and obesity) and is familiar with all of their immediate, underlying and basic causes, and even life course dimensions.
2. Development Pathway	No assessment, and no local analysis or action choice, with goals and activities largely imposed from outside, and more curative than preventive.	No assessment but discussions held with DDC/ VDC/local groups. However, goals and objectives still imposed from outside and actions more curative than preventive, and untargeted.	Local problem assessment by outsiders and discussed with DDC/ VDC whose interests are considered, but goals/objectives still imposed and activities have impact-oriented objectives but no targeting and more curative than preventive.	Community (DDC/VDC/ Ward) does assessment with some outside facilitation and outsider helps in analysis and action choice, but vision/ goals still imposed and activities mostly curative with impact-oriented objectives.	Community (DDC/ VDC/ Ward) does assessment/ analysis/ action choice with facilitation from the outside, and both internal and external goals and vision contemplated, and activities include both curative and preventive interventions. Impact oriented objectives, targeted at at-risk groups.
3. Resource Mobilization	Resources inadequate, with no resource/fees contributed by community. No externally provided supplies or resources. No local partnerships.	Resources inadequate, but no local fundraising, or fees paid. VDC has no control over centrally provided supplies and funds. No local partnerships.	Resources inadequate although central supplies and funds received, with some community fund raising. DDC/ VDC have no control of expenditures. No local partnerships.	Resources barely adequate with centrally provided funds and supplies plus some community contributions and DDC/VDC controlling allocation. No local NGO/ private sector involved in partnerships.	Resources adequate with DDC/ VDC receiving central funds and raising funds, and controls allocation of money. NGO/ private sector involved in local partnerships.

Domain	Ranks (score)				
	Nothing/ Narrow (1)	Restricted/ Small (2)	Mean/ Fair (3)	Open/ Good (4)	Wide/ Excellent (5)
4. Management/ Organization	No district committee and/or supervisor to discuss nutrition/ work plan or budget, no consultation with VDC/community to discuss needs, and no discussion of work plans or progress with anybody.	District committee/ supervisor exists but does not discuss nutrition plan or budget, nor hold any consultation with VDC/ community to discuss needs, and no discussion of work plans or progress.	District committee/ supervisor exists to discuss nutrition plan/ budget, but does not hold any consultation with VDC/community to discuss needs, and no discussion of work plans or progress.	District committee/ supervisor exists which discuss nutrition plan/ budget, and has consultation with VDC/ community to discuss needs but has no discussion of work plans or progress.	District committee/ supervisor discusses/ decides on nutrition budget, and consults with VDC/ community to discuss their needs. Work plans also fully discussed with VDC and community groups also consulted and progress reviewed.
5. Human workforce Training/ skills development	Human resources not adequate, with little or no training of local government and/ or supervisory staff, even in health sector, no training plan, no follow up supervision.	Human resources not adequate, with no training plan for community, and local government actors have not been trained in last two years, with no follow up supervision, but local health staff has nutrition training.	Human resources may be thought adequate, but no training plan for community and local government actors, and none who have been trained in last two years, with follow up supervision. Local health staff has nutrition training.	Human resources may be thought adequate or not, with no training plan for community and local government actors although some have been trained in last two years, but with no follow up supervision. Local health staff has nutrition training.	Human resources adequate, with a training plan for community and local government actors have been trained in last two years, with follow up supervision, and local health staff trained in nutrition.
6. Information systems	Community and local government actors unaware of indicators, do not use indicators, or send any information to anybody, nor had any feedback.	Community and local government actors aware of indicators, but do not use indicators, or send any information to anybody, nor had any feedback.	Community and local government actors aware of indicators, but do not use indicators locally, just send them elsewhere and without any feedback.	Community and local government actors aware of indicators, and use indicators locally as well as sending information to others, but never had any feedback.	Community and local government actors aware of indicators, and use indicators locally as well as sending information to others, and have meaningful feedback.

Domain	Ranks (score)				
	Nothing/ Narrow (1)	Restricted/ Small (2)	Mean/ Fair (3)	Open/ Good (4)	Wide/ Excellent (5)
7. Communication	Community and local government actors have never seen/heard any communication materials such as posters, pamphlets, radio messages or TV spots. DDC/VDC have no local newspaper, TV or radio channel. No community members have a TV.	Very few community members have TV and DDC/VDC have no local newspaper, radio station, or TV channel. Community and local government actors have only seen communication materials such as posters, pamphlets, but no radio messages or TV spots.	Most people have a TV but DDC/VDC have no local newspaper, radio station and/or TV channel. Community and local government actors have only seen communication materials such as posters, pamphlets, but no radio messages or TV spots.	Most people have a TV and DDC/VDC has local newspaper, radio station and TV channel. Community and local government actors have only seen communication materials such as posters, pamphlets, but no radio messages or TV spots.	Everyone has a home TV (and watches/listens on a regular basis), DDC/VDC has a well-established local newspaper, radio station and/or TV channel. Nutrition information is available through all media, newspaper, radio, TV, posters, pamphlets.
8. Infrastructure/ equipment	Most community and local government actors have no equipment/ infrastructure available at DDC/ VDC/Ward levels, with no mobile phones, and/or machines to help with data analysis and/or transport to improve access to communities.	Most community and local government actors have very little equipment available at DDC/VDC/Ward levels, with just a mobile phone, but no computer, PDA, bicycle or public transport.	Most community and local government actors have some equipment such as a mobile phone, and calculator. VDC/ DDC are inadequately equipped with computer or PDA, and means of transport is limited to bicycle or public transport.	Most community and local government actors are reasonably well equipped with a mobile phone, and calculator, but have no computer for doing data analysis. Many means of transport are available such as bicycle and public transport.	Most community and local government actors are well equipped with a mobile phone, and calculator, as well as a computer for doing data analysis. Many means of transport are also available such as bicycle and public transport.

Figure 1. Nutrition Programmatic Model - Local Bodies (to implement MSNP)



ANNEX 2. Results Table

Table 2. Local government and community actors interviewed at district, village, and community levels

LEVEL	DISTRICT	
	Parsa	Achham
District Development Council	- Local Development Officer - Public Health Officer - Agriculture Officer - Livestock Officer - Water Officer - Women's Development Officer - Child Friendly Local Government Officer - Program Officer - Nutrition Focal Officer	- Local Development Officer (Acting) - District Health Officer - Section Officer - Water Officer
Village Development Committee	- VDC Secretary/ Chair health management committee/ Chair Village Wash Committee (Belawa) - VDC Secretary (Pacharukhi) - Chief of Health Centre (2) - Female Community Health Volunteer (2) - Chief Livestock Service Centre (2) - Chair School Management Committee (2) - Health Teacher (2) - Auxiliary Nurse Midwife (2) - Member Village Wash Committee (2) - Early Child Development Officer (2)	- VDC Secretary - Chief Ag Service Centre (1 for Belawa and Pacharukhi) - Chief Livestock Service Centre - Chief sub Health Post - Female Community Health Volunteer (2) - Chief Livestock Service Centre - Agriculture Junior Technical Assistant (2) - Chief Health Management Committee - Health Teacher - Chair School Management Committee - Chair Village Wash Committee - Auxiliary Nurse Midwife (2) - Early Child Development Teacher - Social Mobilizer
Community Groups	- Farmers Groups(2) - Mothers Groups (2) - Ward Citizens Forum (2)	- Farmers Groups(2) - Mothers Groups (2) - Ward Citizens Forum (2)

Table 3. Scores for nutrition in development capacity: Perception of the nutrition situation

Domain: Perception of the nutrition situation				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	0 9 (69.2) 2 (15.4) 1 (7.7) 1 (7.7)	0 4 (100.0) 0 0 0	0 5 (55.6) 2 (22.2) 1 (11.1) 1 (11.1)
Totals		**13**	**4**	**9**
VDC government staff	1 2 3 4 5	1 (2.9) 33 (94.3) 1 (2.9) 0 0	1 (6.3) 15 (93.7) 0 0 0	0 18 (94.7) 1 (5.3) 0 0
Totals		35	16	19
Community groups	1 2 3 4 5	3 (25.0) 9 (75.0) 0 0 0	1 (50.0) 5 (50.0) 0 0 0	2 (33.3) 4 (66.6) 0 0 0
Totals		12	6	6
All	1 2 3 4 5	4 (6.7) 51 (85.0) 3 (5.0) 1 (1.7) 1 (1.7)	2 (7.7) 24 (92.3) 0 0 0	2 (5.9) 27 (79.4) 3 (8.8) 1 (2.9) 1 (2.9)
Totals		60	26	34

Table 4. Scores for nutrition in development capacity: Development pathway

Domain: Development pathway				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	5 (38.5) 7 (53.8) 0 1 (7.7) 0	3 (75.0) 1 (25.0) 0 0 0	2 (22.2) 6 (66.7) 0 1 (11.1) 0
Totals		13	4	9
VDC government staff	1 2 3 4 5	17 (43.6) 12 (34.3) 5 (14.3) 1 (2.9) 0	8 (50.0) 6 (37.5) 2 (12.5) 0 0	9 (47.4) 6 (31.6) 3 (15.8) 1 (5,3) 0
Totals		35	16	19
Community groups	1 2 3 4 5	10 (83.3) 2 (16.7) 0 0 0	6 (100.0) 0 0 0 0	4 (66.7) 2 (33.3) 0 0 0
Totals		12	6	6
All	1 2 3 4 5	32 (53.3) 21 (35.0) 5 (8.3) 2 (3.3) 0	17 (65.4) 7 (26.9) 2 (7.7) 0 0	15 (44.1) 14 (41.2) 3 (8.8) 2 (5.9) 0
Totals		60	26	34

Table 5. Scores for nutrition in development capacity: Resource mobilization

Domain: Resource Mobilization				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	7 (53.3) 5 (8.5) 1 (7.7) 0 0	4 (100.0) 0 0 0 0	3 (33.3) 5 (55.6) 1 (11.1) 0 0
Totals		13	4	9
VDC government staff	1 2 3 4 5	26 (74.3) 7 (20.0) 1 (2.9) 1 (2.9) 0	13 (81.2) 3 (18.8) 0 0 0	13 (68.4) 4 (27.0) 1 (5.3) 1 (5.3) 0
Totals		35	16	19
Community groups	1 2 3 4 5	8 (66.7) 2 (16.7) 2 (16.7) 0 0	4 (66.7) 1 (16.7) 1 (16.7) 0 0	4 (66.7) 1 (16.7) 1 (16.7) 0 0
Totals		12	6	6
All	1 2 3 4 5	41 (68.3) 14 (23.3) 4 (6.7) 1 (1.7) 0	21 (80.8) 4 (15.4) 1 (3.8) 0 0	20 (58.8) 10 (29.4) 3 (8.8) 1 (2.9) 0
Totals		60	26	34

Table 6. Scores for nutrition in development capacity: Management/ organization

Domain: Management/ organization				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	9 (69.2) 2 (15.4) 0 0 2 (15.4)	3 (75.0) 1 (25.0) 0 0 0	6 (66.7) 1 (11.1) 0 0 2 (22.2)
Totals		13	4	9
VDC government staff	1 2 3 4 5	14 (40.0) 10 (28.6) 6 (17.1) 3 (8.6) 2 (5.7)	5 (31.2) 6 (37.5) 4 (25.0) 1 (6.2) 0	9 (47.4) 4 (21.1) 2 (10.5) 2 (10.5) 2 (10.5)
Totals		35	16	19
Community groups	1 2 3 4 5	12 (100) 0 0 0 0	6 (100.0) 0 0 0 0	6 (100.0) 0 0 0 0
Totals		12	6	6
All	1 2 3 4 5	35 (58.3) 12 (20.0) 6 (10.0) 3 (5.0) 4 (6.7)	14 (53.8) 7 (26.9) 4 (15.4) 1 (3.8) 0	21 (61.8) 5 (14.7) 2 (5.9) 2 (5.9) 4 (4.8)
Totals		60	26	34

Table 7. Scores for nutrition in development capacity: workforce skills/training

Domain: Workforce skills/training				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	7 (53.8) 0 4 (30.8) 2 (15.4) 0	3 (75.0) 0 1 (25.0) 0 0	4 (44.4) 0 3 (33.3) 2 (22.2) 0
Totals		13	4	9
VDC government staff	1 2 3 4 5	26 (74.3) 2 (5.7) 6 (17.1) 1 (2.9) 0	14 (87.5) 0 2 (12.5) 0 0	12 (63.1) 2 (10.5) 4 (21.0) 1 (5.3) 0
Totals		35	16	19
Community groups	1 2 3 4 5	12 (100.0) 0 0 0 0	6 (100.0) 0 0 0 0	6 (100.0) 0 0 0 0
Totals		12	6	6
All	1 2 3 4 5	45 (75.0) 2 (3.3) 10 (16.7) 3 (5.0) 0	23 (88.5) 0 3 (11.5) 0 0	22 (64.7) 2 (5.9) 7 (20.6) 3 (8.8) 0
Totals		60	26	34

Table 8. Scores for nutrition in development capacity: Information systems

Domain: Information systems				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	4 (30.3) 1 (7.7) 3 (23.1) 5 (38.5) 0	2 (50.0) 1 (25.0) 1 (25.0) 0 0	2 (22.2) 0 2 (22.2) 5 (55.6) 0
Totals		13	4	9
VDC government staff	1 2 3 4 5	18 (51.4) 7 (20.0) 8 (22.9) 1 (2.9) 1 (2.9)	8 (50.0) 3 (18.8) 3 (18.8) 0 0	10 (52.6) 4 (21.0) 3 (15.8) 1 (5.3) 1 (5.3)
Totals		35	16	19
Community groups	1 2 3 4 5	9 (75.0) 2 (16.7) 1 (8.3) 0 0	6 (100.0) 0 0 0 0	3 (50.0) 2 (33.3) 1 (16.7) 0 0
Totals		12	6	6
All	1 2 3 4 5	31 (51.7) 10 (16.7) 12 (30.0) 6 (12.0) 1 (1.7)	16 (61.5) 4 (15.4) 6 (23.1) 0 0	15 (44.2) 6 (17.6) 6 (17.6) 6 (17.6) 1 (2.9)
Totals		60	26	34

Table 9. Scores for nutrition in development capacity: Communications

Domain: Communications				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	0 4 (30.8) 4 (30.8) 2 (15.4) 3 (23.1)	0 4 (100..0) 0 0 0	0 0 4 (44.4) 2 (22.2) 3 (33.3)
Totals		13	4	9
VDC government staff	1 2 3 4 5	0 15 (42.9) 20 (57.1) 0 0	0 14 (87.5) 2 (12.5) 0 0	0 1 (5.3) 18 (74.7) 0 0
Totals		35	16	19
Community groups	1 2 3 4 5	4 (33.3) 5 (41.7) 3 (25.0) 0 0	2 (33.3) 3 (50.0) 1 (16.7) 0 0	2 (33.3) 2 (33.3) 2 (33.3) 0 0
Totals		12	6	6
All	1 2 3 4 5	4 (6.7) 24 (40.0) 27 (45.0) 2 (3.3) 3 (5.0)	2 (7.7) 21 (80.8) 3 (11.5) 0 0	2 (5.9) 3 (8.8) 24 (70.6) 2 (5.9) 3 (8.8)
Totals		60	26	34

Table 10. Scores for Nutrition in Development Capacity: Infrastructure/ equipment

Domain: Infrastructure/ equipment				
Level of local government	**Domain score**	**Districts**		
		All	**Achham**	**Parsa**
DDC government officials	1 2 3 4 5	2 (15.4) 4 (30.8) 2 (15.4) 4 (30.8) 1 (7.7)	1 (25.0) 3 (75.0) 0 0 0	1 (11.1) 1 (77.8) 2 (11-1) 4 (44.4) 1 (11.1)
Totals		13	4	9
VDC government staff	1 2 3 4 5	4 (11.1) 25 (69.4) 6 (16.7) 1 (2.8) 0	2 (12.5) 14 (87.5) 0 0 0	1 (7.6) 11 (57.9) 6 (31.6) 1 (5.3) 0
Totals		36	16	19
Community groups	1 2 3 4 5	7 (58.3) 4 (33.3) 1 (8.3) 0 0	3 (50.0) 3 (50.0) 0 0 0	4 (66.7) 1 (16.7) 1 (16.7) 0 0
Totals		12	6	6
All	1 2 3 4 5	12 (20.0) 33 (55.0) 9 (15.0) 5 (8.3) 1 (1.7)	6 (23.1) 20 (76.9) 0 0 0	6 (17.6) 13 (38.2) 9 (26.5) 5 (14.7) 1 (2.9)
Totals		60	26	34

F– 1

District level management staff

Semi-structured interview

ID:_____

Completed by:

Date of visit | | | | | | | | |
d d m m y y y y

The following is introductory information that you may wish to provide before starting the interview:

"In order to strengthen reinforce and strengthen nutrition actions aimed at reducing maternal and young child undernutrition the GON has developed a Multisectoral Nutrition Plan (MSNP) through the National Planning Commission (NPC) together with Ministries of Local Development, Health, Education, Agriculture and Public Works, As a first step in its implementation the National Planning Commission, and the partner agencies have decided to undertake an assessment of capacity available a the community and local government level for implementing the MSNP. Therefore, we are seeking your views on current nutrition challenges and how volunteers in your community respond to these challenges.

The interviews will be either one-on-one or focus group discussion and take about 20–30 minutes.

The assessment team will analyse the results of the assessment, and share and present their findings at a District consensus meeting on ….. (insert the date of the meeting, if the date is already decided; if not, inform the interviewee that a meeting will take place). We are confident that your invaluable inputs will enrich the analysis and contribute to the formulation of relevant recommendations."

Province or region:	**District:**

Department:

Respondent:	
Name:	
Position:	
Background:	

Perception of Nutrition Situation Section 1
1.1 What are the major problems in your district?

1.11 If malnutrition is not mentioned, ask if malnutrition is a problem in the area

Yes	**No**	**Don't know**

1.2 How does malnutrition rank relative to other problems in your area? What information are you using to rank/prioritize malnutrition?

1.3 What do you see as the major nutrition problems in the district, and what are the most important causes of these problems?

Problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. But DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Undernutrition:		Underweight:
			Stunting:
			Wasting:
	Overweight and obesity:		
	Vitamin or mineral deficiencies (specify which ones):		
	Other:		

Causes of existing nutrition problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. Again, DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Food insecurity:		Poor dietary quality:
			Poor dietary quantity:
	Increasing food prices:		
	Insufficient health services or unhealthy environment:		
	Inadequate caring practices for infants and young children:		
	Lack of knowledge:		
	Poverty:		
	Natural disasters:		
	Other:		

Development Pathways/Leadership Section 2

2.1 What are the district goals relating to nutrition, if any? *(probe for district development plans or sectorial plans in relevant sectors health, agriculture, education etc)*

2.2 Are there any nutrition education or nutrition-related programs/activities being Implemented in the district?

Yes	No	Don't know
If yes describe:		

2.3 Are you satisfied with the nutrition or nutrition-related programmes and activities in the community? What are the success areas and the areas to improve?

Success areas:
Areas to improve:

2.4 What do you perceive as the major barriers and challenges for scaling-up nutrition or nutrition-related actions in the community? How could your community contribute to overcoming these barriers? Please specify any concrete action or input that you could provide within the current level of human and financial resources

Barriers and challenges to scaling up nutrition or nutrition-related action	**What your village could do to overcome those barriers and challenges**

2.5 Do you participate in any facilitated discussions with colleagues in your work in order to decide what to do?

Yes	**No**
If yes specify	

2.6 Do you have open discussions with groups of people from the district about what to do in regards to nutrition in the district?

yes	**no**
If yes specify	

2.7 Have you ever been trained in how to facilitate discussions within the district?

yes	**no**
If yes specify	

Resource Mobilization Section 3

3.1 Is there adequate financial resources to tackle the nutrition situation in the district?

yes	**no**
If yes specify	

3.1.1 If no, how could the community address lack of funds?

3.2 Do you receive nutrition related resources/supplies from central agencies?

Yes	No	Don't know
If yes describe: Iron/folate? Zinc Vit. A capsules? Others?		

3.3 Do you receive any other equipment, from central agencies, that is used by community workers to help them collect nutrition related information? (measuring board, scale ect)

Yes	No	Don't know

3.4 Do you know of any district organizations that are working together on nutrition related projects, programs or activities?

Yes	No	Don't know

Management/Organization Section 4

4.1 Is there a committee or group that meets within the district to discuss or plan a budget for nutrition related programs or activities?

Yes	No	Don't know

4.2 Do you meet with organizations from the villages within your district to discuss what supplies they need or their plans for budgeting for nutrition related programs and activities?

Yes	No	Don't know

4.3 Do you meet with individuals from the district or VDC level to review their work plan or progress?

Yes	No	Don't know

Human/Workforce Capacity, Skills development Section 5

5.1 Do you have a district training plan for nutrition?

Yes	No	Don't know

5.2 What nutrition-related trainings have there been in your district in the past 2 years?

Training	Participants	Materials Used

5.3 Do any of these trainings include any follow-up training or post-training supervision?

Yes	No	Don't know
If yes describe:		

5.4 Do you feel there is adequate human resources to tackle the nutrition situation in the district?

Yes	No	Don't know

5.4.1 If no, how could the district address the lack in human resources?

5.5 Within the district, in regard to nutrition, do you know how many community workers there are per household?

Yes	No	Don't know
If yes describe:		

5.6 Within the district who has the responsibility of providing technical support regarding nutrition? Technical support includes help with questions and information about recent advances in nutrition.

5.7 Does this individual have training in nutrition?

Yes	No	Don't know
Suggestions for improvement:		

5.8 How often do you review their work plan and progress with the above individual?

Every month	Every six months	Yearly	Never

Information Systems Section 6

6.1 What are the most important nutrition-relevant indicators that are routinely collected and/or collated in the district? How often are data collected? *Consult the reference list of indicators and programmes. Probe for routine data, M&E data. Ask to see copy of reports of routine data relevant for nutrition and note whether they are complete and accurate*

Nutrition indicators	Frequency of data collection	How is it collected/compiled and through which system	Comment (Do data seem to be complete and accurate?)

6.2 How do you use this information?

6.3 Where do you send the nutrition-relevant data collected or collated?

6.3.1 Have you ever received feedback on the information on nutrition that you have sent?

Yes	No
If yes specify	

Communication Section 7

7.1 Do you have or have you seen or heard any communication material on nutrition?

Type	Yes	If yes what	No	Don't know
Posters				
Pamphlets				
Radio messages				
Films or videos or TV spots				

7.1.1 Are any of the above listed distributed from central level agencies?

Yes	No	Don't know

7.2 Within your district do you think most people have a TV or radio in their homes?

Yes	No	Don't know

7.2.1 If yes, do you think they watch or listen on a regular basis?

Yes	No	Don't know

7.3 Do you have any of the following communication methods in your district?

Type	Yes	No	Don't know
TV Station			
Radio Station			
Local News Paper			

Infrastructure/Equipment Section 8

Equipment	Yes	No	Don't Know
Cell phone			
PDA			
Calculator			
Microsoft word/Excel			
Bicycle			
Public transportation			
Other			

Concluding Questions Section 9

9.1 In your opinion, what should be the top priorities of your district to improve nutrition?

9.2 Is there anything else that you think you should tell us to have a better understanding about nutrition situation in the district?

- *Thank the interviewee for taking time to share so much valuable information*
- *Ask if he/she has any questions to ask you*

F– 2

VDC level

ID:_____

Completed by:

Date of visit | | | | | | | | |
d d m m y y y y

The following is introductory information that you may wish to provide before starting the interview:

"In order to strengthen reinforce and strengthen nutrition actions aimed at reducing maternal and young child undernutrition the GON has developed a Multisectoral Nutrition Plan (MSNP) through the National Planning Commission (NPC) together with Ministries of Local Development, Health, Education, Agriculture and Public Works, As a first step in its implementation the National Planning Commission, and the partner agencies have decided to undertake an assessment of capacity available a the community and local government level for implementing the MSNP. Therefore, we are seeking your views on current nutrition challenges and how volunteers in your community respond to these challenges.

The interviews will be either one-on-one or focus group discussion and take about 20–30 minutes.

The assessment team will analyse the results of the assessment, and share and present their findings at a District consensus meeting on ….. (insert the date of the meeting, if the date is already decided; if not, inform the interviewee that a meeting will take place). We are confident that your invaluable inputs will enrich the analysis and contribute to the formulation of relevant recommendations."

Region:	**District:**	**VDC:**

Department:

Respondent:	
Name:	
Position:	
Background:	

Perception of Nutrition Situation Section 1

1.1 What are the major problems in your village?

1.1.1 If malnutrition is not mentioned, ask if malnutrition is a problem in the area

Yes	No	Don't know

1.2 How does malnutrition rank relative to other problems in your area? What information are you using to rank/prioritize malnutrition?

1.3 What do you see as the major nutrition problems within the VDC and what are the most important causes of these problems?

Problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. But DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Undernutrition:		Underweight:
			Stunting:
			Wasting:
	Overweight and obesity:		
	Vitamin or mineral deficiencies (specify which ones):		
	Other:		

Causes of existing nutrition problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. Again, DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Food insecurity:		Poor dietary quality:
			Poor dietary quantity:
	Increasing food prices:		
	Insufficient health services or unhealthy environment:		
	Inadequate caring practices for infants and young children:		
	Lack of knowledge:		
	Poverty:		
	Natural disasters:		
	Other:		

Development Pathways/Leadership Section 2

2.1 What are the village goals relating to nutrition, if any?
(probe for district development plans or sectorial plans in relevant sectors health, agriculture, education etc)

2.2 Are there any nutrition education or nutrition-related programs/activities being implemented in the village?

Yes	No	Don't know
If yes describe:		

2.3 Are you satisfied with the nutrition or nutrition-related programmes and activities in the community? What are the success areas and the areas to improve?

Success areas:
Areas to improve:

2.4 What do you perceive as the major barriers and challenges for scaling-up nutrition or nutrition-related actions in the community? How could your community contribute to overcoming these barriers? Please specify any concrete action or input that you could provide within the current level of human and financial resources

Barriers and challenges to scaling up nutrition or nutrition-related action	**What your village could do to overcome those barriers and challenges**

2.5 Do you participate in any facilitated discussions with colleagues in your work in order to decide what to do?

Yes	**No**
If yes specify	

2.6 Do you have open discussions with groups of people from the district about what to do in regards to nutrition in the village?

Yes	No
If yes specify	

2.7 Have you ever been trained in how to facilitate discussions within the village?

Yes	No
If yes specify	

Resource Mobilization Section 3

3.1 Is there adequate financial resources to tackle the nutrition situation in the village?

Yes	No
If yes specify	

3.1.1 If no, how could the community address lack of funds?

3.2 Do you receive nutrition related resources/supplies from the district level?

Yes	No	Don't know
If yes describe: Iron/folate? Zinc Vit. A capsules? Others?		

3.3 Do you receive any other equipment, from central agencies, that is used by community workers to help them collect nutrition related information? (measuring board, scale ect)

Yes	No	Don't know

3.4 Do you know of any village organizations that are working together on nutrition related projects, programs or activities?

Yes	No	Don't know

Management/Organization Section 4

4.1 Do you have any involvement in/and or discuss your annual work plan with your supervisor?

Yes	No
If yes specify	

4.2 How often do you review your work plan and progress with your supervisor?

Monthly	Every six months	Yearly	Never

4.3 Do you work in partnership with any other group of people or organization?

Yes	No
If yes specify	

Human/Workforce Capacity, Skills Development Section 5

5.1 Do you have a village training plan for nutrition?

Yes	No	Don't know

5.2 What nutrition-related trainings have there been in your village in the past 2 years?

Training	Participants	Materials Used

5.3 Do any of these trainings include any follow-up training or post-training supervision?

Yes	No	Don't know
If yes describe:		

5.4 Do you feel there is adequate human resources to tackle the nutrition situation in the village?

Yes	No	Don't know

5.4.1 If no, how could the district address the lack in human resources?

5.5 Within the village, in regard to nutrition, do you know how many community workers there are per household?

Yes	No	Don't know
If yes describe:		

5.6 Within the village who has the responsibility of providing technical support regarding nutrition? Technical support includes help with questions and information about recent advances in nutrition.

5.7 Does this individual have training in nutrition?

Yes	No	Don't know
Suggestions for improvement:		

5.8 How often do you review their work plan and progress with the above individual?

Monthly	Every six months	Yearly	Never

Information Systems Section 6

6.1 What are the most important nutrition-relevant indicators that are routinely collected and/or collated in the village? How often are data collected? Consult the reference list of indicators and programmes. Probe for routine data, M&E data. Ask to see copy of reports of routine data relevant for nutrition and note whether they are complete and accurate

Nutrition indicators	Frequency of data collection	How is it collected/compiled and through which system	Comment (Do data seem to be complete and accurate?)

6.2 How do you use this information?

6.3 Where do you send the nutrition-relevant data collected or collated?

6.3.1 Have you ever received feedback on the information on nutrition that you have sent? (from the district level)

Yes	No
If yes specify	

Communication Section 7

7.1 Do you have or have you seen or heard any communication material on nutrition?

Type	Yes	If yes what	No	Don't know
Posters				
Pamphlets				
Radio messages				
Films or videos or TV spots				

7.1.1 Are any of the above listed distributed from district level agencies?

Yes	No	Don't know

7.2 Within your VDC do you think most people have a TV or radio in their homes?

Yes	No	Don't know

7.2.1 If yes, do you think they watch or listen on a regular basis?

Yes	No	Don't know

7.3 Do you have any of the following communication methods in your VDC?

Type	Yes	No	Don't know
TV Station			
Radio Station			
Local News Paper			

Infrastructure/equipment Section 8

8.1 What equipment, if any, is used by community workers?

Equipment	Yes	No	Don't Know
Cell phone			
PDA			
Calculator			
Microsoft word/			
Excel			
Bicycle			
Public transportation			
Other			

Infrastructure/equipment Section 8

9.1 In your opinion, what should be the top priorities of your village to improve nutrition?

9.2 Is there anything else that you think you should tell us to have a better understanding about nutrition situation in the district?

- *Thank the interviewee for taking time to share so much valuable information*
- *Ask if he/she has any questions to ask you*

F– 3

Most distal government employed workers

Structured interview for all distal sectoral staff linking to community workers in MSNP
(Junior Agricultural Technicians, Teachers. Auxiliary Nurses, Social mobilizers)

ID:_____

Completed by:

Date of visit | | | | | | | | |
d d m m y y y y

The following is introductory information that you may wish to provide before starting the interview:

"In order to strengthen reinforce and strengthen nutrition actions aimed at reducing maternal and young child undernutrition the GON has developed a Multisectoral Nutrition Plan (MSNP) through the National Planning Commission (NPC) together with Ministries of Local Development, Health, Education, Agriculture and Public Works, As a first step in its implementation the National Planning Commission, and the partner agencies have decided to undertake an assessment of capacity available a the community and local government level for implementing the MSNP. Therefore, we are seeking your views on current nutrition challenges and how volunteers in your community respond to these challenges.

District:	**VDC**	**Ward**

Participant:

Sector:	**Unit:**
Health Agriculture Education Water and Sanitation Womens Development Other	

Respondent:	
Name:	
Position:	
Background:	

Perception of nutrition situation and priorities Section 1

1.1 What are the mayor problems in your area?

List:

1.1.1 If malnutrition is not mentioned, ask if malnutrition is a problem in the area

Yes	**No**	**Don't know**

1.2 How does malnutrition rank relative to other problems in your area? What information are you using to rank/prioritize malnutrition?

1.3 What do you perceive as the major nutrition problems in the area and what are the most important causes of these problems?

If the respondent only mentions underlying causes (e.g. poverty, lack of education, etc), try to obtain information on how the respondent sees those underlying causes affect the nutrition status of people (e.g. how does poverty affect nutrition among children).

Problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. But DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Undernutrition:		Underweight:
			Stunting:
			Wasting:
	Overweight and obesity:		
	Vitamin or mineral deficiencies (specify which ones):		
	Other:		

Causes of existing nutrition problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. Again DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words. If the respondent mentions more causes ask him/her to rank them.

	Food insecurity:		Poor dietary quality:
			Poor dietary quantity:
	Increasing food prices:		
	Insufficient health services /unhealthy environment/ poor quality of health services:		
	Inadequate caring practices for infants and young children:		
	Lack of knowledge:		
	Poverty:		
	Natural disasters:		
	Other (Inadequate water/sanitation, poor water quality):		

1.4 Knowledge of nutrition guidelines and protocols

Ask the question and give time for the respondent to answer. If necessary, read out the options. (Note: asterisks denote correct answer).

A) What micronutrient supplement should pregnant women receive?

Iron only	Folic acid only	Iron and folic acid	Iron and folic acid, and calcium	Iron and folic acid, calcium, and iodine (where salt iodization is inadequate)*	Don't know

B) How soon after delivery should a baby be put to the breast?

Within 1 hour*	Within 6 hours	Within 24 hours	After the mother has recovered	Don't know

C) When should breastfed children start receiving complementary foods?

At 4–6 months of age	At 6 months of age*	At 8 months of age	When the child has got teeth	Don't know

D) Should all infants receive vitamin A supplements?

Yes	No, only if living in areas where vitamin A deficiency is a public health problem, or if suffering from measles*	Don't know

E) Zinc supplements should be given to all children who have diarrhoea.

True*	False	Don't know

F) All children in all countries have the same potential to grow from birth until 5 years,

True*	False	Don't know

G) Infants younger than 6 months who are exclusively breastfed and who get diarrhoea may need some water to replace loss of fluids.

True*	False	Don't know

H) Overweight and obesity are the problems of the high-income segment of the society, so education on balanced diets and healthy lifestyle is not necessary in poor communities.

True*	False	Don't know

Development pathway Section 2

Please select only one response in this section

2.1 Do you have a work plan that you follow?

Yes	**No**	**Don't know**
If yes where does it come from?		

2.2 Is nutrition one of the stated goals or objectives of you work?

Yes	**No**	**Don't know**

2.3 Do you receive standard procedures from central level and if so do they have any nutrition related activities?

Yes	**No**	**Don't know**
If yes, specify (and if possible as being more curative or preventive)		

2.4 Do you participate in any facilitated discussions with colleagues in your work in order to decide what you do?

Yes	**No**
If yes specify	

2.5 Do you have open discussions with groups of people from the community about what to do in your area of work

Yes	**No**
If yes specify	

2.6 Do you target any of your interventions/work at any particular population group?

Yes	**No**
If yes specify	

Resource mobilization Section 3

3.1 Do you get a budget from central level that you control?

Yes	**No**
If yes specify	

3.2 Do you receive funds from any other source such as local government (VDC/DDC)?

Yes	**No**
If yes specify	

3.3 Do local community members pay any fees for services they receive?

Yes	No
If yes specify	

3.4 Do you get provided with supplies from central level

Yes	No
If yes specify	

Management/organization Section 4

4.1 Do you have any involvement in/and or discuss your annual work plan with your supervisor?

Yes	No
If yes specify	

4.2 Who do you consult if you need technical support regarding nutrition? Technical support includes help with questions you get asked, information about recent advances in nutrition.

4.3 Do you feel that you receive adequate support regarding nutrition? How do you think the support could be improved?

Yes	No	Don't know
Suggestions for improvement:		

4.4 How often do you review your work plan and progress with your supervisor?

Monthly	**Every six months**	**Yearly**	**Never**

4.5 Do you work in partnership with any other group of people or organization?

Yes	**No**

Human Workforce capacity skills development Section 5

5.1 Have you ever been trained in nutrition?

Yes	**No**
If yes Where and When? Was it helpful?	

If Yes which of the following:

Maternal nutrition	Yes	No
Infant and young child nutrition	Yes	No
Breastfeeding	Yes	No
Complementary feeding	Yes	No
Counselling skills	Yes	No
Micronutrients	Yes	No
Nutritional care of sick children	Yes	No
Management of severe or moderate malnutrition	Yes	No
Growth monitoring and promotion	Yes	No
Healthy diets (including use of locally available food) and physical activity	Yes	No
Hygiene and food safety	Yes	No
Other: _____	Yes	No

5.2 Are there any areas in nutrition in which you feel that you need more training?

Yes	**No**
If yes, please describe the nutrition areas and the types of training needed:	

5.3 Does your superior officer have training in nutrition?

Yes	No	Don't know
Observations:		

5.4 Does your superior ever give you any on the job training in nutrition as part of supervision?

Yes	No	Don't know
Observations:		

5.5 Have you ever been trained in how to facilitate community discussions?

Yes	No
If yes how where when?	

Information systems Section 6

6.1 What are the most important nutrition-relevant indicators that you routinely collected and/or collated in your work? How often are data collected?
Consult the reference list of indicators and programmes. Probe for routine data, M&E data. Ask to see copy of reports of routine data relevant for nutrition and note whether they are complete and accurate

Nutrition indicators	Frequency of data collection	How is it collected/compiled and through which system	Comment (Do data seem to be complete and accurate?)

6.2 Do you use this information?

Yes	No
If yes how?	

6.3 Where do you send the nutrition-relevant data collected or collated?

6.3.1 Have you ever received feedback on the information on nutrition that you have sent?

Yes	No	Don't know

6.3.2 If yes, is this feedback useful? And how do you use this feedback?

6.4 Do you give feedback to the communities regarding any nutrition information collected?

Yes	No
If yes how?	

6.5 Do your VDC/DDC give feedback to the communities regarding any nutrition information collected?

Yes	No
If yes how?	

Communication Section 7

7.1 Do you have* or have you seen or heard any communication material on nutrition? (wait to hear an answer and if there is none then probe

Type	Yes	If yes what	No	Don't know
Posters				
Pamphlets				
Radio messages				
Films or videos or TV spots				

* if they have then ask to see and keep a copy if you can

Observations: where seen/heard?

7.2 Do you know what "misinformation is?

Yes	No	Don't know
If yes what:		

7.3 Within your community do you think most people have a TV or radio in their homes?

Yes	No	Don't know

7.3.1 If yes, do you think they watch or listen on a regular basis?

Yes	No	Don't know

7.4 Do you have any of the following communication methods in your district?

Type	Yes	No	Don't know
TV Station			
Radio Station			
Local News Paper			

Infrastructure/Equipment Section 8

8.1 Are you well equipped to do your job?

Yes	No	Don't know
If yes what equipment do they have? If no how could it be improved		

8.2 Is your supervisor well equipped to do his job?

Yes	No	Don't know
If yes what equipment do they have? If no how could it be improved		

8.3 What equipment do you have out of the following?

Equipment	Yes	No	Whose? Own or job provided?
Mobile phone			
Calculator			
Laptop			
Bicycle			
Motor bike			
Others? Specify.....			

8.4 Is their any particular equipment that you think you need to do your job better?

Yes	No	Don't know
If yes what equipment do they suggest?		

Concluding questions Section 9

9.1 In your opinion, can the nutrition programmes in your VDC/DDC be improved?

Yes	No	Don't know
If yes how?		

9.2 Is there anything else that you would like to add or to ask me? Especially with regard to the implementation of nutrition services in your work and/or in your VDC?

- *Thank the interviewee for taking time to share so much valuable information*
- *Ask if he/she has any questions to ask you*

F– 4

Community Groups

Group discussion with the community groups (mothers, farmers, etc)

ID:_____

Completed by:

Date of visit | | | 0 | 7 | 2 | 0 | 1 | 2 |
d d m m y y y y

The following is introductory information that you may wish to provide before starting the interview:

"In order to strengthen reinforce and strengthen nutrition actions aimed at reducing maternal and young child undernutrition the GON has developed a Multi-sectoral Nutrition Plan (MSNP) through the National Planning Commission (NPC) together with Ministries of Local Development, Health, Education, Agriculture and Public Works, As a first step in its implementation the National Planning Commission, and the partner agencies have decided to undertake an assessment of capacity available a the community and local government level for implementing the MSNP. Therefore, we are seeking your views on current nutrition challenges and how volunteers in your community respond to these challenges.

District:	**VDC:**	**Ward**

Participants:	
Mothers Groups:	
Farmers Groups:	
Other:	

Perception of the nutrition situation Section 1

1.1 What are the mayor problems in your village?

List

1.1.1 If malnutrition is not mentioned, ask if malnutrition is a problem in the village

Yes	No	Don't know

1.2 How does malnutrition rank relative to other problems in your village? What information are you using to rank/prioritize malnutrition?

1.3 What do you perceive as the major nutrition problems in the village and what are the most important causes of these problems?
If the respondent only mentions underlying causes (e.g. poverty, lack of education, etc), try to obtain information on how the respondent sees those underlying causes affect the nutrition status of people (e.g. how does poverty affect nutrition among children).

Problems mentioned:
Tick the appropriate box(es) and take brief notes of any further description. But DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Undernutrition:		Underweight:
			Stunting:
			Wasting:
	Overweight and obesity:		
	Vitamin or mineral deficiencies (specify which ones):		
	Other:		

Causes of existing nutrition problems mentioned:
Tick the appropriate box(es) and take brief notes of any further description. Again DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words. If the respondent mentions more causes ask him/her to rank them.

	Food insecurity:		Poor dietary quality:
			Poor dietary quantity:
	Increasing food prices:		

	HIV/AIDS:	
	Insufficient health services /unhealthy environment/ poor quality of health services:	
	Inadequate caring practices for infants and young children:	
	Lack of knowledge:	
	Poverty:	
	Natural disasters:	
	Other (Inadequate water/sanitation, poor water quality):	

Development Pathway/choice of actions/leadership Section 2

2.1 Is nutrition included in the DDC/VDC Plan

Yes	No	Don't know

2.1.1 If yes, does the plan adequately address the main nutrition problems and their causes that you discussed?

Yes	No	Don't know
Describe:		

2.1. 2 If yes Which nutrition or nutrition-related programmes and activities are included in the VDC/DDC plan? Please indicate if these activities are implemented,

Nutrition/nutrition related programmes in the plan	Currently being implemented?	Preventive or curative?

2.1.2 Are there other nutrition or nutrition-related programmes and activities implemented that are not included in the VDC/DDC plan?

2.2 Are you satisfied with the nutrition or nutrition-related programmes and activities in the community? What are the success areas and the areas to improve?

Success areas:
Areas to improve:

2.3 Have you participated in community discussions of the development of the Village plan?

Yes	**No**	**Don't know**

2.4 What do you perceive as the major barriers and challenges for scaling-up nutrition or nutrition-related actions in the community? How could your community contribute to overcoming these barriers? Please specify any concrete action or input that you could provide within the current level of human and financial resources

Barriers and challenges to scaling up nutrition or nutrition-related action	**What your village could do to overcome those barriers and challenges**

2.5 Is there anybody that has lead the discussion of nutrition related issues for the VDC plans?

Yes	No	Don't know
If yes describe:		

Resources for nutrition Section 3

3.1 Are there adequate financial resources to tackle the nutrition situation in the community?

Yes	No	Don't know
If yes from where?		

3.1.1 If no, how could the community address lack of funds?

3.2 Do your community have access to any funds from central level that you control?

Yes	No	Don't know
If yes specify:		

3.3 Do you receive funds from any other source such as local government (VDC/DDC)?

Yes	No	Don't know
If yes specify:		

3.4 Do local community members pay any fees for services they receive?

Yes	No	Don't know
If yes specify and to who?		

3.5 Do you get nutrition related supplies from the VDC and/or DDC level?

Yes	**No**	**Don't know**
If yes describe: Iron/folate? Zinc Vitamin A capsules? Others?		

3.6 Are you working with any partners in nutrition?

Yes	No
If yes, can you give some examples of successful partnerships in nutrition in the community and indicate the reasons why these partnerships are successful?	

3.7 What are your suggestions to how partners could work better together to improve nutrition? Give examples of areas to improve.

Management and Coordination Section 4

4.1 Within the Ward /VDC who has the main responsibility for carrying out nutrition actions?

4.2 Who does this person report to and/or is supervised by?

Somebody in the DDC/VDC	
Somebody in the health service	
Somebody in the education service	
Others (specify)	

4.3 How often and what kind of support has your community received from the VDC or the district regarding nutrition related programming, planning and implementation? Probe for training, research, dialogue, field visits.

4.4 Are you satisfied with the support received from the VDC or the district? What are your specific suggestions to improve?

Human resources /workforce training/skills development Section 5

5.1 Do you feel there are adequate human resources to tackle the nutrition situation in the community?

Yes	No	Don't know

5.2.1 If no, how could the community address lack of human resources?

5.2 Are you aware that a focal person for nutrition has been/will be appointed at the district?

Yes	No	Don't know
How could having such a nutrition focal person help the community in scaling-up nutrition?		

5.3 Have any extension workers in the community received training or participated in workshops relevant to nutrition?

Yes	No

5.3.1 If yes, please note who received the training, what kind of training it was (title of training course, where the training was done, duration of training, etc) and when it took place.

Who?	What kind of training or workshop?	When was the training?

5.3.2 Do any of these trainings include any follow-up training or post-training supervision?

Yes	No	Don't know
If Yes Describe:		

Information systems Section 6

6.1 Are any nutrition related indicators collected and/or collated in the village/community?

Yes	No	Don't know

If Yes what are the most important nutrition-relevant indicators that are routinely collected and/or collated in the community? How often are data collected?
Consult the reference list of indicators and programmes. Probe for routine data, M&E data. Ask to see copy of reports of routine data relevant for nutrition and note whether they are complete and accurate

Nutrition indicators	Frequency of data collection	How is it collected/compiled and through which system	Comment (Do data seem to be complete and accurate?)

6.2 How is this information used?

6.3 Where do you send the nutrition-relevant data collected or collated?

6.3.1 Have you ever received feedback on the information on nutrition that you have sent?

Yes	No	Don't know

6.3.2 If yes, is this feedback useful? And how do you use this feedback?

6.4 How or do you give feedback to the communities regarding nutrition information collected?

6.5 If nutrition research or surveys have been taking place in your village, have you received any feedback on the results of this research?

Communication materials Section 7

7.1 Do you have or have you seen or heard any communication material on nutrition?

Type	Yes	If yes what	No	Don't know
Posters				
Pamphlets				
Radio messages				
Films or videos or TV spots				

7.2 If Nutrition communication material exists (posters/pamphlets) where have they been seen and what were they about?

Where?	About?

7.3 If nutrition communication material (messages/videos) were seen where were they seen and what were they about?

Where?	About?

7.4 Within your district do you think most people have a TV or radio in their homes?

Yes	No	Don't know

7.4.1 If yes, do you think they watch or listen on a regular basis?

Yes	No	Don't know

7.5 Do you have any of the following communication methods in your district?

Type	Yes	No	Don't know
TV Station			
Radio Station			
Local News Paper			

Infrastructure / equipment Section 8

8.1 Do you all think that you are sufficiently well equipped to do your work?

Yes	No	Don't know
If no what is the most important equipment that you need for it to be improved (give two most spoken about)		

8.2 How many of you has the following?

Equipment	Yes	No	Whose? Own or job provided?
Mobile phone			
Calculator			
Laptop			
Bicycle			
Motor bike			
Others? Specify.....			

8.3 Is their any particular equipment that you all think you need to do your job better?

Yes	No	Don't know
If yes what are the main two pieces of equipment do they suggest?		

8.4 Do any of you know what your haemoglobin level is?

Yes (%)	No (%)

8.5 Have you ever had your haemoglobin level measured?

Yes (%)	No (%)

8.6 s there a specific place that you are able to meet frequently as a group?

Yes	No
f yes where? If no would it be used if one were made available?	

Concluding questions Section 9

9.1 In your opinion, what should be the top priorities of your village to improve nutrition?

9.2 Is there anything else that you think you should tell us to have a better understanding about nutrition situation in the village?

- *Thank the interviewee for taking time to share so much valuable information*
- *Ask if he/she has any questions to ask you*
- *Remind the respondent about the (analysis workshop and?) Stakeholder meeting*

Community level nutrition workers (FCHVs)

Structured interview for all community level volunteers providing nutrition services to young adolescents, pregnant and lactating women and/or infants young children

ID:_____

Completed by:

Date of visit | | | | | | | | |
d d m m y y y y

The following is introductory information that you may wish to provide before starting the interview:

"In order to strengthen reinforce and strengthen nutrition actions aimed at reducing maternal and young child undernutrition the GON has developed a Multisectoral Nutrition Plan (MSNP) through the National Planning Commission (NPC) together with Ministries of Local Development, Health, Education, Agriculture and Public Works, As a first step in its implementation the National Planning Commission, and the partner agencies have decided to undertake an assessment of capacity available a the community and local government level for implementing the MSNP. Therefore, we are seeking your views on current nutrition challenges and how volunteers in your community respond to these challenges.

The interviews will be either one-on-one or focus group discussion and take about 20–30 minutes.

The assessment team will analyse the results of the assessment, and share and present their findings at a District consensus meeting on ….. (insert the date of the meeting, if the date is already decided; if not, inform the interviewee that a meeting will take place). We are confident that your invaluable inputs will enrich the analysis and contribute to the formulation of relevant recommendations."

Province or region:	**District:**	**VDC:**

Community Worker	
FCHV	
Other:	

Respondent:	
Name:	
Position:	
Background:	

Perception of the nutrition situation Section 1

1.1 What are the mayor problems in your area?

List

1.1.1 If malnutrition is not mentioned, ask if malnutrition is a problem in the area

Yes	**No**	**Don't know**

1.2 How does malnutrition rank relative to other problems in your area? What information are you using to rank/prioritize malnutrition?

1.3 What do you perceive as the major nutrition problems in the area and what are the most important causes of these problems?
If the respondent only mentions underlying causes (e.g. poverty, lack of education, etc), try to obtain information on how the respondent sees those underlying causes affect the nutrition status of people (e.g. how does poverty affect nutrition among children).

Problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. But DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words.

	Undernutrition:		Underweight:
			Stunting:
			Wasting:
	Overweight and obesity:		
	Vitamin or mineral deficiencies (specify which ones):		
	Other:		

Causes of existing nutrition problems mentioned:

Tick the appropriate box(es) and take brief notes of any further description. Again DO NOT READ OUT THE OPTIONS. Try to obtain the views of the respondents in their words. If the respondent mentions more causes ask him/her to rank them.

	Food insecurity:		Poor dietary quality:
			Poor dietary quantity:
	Increasing food prices:		
	HIV/AIDS:		
	Insufficient health services /unhealthy environment/ poor quality of health services:		
	Inadequate caring practices for infants and young children:		
	Lack of knowledge (please specify):		
	Poverty:		
	Other (Inadequate water/sanitation, poor water quality):		

1.4 Knowledge of nutrition guidelines and protocols

Ask the question and give time for the respondent to answer. If necessary, read out the options. (Note: asterisks denote correct answer).

A) What micronutrient supplement should pregnant women receive?

Iron only	Folic acid only	Iron and folic acid	Iron and folic acid, and calcium	Iron and folic acid, calcium, and iodine (where salt iodization is inadequate)*	Don't know

B) How soon after delivery should a baby be put to the breast?

Within 1 hour*	Within 6 hours	Within 24 hours	After the mother has recovered	Don't know

C) When should breastfed children start receiving complementary foods?

At 4–6 months of age	At 6 months of age*	At 8 months of age	When the child has got teeth	Don't know

D) Should all infants receive vitamin A supplements?

Yes	No, only if living in areas where vitamin A deficiency is a public health problem, or if suffering from measles*	Don't know

E) Zinc supplements should be given to all children who have diarrhoea.

True*	False	Don't know

F) All children in all countries have the same potential to grow from birth until 5 years,

True*	False	Don't know

G) Infants younger than 6 months who are exclusively breastfed and who get diarrhoea may need some water to replace loss of fluids.

True*	False	Don't know

H) Overweight and obesity are the problems of the high-income segment of the society, so education on balanced diets and healthy lifestyle is not necessary in poor communities.

True*	False	Don't know

I) HIV-infected women who choose to breastfeed should practice exclusive breastfeeding up to 6 months and continued breastfeeding until 12 months.

True*	False	Don't know

Development Pathway/Leadership Section 2

2.1 Do you have a work plan that you follow?

Yes	No	Don't know
If yes where does it come from?		

2.2 Is nutrition one of the stated goals or objectives of you work?

Yes	No	Don't know

2.3 Do you receive standard procedures from central level and if so do they have any nutrition related activities?

Yes	No	Don't know
If yes, specify (and if possible as being more curative or preventive)		

2.4 Do you participate in any facilitated discussions with colleagues in your work in order to decide what you do?

Yes	No
If yes specify	

2.5 Do you have open discussions with groups of people from the community about what to do in your area of work

Yes	No
If yes specify	

2.6 Do you target any of your interventions/work at any particular population group?

Yes	No
If yes specify	

Resource mobilization Section 3

3.1 Do you get a budget from central level that you control?

Yes	No
If yes specify	

3.2 Do you receive funds from any other source such as local government (VDC/DDC)?

Yes	No
If yes specify	

3.3 Do local community member pay any fees for services they receive?

Yes	No
If yes specify	

3.4 Are you provided with supplies from the central/district level?

Yes	No
If yes specify	

Management/organization Section 4

4.1 Do you have any involvement in/and or discuss your annual work plan with your supervisor?

Yes	No
If yes specify	

4.2 Who do you consult if you need technical support regarding nutrition? Technical support includes help with questions you get asked, information about recent advances in nutrition.

4.3 Do you feel that you receive adequate support regarding nutrition? How do you think the support could be improved?

Yes	**No**	**Don't know**
Suggestions for improvement:		

4.4 How often do you review your work plan and progress with your supervisor?

Monthly	**Every six months**	**Yearly**	**Never**

4.5 Do you work in partnership with other group of people or organization?

Yes	**No**
If yes specify	

Human Workforce capacity skills development Section 5

5.1 In the last two years have you been trained in:

Maternal nutrition	Yes	No
Infant and young child nutrition	Yes	No
Breastfeeding	Yes	No
Complementary feeding	Yes	No
Counselling skills	Yes	No
Micronutrients	Yes	No
Diarrhoea treatment (Zinc/ORS)		

Nutritional care of sick children	Yes	No
Management of severe or moderate malnutrition	Yes	No
Growth monitoring and promotion	Yes	No
Healthy diets (including use of locally available food) and physical activity	Yes	No
Hygiene and food safety	Yes	No
Other: _____	Yes	No

5.2 When was the last time you received training in nutrition?

Monthly	**Every six months**	**Yearly**	**Never**

5.3 Are there any areas in nutrition in which you feel that you need more training?

Yes	**No**
If yes, please describe the nutrition areas and the types of training needed:	

5.4 Does your superior officer have training in nutrition?

Yes	**No**	**Don't know**
Observations:		

5.5 Does your superior ever give you any on the job training in nutrition as part of supervision?

Yes	**No**	**Don't know**
Observations:		

5.6 Have you ever been trained in how to facilitate community discussions?

Yes	**No**
If yes how where when?	

5.7 How relevant is the training you have received to your current nutrition tasks?

Not relevant at all	Partly relevant	Relevant	Very relevant	Not applicable

5.8 How confident do you feel when implementing the nutrition actions in your community?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.9 How confident do you feel about advising and supporting a mother to breastfeed exclusively for 6 months?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.10 How confident do you feel about advising on complementary feeding?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.11 How confident do you feel about interpreting growth charts?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.12 How confident do you feel about treating severely malnourished children?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.13 How confident do you feel about counselling HIV-infected women on infant feeding?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

5.14 How confident do you feel about advising on healthy diet and physical activity to prevent overweight, obesity and noncommunicable diseases?

Not confident at all	Confident about some aspects	Confident about most aspects	Confident about every aspect	Not applicable

Information systems Section 6

6.1 What are the most important nutrition-relevant indicators that you routinely collected and/or collated in your work? How often are data collected?
Consult the reference list of indicators and programmes. Probe for routine data, M&E data. Ask to see copy of reports of routine data relevant for nutrition and note whether they are complete and accurate

Nutrition indicators	Frequency of data collection	How is it collected/compiled and through which system	Comment (Do data seem to be complete and accurate?)

6.2 Do you use this information?

Yes	No
If yes how?	

6.3 Where do you send the nutrition-relevant data collected or collated?

6.3.1 Have you ever received feedback on the information on nutrition that you have sent?

Yes	No	Don't know

6.3.2 If yes, is this feedback useful? And how do you use this feedback?

6.4 Do you give feedback to the communities regarding any nutrition information collected?

Yes	No
If yes how?	

Communication Section 7

7.1 Do you have* or have you seen or heard any communication material on nutrition? (wait to hear an answer and if there is none then probe

Type	Yes	If yes what	No	Don't know
Posters				
Pamphlets				
Radio messages				
Films or videos or TV spots				

* if they have then ask to see and keep a copy if you can

Observations: where seen/heard?

7.2 Do you know what "misinformation is?

Yes	No	Don't know
If yes what		

7.3 Within your community do you think most people have a TV or radio in their homes?

Yes	No	Don't know

7.3.1 If yes, do you think they watch or listen on a regular basis?

Yes	No	Don't know

7.4 Do you have any of the following communication methods in your community?

Type	Yes	No	Don't know
TV Station			
Radio Station			
Local News Paper			

7.5 How do you counsel a mother with breastfeeding difficulties?

- *Ask the health worker to describe a regular counselling session with a mother with breastfeeding difficulties.*
- *What questions will he/she ask the mother?*
- *What signs will he/she look for?*
- *Will he/she talk in a certain way with the mother?*

Breastfeeding difficulties: The health worker mentions that he/she

- Considers baby's positioning relative to the mother
- Considers baby's attachment to the breast
- Considers suckling
- Looks for other signs, e.g. mother health status, breast condition

Counselling skills: the health worker mentions that he/she

- Listens to and learn from mothers[1]
- Builds confidence and gives support[2]

Other:

7.6 How do you counsel a mother or caretaker whose child is not growing adequately according to the growth chart?

- *Ask the health worker to describe a regular counselling session with a mother of a child who is not growing well.*
- *What questions will he/she ask the mother?*
- *Will he/she talk in a certain way with the mother?*
- *How will he/she make sure that the mother follows advice?*

Inadequate growth: The health worker mentions that he/she

- Talks to mother to find out whether she follows good feeding practice; that is:
  - Exclusive breastfeeding for infants up to 6 months
  - Continued frequent, on-demand breastfeeding until 2 years or beyond
  - Good hygiene and proper food handling practice
  - Variety of food to ensure that nutrient needs of children are met
  - Appropriate amount and frequency of meals (i.e. increase the number of times and the amount of complementary food as the child gets older)
  - Fortified complementary foods or micronutrient supplements, as needed
- Involves mother in identifying underlying problems and how to solve them:
  - Gives some practical and feasible advice
  - Sets goals with the mother
  - Checks that the mother has understood

Counselling skills: the health worker mentions that he/she

- Listens to and learns from mothers1
- Builds confidence and gives support2

7.7 What are the main challenges you are facing when you counsel mothers or caretakers?

Yes	**No**	**Don't know**
If yes, please describe:		

7.8 How often do you meet with groups of mothers to discuss nutrition related topics?

Once a week	**Once a month**	**Once a year**	**Never**

7.9 Have you been trained to meet with groups of groups in relation to nutrition related topics?

Yes	**No**	**Don't know**
If yes, please describe:		

Infrastructure/Equipment Section 8

8.1 Are you well equipped to do your job?

Yes	No	Don't know
If yes what equipment do they have? If no how could it be improved		

8.2 Is your supervisor well equipped to do their job?

Yes	No	Don't know
If yes what equipment do they have? If no how could it be improved		

8.3 What equipment do you have out of the following?

Equipment	Yes	No	Whose? Own or job provided?
Mobile phone			
Calculator			
Laptop			
Bicycle			
Motor bike			
Others? Specify.....			

8.4 Is their any particular equipment that you think you need to do your job better?

Yes	No	Don't know
If yes what equipment do they suggest?		

Concluding Questions Section 9

9.1 In your opinion, can the nutrition programmes in your VDC/DDC be improved?

Yes	No	Don't know
If yes how?		

9.2 Is there anything else that you would like to add or to ask me? Especially with regard to the implementation of nutrition services in your work and/or in your VDC?

- *Thank the interviewee for taking time to share so much valuable information*
- *Ask if he/she has any questions to ask you*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