Similarly, there are wide disparities by age and sub-ecological regions in the prevalence of childhood anaemia. Anaemia among children aged 6-59 months is the highest (more than 56 per cent) in the Eastern region compared to the hills (40.1 per cent). Anaemia prevalence is 67.5 per cent among infants 6-8 months and 35.8 per cent among children aged 48-59 months[29], indicating that young infants are not receiving adequate nutrition during their first year, which is a critical window of opportunity for overall survival, growth and development.

Many pregnant and lactating mothers continue to miss out on other interventions to protect micronutrient status: for example, only 40 per cent of women received a dose of vitamin A during the postpartum period, and only 55 per cent of women took deworming medication during their last pregnancy[30].

Even though coverage of households using adequately iodized salt has increased from 55 per cent in 1998 to 94.5 per cent in 2016 (23,469,799), [8, 31] the rate is low (86.2 per cent) in the mid Terai compared to the rest of development regions. Only 83.3 per cent of the poorest wealth quintile households are using adequately iodized salt compared to 98.5 per cent of the richest households[32]. Iodine deficiency has severe consequences for brain development.

### 2.4 Systems Strengthening including DRR/CCA

Improving nutrition requires a combination of interventions that are both nutrition specific and nutrition sensitive along with a strong enabling environment with effective legislative/policy framework, adequate institutional capacity for coordination, planning, management, monitoring, an adequate budget and a skilled workforce. However, effective coordination among multiple stakeholders remains a challenge; existing bodies such as the national nutrition and food security steering committee remain ineffective for SUN coordination, multi-sector planning, top-down and bottom-up coordination. In addition, the lack of effective institutional capacity, especially at local levels, to plan, coordinate, implement and monitor nutrition specific and nutrition sensitive interventions continues to pose a challenge. The allocation of resources for scaling-up nutrition specific interventions is not adequate and to this end, there is a need to leverage the health SWAp resources. Moreover, the lack of a skilled nutrition workforce at all levels across all multi-sectoral partners is another constraint. These challenges are further aggravated by frequent natural disasters such as floods, landslides, droughts, and earthquakes and political instability in the country. During such times, the nutrition status of the most vulnerable population including children, adolescents and women is most affected. Hence, any system strengthening efforts for improved nutrition must incorporate DRR, and building resilience to cope with shocks to mitigate nutrition risks and hazards and effects of climate change and other emergencies.

## 3. Theory of Change for Programme Components

The Nutrition theory of change outlined below illustrates the change pathway from activities, outputs, outcomes to the desired impact defined by the Government of Nepal. The nutrition theory of change is guided by the nutrition deprivation analysis, analysis of Gender Empowerment and Social Inclusion (GESI), analysis of causes of adolescent, maternal and young child under nutrition, and the current Nutrition intervention trends and coverage. The theory of change also embraces enablers like leadership, coordination, creating high level ownership and accountability. In order to achieve the nutrition outcomes and outputs, UNICEF will collaborate with the NPC, concerned sectoral ministries, development partners including Suahaara (USAID), WFP, FAO and WHO, civil society organizations,

[29] Ministry of Health and population, USAID, and New Era, Nepal Demographic and Health Survey, Key Indicators Report 2016
30 Ministry of Health and Population, USAID, and New Era. Nepal Demographic and Health Survey, 2011
[31] His Majesty Government of Nepal/Ministry of Health, UNICEF, WHO, the Micronutrient Initiatives, and New Era. Nepal Micronutrient Status Survey ,1998
[32] Ministry of Health and population, USAID, and New Era, Nepal Demographic and Health Survey, Key Indicators Report 2016

and other relevant partners. Together with these partners, UNICEF will contribute to achieving the goals and targets set in national MSNP II, as well as global nutrition targets.

***Outcome:***

***By 2022, children – including adolescent girls – and women of reproductive age have improved and equitable access to and use of adequate nutritious diet and improved nutritional care behaviour and care practices***

Specifically, UNICEF will contribute to this outcome through the following four outputs:

- *Caregivers and communities have increased knowledge and skills to provide improved adolescent, maternal, infant and young child nutrition and care practices*
- *Health workers at subnational levels have increased capacity to provide quality care and treatment for/services to SAM children using standard protocols*
- *Health workers, FCHVs and communities have increased capacity to stimulate demand for supplementation (Vitamin A, IFA, MNP) and to promote fortified foods (iodised salt, wheat flour) and a diversified diet*
- *MSNP sector ministries and partners have increased resourcing and accountability to legislate, plan and influence budget to improve nutrition interventions, including mainstreaming DRR/CCA to plan for, respond to and mitigate the effects of disasters and climate change*

Childhood stunting is one of the most significant impediments to human development. Addressing maternal nutrition and health before, during and after pregnancy (including during lactation), and ensuring exclusive and continued breastfeeding and complementary feeding that is adequate in quantity, quality and variety will be important for further reducing stunting in Nepal. In addition, efforts to reduce gender differences and other inequities through providing gender responsive nutrition services, focusing on under five year's children, adolescent girls and women at reproductive age, are needed.

At the same time, treating SAM among children under five and addressing micronutrient deficiencies among children, adolescent girls and women will be crucial. Finally, unless there are robust systems to enhance the enabling environment and to prevent and respond to the impact of disasters and climate change, achieving and sustaining adequate nutritional status to further reduce stunting will be challenging.

### 3.1 Protection, Promotion and Support of Adolescent, Maternal, Infant and Young Child Nutrition

During the next country programme, UNICEF will continue to support efforts to strengthen the enabling environment to promote MIYCF practices with the overall objective of reducing all forms of malnutrition. Building on current efforts to mainstream the Golden 1000 Days initiative in MIYCF interventions, UNICEF will advocate for and provide technical support to the government for certification of maternity hospitals according to the WHO recommended 10 steps of Baby Friendly Hospital Initiative. This includes identifying hospitals who are adhering to BFHI, training health workers on steps of BFHI and also supporting MoH in monitoring hospitals on the maintenance of BFHI status. The maternity protection act (currently being drafted) has provision of only 16 weeks of paid maternity leave and UNICEF will play a key advocacy role in advocating for its extension to 24 weeks.

UNICEF will advocate for the enforcement of the already existing law on Nepal Code of Marketing of Breastmilk Substitutes to regulate the aggressive marketing of baby formula. UNICEF will also provide support to the implementation of the Maternal Nutrition Strategy (2014) as well as the National IYCF Strategy (2016) and the action plan on Maternal Infant and Young Child Feeding (2016).

In this regard, UNICEF will focus on improving the early initiation of breastfeeding, feeding during illness and improving dietary diversity and minimum meal frequency, exclusive breastfeeding and timely introduction of complementary food. Similarly, attention will be provided in expanding the use of Multiple Micronutrient Powders (MNP) linked with MIYCF in children 6-23 months, sustaining its high coverage and improving compliance.

To this end, support will be provided to implement the national MIYCN action plan with a focus on low performing areas, through capacity development of health workers (at in-service and pre-service level) on the provision of counselling to caregivers on optimal MIYCF practices. Similarly as part of evidence generation, UNICEF will support comprehensive studies on knowledge attitude and practice (KAP) on MIYCF to further understand social norms that undermine breastfeeding and complementary feeding practices, including the gender differences.

In order to increase access to information (and address supply side bottlenecks), UNICEF will promote community dialogue and behaviour change, support capacity development of community groups (female community health volunteers (FCHVs), mother's groups and saving and credit groups) to improve their knowledge and awareness on MIYCF. Similarly, UNICEF efforts will also focus on demand creation through counselling of adolescents and women during pregnancy, delivery and during the neonatal period, caregivers including men on adolescent and maternal nutrition, early and exclusive breastfeeding, frequency and diversity of complementary feeding, hygiene, sanitation and early child care and development through comprehensive social and behaviour change communication for nutrition.

UNICEF assistance will focus on bringing about changes in social norms drawing on a wide network of community level outreach agents. In addition, UNICEF will assist in exploring innovative ways for nutrition education and counselling using mobile technology and social media and to that end, cross-sectoral linkages with C4D will be critical.

As part of cross-sectoral linkages, UNICEF will support the continued integration of MIYCF with ECD through responsive feeding and play therapy and with WASH on hand washing with soap during critical moments and improved hygiene and sanitation. UNICEF will continue strengthening the promotion of IYCF linked with the distribution of Child Cash Grant. Similarly, UNICEF will support to accelerate comprehensive package of nutrition interventions based on the life-cycle approach focusing on adolescent girls and boys, pregnant and lactating women, young children and their caregivers as well as engaging men. UNICEF will also assist in efforts to generate evidence on important and emerging issues such as overweight and obesity and adolescent malnutrition.

### 3.2 Prevention, Care and Treatment of Severe Acute Malnutrition (SAM)

There is a clear recognition that both stunting and wasting confers an even higher risk of morbidity and mortality. In order to address the higher risk of mortality and morbidity due to malnutrition, UNICEF will continue to advocate with the government for the integration of community management of acute malnutrition (CMAM) into the health system including, for example, the addition of ready to use therapeutic food (RUTF) to the essential drugs list. Efforts will also focus on strengthening government capacity to improve coverage and quality of integrated management of acute malnutrition. Similarly, efforts will focus on evidence generation, including, for example, a coverage study of SAM treatment in selected programming areas.

As part of service delivery and in order to address supply side bottlenecks, UNICEF will continue its advocacy for the local production of RUTF along with strengthening MOH capacity to procure and supply RUTF and other nutrition supplies through its supply chain management procedures. UNICEF will also support capacity development of health workers and FCHVs at sub-national levels to screen and refer children for treatment. Efforts will also focus on the establishment of new outpatient therapeutic centres (OTCs) and inpatient treatment centers, and the strengthening of existing out and in-patient treatment centres for the treatment of SAM. In order to address the issues of SAM, the equity issues will be address to maintain equality by focusing focus on the

establishment of new outpatient therapeutic centres (OTCs) and inpatient treatment centres to increase access and utilization to services, particularly in underserved areas. Attention will be provided to scale up the CMAM program in other needy areas and sustaining the cure rates of SAM children.

In order to stimulate demand for treatment of SAM at community levels, UNICEF will focus on social mobilization of communities, religious leaders and caregivers integrating with the MIYCF promotion, WASH, health and ECD services.

### 3.3 Prevention and Control of Micronutrient Deficiencies

Based on the findings of the National Micronutrient Survey (2016), and with a view to strengthening the enabling environment, UNICEF will support efforts to update the national micronutrient control strategy, focusing on anaemia, vitamin A deficiency and IDD. UNICEF assistance will also focus on strengthening monitoring and evaluation of the current anaemia control programme, including through the use of the innovative district assessment tool for anaemia (DATA). In addition, UNICEF will continue its support in the internal monitoring and external verification of adequately iodized salt to ensure the quality of adequately iodized salt reaching at household level. UNICEF will continue focusing on sustaining and maintaining high coverage of micronutrients especially vitamin A, deworming, use of iodized salt, IFA supplementation and flour fortification in large mills. Further, attention will be provided for reversing the negative trends of IFA compliance among pregnant women.

Advocacy for the involvement of the private sector in strengthening the national micro-nutrient initiatives will be important, including advocacy for the local production of multiple micro-nutrient powder (MNP and fortified foods (such as wheat flour, rice and edible oil fortification).

As part of service delivery, UNICEF will continue to provide support for the bi-annual vitamin A supplementation to children aged 6-59 months, along with deworming medicines. In addition, UNICEF will support efforts to improve the supply and delivery of IFA supplements through capacity development on monitoring and supervision along with efforts to increase demand for IFA among adolescents, during pregnancy and during the post-partum period through communication for development efforts such as social mobilization and social marketing.

### 3.4 Systems Strengthening including DRR/CCA

One of the key areas of support during the next country programme will be the implementation, monitoring and evaluation of the MSNP (2018-2022). UNICEF will continue mainstreaming nutrition in different sectors such as Education, WASH, Health, Agriculture, Livestock, Women Empowerment, Child Protection and Governance. UNICEF will support and strengthen evidenced-based bottom-up local planning process, including incorporation of nutrition related Child Friendly Local Governance (CFLG) actions in the plans and programmes of Municipalities and Rural Municipalities, to leverage resources and actions for maternal and child nutrition. UNICEF will also advocate for the creation of a budget code for nutrition and for overall increase in budget allocations for both nutrition specific and sensitive actions through SWAp or pooled funds and non-conditional block grants provided to local bodies. Similarly, UNICEF will initiate leveraging private sectors/corporate partnerships in scaling up nutrition in Nepal.

UNICEF will continue to be engaged in the global SUN movement and strengthen the UN working together through the UN network for SUN. UNICEF will also promote south-south and horizontal collaboration for nutrition.

Disasters and the effects of climate change pose considerable risks to nutrition by undermining service provision, interrupting supply chains and making traditional coping strategies less effective. Ensuring that children, particularly those in their first 1,000 days, have adequate nutrition in emergencies is both an intervention that is immediately lifesaving and one that provides important lifelong benefits. To this end, UNICEF will advocate and provide support to government in the

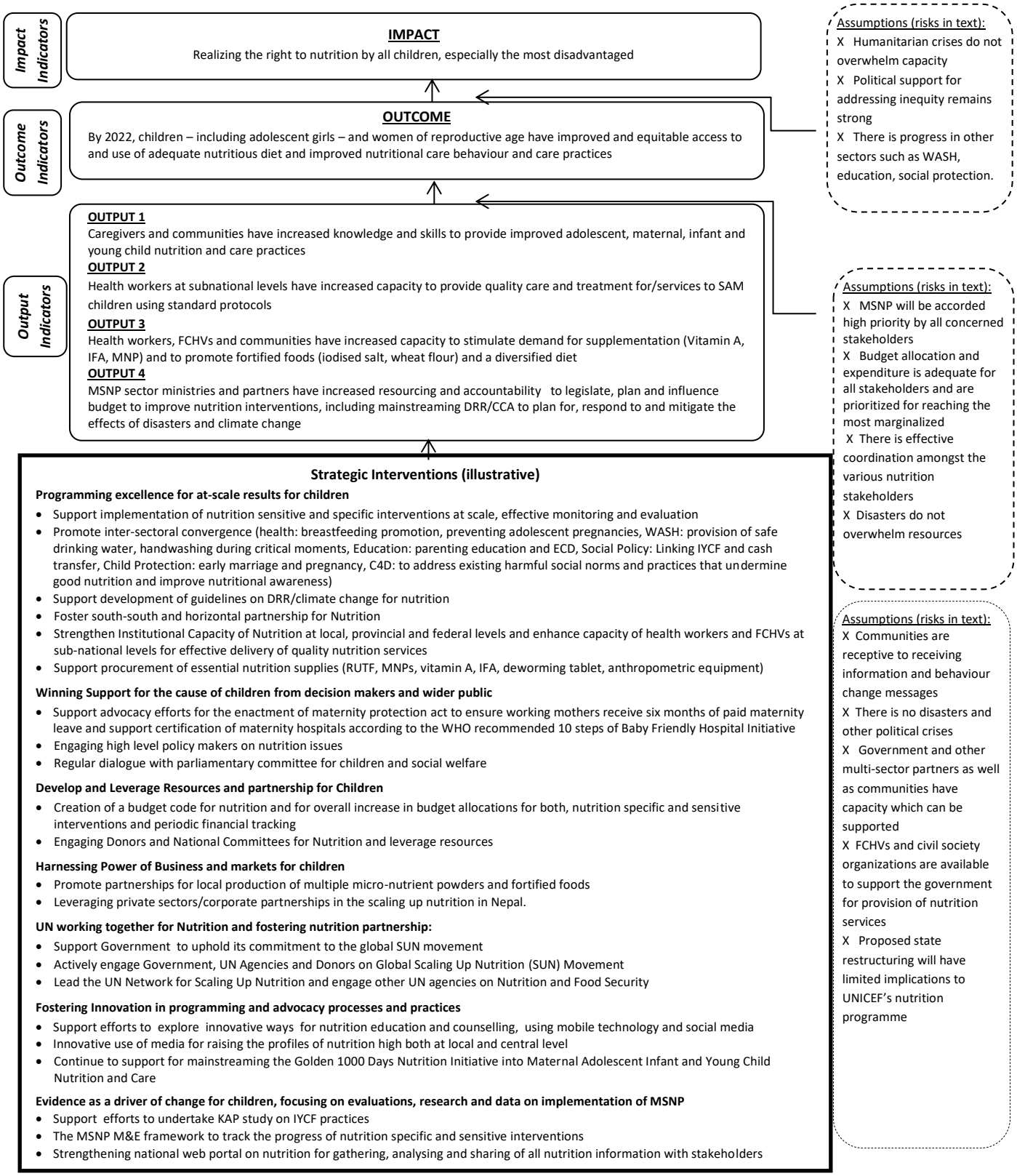
development of guidelines on resilience and disaster risk management/climate change action. UNICEF will support efforts to build resilient families and communities through IYCF, management of SAM in children under-five and through strengthening mechanisms to prevent micronutrient deficiencies in infants, young children, adolescents, and pregnant and lactating women who are particularly vulnerable to shocks and hazards. Similarly, UNICEF will support the government as the cluster lead for the nutrition cluster to coordinate emergency preparedness, mitigation and response.

### 3.5 Major assumptions, key risks associated and mitigation measures

A number of assumptions underlie the above theory of change. The first and foremost is that addressing nutrition continues to be high on the government agenda and that government capacity, including financial and human resources and political commitment are adequate to sustain nutrition specific and sensitive interventions. In particular, it is assumed that delivering services to the most disadvantaged is given priority. Secondly, it is assumed that natural disasters do not overwhelm government and UNICEF resources. Thirdly, it is assumed that the establishment of a federal state structure with substantial devolution of power to the provinces as part of the implementation of Nepal's new constitution in the coming years will proceed smoothly. In particular, it is assumed that the functional distribution of the different tiers of government will happen soon, including civil service restructuring. Fourthly, it is assumed that the enabling environment provides the necessary conditions for both public and private providers to deliver cost-effective nutrition services. Finally, it is assumed that individuals and communities are open to receiving information and behaviour change messages.

Some of the associated risks include natural disasters and the risk of disease outbreaks. Nepal is highly prone to natural disasters and that pose considerable risks to nutrition by undermining the provision of services, interrupting supply chains (both public and private) and overwhelming traditional coping strategies. Key mitigation measures will include continued advocacy on the importance of systems strengthening for disaster risk management and effects of climate change. There is a risk that prolonged disputes over the implementation of the constitution and federalization could lead to political instability, protests and strikes. Key mitigation measures will include supporting and strengthening ongoing participative processes (including UN coherence) and political dialogues. Another major risk includes the current lack of government capacity for coordination among the numerous nutrition stakeholders and the frequent transfer of government staff in their institutions which may lead to delay in programme implementation or failure to achieve results. Key mitigation measures will include rapid orientation of transferred staff as well facilitation of knowledge sharing. In addition, government bureaucracy as well as budget (delay in planning and budget allocations) and cash management practices may pose risk as well. Key mitigation measures include mechanisms that have already been put in place to reduce risks related to high cash transfer including a monitoring system of payment to partners as well as providing support to national budget planning process and harmonizing UNICEF's annual and multi-year planning process with the government's framework.

## Schematic Illustration of the Theory of Change – Nutrition



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[redacted]

[redacted]

**Note for the Record**

Subject: **Environmental Impact Assessment (EIA)**

As part of the development of the [redacted] and in accordance with recommended practice, the UNICEF Country Office [redacted] has undertaken an initial screening of all proposed activities within each draft programme component to assess their potential impact on the environment.

The Country Office applied the recommended assessment methodology as described in the PPP Manual, Chapter 6, Section 3 (the Manual's 2011 version), namely Checklist 1 "Initial Screening". The completed checklist attached to this note reflects that the Country Office considers that the programme components contemplated in the draft Country Programme Document, submitted to the UNICEF [redacted], should have no impact on the environment.

Sincerely,

[redacted]

Attachment 1 – Checklist 1 *"Initial Screening"*

[redacted]

**Checklist 1- Initial Screening**

Does the proposed programme or project contain activities that fall under one or more of the following categories? If the answer is **NO,** and EIA is not required, and the process is complete

- Extraction of water (e.g., groundwater, surface water, and rain water) NO
- Disposal of solid or liquid wastes (e.g., human faeces, animal wastes, used supplies from a health centre or health campaign) NO
- Use of chemical (e.g., pesticides, insecticides, paint and water disinfectant) NO
- Use of energy (e.g., coal, gas, oil, wood and hydro, solar or wind power) NO
- Exploitation of natural resources (e.g., trees, plants, minerals, rocks, soil) NO
- Construction work above household level (e.g., hospital or school) NO
- Changing land use (deforestation, forestation, and developing industrial housing or recreational centres) NO
- Agricultural production (e.g., growing crops, fish farming) NO
- Industrial production (e.g., small scale town/village workshops) NO

[redacted]

[redacted]