SUAAHARA-GOOD NUTRITION
(INTEGRATED NUTRITION PROGRAM)

Program Description

August 2011-August 2016

Implemented by

Save the Children in collaboration with Helen Keller International, Jhpeigo, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Nutrition Promotion and Consultancy Service (NPCS), Nepali Technical Assistance Group (NTAG), and Nepal Water for Health (NEWAH)
A. Executive Summary

Rates of malnutrition in Nepal are among the highest in the world, and while the government has made progress reducing child mortality, there has been little impact on improving maternal and child nutritional status. The Government of Nepal (GoN) received international acclaim for its Vitamin A supplementation coverage a decade ago, but other nutrition-focused programs have not achieved the same successes, such that Nepal is currently unlikely to achieve the Millennium Development Goals (MDG). The Integrated Nutrition Program (SUAAHARA), or Suaahara (Good Nutrition)\(^1\) is intended to target this challenge and will support the government in addressing under-nutrition and related health issues for women and children under two years of age in 25 targeted districts in Nepal with poor nutrition indicators. The goal, strategic objective (SO), and intermediate results (IRs) of this program are expressed in the table below.

<table>
<thead>
<tr>
<th>Goal: Health and Well-being of Nepalis Improved and Sustained</th>
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<tr>
<td><strong>SO:</strong> To Improve the Nutritional Status of Women and Children Under Two Years of Age</td>
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<td><strong>IR1:</strong> Household (HH) health and nutrition behaviors are improved.</td>
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<td><strong>IR2:</strong> Women and children increase use of quality nutrition and health services.</td>
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<td><strong>IR3:</strong> Women and their families increase consumption of diverse and nutritious foods.</td>
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<td><strong>IR4:</strong> Coordination on nutrition between government and other actors is strengthened.</td>
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Save the Children Federation Inc. (SC/US) has formulated an exceptional partnership with local, national, and global expertise and experience necessary to achieving Suaahara’s strategic objective and reducing malnutrition in Nepal. The partnership is uniquely placed to work with the GoN and local institutions to develop and implement the Suaahara strategy in 20-25 districts, as well as to deliver the program at the community and household level where there is urgent need to improve nutrition practices.

<table>
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<tr>
<th>Partner</th>
<th>Expertise and Experience for SUAAHARA</th>
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| Save the Children (prime) | Infant and Young Child Feeding (IYCF) programs and advocacy  
Community-based growth monitoring and promotion  
Community management of acute malnutrition (CMAM)  
Reducing newborn mortality  
Integrated Management of Childhood Illness (IMCI) and Community-based IMCI  
Capacity building of local partners and supportive supervision  
Maternal, newborn, and child health (MNCH) advocacy and policy  
Gender and social inclusion (GeSI) |
| Helen Keller International (HKI) | Essential Nutrition Actions (ENA)  
Home-based food production (HFP)  
Nutrition policy and advocacy  
Micronutrient supplementation and fortification |
| Jhpiego | Improving maternal and child health (MCH) service delivery  
Promotion of healthy timing and spacing of pregnancy  
Health and reproductive health (RH) policy |
| Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP) | Design of targeted communications strategies  
Materials and media development  
Public-private partnerships  
Behavior change communications (BCC) programming |
| Nutrition Promotion and Consultancy Service (NPCS) | Community-level implementation of ENA  
Food-based approaches to preventing malnutrition  
Female community health volunteers (FCHV) training and support |
| Nepali Technical Assistance | Training-of-Trainers (TOT) for district health staff in ENA |

\(^1\) Suaahara (Good Nutrition) stands for Suddha Santulit Aahar Hamro Jeevan ko Rakshha ko Baliyo Aadhar – “A good balanced diet is the strong foundation protecting our lives.”
<table>
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<tr>
<th>Group (NTAG)</th>
<th>Implementation of initiatives, such as Vitamin A and community-based IMCI and Intensification of maternal micronutrients programming</th>
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<tr>
<td>Nepal Water for Health</td>
<td>Hygiene promotion</td>
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<td>(NEWAH)</td>
<td>Implementation of Essential Hygiene Actions (EHA)</td>
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<td></td>
<td>Community-led total sanitation (CLTS) approach</td>
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<td></td>
<td>Low-cost technology for water and sanitation</td>
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<td></td>
<td>GeSI</td>
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</tbody>
</table>

Lessons learned and successes generated from members have informed the strategy for *Snaabara*, including the *Saving Newborn Lives (SNL)* initiative managed by SC globally and in Nepal; *Alive and Thrive* in which SC is a core technical partner on the global team and serves as country lead in Vietnam; the USAID-supported *Nepal Family Health Program (NFHP II)* in which SC and Jhpiego are partners; the USAID-funded *Maternal and Child Health Integrated Program (MCHIP)* led by Jhpiego with SC as a partner; the USAID-funded *Jibon-o-Jibika* and *Nobo-Jibon* food security programs in Bangladesh managed by SC with HKI as a partner; *Pakistan Initiative for Mothers and Newborns (PAIMAN)* in which JHU/CCP and SC are consortium members; USAID-HKI’s *AAMA* project; and the recent DFID-funded *Support to Safe Motherhood Program in Nepal* where JHU/CCP strengthened government and NGO BCC capacity to use localized approaches to reach out to marginalized populations.

*Snaabara* will focus on improving health and nutrition behaviors at the household level through promotion of the ENA, particularly IYCF, and addressing other determinants of under-nutrition, such as availability of and access to food, quality of health care, child spacing, and socio-cultural factors including gender and marginalization. *Snaabara* will support the GoN to institute nutrition interventions and policies enabling achievement of goals in the National Nutrition Action Plan. *Snaabara* will assist the government to build capacity of health workers, as well as staff from the Departments of Agriculture, Local Governance, Education, and Water. This will create multi-sectoral collaboration and synergy to address the pervasive problem of under-nutrition.

The project will employ the USAID-developed ENA as the foundation of the technical approach. *Snaabara* will incorporate Essential Hygiene Actions (EHA) into the project’s ENA framework, along with promotion of child spacing and family planning and activities to discourage smoking among women. All components will be integrated creating the ENA Plus (ENA+) package. A behavior change (BC) strategy using multiple approaches will be developed after conducting rapid formative research around barriers and facilitating factors for BC among the target population. BC approaches will range from interpersonal communication (such as counseling by health workers), to mass media (e.g. radio). *Snaabara* will inventory existing curricula and materials in Nepal, making revisions as needed for ENA+.

To improve access to nutritious food for a varied diet, *Snaabara* will implement HKI’s HFP model in food insecure districts. This model promotes small-scale poultry production and home gardening to increase year-round HH-level availability of micronutrient-rich foods and animal foods. The on-going USAID-funded *AAMA* project has fully integrated HFP with ENA in two Far West districts. In other districts, *Snaabara* will introduce less-intensive efforts to increase local poultry production and raising micronutrient-rich vegetables in collaboration with the district agriculture staff. *Snaabara* will pilot a larger-scale poultry production as a social enterprise in some districts and will facilitate public-private partnerships to make fortified foods or supplements accessible.

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2 Both SNL and Alive and Thrive are funded by Bill and Melinda Gates Foundation. Alive and Thrive is seeks to reduce under-nutrition and death by addressing sub-optimal infant and young child feeding practices.
Suaahara’s main local coordination partners at the district level for the care and health dimensions will be the District Health Office (DHO), as well as the District Water Supply and Sanitation Office (DWSSO), while the District Departments of Agriculture and Livestock and will be the key partner for the food dimension of Suaahara. The District Development Committee will be a key partner for coordination, capacity building, and community outreach. Health center staff will be trained and supported to provide supervision and assistance to community volunteers. Suaahara will form a new cadre of volunteers “poshan aamas” (PAs) from existing mothers’ groups to help the FCHVs expand nutrition activities to reach all community members. The Suaahara team will partner with local NGOs active in the targeted districts to implement key project activities, including field assistance for the agriculture component and follow-up and supervision of ENA+ interventions in communities.

Suaahara will be linked to and mainstreamed into existing platforms such as Safe Motherhood (SM), Birth Preparedness Program (BPP), Community-Based Newborn Care Program (CBNCP), Integrated Management of Childhood Illnesses (IMCI), Family Planning (FP), Infectious Diseases, and Water and Sanitation operating in the target districts to the extent possible. ENA will simultaneously create a platform for introducing new programs such as USAID’s Feed the Future, the European Commission’s (EC) Food Facility and other relevant programs.

From the onset, Suaahara will work with and through district-level actors and community structures building linkages needed to continue programming after a shift to federalism. This strategy will allow project activities to proceed in the event of political unrest, a possible challenge in some of the target districts.

Overwhelmingly, the majority of Suaahara staff will be based in the field to ensure maximum coverage in the 20-25 project districts. Our management approach employs a two-tiered system – clusters and district - grouping target districts into three clusters to place technical support as close as possible to the point of implementation. The project will also address the needs of municipalities that are growing in size and number and currently operating under a parallel system of government. The approach will be tailored to address the varying needs of the different types of municipalities, whether urban slum populations of Terai districts or remote settlements of hill districts. As community volunteer systems are not uniform across municipalities the innovative new cadre of “poshan aamas” will be introduced and tested, reaching more marginalized communities and families.

With Suaahara partners already working in 19 of the 25 districts, SC’s team is well-placed to mobilize staff and project start-up rapidly and commence work with and through community-level organizations, government counterparts and USAID to help Nepali mothers ensure their newborn children survive and thrive.
II. TECHNICAL APPROACH
A. Introduction

In Nepal, while maternal and child mortality rates have fallen considerably over the past decade, maternal and child nutritional status remains poor. This is part of a global phenomena where advances in child survival fail to translate into commensurate nutrition gains. The primary determinants of under-nutrition in Nepal include care dimensions (poor feeding and care-related behaviors), health dimensions (including hygiene and sanitation; lack of potable water, and a high prevalence of infections that reduce food absorption and utilization); and food dimensions (inadequate food availability, access, affordability, quality, and nutrient density).4

There have been a number of successful child health and nutrition initiatives in Nepal over the past two decades; yet, care practices - particularly those related to nutrition - at the family level remain poor. For example: exclusive breastfeeding has decreased from 74% in 1996 to 53% in 2006, only 20% of children 6-9 months of age consume vitamin A rich food and animal protein intake is much lower, 43% of children under-two years of age are not fed according to the recommended IYCF practices, use of oral re-hydration solution during diarrhea has dropped to 29% in 2006 from 32% in 2001, and feeding practices during illnesses continue to be poor, with only 6% of children receiving more food during the diarrheal episode. Though some hygiene and sanitation practices have improved, such as safe disposal of children’s stools, more needs to be done to ensure appropriate hygiene and sanitation practices and improved provision of adequate and safe drinking water. Nepal has achieved high Vitamin A supplementation coverage twice yearly to children 6-59 months, which dramatically improves child survival but does not address caloric and other nutrient needs. This program seeks to build on successful experiences from the health sector that a number of Suaahara partners have directly contributed to, notably the groundbreaking work of community-based treatment of pneumonia and successes in family planning and newborn care, and bring this expertise to integrated nutrition programming.

Health facilities suffer from issues of access and quality of care. In mountain and hill regions, people must routinely walk many hours to reach the nearest health post, which may be open only limited hours per week. Health facilities are chronically understaffed and patient loads are high, particularly in densely populated areas, with a single health worker attending up to 100 patients per day. With donor support, the Ministry of Health and Population (MOHP) has begun to improve infrastructure, equipment, and supply chains, but much remains to be done. The institutionalization of IMCI and CB-IMCI represents major progress in provision of better care.

The health system is not always well-equipped to deliver key nutrition interventions nor is it always the appropriate mechanism to address the underlying determinants of under-nutrition and current strategies are insufficient to achieve significant nutritional improvements. These programs have partially incorporated counseling mothers on maternal nutrition, breastfeeding, complementary feeding, or feeding of the sick child, but lack rigor in implementation. Growth Monitoring Promotion (GMP), a health facility-based intervention that is implemented nationally, does not reach the majority of the target population and lacks counseling and follow-up components. Most child health interventions of the government focus on under-fives; however, evidence shows nutrition programs are more likely to have impact when targeting the window of opportunity for interventions: pregnancy through 24 months of age.

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3 2006 Nepal Demographic and Health Survey
5 2006 Nepal Demographic and Health Survey.
6 2006 Nepal Demographic and Health Survey
7 2006 Nepal Demographic and Health Survey
Nepal is recognized for successes in community health programming, particularly in implementing a nation-wide cadre of FCHVs that has been vital to scaling-up some successful community-based programs, such as the National Vitamin A program, the Iron Intensification program, CB-IMCI, a Birth Preparedness Package (BPP), and piloting Community-Based Newborn Care Program (CB-NCP). These evidence-based interventions to address under-nutrition have been highlighted in the 2008 Lancet Series.

In terms of food dimensions, improvements in agricultural productivity have not maintained pace with population growth, particularly among small landholders and female farmers, the latter constituting over 60% of the agricultural labor force. In rural areas, particularly in the more inaccessible hill and mountain regions, year-round HH food security is a critical obstacle to achieving optimum nutrition in young children and women. HHs are unable to produce a variety of adequate food or do not have resources to purchase high-nutrient foods from the local market. The most recent WFP surveillance data indicate that 10 out of 18 Suaahara districts surveyed were food insecure in 2009, including four of six mountain districts, two of six hill districts, and three of five Terai districts. IFPRI’s 2008 Global Hunger Index Report categorized nine Suaahara hill districts as having a serious hunger problem, two hill, eight mountain, and five Terai districts as being alarming and one mountain district as extremely alarming. Fortified foods, which also can provide critical benefits to young children and women of reproductive age, are not yet available in remote areas where under-nutrition is greatest.

The relationships between household (HH) food insecurity and under-nutrition are inconsistent and complicated by multiple determinants. A recent study in Kailali (Terai), found no significant association between HH food insecurity and stunting, underweight, or anemia among preschool children. Conversely, in Baitadi (hill), a significant association was found between HH food insecurity and stunting in children and anemia among mothers. However, this association was not seen with wasting, underweight, or anemia in children and BMI in mothers. This underscores the need to better understand, classify, and address the local determinants of under-nutrition that vary by such factors as geographic area, socio-economic groups, and by HH, as a critical step towards effective programming. In addition, the project will consider social and cultural dynamics of community and intra-HH food distribution and behaviors.

The emphasis going forward must be building upon existing successful government and non-government platforms of maternal and child health and food security programs, and strengthening the focus to achieving BCs at the HH level. This will require a customized strategy for addressing local determinants of currently inadequate health and nutrition practices with approaches that are scalable and sustainable.

B. Implementation Approach
The purpose of Suaahara is to improve the nutritional status of women and children under-two years of age in 20 - 25 target districts. To achieve this, support will be provided at all levels:

- at the national level to improve advocacy leading to better national policies, strategies and guidelines and increase investment in nutrition;
- at the regional level to strengthen health and agricultural systems for nutrition;

• at the district and sub-district levels to improve service provider capacity through training; and
• at the community level to support communities to improve family actions on nutrition.

Suaahara will work with the GoN with multiple Ministries including MoHP, Ministry of Agriculture (MoA), Ministry of Local Development (MoLD), and Department of Water Supply and Sanitation to strengthen programs and promote needed supportive policies. Suaahara will develop a strategic multiple-level BCC approach. To address, at scale, the nutrition problems facing under-two children and women in the project areas, the program will strengthen HH nutrition knowledge, attitudes, and practices; improve quality of health, counseling, and referral services; encourage more care-seeking behavior; and work closely at the district level with the health sector, and other sectors, specifically in water/sanitation, agriculture, micro-enterprise development, and education, with a focus on building local capacity to promote improved nutrition and related behaviors at the HH level.

<table>
<thead>
<tr>
<th>Goal: Health and Well-being of Nepalis Improved and Sustained</th>
<th>1. HH Health and Nutrition Behaviors are Improved</th>
<th>2. Women and Children Increase Their Use of Quality Nutrition and Health Services</th>
<th>3. Women and Their Families Increase Their Consumption of Diverse and Nutritious Foods</th>
<th>4. Coordination on Nutrition between Government and Other Actors is Strengthened</th>
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<tr>
<td>IR1: HHs adopt ENA including IYCF</td>
<td>2.1 PLW and infants have improved access to high quality facility-based services (inc. micronutrient supplementation)</td>
<td>3.1 Mothers and children have access to locally-produced nutrient-dense and fortified foods (inc. animal source protein)</td>
<td>4.1 A national mechanism is in place that allows for regular coordination and information sharing among government and other entities with responsibilities for achieving MDG1 and reducing the level of under-nutrition in Nepal.</td>
<td>4.2. A regional and district mechanism is in place to improve collaborative action on nutrition and hygiene among government entities, civil society partners, and the private sector.</td>
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<tr>
<td>1.2 HHs adopt EHA</td>
<td>2.2 Facility-based IMCI activities, including supervision of CB-IMCI are improved</td>
<td>3.2 HHs have increased knowledge of nutrition of locally available foods</td>
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<td>2.3 Facility-based GMP services comply with national/global standards (inc. shifting GMP work to community level with MOHP plans)</td>
<td>3.3 Communities increase resilience to potential nutrition shocks through community-based initiatives</td>
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<td>2.4 Services for the treatment of severe acute malnutrition (SAM) adhere to national/global protocol (with possible CMAM activities in areas with high SAM prevalence)</td>
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<td>2.5 Facility-based and outreach family planning services provide effective counseling on healthy timing and spacing of pregnancy (HTSP)</td>
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### Key Strategies and Activities under SUAAHARA

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<th>Assessments:</th>
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<th>Integrated coordination and advocacy strategy:</th>
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<tr>
<td>Community mobilization for improved nutrition; multiple channel BCC strategy (from IPC to mass media); training and capacity building; community level volunteer cadre (poshan aama) to support FCHV</td>
<td>Community mobilization; BCC; service delivery for nutrition under FP, IMCI, GMP, SAM management, HTSP and ENA+ contacts; training and capacity building; supportive supervision tools; improved provision/access to materials, supplies and commodities; advocacy and guideline development</td>
<td>Community mobilization; BCC; village model farms; access to agriculture extension; integration of nutrition actions into disaster preparedness plans and response; training and capacity building; small grants program with TAG; coordination and advocacy</td>
<td>National level nutrition coordination meetings; inter-sectoral coordination among ministries; technical meetings and briefings; district coordination meetings; capacity strengthening in planning and preparing budgets</td>
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#### BCC, Training and Capacity Building

- Gender and Social Inclusion (GeSI) and Public and Private Partnerships

#### M&E

- District Implementation

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The *Suaahara* consortium includes three experienced national NGOs and will reach out to additional local NGOs and CBOs through a small grants program and coordination committees organized at the district level. *Suaahara* will also coordinate with international NGOs implementing related programs and build on successes and lessons learned from previous nutrition projects. SC and HKI will use current participation in the National Nutrition Coordination Committee (NNCC) to link with UN agencies and other donors. Details on how *Suaahara* will build linkages and momentum with government, donors, and other agencies are described in Section IR.4.

*Suaahara* will create the foundation for the introduction and implementation of programs such as the *Feed the Future*, the *Food Facility Project*, EIG, and other key initiatives focused on economic development and infrastructure construction. The project will work closely with other groups providing food, agriculture and nutrition assistance to vulnerable HHs in the project areas such as the WFP Protracted Relief and Recovery Operation, FAO’s support to agriculture, Suaaharauls, and UNICEF/WFP micronutrient powders. The project will emphasize working across a variety of levels, partners, and entry points to achieve public health and nutrition impact and sustainability.

The *Suaahara* team will take the program to scale in all 25 districts, phasing in the well-defined series of project activities in two groups or phases of districts with 20 districts in the first phase in Year 1 and 5 districts in the second phase in Year 3. *Suaahara* will adapt the phasing strategy in response to baseline data and formative research conducted in the first months of the project, with all districts beginning the series of activities by month 12 after project launch. Districts with large populations, high levels of food insecurity, and stunting will be given priority in the phasing. And over the last 18 months of the project, *Suaahara* district staff will be gradually phased out so as to build up the self-reliance of district government offices. The local district NGOs and the *Suaahara* cluster teams will continue to monitor the districts and provide support as required.
Phasing District Entry Plan and Anticipated Districts

<table>
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<tr>
<th>Phase 1 (Year 1)</th>
<th>Sankhuwasava, Dolakha, Sindupalchok, Baglung, Darchula, Rupandehi, Parbat, Taplejung, Bajura and Bajhang, Gorkha, Myagdi, Solukhumbu, Nawaplarasi, Bhopur, Rasuwa, Manang, Lamjung, Mustang, Syangja</th>
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<tr>
<td>Phase 2 (Year 3)</td>
<td>Five districts to be determined with USAID</td>
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C. Key Strategies and Interventions

- *Suaabara* will reach about 350,000 children under two and their mothers in the 20-25 target districts
- The project will improve nutritional status of and save over 35,500 lives
- The target area includes 1201 VDCs with approximately 1200 functioning health facilities.

The project will employ the USAID-developed ENA framework as the foundation of the technical approach. *Suaabara* will incorporate EHA into the project’s ENA framework along with promotion of child spacing and family planning and activities to discourage smoking among women. All these components will be integrated into one package developing an ENA+ framework, which will be promoted through the six critical life cycle contact points (pregnancy, delivery, postnatal and family planning, immunization, well child and GMP and caring for the sick child). *Suaabara* will mainstream ENA+ interventions, within Nepal’s current nutrition programs and through the other aforementioned sectors. *Suaabara* will be linked and mainstreamed to the extent possible, into existing platforms such as the safe birthing, birth preparedness package, community-based newborn care package, IMCI, family planning, and infectious diseases and water and sanitation programs operating in the target districts. Thus, reinforcing a continuum of care from pregnancy and delivery to children under two years of age. With the inclusion of the ENA+ framework, these existing programs will be able to reach more women and young children more often with critical nutrition support.

### The ENA+ Package

- Optimal breastfeeding during the first six months
- Optimal complementary feeding at 6 months with continued breastfeeding up to two years
- Optimal nutrition care of sick and severely malnourished children, and targeting moderately undernourished children for prevention education
- Prevention of Vitamin A deficiency for women and children
- Promotion of adequate intake of iron and folic acid, and prevention and control of anemia for women and children
- Adequate intake of iodine by all members of the family
- Optimal nutrition for women (especially during pregnancy and lactation period)
- Promotion of child spacing and family planning
- Dangers of smoking to the health of mother and baby
- Treatment and safe storage of drinking water
- Hand washing with soap or ash at critical times (after defecation or handling feces and before preparing food, feeding children, and eating)
- Safe disposal of feces
- Proper storage and handling of food to prevent contamination
- Community construction and use of affordable latrines

*Suaabara* will implement behavior change strategies at all levels to create demand for improved ENA+ policies and practices. *Suaabara* will bring growth monitoring and promotion (GMP) to

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the community through the development and testing of community-based GMP (CB-GMP). It will support the GoN to develop a GMP strategy for the country, based on the testing of the CB-GMP and through analysis of the present facility-based GMP model. In districts that are severely food insecure\textsuperscript{16}, Suaahara will implement a homestead food production (HFP) model targeted at HHs with pregnant women and children under two years of age. These HHs will receive support from the establishment of village model farms, a model adapted from the currently implemented AAMA project that has successfully mainstreamed the ENA framework within agriculture production field activities and created strong links to existing health workers, including FCHVs. Suaahara will promote hygiene and sanitation behaviors through inter-personal communication (IPC), schools, social events, and mass media messages. Suaahara will expand UNICEF’s successful Community-Led Total Sanitation (CLTS) to improve access to and use of latrines. To prepare for nutritional support during emergencies, the project will identify vulnerable areas and will strengthen the nutrition component of the district emergency preparedness plans.

**IR.1 HH health and nutrition behaviors are improved**

**Output 1.1: HH Adopt Essential Nutrition Actions Plus (ENA+) including IYCF**

The ENA+ framework will include the EHA, family planning, and smoking reduction. Each component of the framework is comprised of multiple behaviors, and Suaahara will give particular emphasis to IYCF behaviors, maternal nutrition, child spacing, and anti-smoking. For IYCF, Suaahara will apply the “FATVAH method” (age specific -Frequency, Amount, Texture, Variety, Active Feeding, and Hygiene) to make complementary feeding more understandable and practical for mothers including child feeding during/after illness.

A primary means of reaching HHs with the BC activities is through community volunteers. The FCHVs already promote many of these behaviors and will participate in ENA+ training to further enhance their knowledge and skills in transmitting messages and promoting BC. To reach a greater number of HHs with the intensity and frequency needed to affect this change, Suaahara will create a new cadre of volunteers called posthan aama (PA), or “nutrition mothers.” It will recruit women from the members of existing mothers’ groups, many who have been participating and learning for over a decade. Suaahara will select one or two PAs for each community, with a preference for those who can reach marginalized groups and castes. FCHVs will direct them to become change agents at the community and HH level. As a team, the FCHVs and PAs can reach beyond the mother’s groups to identify newly pregnant women, meet with mothers-in-law, grandmothers, opinion leaders and men’s groups, as needed, and promote community understanding of the need to change behaviors.

For sustainability, Suaahara will collaborate with VDCs to solicit support for the PAs, including funding to cover participation costs for trainings. Suaahara will build upon existing examples of VDC support for FCHVs, such as the provision of bicycles in Kailali, and will explore new incentives options for FCHVs and PAs. For example, the project may provide chickens to FCHVs who would share offspring with PAs, but this is dependent on maintenance resources for poultry.

The current mothers’ groups have become lethargic as there is no mandate for the FCHVs to recruit new, younger mothers. Suaahara will rejuvenate the concept of mothers’ groups to include mothers of children under two and pregnant women. In smaller communities, all women in the community (e.g. older women and adolescent girls) will be invited, as well. Suaahara will train and mentor FCHVs and PAs in group facilitation and use of adult learning principles.

\textsuperscript{16} Darchula, Baitadi, Doti, Mustang, Manang, Gorkha, Dolakha, Sankuwashabha and Taplejung. Districts were selected based on MoAC/ WFP’s Food security targeting map, 2010.
Suaabara will compile existing materials from all related projects such as AAMA, SNL, Alive & Thrive, Nobo-Jibon, and prior projects. The project will be review and adapt these materials, with permission, for use by FCHVs, PAs, and health staff. Counseling cards, posters, and job aids will be available for different levels of literacy. Suaabara will conduct brief ethnographic studies to inform design and will pre-test all materials in a variety of contexts across the target districts. These studies will also provide information needed for mass media interventions.

The training curricula for health sector managers, workers, and community volunteers adapted for the AAMA project from the Linkages project will be further adjusted based on lessons learned and adapted to the culture and context of the initial 20 target districts through formative research. This module and the AAMA materials will form the basis of an expanded set of ENA+ training materials. Suaabara will use a cascade training approach, first creating a team of Master Trainers at the national level, who will train trainers at the district level. The district-level trainers will train health facility staff and the FCHVs and PAs under supervision of the Master Trainers. A one-day refresher training on ENA+ will be conducted. Suaabara will train all 16,562 FCHVs in the project districts, and estimates it can train, mobilize and support almost 25,000 PAs.

Suaabara will also support integration of ENA and BC content using state-of-the-art pre-service education approaches for tomorrow’s health service providers to foster long-term capacity development and sustainability. To this end, Suaabara will implement a small annual workshop series throughout the life of the project that will target key academic, government, and external development partner (EDP) stakeholders from outside the Suaabara project. This will help to enhance pre-service uptake of ENA+ but will also help to socialize ENA+ within the larger pool of implementers and donors in Nepal. Suaabara will work with the national and regional health training centers and the department of health systems to develop official government certification processes for these ENA + modules and support them to incorporate the training into health facility and FCHV level training on the national level.

Elements of supportive supervision and the system of community self-monitoring will be integrated, as appropriate, into the ENA+ training of NGO partners, district staff and FCHVs. Key information that may be collected by the FCHV and PAs includes number of visits made to mothers with children under two, number of new mothers included in the group, or number of training sessions provided on specific ENA+ topics. Suaabara trainings will include practical sessions providing hands-on practice in supportive supervision and monitoring skills, important management tools for the FCHVs. Suaabara will build on prior experiences of the FCHV program using community-based pictorial monitoring forms to capture relevant ENA+ information. On-the-job review and training by Suaabara district staff will ensure understanding and improve overall performance. The monthly FCHV meetings at the ilaka level will serve to reinforce knowledge and FCHV skills in counseling using negotiation for BC and in group facilitation.

**Output 1.2: HHs Adopt Essential Hygiene Actions (EHA)**

The EHAs will become an integral part of the ENA+ framework, with locally appropriate and targeted messages included as part of the ENA+ training package and social mobilization activities. The inclusion of EHA messages and actions into the ENA+ package will be coupled with activities to ensure HHs and communities have the means to undertake the BC promoted. Because lack of clean water and poor sanitation and hygiene are determinants of malnutrition in
all 20-25 target districts to some extent, promotion of EHA actions are key to project success. *Suaahara* will focus EHA messages and actions on the five key aspects of water and sanitation: 1) Treatment and safe storage of drinking water; 2) Hand washing with soap or ash at critical times (after defecation or handling children feces, before preparing food, before feeding children, before eating); 3) Safe disposal of feces; 4) Proper storage and handling of food to prevent contamination; and 5) Community or family construction and use of affordable latrines. Some of the EHAs require BC only, whereas others, such as use of safe water for drinking and cooking or latrine use, require that a HH has access to clean water or a latrine. Based on the situation analysis, *Suaahara* will target more intensive interventions to the districts with greatest need.

The project will begin by collecting all available data and existing information related to current water availability and usage and hygiene practices in the initial 20 target districts. NEWAH will conduct an inventory of the materials (promotional, training, and informational educational communication or IEC) currently existing and relevant which may be adapted for the present effort. After conducting formative research to discern barriers to adoption of optimal EHA behaviors, *Suaahara* will work with the partners and local stakeholders to develop an appropriate communication strategy incorporating key EHA messages relating to poor nutrition among women and children. It will train PAs to monitor and support HHs to adopt the EHA practices.

Where lack of clean water or sanitation infrastructure are barriers to EHA, *Suaahara* will mobilize communities to work actively with government departments and the water, sanitation, and hygiene (WASH) agents at the district and community level to advocate for improved water and sanitation services. It is beyond the scope of this project to construct water systems or latrines; however, the project can demonstrate the importance of testing water and promote knowledge on water treatment.

The project will follow guidelines of the National Hygiene and Sanitation Master Plan to promote Open Defecation Free (ODF) VDCs through CLTS approach for building simple latrines and linking communities or HHs with available resources to move towards an improved stage of sanitation. The project will also provide technical assistance, access to appropriate technology, and conservation ideas for improved use of water for cooking and hygiene, particularly in areas where water is scarce at least during certain periods of the year.

*Suaahara* will introduce EHA in all schools in the target areas, using Global Hand Washing Day, National Sanitation Week, and similar occasions to motivate children to become change agents in the community. *Suaahara* may also work with some schools to implement the child-to-child approach for promoting EHA behaviors with which SC has had success in Nepal through its ongoing School Health and Nutrition program.

**IR2. Women and children increase use of quality nutrition and health services**

**Output 2.1: Pregnant and lactating women and infants have improved access to high-quality facility-based services during the pregnancy and first year post-delivery**

Continuing the strategy of maximizing all existing program opportunities both inside and outside the health sector, *Suaahara* will work within the health system and be ready to respond to the demand created for services. *Suaahara* will strengthen health services focusing at the peripheral level to improve links between community-based service delivery and outreach services. The project will train health workers to ensure nutrition services are incorporated into all facility-based contacts such as antenatal care, facility-based deliveries, and postnatal care for sick infants and children.
Working with the MOHP and NFHP II, Suaahara will conduct a rapid inventory of available health services in the target area to assess level of staffing, supply issues, demand for services, application of IMCI, BPP, and compliance with protocols for outreach clinics. The inventory will also identify the number of active FCHVs and their mothers’ groups. The results of this inventory will enable Suaahara to prioritize efforts where health facilities are most in need of support, which will focus on the technical aspects of service quality for women and their infants during both the antenatal period and the first year post-delivery with special effort on nutritional screening, counseling and support and provision of micronutrient supplementation. Suaahara will also work with NFHP II to coordinate efforts for MNCH/FP, to leverage ongoing work and lessons learned, with strong nutrition programming. As NHSP II seeks to expand and strengthen essential health care services, Suaahara will work to facilitate improved processes and impact.

As described in Output 2.5, Suaahara will strengthen the range of services in outreach clinics and in facilities by using performance standards to improve service quality, training providers to integrate services and identify missed opportunities, and closely monitoring progress. Across all contacts, Suaahara will promote counseling supported by job aids and needed equipment (e.g. weighing scales). Suaahara will refocus antenatal care to prioritize evidence-based interventions, provide job aids to improve efficiency of visits, and strengthen nutrition counseling through a variety of approaches. These messages and information will be reinforced by FCHVs using the Family Health Division-endorsed Birth Preparedness Package. Suaahara will train FCHVs to follow-up and refer clients to facilities as needed. Health staff and FCHVs will learn to use post-partum visits as an entry point to explain nutrition needs during lactation and to ensure the mother is practicing exclusive breastfeeding.

Considering complexities of availability of food as well as beliefs and practices around nutrition, Suaahara will prioritize attention to client-provider interactions so that nutrition education can be appropriately customized for women visiting health facilities to address newborn, infant, and child nutritional practices. The project will address these issues during in-service training by including health workers in the ENA+ training and evaluating their skills as well as by supporting clinical preceptors and experienced supervisors to conduct site visits and provide on-site coaching using varied approaches (observation, role play, behavior modeling) during trainings and on-site support visits.

District and health facility quality assurance systems will be assessed and client exit interviews incorporated to improve service quality and counseling being provided. Suaahara will work on localized performance and quality improvement approaches incorporating principles and tools from Standards Based Management and Recognition. To strengthen local capacity and promote sustainability within district systems, Suaahara will engage the District Quality Assurance Working Committees in implementing this intervention.

Suaahara will support and advocate for year-round availability of key FP/MNCH and nutrition commodities (micronutrients, weighing scales, Mid-Upper Arm Circumference (MUAC) tapes, etc.) at all levels of service delivery. In particular, Suaahara will provide training to store staff to increase their efficiency and provide limited material support (renovation/repair, furnishing, equipments) to peripheral facilities for improving storage of commodities. Suaahara will monitor the current MOHP discussion of providing calcium supplementation to pregnant women, and scaling up the neonatal Vitamin A supplementation activity based on results from ongoing district-level pilots providing support if needed to create an efficient supply and delivery mechanism for these supplements.
Suaahara will develop and test a variety of approaches and job aids to incorporate IYCF and maternal nutrition into antenatal care and post-delivery services without overburdening health workers. Suaahara will explore innovative approaches to improve patient flow, reduce waiting times, task-shift, reduce time spent on paperwork, and otherwise foster more time for health workers to spend on counseling patients.

**Output 2.2: Facility-based IMCI, including supervision of CB-IMCI, is improved**

The Suaahara baseline survey will assess care-seeking patterns for childhood illnesses. In districts where providers other than facility staff and FCHVs provide a substantial proportion of case management services, Suaahara will explore with partners the feasibility of training and monitoring the other providers, including drug retailers, in case management of childhood malnutrition and diarrhea. This may include work with the private sector to improve supplies (such as zinc) and to improve the performance of drug retailers. IMCI services provided by facilities will be reviewed, gaps in effective service delivery will be identified and approaches for enhancing these services will be jointly developed with IMCI stakeholders at national level and implemented in Suaahara districts. Suaahara will focus on the nutrition component of IMCI, with emphasis on developing the aspect on feeding during and after illness. For this, the project will work closely with the IMCI and Nutrition sections within the Child Health Division, and jointly come up with an approach for strengthening this component in the 20-25 districts.

Suaahara will support competency-based refresher training (including training of replacement staff and volunteers) in nutrition and diarrhea components of IMCI and CB-IMCI, including assessment, classification, treatment, reporting, referral, and counseling, using job aides to be adapted and tested by Suaahara. This training activity will be integrated into the Suaahara ENA+ training package and training for management of severe acute malnutrition (SAM). Suaahara will conduct competency-based refresher training of DHO IMCI focal points and facility staff on supervision of nutrition and diarrhea components of IMCI/CB-IMCI as part of the integrated MOHP approach to supervision, including observation of case management, coaching to improve skills, reporting, and using job aides to be adapted and tested by Suaahara.

District staff will work with the DHOs, District Development Centers (DDCs), and VDCs to encourage funding for FCHVs attending monthly meetings with health post (HP) and sub-health post (SHP) staff, which will include review of case management of malnourished children and those with diarrhea, and will address challenges to implementation of IMCI. Suaahara will also promote and support collaborative case management of children by health facility staff and FCHVs during outreach clinics (and at health facilities for FCHVs living near facilities). Ongoing meetings at the ilaka level to discuss IMCI between health facility staff and FCHVs will provide an opportunity to evaluate FCHV performance and facilitate improved contacts and referrals.

Data on the supply and use of zinc and oral rehydration salts (ORS) in diarrhea case management will be collected through routine supervision and reporting, and any inadequate supplies or low rates of use investigated and addressed in cooperation with partners.

Suaahara will engage with the national IMCI and CB-IMCI technical working groups to contribute Suaahara findings and coordinate strategies for improving the nutrition and diarrhea components of IMCI and CB-IMCI. The Suaahara strategy will include approaches to promoting prompt recognition and appropriate care-seeking for childhood malnutrition and diarrhea. The BC approach will be based on formative research to understand barriers and delays in care-seeking.

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*Suaahara*
Output 2.3: Facility-based growth monitoring and promotion (GMP) services comply with national/global standards (including support for shifting GMP work to community level in accordance with MOHP plans)

GMP is a critical contact point for BCC within an ENA strategy. Suaabara will support improved, in quality and access, GMP at all levels with specific effort directed at shifting monthly growth monitoring to children under two at the community level. FCHVs will conduct CB-GMP with support of other health workers, who will monitor and supervise. It will be crucial to ensure that, using the relevant ENA/BCC modules, counseling mothers on the meaning of the child’s weight is the focus of GMP and that promotion of healthy weight outcomes rather than the monitoring of weight is the objective. The promotion/prevention has been particularly successful when volunteers are provided explicit counseling tools.

Suaabara will conduct a review of GMP experiences and best practices of facility and CB-GMP globally and in Nepal. Suaabara will adopt lessons learned from the impact evaluation of UNICEF’s GMP program. Where information gaps exist, Suaabara will conduct formative research to identify facilitating factors and barriers for caregivers participating in monthly GMP, perform mapping exercises to determine where GMP services are currently conducted, assess current quality of weighing and counseling, and identify and plan how the services can most efficiently reach remote communities (i.e. those requiring more than one hour to reach by walking).

The ENA BCC strategy will include approaches to promoting monthly participation by mothers with children under two years of age in coordination with the MOHP district officers (DPHOs, DDCs) and VDCs. Incentives might include “Healthy Baby” recognition or non-monetary awards for perfect attendance at GMP during the year. To improve community ownership of GMP, Suaabara will explore options for sharing results visually with the community, promoting community goal-setting to reduce levels of malnutrition. For instance, district-based Suaabara staff will work with the DPHOs, DDCs, and VDCs to encourage VDCs to fund incentives to FCHVs for monthly GMP sessions and referrals.

Suaabara will mobilize and train PAs to support the FCHVs in conducting CB-GMP each month in communities and also conduct home visits as necessary on the adoption of the behaviors. Suaabara will support competency-based trainings and refresher trainings for facility-based staff, FCHVs and PAs in the key steps to conducting quality CB-GMP, including measurement, recording, classifying, and analyzing the cause of growth faltering; counseling and negotiation with mothers of at-risk children; referrals and follow-up (if necessary), using job aides to be adapted and tested by Suaabara. This will be included as a key element of the ENA+ training package for FCHVs/PAs. Additionally, Suaabara will train those assessing child’s weight as part of GMP in collecting MUAC measurements to screen children with SAM. Suaabara will assist the current effort of MOHP to roll-out use of the new growth charts based on 2006 WHO Growth Standards.

Suaabara will include competency-based refresher training for DPHO staff and HP/SHP staff on the integrated MOHP approach to supervision, including observation of GMP sessions, coaching to improve skills, and using job aides to be adapted and tested by Suaabara. Regular meetings of health facility staff at ilaka (or VDC) level will include review of methods of supportive supervision for CB-GMP. Suaabara will work with MOHP to ensure provision of basic supplies (scales, MUAC tapes, registers, growth charts, and height boards) and counseling.

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materials. *Suaahara* will integrate select indicators into regular HMIS monitoring systems (e.g. % of children under 24 months growth faltering in past month, past 2 consecutive months).

*Suaahara* will seek the most efficient way to link CB-GMP to other health services including immunization, IMCI, vitamin A supplementation, de-worming, management of acute malnutrition, and link into community health programs for women and children. *Suaahara* will promote and support collaborative and improved case management of children referred via GMP sessions (see IRs 2.2 and 2.4). Two-way referral for initial treatment and follow-up of malnourished children will also strengthen the links between communities and health services.

**Output 2.4: Services for the treatment of SAM adhere to national/global protocol (with possible CMAM activities in areas with high SAM prevalence)**

Rates of SAM among children in Nepal is exceptionally high (3%), is even more alarming among infants 6-12 months of age (14%),

and indicate that substantially more support to address SAM in children is needed. The recent introduction of new diagnostic and treatment protocols together with ready-to-use therapeutic foods has dramatically improved treatment of SAM in children and has been shown to be effective in reaching and treating a greater number of children with SAM in a shorter time than previous methods. The current standard of care in Nepal, which has worked on a small scale, is to rehabilitate malnourished children (identified via severe low weight for age) through an intensive process at nine Nutrition Rehabilitation Centers (NRCs) (plus three in process of opening) followed by home-based care. The rehabilitation model is based on locally-produced super-flour, *Nutritious Jaulo*, and improved care. This model requires the caregiver to spend a great deal of time away from home while the child recuperates. These centers are managed by NGOs and are gradually being handed over to the government, and *Suaahara* will support government to open a further five centers and also provide support for mothers to access these centers.

*Suaahara* will support the GoN and UNICEF in improving the management of SAM in children. UNICEF is currently conducting a pilot of CMAM in five districts, with promising results. *Suaahara* will support scale-up of CMAM applying findings from the current UNICEF studies. SC has extensive experience treating SAM in emergency and non-emergency contexts and has led the process of developing CMAM policies and guidelines in Pakistan and Bangladesh that it can bring to Nepal. *Suaahara* will work at community, facility, and policy levels to improve the management of SAM in children and will look at innovative means of integrating IYCF into SAM management to improve rehabilitation and prevention of malnutrition in infants and children. Using a phased approach, *Suaahara* will first focus on improving detection and treatment of SAM at the district level and this will be followed by strategy in consultation with GoN, MOHP, UNICEF, and other stakeholders to explore process to bring CMAM to prioritized districts based on data coming out of GMP and program monitoring.

The *Suaahara* baseline survey will define prevalence rates for severe and moderate acute malnutrition by district cluster, age groupings, and other factors and analyze against key determinants and other related factors that influence child under-nutrition. This will assist in

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18 Nepal DHS 2006, rates for severe wasting are presented.
20 SUAAHARA can support the MOHP and UNICEF to develop a standardized national guideline for community based management of SAM (see IR4). Such a process would include a consultative workshop with MoHP, UNICEF, and other key stakeholders. With these partners, a simple package of protocols (called the “fast pack”) and reporting formats based on those developed for Asia, but adapted specifically for Nepal can be designed for use by health workers and community health volunteers.
targeting resources for CMAM and reinforce the prevention strategy that is the main initiative under Suaahara.

In coordination with UNICEF and MOHP, Suaahara will review the current MOHP nutrition rehabilitation materials and procedures followed by district hospital staff, HP/SHP staff, DPHO teams, and agencies managing NRCs in pre-service and in-service training content. MOHP recently conducted trainings at regional levels on SAM management and in 2009 developed a new manual (based on a WHO field publication for the management of SAM). As necessary, Suaahara will work with the GoN Child Health Division (CHD) and Family Health Division (FHD), UNICEF, WHO, and other partners to improve/adapt curricula content for improved facility-based treatment to expand these trainings to Suaahara districts and will actively work to include CMAM in pre-service training curricula.

Suaahara will conduct trainings for community-based FHCVs and PAs in the measurement of MUAC in children less than 24 months as part of GMP to screen for SAM, and refer to district facility as part of the integrated approach. Training and capacity-building in SAM identification and management will be integrated with the IMCI trainings and the ENA prevention package specific to improving IYCF and improved counseling and negotiation at multiple levels. A critical part of these trainings will focus on improved methods for supporting care and feeding at the HH level (post-stabilization for complicated cases and for all non-complicated cases). This training will draw upon the IYCF/CMAM modules that have been recently been developed. The project will assist DPHOs to establish improved community and facility based links, including strengthened referral procedures from GMP by FCHVs for children identified with SAM and improved coordination with IMCI and CB-IMCI.

Suaahara will work with MOHP to develop a plan – specific to maternal and child health workers (MCHWs) and village health workers (VHWs) – to support FCHVs in detecting SAM, and a small package of checklists and tools to assist the service providers. Suaahara will coordinate with UNICEF, WHO, and the GoN in securing required supplies for improved management of SAM at the facility level with exploration for community-based management (this includes provision of ready-to-use therapeutic foods (RUTF), antibiotics, de-worming medication) This may include facilitating production of RUTF by a local private entity. Suaahara will provide basic supplies, including MUAC tapes, scales, and BCC materials including improved counseling and negotiation tools at project onset if not available from the GoN, UNICEF, or other sources.

Output 2.5: Facility-based and outreach family planning services provide effective counseling on healthy timing and spacing of pregnancy (HTSP) as important for good health and nutrition

Suaahara will help the GoN reposition and revitalize family planning (FP) programs as a health and nutrition intervention for mothers and families. At the district level, Suaahara will ensure FP and HTSP are integrated to address “missed opportunities” to reach pregnant and new mothers. As HTSP addresses the unmet need for FP and is one of the most effective interventions to protect MNCH, Suaahara will ensure HTSP messages, counseling, and services are integrated at the community, outreach, and facility levels. For example, during mothers’ groups’ meetings, IPC models will include counseling mothers and families about hygiene, nutrition, and HTSP.

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21 Integration of IYCF support into CMAM: Guides and Tools. Nutrition Policy and Practice. Produced by Emergency Nutrition Network with funding from IASC Global Nutrition Cluster. 2009. www.ennonline.net/ifc. These modules have been successfully used for national and district level training and implementation in Africa.

Some modern methods of contraception are highlighted in the ENA framework. Within facilities, Snaahara will educate women about lactational amenorrhea (LAM) as a health and nutrition intervention before and after delivery. FCHVs and PAs will reinforce these messages at the community level and reach women delivering at home. With a focus on the first two years after birth, Snaahara will increase awareness of the benefits of HTSP and increase access to FP services by offering a range of FP methods at a variety of intervention points. With a shift in thinking about FP as a means to healthier families, the interest in spacing methods will increase. Snaahara will strengthen FP services and integrate them into delivery services, offer them during outreach and EPI clinics, and promote distribution by FCHVs and during post-natal care contacts. While most of the appropriate methods are available in the public sector, Snaahara will scale up planned activities to introduce and expand postpartum contraceptives at work in MCHIP and NFHP II. Snaahara will collaborate with the new Ghar Ghar Ma Syastha Initiative, to improve supplies to the peripheral levels in the 20-25 project districts.

Snaahara and DPHO staff will monitor quality of FP services in the broader context of the program. Snaahara will apply simple, performance-based standards at facilities that can serve as job aids for providers and quality monitoring tools for district staff. Consistent use of tools across facilities and districts will allow Snaahara to aggregate and compare quality of services. One of the challenges to improved quality, outreach, and integration, is the limited number of healthcare providers in districts. While these larger human capital issues will be addressed under NHSP-II, Snaahara recognizes increases in use of public sector services with free essential health care services (EHCS) may exacerbate this problem. Snaahara will pilot approaches that improve quality of services and counseling without overburdening providers. To revitalize FP, Snaahara will identify unmet need for FP among under-nourished women or those with under-nourished newborns, infants, and children—and vice versa. FCHVs, private sector providers, pharmacists, and healthcare providers will be trained to make MNCH, nutrition, and FP referrals. Community mapping and ward, village, and district monitoring of all interventions will identify missed opportunities for other related services. Further, when combined with equity and access monitoring, Snaahara will reach those under-served and undernourished more rapidly and equitably.

**IR3: Women and their families increase consumption of diverse and nutritious foods**

**Output 3.1 Mothers and children have access to locally produced nutrient-dense and fortified foods (including animal source protein)**

Based on a ranking of food insecurity by district and factors such as altitude, climate, and access to water for irrigation, the project will implement varied strategies to increase access to quality locally produced micronutrient-rich and nutrient-dense foods among HHs with children under two years, with a focus on reaching the ultra poor and marginalized population. Increasing access to animal products will be a key component in all districts as well as ensuring that diverse and nutritious foods are available year round in target HHs and communities. HH and community production activities will be linked to nutrition education to promote consumption by small children and pregnant or lactating women.

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**The AAMA Project**

AAMA addresses the food and care dimensions of under-nutrition by integrating HFP and ENA to improve nutritional status of children <two years of age and pregnant women, as well as HH food security, in two districts of Far West Nepal. The project focuses on increasing HHs’ year-round access to nutritious foods while serving as a platform to improve ENA practices. This approach establishes local, woman-led, VMFs providing technical support and Suaaharauts to affiliated women homestead food production beneficiaries (HFPB) groups to enable year-round production of micronutrient-rich vegetables and increased production of eggs as a source of animal protein for small children and pregnant or lactating women. While learning gardening and poultry care, HFPB also learn ENA from the participating FCHV.
The HFP strategy increases HH production of micronutrient-rich foods and improves food security and diet quality among vulnerable HHs. Using lessons learned from a series of homestead food production projects in Nepal, Suaahara will adapt the model to conditions in the most food insecure districts. One or more HHs in each ward will be selected to become a Village Model Farm (VMF), with preference given to interested FCHVs. The VMF, with state-of-the-art but locally-appropriate agriculture practices, will serve as a demonstration site for mothers groups to learn how to improve gardening and poultry production. The VMF will become a social enterprise, providing seedlings, seeds, and chicks to other families in the community, along with technical advice. Emphasis in gardening will be on production of nutrient-dense vegetables such as sweet potatoes, dark green leafy vegetables, pumpkin, and broccoli. Suaahara will provide VMFs with improved breeds of chickens and training in poultry management (e.g. vaccinations and producing quality feed for the chickens).

For those FCHVs who become VMF owners, it will be under the condition that the enterprise is the responsibility of her entire household and not the sole responsibility of the FCHV. Additionally, HKI’s prior experience with HFP suggests that other household members will help provide the labor and that, by developing production close to the household, the system reduces the burden of the traditional practice of tending to distant plots. While the challenges will be greater at start-up, once the HFP is established and a routine for ENA/BCC meetings the work load will lessen. Also, the program will encourage FCHVs to use the village model farm as a contact point to deliver key ENA messages and to conduct nutrition activities such as growth monitoring, IYCF counseling, vitamin A supplementation so that the FCHVs do not have to conduct home visits. Furthermore, the income generated from the village model farm will also motivate her to continue her community health/nutrition promotion and service delivery activities.

Since eggs are the most viable way to quickly increase consumption of animal protein among poor families, Suaahara will promote improved practices for raising local chickens across all districts. This may include campaign-style messages to encourage protecting chickens from predators, promoting vaccinations, and provision of appropriate feed and water. The activity will be coordinated with the District Livestock Service Offices (DLSO), supporting their Junior Technical Assistants to provide direct technical assistance to families.

Likewise, across all districts, Suaahara will promote production of micro-nutrient rich vegetables. Most rural families in Nepal currently raise some vegetables so the project, in cooperation with the District Agriculture Development Offices (DADO), will build on this to help them make minor modifications such as replacing cultivation of bottle gourd with pumpkin and using waste water to irrigate plants for year around production. A few VMFs will be established in all districts as demonstration sites and to provide seed, seedlings, and technical advice. These VMFs will be linked to all area FCHVs who can bring mothers groups to the VDC to learn, strengthening the link between food production and improved family nutrition.

In more food secure Suaahara districts, Suaahara will pilot the concept of creating hatcheries with the primary purpose of making improved breeds of chickens and eggs available at scale. This will be a joint effort with the DLSO and private hatcheries. The project will develop community hatcheries as social enterprises providing the owner with a substantial business opportunity and instilling a strong focus on community support. Each community hatchery will be linked to the FCHVs to ensure new mothers have access to agricultural technical assistance. The hatcheries can also serve DLSO as points of contact with rural families in order to provide technical support and health services for other livestock. If the hatcheries prove successful, Suaahara will expand the model to create up to ten brooding centers per district.
In recognition of the need to sustain VMFs beyond the timeframe of the project, Suaahara will work in partnership with the AAMA project, to continue efforts with MOAC and district counterparts to establish the VMF as a community level extension of the government’s agriculture service centers (ASC). This will greatly enhance the capacity of DADO and DLSO to implement community-level programming and monitoring across the districts that currently lack mechanisms to bring agriculture extension services to the HH level.

Specific strategies for VMF sustainability are:

- VMF registration as a network at District Agriculture Development Office (DADO)/District Livestock Office (DLSO) to:
  - Obtain regular technical advice from DADO and DLSO.
  - Promote VMF as a local level contact point for agriculture and livestock extension workers.
  - Procure vaccinations or be trained to vaccinate with supply from a commercial/government source.

- Market linkages in support of income generation:
  - Link VMF with seed entrepreneur network or private seed companies so that they may have access to quality seeds.
  - Link VMFs with local level farmers groups and private sector especially agro vets and brooding centers.
  - Establish/improve local markets to ensure income generation from surplus high fat product (HFP) produce.
  - Link saving and credit groups to VMFs to provide economic credits to women's groups.
  - Create demand for procurement of seeds and poultry by community members.

- Support strengthened local governance:
  - Facilitate multi sectoral planning at VMF network level for income generation, food security and nutrition in order to access some funds from VDCs/DDC.
  - Strengthen existing agriculture services structure such as Ag depots and brooding centers at district level.
  - Link VMFs to have access to small scale irrigation facilities with DADO and irrigation department.

In most of the program districts year-round access to water for agricultural production is a concern. Using lessons learned from the AAMA project, Suaahara will have an agricultural water technology specialist on staff to ensure water conservation, appropriate water technology, and water usage are key elements of Suaahara’s activities. Additionally, Suaahara will coordinate with the Ministry of Local Development (MOLD)’s expansive small irrigation project to mobilize government resources for beneficiaries. Suaahara will also work closely with MOAC, FAO, the Food Facility project, the WFP, and incoming Feed the Future program to identify synergies that can be leveraged to improve water accessibility for program beneficiaries.

Nepal has nascent programs to fortify foods, including flour, and to produce fortified “instant” foods for complementary feeding. Suaahara will stay abreast of such efforts and work with the private sector to develop methods for ensuring these foods are marketed in target districts at affordable prices, where feasible. Because the marketing of fortified flour in the remote districts
is unlikely, Suaahara will conduct pilot projects on fortification of flour at local mills. Suaahara will also follow-up on the current HKI pilot, funded by Alive & Thrive, for providing micronutrient powder (Sprinkles©) to HHs to add to complementary foods daily. There may be potential for local production of the micronutrient powder with distribution through the FCHVs.

**Output 3.2 HHs have increased knowledge of nutrition of locally-available foods**

To promote understanding of the relative nutritional value of locally available foods, Suaahara will use two strategies. The first will involve including learning activities into ongoing mothers’ group sessions and into counseling messages around ENA. These messages will be reinforced through the HFP activities which will stress year-round production of nutrient-dense foods. Suaahara will adapt the food identification cards developed in SC’s project in Bangladesh and other materials for use in this strategy. FCHVs and PAs will share this information with mothers-in-law, husbands, and other community members as possible, visiting forestry, micro-credit, and related groups. Information on fortified foods and iodized salt will be included with messages to dissuade the rapidly-increasing consumption of packaged snack foods. The second strategy will involve reaching a broader audience. Suaahara will use radio and other mass media to disseminate social marketing messages on which local foods are most nutritious. Posters and food-tasting or food demonstrations in markets and local shops can further the messages. Suaahara will develop games and songs for schools to promote recognition and consumption of the nutritious local foods and dissuade the consumption of packaged snack foods.

Suaahara will conduct learning needs assessments with health staff, FCHVs, PAs, agriculture extension workers, and teachers to assess their current knowledge of the nutrient content of local foods and the foods Suaahara will introduce through HFP. Based on the results, the project will prepare simple materials to improve their understanding of nutritious foods and which foods are most needed by different stages in the life cycle. The project will use the newly formed National Nutrition Steering Committee/National Nutrition Coordination Committee (NNSC/NNCC) and its ministerial relationships to ensure key nutrition and local food messages are adopted by the government and used beyond Suaahara.

**Output 3.3 Communities increase resilience to potential nutrition shocks through community-based initiatives.**

Whether from a short-term shock (i.e. flood, landslides) or longer-term chronic food deficits that plague Nepal, Suaahara districts are highly vulnerable. Suaahara will take action to prepare for such shocks and mitigate nutritional impacts. Nepal has a national level Disaster Management Plan, and District Disaster Plans are prepared; however, preparedness and mitigation practices and resources are uneven and do not always account for adequate nutrition for vulnerable groups during shocks and emergencies. Suaahara will integrate feasible ENA and contingency planning into district and VDC-level disaster planning and response (e.g., protecting continued breastfeeding); promote BCC for expanded use of key HH practices to will increase resiliency and mitigate nutrition shocks, such as low cost food processing, preservation, and storage techniques (in coordination with activities under IR3.1, 3.2); manage a small grant program to identify and test innovations; and improve national and district level coordination among partners. Suaahara will draw on SC’s experience from the OFDA funded Disaster Preparedness and Response program.

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Focused risk and resource mapping will be conducted during community entry at district and VDC levels. This will help identify vulnerable areas within the community, coping strategies, and assets found in the VDCs. These assets include ‘hardware’ such as: buildings that can serve as community shelters and livestock shelters, seed protection mechanisms, simple food dryers-processors, and other appropriate preservation and processing technologies, access to roads, radios, cell phones, vehicles, megaphones, and flags, but also the ‘software’ including the presence of trained emergency volunteers and relationships with GoN service providers and NGOs working in disaster preparedness and response. *Suaabara* will review existing seasonal food and dietary calendars, current storage techniques, opportunities for adding local foods to the diet and prepare new seasonal calendars if needed to fill gaps. Formative research, especially related to understanding barriers and motivations related to the promotion of consumption of local foods and highly nutritious foods and use of low-cost HH food preservation and storage techniques, will also inform programming.

*Suaabara* will facilitate community emergency preparedness, disaster risk reduction, and contingency planning by working with DDC and VDC planning committees (in particular the District Disaster Management Committees), local NGOs, and other stakeholders to better plan, prepare for, and respond to shocks with a focus on ensuring that nutrition is well integrated. It will also train DDC and VDC counterparts in skills that will support nutrition resiliency in short-onset and chronic emergencies such as protecting seeds in watertight containers and off the ground so that they are more secure, food preservation, processing and storage, and ensuring that breastfeeding practices are maintained in crisis situations, including identifying five to seven core nutrient resiliency competencies.

A small grants program (to be up to $5,000US per grant) will test and seed innovative ideas that can eventually inform program implementation. *Suaabara* will form a technical advisory group (TAG), and under this a sub-group comprised of *Suaabara* partners and Nepali agencies working in this area, who will review and select grantees and may provide technical assistance to awardees. The small grant program will be managed by a *Suaabara* grants manager. Drawing from the example of the small grants innovations program and guidelines developed in the *Alive and Thrive* project, *Suaabara* will finalize clear guidelines and criteria for small grants selection to include cost, innovation, feasibility, and potential for direct translation. *Suaabara* will finalize criteria for ranking applications and selecting awardees, reporting requirements, expected outcomes, and develop a dissemination plan to share results. The call for proposals is anticipated to be issued annually during years 2, 3, 4 of *Suaabara*. The results will be documented, disseminated, and applied to the *Suaabara* program as is appropriate.

*Suaabara* will map partners in government, NGOs, and private sectors to review opportunities and partnerships for nutrition resiliency. *Suaabara* will work with key partners including UNICEF and GoN in strengthening Nutrition in Emergencies at the national level and will explore the feasibility for stockpiling food commodities and other supplies at the district level for rapid response in a disaster. *Suaabara* may need to access resources under the “Windows of Opportunity” directly related to protecting nutrition resiliency as a part of disaster preparedness and response.

**IR 4: Coordination on nutrition between government and other actors is strengthened**

**Output 4.1: A national mechanism in place that allows for regular coordination and information sharing among government and other entities with responsibilities for achieving MDG 1 and reducing the level of under-nutrition in Nepal**

24 SC and HKI are active partners of Emergency Nutrition Cluster.
Suaahara will coordinate intensively at national level with NPC, Ministry, donors, private actors, NGOs, and others to create a strengthened coordination and policy environment translating into increased scale, impact, and sustainability of nutrition investments. Substantial Suaahara inputs from GoN representatives at multiple levels informed the design of this proposal and Suaahara partners currently collaborate with GoN, donor, and NGO partners; the project will build on these relationships and foster new associations with private sector. At project start, Suaahara will develop an integrated coordination and advocacy strategy with key partners and will use the Program Assessment Guide (PAG), a tool developed with USAID-support, defining a participatory process for assessment and developing a shared understanding and capacity to advance nutrition programs.25

Since release of the Nutrition Assessment and Gap Analysis (NAGA), the MOHP, UNICEF, USAID/NHFP, HKI, DFID, World Bank, and WFP have worked closely to support the reformation of the NNSC/NNCC. Suaahara will work with the NPC, the MOHP, the MOAC and others to make the NNCC a more productive mechanism that better aligns policies, plans, and activities and will provide assistance to the NNSC in quarterly review meetings.26 Specifically, Suaahara, with USAID/NHFP, WFP, UNICEF, FAO, and others, will work to ensure that the MOHP’s Multi-sectoral Nutrition Action Plan and relevant sector-specific planning documents result in a definitive action plan with support among the ministries. Suaahara program staff in nutrition, health, and hygiene/sanitation will work directly with the respective ministry Nutrition Focal Officers. Suaahara will represent the nutrition agenda in existing relevant national coordination bodies, such as the child-health, safe motherhood/neonatal, and adolescent reproductive health sub-committees. Similarly, Suaahara will facilitate regular Nutrition Coordination Meetings with MOHP/CHD/FHD, EDPs, and others to align project priorities with the Nutrition Plan of Action and the National Food Security Plan. Suaahara will also coordinate with planned and upcoming projects, specifically the NHSP II project. Both SC and HKI are consortium members and HKI is the nutrition focal group for NHSP II.27 Suaahara expects a substantial cost-share for this output through partners.

The project will also conduct technical meetings and briefings on prioritized nutrition topics. Such meetings and briefings will provide a forum to disseminate evidence (global and national), review nutrition trend data with focus on women and children under-2, and discuss program progress and results. It is anticipated that these events will raise awareness and stimulate discussions that support policies, norms, and guidelines for improved nutrition/IYCF practices.

**Output 4.2: A regional and district mechanism in place to improve collaborative action on nutrition and hygiene among GoN entities, civil society, and the private sector**

Suaahara will hold monthly district coordination meetings with DHO, DDO, DLO, DAO, DWSO, and DEO for coordination and direct capacity building initiatives. Suaahara will facilitate regional meetings with the directors from the same GoN regional offices to discuss alignment and ensure nutrition is included in each sector’s annual plans and budgets. Sessions

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26 The meetings will familiarize the ministry level Nutrition Focal Officers (NFOs) with key documents including the the Nepal Health Sector Plan II, the National Nutrition Assessment and Gap Analysis document, the upcoming MOHP Nutrition Action Plan, the National Agricultural Policy 2004, the National Agriculture Development Priorities for the Mid Term Plan 2010-2014, the upcoming MOAC National Food Security Strategy, the Nepal GAFSP Application, the National School Health and Nutrition Strategy and the National Hygiene and WASH strategy.

27 NHSP2 is due to begin in early 2011.
will include joint assessment, appropriate analysis, planning, budgeting coordination, and governance. Sessions will focus on key governance capacities needed to ensure sustainability and scale-up of ENA+ within districts. Building on AAMA’s recent governance initiative in the Far Western Region, *Suaahara* will provide TA to government departments and strengthen links among these departments. These trainings will facilitate better understanding of current government policies and objectives and serve to improve local government systems capacity in preparation for decentralized governance within a federal system.

**D. Capacity Building**

In *Suaahara*, SC will serve as lead in Training and Capacity Building but with notable contributions from NTAG and HKI. SC globally and in Nepal works to build the capacity of government, civil society and private sector partners. Through its partnership with over 90 NGOs, SC has built and continues to build their capacity through a set of capacity building tools, as illustrated in the USAID-funded *Sustainable Organizational Development for Nepali NGOs program (SANDEEP)*. SC has and is working within the CHD on SNL and through NFHP on IMCI, and has developed jointly with the MOHP and MOE, the School Health Nutrition (SHN) Policy. Currently SC is working with national micro-finance institutions and banks to develop affordable health insurance and youth saving accounts. Based on the substantial experience and strong links with the GoN, *Suaahara* will jointly agree to and roll-out with the GoN a training package for government staff at the district and health facility level, which will then roll out it to community level. *Suaahara* is partnering with three national NGOs to build their technical and organizational capacity to advocate for the integration of nutrition into government programming and to deliver the ENA+ approach at district level. Save the Children has designed the management plan to include the opportunity for two NEWAH and NPCS to assume direct leadership of program activities in three districts each, which will provide opportunities for these national organizations to gain valuable experience in implementing more integrated programs with close mentoring of the international NGO partners. SC, as prime, will guarantee the same standard of program monitoring and quality as well as compliance from all operationally implementing partners to SC and USAID’s standards, and therefore work closely with these two operational partners to build their capacity to do so. Additionally, SC will consider increasing the number of districts directly managed by these two partners in further years of the project depending on their performance and in consultation with USAID.

*Suaahara* staff will be located in DHOs where possible. While at the district level *Suaahara* will work with local NGOs to strengthen community groups and develop the capacity of NGOs to work with district government. The project will work with the private sector to strengthen the links between these businesses, the medical profession, and the communities that will benefit from ENA+ products and services.

Rooted within *Suaahara* is an extensive Training and Capacity Building strategy aimed at community, district and national levels. As an example, the ENA+ trainings will focus on skills-transfer, particularly in counseling, negotiation, training, supportive supervision, and monitoring and, for specific government stakeholders, in policy analysis and assessment, advocacy, and program planning. Training activities will equip public and private sector providers to encourage, counsel, and support mothers and other family members to try, adopt, and maintain new ENA+ behaviors, especially related to IYCF. *Suaahara* will develop the capacity of a pool of master trainers in coordination with the NHTC, tapping local talent from relevant professional organizations such as the Nepal Pediatric Society, Nepal Society of Obstetricians and Gynecologists, Nepal Midwifery Society, national and regional government training offices, local NGO partners and *Suaahara* partners. The training program will focus on quality assurance and facilitative supervision, using the tools and training materials developed through various
successful programs by SC, JHU/CCP, HKI, and others. Performance monitoring will involve follow-up assessments of trainees’ knowledge and practice on sub-samples six months post-training. Each year, Suaahara will revisit proposed training plans with government counterparts and USAID and make adjustments based on prioritization and need. Suaahara will seek opportunities to cost-share and leverage other training opportunities, as is feasible, and it is possible that under the ‘Windows of Opportunity’ designation, Suaahara may request resources for special trainings or capacity building exercises.

E. Government Policies and Standards

The GoN adopted the National Health Policy (NHP2) for 2010-2015 demonstrating the country’s efforts to strengthen the health sector. To improve the overall health status of the people of Nepal, the principal objective of the NHP2 is to extend the primary health care system to rural populations with modern facilities and services of trained health care providers\(^28\). Among the areas that the NHP2 is intended to address, those particularly relevant to Suaahara include:

- **Preventive Health Services**: Programs that directly help reduce infant and child mortality;
- **Community Participation in Health Services**: Community participation is sought at all levels of health care through the participation of FCHVs, traditional birth attendants, and leaders of various local social organizations;
- **Private, Non-Governmental Health Services and Inter-sectoral Coordination**: The private sector and NGOs are encouraged to provide health services to expand services and access; and
- **Health Research**: Health research is encouraged to contribute to evidence-based policy formulation and better management of health services.

The proposed programming will be implemented in close collaboration with MOHP, DHO, DDCs, DAO, and will encourage linkages between these entities, as well as between government and non-governmental providers. The project’s formative research and M&E system will contribute to improved health research by generating data on food security, health and nutritional behaviors and status of mothers and children, and by documenting and disseminating the information to stakeholders at all levels, which, in turn, will strengthen evidence-based policy formulation and the management of health services.

Suaahara will also support the government’s Second Long-Term Health Plan (SLTHP), which covers the period 1997-2017 and focuses on addressing disparities in healthcare, and assuring gender sensitivity of and equitable community access to quality health care services. This includes strengthening the sustained delivery of MCH services, enhancing coordination, decentralizing health administration, and promoting the participation of national and international NGOs\(^29\). Suaahara addresses all these objectives and the effort to reduce iron deficiency anemia among pregnant women from 42 percent in 2006 to 15 percent by 2017\(^30\).

Suaahara is fully aligned with the MOHP’s “Five Year Plan of Action for the Control of Anemia among Women and Children in Nepal, 2005/06-2009/10,” addressing: the promotion of maternal care practices and services to improve the health and nutritional status of pregnant and lactating women and babies through the promotion of ENA. Suaahara is also consistent with the CHD’s National Nutrition Policy and Strategy, issued in 2004, addressing strategic objectives: reduce protein-energy malnutrition in children under five years of age and reproductive aged women; reduce the prevalence of anemia among women and children; virtually eliminate Vitamin A deficiency and sustain the elimination; reduce the prevalence of low birth weight; improve HH

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\(^{29}\) Trends in Demographic and Reproductive Health Indicators in Nepal.

\(^{30}\) NDHS 2006.
food security to ensure all people have adequate access, availability and utilization of food needed for a healthy life; promote the practice of dietary habits to improve the nutritional status of all people; reduce the critical risk of malnutrition during exceptionally difficult circumstances; and strengthen the system for analyzing, monitoring and evaluating the nutrition situation.\footnote{Nutrition Section, Child Health Division, Department of Health Services, MOHP. National Nutrition Policy and Strategy, Kathmandu, Nepal, December 2004.}