Promoting Holistic Child Development: Opportunities for Synergistic Investments in Early Years in Nepal

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Abbreviations

AF	Analytical Framework
AFS	Adolescent-friendly Services
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASRH	Adolescent Sexual and Reproductive Health
B/CEONC	Basic and Comprehensive Emergency Obstetric and Newborn Care
BCC	Behavior Change Communication
CAO	Chief Administrative Officer
CHW	Community Health Worker
CLC	Community Learning Center (for adult literacy)
DoCR	Department of Civil Registration
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECDI	Early Childhood Development Indicator
ECE	Early Childhood Education
ECEC	Early Childhood Education Center
ECED	Early Childhood Education Development
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
GBG	Go Baby Go
GER	Gross Enrolment Rate
HDI	Human Development Index
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IEMIS	Integrated Education Management Information System
IEY	Investing/Investments in Early Years
IFA	Iron and Folic Acid
IMNCI	Integrated Management of Newborn and Childhood Illness
INGO	International Nongovernmental Organization
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
L&S	Learning and Stimulation
LDO	Local Development Office
LG	Local Government
LIECDP	Local Integrated ECD Planning
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MoEST	Ministry of Education, Science, and Technology
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MoHA	Ministry of Home Affairs
MoWS	Ministry of Water Supply

MoWCSW	Ministry of Women, Children, and Social Welfare
MSNP	Multisectoral Nutrition Plan
MUAC	Mid Upper Arm Circumference
NASRHP	National Adolescent Sexual and Reproductive Health Programme
NDHS	Nepal Demographic and Health Survey
NGO	Nongovernmental Organization
NHFS	Nepal Health Facility Survey
NPC	National Planning Commission
ODF	Open Defecation Free
ORS	Oral Rehydration Solution
PE	Parental Education
PHCC	Primary Health Care Center
PNC	Postnatal Care
PPE	Prepimary Edcuation
SBA	Skilled-Birth Attendant
SDG	Sustainable Development Goal
SMP	Safe Motherhood Program
SSDP	School Sector Development Program
SSRP	School Sector Reform Project
STR	Student-Teacher Ratio
TPD	Teachers Professional Development
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WDP	Women Development Program
WHO	World Health Organization

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Executive Summary

Introduction	The global development community has recognized holistic investments in early years as a sound foundation to achieve at least seven Sustainable Development Goals (SDGs) on poverty, hunger, health, education, gender, water and sanitation, and inequality. In Nepal, the 2005–2015 Early Childhood Development (ECD) Strategy, a Thematic Working Group on ECD in the National Planning Commission (NPC), and a Parliamentary ECD Caucus—all indicate a strong political will to prioritize the ECD agenda. Recent programming from development partners has also provided a substantive push toward a holistic, integrated approach to ECD in the country. However, ECD is still understood by stakeholders mainly as an 'education' agenda, and programs that comprise the various ECD dimensions, including nutrition, stimulation, and social protection, are not coordinated. A transition to federalism offers unprecedented opportunities for integrating and packaging ECD interventions at the local level. As such, this review aims to (a) build a common definition and framework to guide the integrated approach in investing in early years (b) identify current successes and gaps in current programming, and (c) explore actionable opportunities to integrate services in early childhood to ensure that every child gets a healthy start in life.
Methodology	The study consisted of four phases, starting with a desk study, followed by national-level discussions and field-level discussions and then evidence synthesis to design a framework for synergizing investments in early years. An analytical framework (AF) was formulated based on the findings of desk reviews to guide the consequent discussions and selection of respondents for national-level consultations from relevant government agencies, donor partners, and nongovernmental organizations (NGOs). The team conducted field visits to further deep dive into specific cases, challenges, and potential opportunities in scoping for work in ECD. Field visit sites were chosen through purposive sampling aimed at iteratively filling the information gaps in the AF and improving the accuracy of data already collected. To this end, about 18 key informant interviews (KIIs) and nine focus group discussions (FGDs) were conducted in Mahottari, Mugu, Lalitpur, and Kathmandu Districts. The consultations at both the national and field level generated critical lessons, considerations, and potential entry points for increasing delivery efficiency of ECD services offered across the three thematic pillars of health and nutrition, learning and stimulation (L&S), and social protection.
Key Findings	The study offered critical insights into the current policies, priorities, and programming, including a spectrum of interventions in ECD and care. It also provided the necessary background to explore current definitions and scope of 'integration'. For consistency purposes, hereafter, the report defines the concept as a synergy of (a) **goals** (objectives that can be met only through multisectoral approaches); (b) **processes** (implementation modalities, client-engagement models, communication activities, and information systems); and (c) **resources** (financial, human, and technical) to enable holistic development of the individual child over the life course.

	The key findings from the desk study and consultations are summarized as follows: • **Policies, Programs, and Prioritization:** There is a high level of commitment on the ECD agenda in Nepal with multiple champions at all levels of the government. However, ECD is still understood by stakeholders mainly as an 'education' agenda. Programs that comprise the various ECD dimensions—nutrition, stimulation, and social protection—are not coordinated and do not all have national coverage. Mental health interventions for mothers are a missing dimension in current programming. However, recent initiatives have provided a substantive push toward a holistic, integrated approach to ECD. The recent decentralization provides an unprecedented opportunity to achieve the vision of holistic ECD, with new opportunities arising for integrating and packaging ECD interventions. The private sector remains a major player in ECD but also a huge unknown. • **Resource Allocation and Management:** Resource constraints for exploring holistic, integrated ECD outcomes are visible. Most common concerns are around the lack of unconditional financial and human resources to explore multisectoral awareness programs, conduct integrated planning or coordination workshops, or enhance the quality of existing health or education services. • **Skills and Capacity:** The lack of personnel well versed in integrated ECD and lack of capacity in the existing personnel to coordinate across sectors are both major challenges. Another gap that was also pointed out by development partners interviewed is the general human resource gap on ECD in the country. Even when committed local governments (LGs) request and are willing to pay for ECD resource persons to help in the planning or implementation of holistic ECD, these resource persons are not available in the country. • **Integration Potential:** Packaging of various interventions into one platform has been achieved in various degrees and modalities. The LGs play a critical role in prioritizing and packaging ECD interventions and providing necessary implementation and monitoring support. In the new federal structure, provincial governments and LGs will be increasingly playing a critical role in driving ECD agendas with varying degree of vertical coordination. • **Future Research Needs:** Some of the future research needs exist in producing economic analyses of integrated ECD and systematically funding its various components, a better understanding of ECD programming among the urban poor, maternal mental health, and the role of the private sector in ECD service provision.

Developing Synergistic Investments	Based on the synthesis of key findings from the literature review and KIIs, we propose a three-part strategy for identifying, assessing, and designing opportunities. The step-by-step approach is particularly important because we must (a) ensure that we are guided by the science of childhood development so that we have a holistic understanding of goals to be achieved throughout the life cycle, (b) map and assess the gaps in quality and coverage of current interventions implemented to achieve such goals, and (c) design innovative programming and delivery mechanisms that can fill the gaps and increase efficiency of the overall governance and change ecosystem. The three parts are as follows: • **Part 1: Identifying Strategic Goals for Investing in Early Years (IEY):** At the strategic level, the planning for IEY must begin with first identifying a range of IEY goals that best pertain to the existing needs across different stages of life course including in areas such as health/nutrition, L&S, and social protection. The clarity in the strategic goals will help determine not only the interventions that are best suited to achieve them but also the integration opportunities for increasing delivery efficiencies, sustainability, and effectiveness. • **Part 2: Mapping and Assessing IEY Interventions:** The second part of the process was to map and assess interventions that are being implemented by various agencies/organizations in Nepal. For each stage of the life cycle, we distilled key approaches leveraged to meet the goals. *A similar mapping exercise should be conducted at the local level to identify existing interventions and their quality and outcomes for planning purposes.* The national-level mapping exercise resulted in the following key learnings across the three life-course stages: ▪ **Adolescence and Adulthood:** IEY interventions during adolescence and adulthood include adolescent sexual and reproductive health (ASRH) services provided by the health sector and the related education, which has been incorporated into the school curriculum in Nepal. Resource centers, awareness programs, and livelihood interventions targeted toward adolescents are also implemented by various NGOs as well as the government's Women Development Program (WDP). However, a few key gaps in quality and coverage remain: (a) out-of-school, married, and migrant adolescents, who are the most vulnerable, are not reached by much of the current programming; (b) teachers are not well trained on delivering comprehensive sexual and reproductive health education; (c) the future of adolescent girls' resource centers, livelihood grants, and skills training programs run independently by cooperatives promoted by the WDP is uncertain in the new federal structure; and (d) the low coverage and quality of the ASRH. ▪ **The Golden Thousand Days:** Maternal and newborn health and nutrition programs run by the health sector constitute the majority of interventions in this period. While the coverage of

	antenatal care (ANC) visits has notably increased, the quality and content of services are yet to catch up. The almost-universal provision of institutional deliveries in hospitals and primary health care centers (PHCCs) (supply) is matched with increased utilization (demand) but without uniform quality and availability of essential maternal and reproductive health services. Financial incentives and cash transfers have been a strong motivation for increasing institutional deliveries, but some fund flow inefficiencies exist. Female Community Health Volunteers (FCHVs) continue to play an important role in community-based delivery of services, such as in providing counseling in ANC, newborn care, parenting, nutrition surveillance and management, and infant and young child feeding (IYCF). In the Karnali region, the introduction of a child grant (which starts at birth and continues until the child is 5 years) has increased the birth registration of children. ▪ **Early Childhood:** Most current interventions in the country under the heading of 'ECD' fall in this time frame and can also be described as early childhood education development (ECED). The early childhood education (ECE) in Nepal is marked by high achievements in access, with the School Sector Development Program (SSDP) providing a strong focus on various supply and demand activities to increase enrollment in the Early Childhood Education Centers (ECECs). However, compared to access, quality is far from commensurate. • **Part 3 (a): Designing an Appropriate Integrated Local Governance Structure:** The recent devolution of powers to the local level offers immense opportunities for holistic IEY planning and integrated governance of the IEY agenda at the municipal level. The most desirable governance mechanism to drive the IEY agenda is for the LG head (Mayor/Chairperson) to mobilize the 'Health and Social Development Section' for strategizing and implementing IEY activities. This 'umbrella section' has advantages in leveraging its strong executive leadership to create an authorizing environment for operational partnerships among existing units; optimizing resource allocation, monitoring, and evaluating programs using a joint monitoring and evaluation (M&E) framework; and enabling cross-learning and creative problem-solving opportunities. • **Part 3 (b): Designing Integrated Implementation Platforms and Programs:** To achieve the strategic IEY goals for holistic ECD, it is important to identify and experiment with viable opportunities to integrate interventions and investments for early years, particularly under the new LG structure. A range of programs and services are currently being and can be implemented, from social protection programs ensuring that children receive adequate support and care, L&S interventions through ECECs, to maternal and child health services at health facilities and through FCHVs. It is critical to make sure that such integration increases efficiency while minimizing costs; has high

	acceptance, ability, and authority to initiate the proposed changes with a simplified process; and leverages local leadership and existing systems and programs to increase effectiveness and sustainability. We recommend three areas for potential integration of IEY activities, which are not mutually exclusive and can be further modified or assessed for actual project design and pilot testing. ▪ **Leveraging child grant:** The model capitalizes on the existing cash transfer, namely the child grants given to all Dalit children under five and all children under five in selected districts.[1] ▪ **Leveraging ECEC-based investments:** The model intensifies integrated ECD interventions to students enrolled in public ECECs[2] (with provisions to require or recommend similar actions in private ECECs) by symbiotically interfacing with corresponding local service providers (such as of health; social protection; water, sanitation, and hygiene [WASH] services) and stakeholders (such as parents). ▪ **Leveraging community-based investments in health and nutrition services:** The model streamlines delivery of services at (a) household or 'home' level and (b) at the community level, by leveraging existing community mobilization channels or resources of the local institutions, such as FCHVs, social mobilizers/workers, and animal/agricultural workers, including microfinance and cooperative group members.
Conclusion	Nepal has prioritized investments in the early years, in more recent years, through the multisectoral channels of health, nutrition, education, and social protection. With the new transition of power to subnational governments, which can now plan, execute, and more closely supervise the progress on programs and interventions, some promising opportunities have surfaced in synergizing resources through greater integrated implementation of interventions. Considering the growing interest and initiation (in some districts) of local-level integrated planning of early year interventions, this report identifies a strategy for developing synergistic investments to support this new movement. Instead of a sector-centric approach, that is, beginning with the question of 'which sector can contribute where', we propose taking a child-centric life-course stage approach, beginning with identifying strategic goals that must be met so that the child can temporally achieve all developmental milestones. This is then followed by mapping the interventions that are already being provided and those that are missing. This creates an opportunity to identify a governance structure that best suits the overall management of the IEY agenda and specific integration opportunities to increase delivery efficiency and effectiveness. We provide three examples of potential

[1] Currently in Kalikot, Jumla, Humla, Dolpa, Mugu, Achham, Rautahat, and Bajhang.
[2] While these centers are called early childhood development centers, or ECD centers in regular parlance, we call them ECECs throughout this report to differentiate the education focus of these centers from the more holistic concept of ECD, which includes other thematic interventions such as health, nutrition, sanitation, and social protection.

	integrated implementation models, leveraging the existing (a) social protection services through a cash transfer approach, (b) ECECs and their programs through institution-based approach, and (c) health and nutrition services through a community-based approach. Further analysis and contextualizing of sample models can help in innovating the existing programs or refining strategies for synergistic IEY in Nepal.

Background

Why Invest in Early Years?

1. A growing body of evidence suggests that early childhood experiences are critical for proper brain development, with lifelong implications for health, cognitive abilities, and income. According to the Nurturing Care Framework, launched jointly by the World Bank Group, World Health Organization (WHO), and the United Nations Children's Fund (UNICEF) at the 71st World Health Assembly, every US$1 spent on early childhood development (ECD) interventions can provide a return as high as US$13.[3] These findings call for a concerted effort during this period, particularly in the context of poor nutritional status and access to education globally. Worldwide, more than 150 million children suffer from stunting, with much higher numbers in South Asia and Africa, and almost 50 percent of children between 3 years and 6 years do not have access to preprimary education (PPE).[4]

2. The global development community, under the leadership of the World Bank and UNICEF, has hailed investment in early years (IEY) as a critical opportunity for economic growth and equitable development. With this recognition, the Sustainable Development Goals (SDGs) include an ECD target (Target 4.2) which aims to increase the percentage of children under 5 years of age who are developmentally on track in health, learning, and psychosocial well-being. ECD has also been recognized more broadly as a foundation for achieving at least seven of the SDGs: on poverty, hunger, health (including child mortality), education, gender, water and sanitation, and inequality.[5] The Nurturing Care Framework itself was introduced to help children not just survive but thrive, focusing on responsive caregiving, good health and nutrition, safety and security, and early learning, with 'one domain of development influencing the other' .[6]

How to Leverage Synergized Investments

3. In response to the global call for greater focus on early years, Nepal has already adopted a multisectoral approach in addressing multiple risks to proper child development by coordinating interventions with existing maternal and child health services, particularly through the national Multisectoral Nutrition Plan (MSNP) and ECD strategy. A range of social protection programs such as child grants are availed to address the underlying socioeconomic disadvantages faced by certain groups. Building on such existing national strategies, plans, and programs and recognizing the country's unique implementation context and institutional dynamics, including the recent transition to a federal structure, a future synergistic investment strategy must consider the following dimensions:

- **Life course perspective** helps frame interventions for childhood development, starting from adolescence/adulthood stage and pregnancy/motherhood stage of mothers to neonatal/infancy stage and early childhood stage of children. Each stage

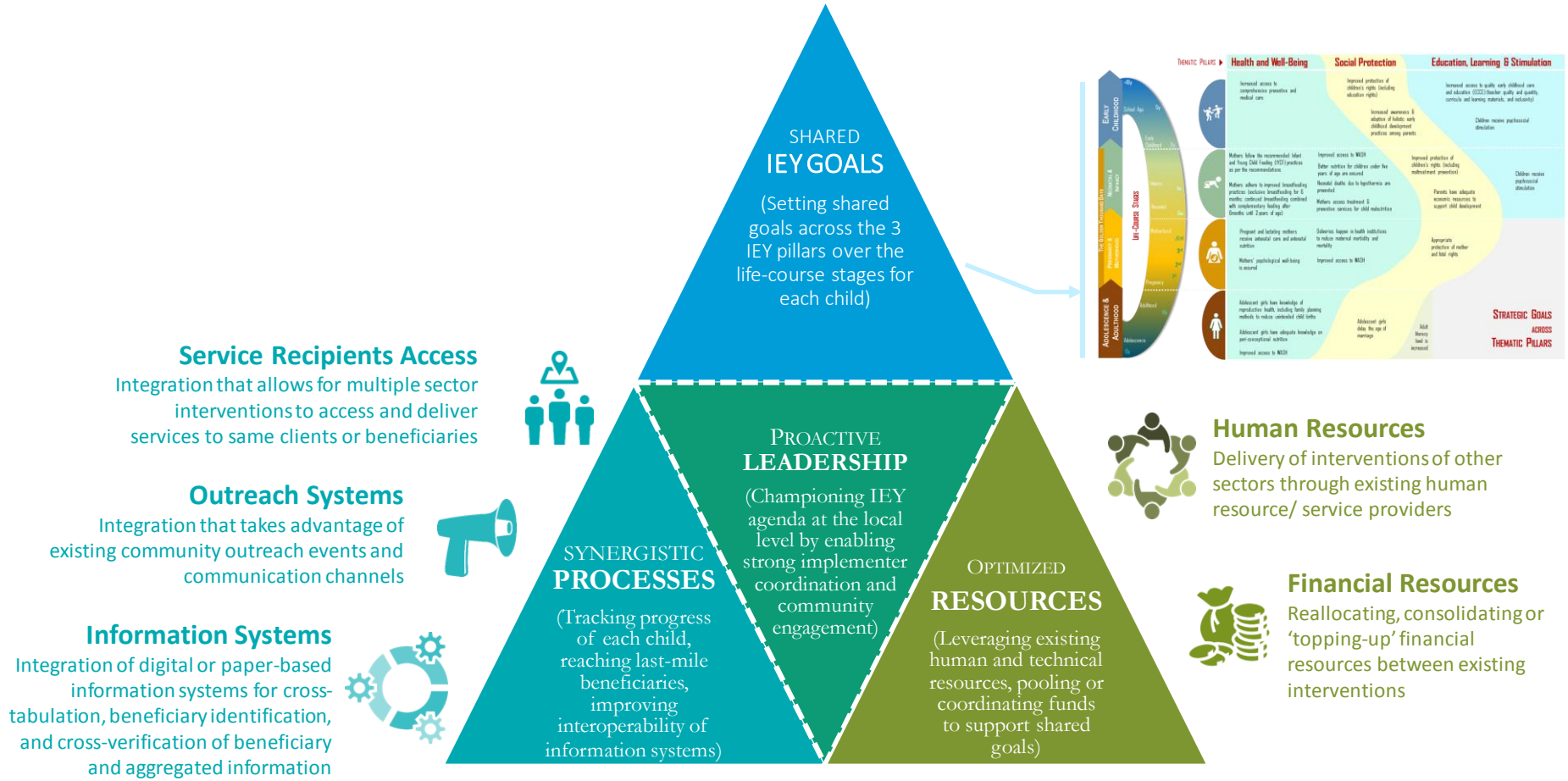
[3] WHO, UNICEF, World Bank 2018. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential
[4] Save the Children 2018.
[5] "Early Childhood Development in the SDGs", *Young Lives Policy Brief 28*, January 2016. http://www.younglives.org.uk/sites/www.younglives.org.uk/files/YL-PB28_Early%20Childhood%20Development%20in%20the%20SDGs.pdf.
[6] Lombardi, J. 2018. "Towards Nurturing Care: Advancing Early Childhood Development in 2018." *Early Childhood Matters 2018*. https://dartcenter.org/resources/early-childhood-matters-2018

represents a unique set of features in the maturation process for the perceptual, motor, cognitive language, and socioemotional and self-regulation skills.

- **Three pillars of childhood development** include the multiple factors that influence the acquisition of competencies and skills at various life-course stages.
    - *Health and well-being*, which incorporates nourishment-related factors
    - *Social protection*, which provides safety nets for vulnerable families to protect them from poverty and enable access to basic services
    - *Education and learning and stimulation (L&S)*, such as access to and quality of early education
- **Enhancing delivery efficiency** becomes critical given the range of interventions, many of which can be delivered jointly through the existing platforms rather than through multiple agencies that are already constrained by limited resources and institutional dynamics, particularly in the context of the new federalized structure of Nepal.

4. For consistency purposes, hereafter, the report defines the concept of 'integration' as a synergy of (a) shared **goals** (setting share goals that can be met only through multisectoral approaches across the three IEY pillars over the life-course stages for each child); (b) synergistic **processes** (tracking progress of each child, reaching last mile beneficiaries and improving interoperability of information systems; and (c) optimized **resources** (leveraging existing human and financial resources and pooling or coordinating funds to support shared goals. Such synergistic efforts can only be possible with a proactive **leadership** that champions the IEY agenda at the local level by enabling strong implementer coordination and community engagement for holistic development of the individual child over the life-course stages (see Figure 1).

FIGURE 1: THE KEY COMPONENTS OF AN 'INTEGRATED' APPROACH FOR SYNERGIZING IEY



What Opportunities Exist?

5. An IEY Framework is a critical tool for designing and synergizing investments across different pillars, geared toward improving shared outcomes in each of the life-course stages. To develop the IEY Framework, it is first important to build an adequate understanding of the current landscape of interventions across life-course stages and the three thematic pillars. While evaluative studies have looked at national strategies and pillar-specific impact and learnings, there is a dearth of information on how interventions can be packaged through common platforms, considering institutional responsibilities and mechanisms in the new decentralized administrative and political structure. Therefore, the IEY Framework must identify a process by which interventions can be effectively integrated, leveraging existing systems and processes, while maximizing efficiency.

6. This study aimed to provide critical input toward developing an IEY Framework by mapping and assessing major interventions in Nepal and identifying opportunities for increasing delivery efficiencies through potential integration of services through existing platforms, streamlining roles and responsibilities, and promoting greater coordination at the central and local levels.

Methodology

7. The study had the following objectives:

a) To understand what exists in Nepal in terms of major programs or investments that fit the IEY Framework

b) To identify institutional responsibilities for what exists as well as what is missing

c) To map major development support

d) To provide concrete recommendations and a framework for engagement at local governments (LGs) to improve IEY outcomes

8. The study consisted of four phases, starting with a desk study, followed by national-level discussions and field visits, and culminating in evidence synthesis and dissemination (as shown in Annex III). The desk study reviewed different programs related to investing in early childhood, including health programs related to adolescent, maternal, and child health and nutrition; early childhood education (ECE) programs; and social protection programs, including cash transfers for children. The review informed the development of an analytical framework (AF) that guided the discussions and selection of respondents for national-level consultations from relevant government agencies, donor partners, and nongovernmental organizations (NGOs). The team conducted field visits to further deep dive into specific cases, identifying challenges and scoping out integration opportunities for holistic ECD.

9. The study used purposive sampling aimed at iteratively filling the information gaps in the AF. Respondents and field visit sites were chosen to help in reviewing in-depth the topics emerging from the AF. In this way, the consultations and discussions at both the national and field level generated critical lessons, considerations, and potential entry points for increasing delivery efficiency of ECD services offered across the three pillars. The charts in Annex III explain in detail the four phases of the study, including each phase's purpose, approach, and expected output, as well as the sample selection categories, stakeholders consulted, and sample size used.

Key Findings

Policies, Programs, and Prioritization

10. **There is a high-level commitment on the ECD agenda in Nepal with generally multiple champions at all levels of government.** With the implementation of the 2005–2015 ECD strategy and additional programming from UNICEF, Save the Children, World Vision, and other organizations, the ECD agenda has found champions at all levels of government. The National Planning Commission (NPC) counts on multiple ECD champions who have been leading this work at the central level. The Prime Minister had inaugurated a June 2018 regional conference on integrated ECD which brought stakeholders from across the region to discuss 'a successful multisectoral approach to ECD'. An evaluation of the previous ECD strategy has been carried out to inform the NPC's current process of developing a new ECD strategy.

11. **However, ECD is still understood by stakeholders mainly as an 'education' agenda.** Since the first ECD strategy covering 2005–2015, there has been an increasing push toward integrated ECD. However, the review of the ECD strategy 2005–2015 found that the leadership of the Ministry of Education, Science, and Technology (MoEST) of the strategy resulted in ECD being tagged as an education agenda, with little ownership from other sectors such as health and social protection. Our desk research, interviews, and field visits underscore this finding. Many champions of the ECD agenda still understood ECD as primarily education, and other sectors did not feel that they were doing ECD even when they were working on providing core ECD services such as child grants, nutrition, immunization, or birth registration. Removing this misconception where ECD is equated with Early Childhood Education Centers (ECECs)[7] is one of the biggest challenges in moving toward a holistic, integrated approach.

12. **Programs that comprise the various ECD dimensions—nutrition, stimulation, and social protection—do not necessarily overlap and do not all have national coverage.** Our study does not point to a single community where all interventions across the life-span were implemented, even if in an uncoordinated manner. So, there is little scope to forge a national holistic, integrated approach by just pulling together existing programs. While reproductive health programs have nationwide coverage, school meal programs, child grant programs, and parental education (PE) programs run in a subset of districts, with little overlap. Also, not all nutrition-specific and nutrition-sensitive interventions run by different ministries are implemented nationwide. Districts with a low human development index (HDI) score, especially in Province 2 and Karnali Province have (expectedly) seen a lot more interventions, being prioritized for health, education, nutrition, PE, and child grant interventions. However, we visited communities where interventions were highest (both in number and scope) and even there, achieving a holistic ECD might require introducing new services such as early L&S and caregiver mental health.

13. **Mental health interventions for mothers (caregivers) are a missing dimension in the current programming.** A maternal mortality and morbidity study from 2008/09 identified suicide as the leading cause of death among women of reproductive age in Nepal.[8] Maternal depression results in emotional unavailability of the primary caregiver and can have major impacts on ECD. Early studies in Nepal show a high prevalence of maternal depression—between 10 percent and 20 percent—and have identified the need to integrate mental health aspects into Female Community Health Volunteer (FCHV) or Auxiliary Nurse Midwife (ANM) trainings.[9] These smaller studies and pilots have provided early indications that mental health interventions

[7] There are two types of public ECECs in Nepal: Community-based ECECs and community school-based ECECs.
[8] Suvedi et al. 2009.
[9] Simkhada et al. 2016.

for mothers/caregivers is likely to emerge as a major gap in current health programming as data on the mental health gap become available from the ongoing National Mental Health Survey.[10] In early stages, various pilots in Nepal have also tried to integrate mental health aspects into existing health services, either through FCHV or ANM training[11] or other facets of health service delivery, including a Grand Challenges-supported[12] pilot currently under way. While these are encouraging initiatives, caregiver mental health is a missing dimension that needs to be incorporated in ECD programs.

14. **Early L&S is another missing dimension.** With sectoral interventions that are focused on health, nutrition, or education, L&S is seen as the responsibility of the education sector. Thus, the current programs are unable to address the L&S needs of children under 3 years of age, before they start to attend ECECs.

15. **Recent initiatives have provided a substantive push toward a holistic, integrated approach to ECD.** On the demand side, a PE package from UNICEF has been prepared and after being piloted in five districts, the package has been handed over to the MoEST for potential scaling up.

16. Another intervention that is in its very early stages but has been anecdotally successful in raising awareness on holistic, integrated ECD is a Parents' Fair (*abhibhawakmela*). In Chhayanath Rara in Karnali Province, a fair which hosted national artists, organized for parents, created district-wide excitement. Organized by the municipality, with support from UNICEF and the national MSNP, the fair showcased booths from across the menu items that make up ECD interventions, including health, nutrition, stimulation, learning, and child protection.

17. On the supply side, a Local Integrated ECD Planning (LIECDP) resource guide has been developed with UNICEF support and integrated draft ECD plans have been developed using this resource guide in 39 (out of 753) LGs, also with UNICEF support. The planning process is a two-day workshop, where stakeholders are sensitized on holistic, integrated ECD on the first day and design programs and budgets on the second day. The resource guide recommends participation from the following stakeholders in the planning process: (a) head of the LG - 1; (b) deputy head of the LG - 1; (c) all ward chairs from the LG; (d) chief administrative officer - 1; (e) department heads (health, education, women and children, planning, water and sanitation, and so on) - 6; (f) all ward secretaries; (g) chair of LG education committee - 1; (h) head of children's club network - 1; (i) representatives of service delivery organizations working in ECD - 2; and (j) headmaster of the community schools - 1. The LIECDP resource identifies five areas of development necessary for holistic ECD: physical, cognitive, emotional, social, and language development. Four areas of interventions are presented to achieve holistic ECD: health and nutrition, care and stimulation, protection (especially as it related to violence against children), and ECE.

18. UNICEF is supporting the rollout of this planning process in 41 LG units. The resource guide has been launched in partnership with the Ministry of Federal Affairs and General Administration (MoFAGA), with the possibility of introducing this resource material to all 753 LGs. A parliamentary caucus on ECD has been actively lobbying for ECD causes since 2008 and is a key voice raising ECD issues in the legislature. [13] Similarly, various international nongovernmental organizations (INGOs) have been experimenting with integrated ECD approaches. Save the Children has been working in Sindhupalchowk to implement integrated ECD

[10] Nepal Mental Health Survey, Nepal 2018.
[11] van Teijlingen et al. 2015.
[12] Bill and Melinda Gates Foundation 2018.
[13] UNICEF 2008.

(0–3 years) for the last three years (*Subharambha*)[14] and plans to apply the lessons in future programming in Karnali District. World Vision is in the process of implementing an ECD in Health program (Go Baby Go [GBG]).[15] As they work on a holistic ECD agenda, including sensitizing parliamentarians, international organizations interviewed shared that they were also regularly having multisectoral discussions with colleagues within the organization on the ECD agenda to experiment with new and innovative ways to move forward. However, there is still a huge need for awareness at all levels—across the various government departments, parliamentarians, LG representatives, and service providers across the country.

19. **The devolution of functions to LGs provides an unprecedented opportunity to achieve the vision of holistic ECD.** Where the LGs have internalized the importance of ECD (and holistic ECD), they have been planning interventions from their own fund sources. For example, Chhayanath Rara Municipality in Mugu District has invested municipal funds in birthing centers and doubled the salaries of ECEC facilitators. Others are introducing water, sanitation, and hygiene (WASH) interventions in ECECs to achieve the Open Defecation Free (ODF) goal, for example, by focusing on potty training for children enrolled in ECECs or building special toilets and drinking water facilities for children attending ECECs. In Bardibas, ward representatives helped organize parents into mothers' groups, who are actively involved in the nutrition and learning of their children attending the ECECs.

20. **In the new federal structure, some provincial government and LGs are increasingly leading the way through good practices in driving ECD agendas and providing necessary implementation and monitoring support to ECECs.** Some promising initiatives and their learnings are presented in the following paragraphs:

- As mentioned earlier, Chhayanath Rara Municipality has topped up the salary of its ECEC facilitators by NPR 5,000, increasing it from an extremely low NPR 6,000 per month to NPR 11,000 per month, thus increasing the possibility of attracting and retaining quality manpower in ECECs, as well as boosting their job performance. Similarly, Province Number 4 has been conducting training of ECEC facilitators in coordination with the LGs, and provinces have been able to allocate money in improving capacity.

- The accuracy of data on students, teachers, and school facilities has improved in the sites visited after the LGs took over the overall responsibility for education up to the secondary level. The LGs have collected the most accurate data on ECEC classes, students, and teachers. Data collected from each school through the Integrated Education Management Information System (IEMIS) go through verification from the LGs, through headcount or triangulation with alternative datasets that might be available at the LGs. Resource allocation to ECECs, which mostly comes in the form of per capita financing and salary of facilitators, has also improved along with improvement in the accuracy of data.

- Monitoring and evaluation (M&E) has become more effective or shows great potential for improvement with effective local leadership. Service delivery points such as schools and health posts have more accountability to the LGs now. Additionally, due to physical proximity, it is easier for stakeholders and authority to engage closely in the evaluation of the progress and making improvement plans. Likewise, grievances'

[14] Still work in progress.
[15] Activities under the GBG include (a) preparation of children under 3 for psychosocial screening, assessment, counseling tools; (b) supportive supervision for health care service providers/GBG facilitators; (c) development of community structures; and (d) development of ECD behavior change communication (BCC) tools - GBG toolkit.

registration and redressal mechanism are also more efficient, unlike in the past, where hearings were done from district headquarters or centrally. Committees have been formed to look into specific sections in social development. In Mugu, anecdotal evidence indicates that direct field monitoring by the Mayor has increased the attendance of teachers and health workers, improving service delivery. The LGs which were not using banking channels are now using them (through commercial banks available in the area) to transfer the salary of the teachers and support to service centers through checks. This will enhance fiscal transparency and accountability.

- Increased collaboration and meaningful coordination have decreased duplication and increased sustainability. Developing minimum infrastructures and running ECECs can be costly processes. The LGs were found to have collaborated with NGOs in providing training to headmasters and ECEC facilitators on the utilization of local materials and resources in developing play materials or producing foods. Similarly, NGOs also trained the ECEC facilitators in creating play materials using local resources, which was appropriate for catering to stimulation while also making ECECs sustainable. Similarly, there have been gains in facilitating greater coordination between and among I/NGOs and reduction of duplication of efforts, with the Chief Administrative Officer (CAO) and Mayor/Chairperson being directly engaged in approval of programs and monitoring

21. **New opportunities are arising for integrating and packaging ECD interventions.** Expansion plans for the child grant represent a major opportunity to package ECD interventions. In Kalikot, Jumla, Humla, Dolpa, Mugu, Achham, Rautahat, and Bajhang, where the grant is "designed to reach all children under 5 (with a cap of two children per family), the coverage rate reached almost 80 percent and it has led to a phenomenal increase in birth registration to 90 percent compared to the national average of 42 percent."[16] The beneficiary database of child grant is maintained electronically and linked to the civil registration system at the Department of National ID and Civil Registration. The government's budget speech of 2018/19 committed to broadening coverage of the child grant to "include the districts in Terai-Madhesh that rank low in HDI."[17] Interviews with the MoFAGA revealed that the ministry is currently engaged in the groundwork to expand the grant to six districts with low HDI: Jajarkot, Doti, Bajura, Mahottari, Sarlahi, and Siraha. As the grant expands coverage, the LGs can use this opportunity to package other interventions to achieve integrated ECD outcomes.

22. **The private sector remains a major player in ECD but also a huge unknown.** The private sector is an important actor, in both health and education sectors. For example, the contribution of households to PPE expenditure in FY2014/15 was about 60 percent, compared to a 19 percent contribution by the MoEST.[18] Initial observation of private ECECs during our field visit sites outside Kathmandu and discussions with stakeholders indicate that parents prefer private ECECs. Public ECECs usually run between 10 a.m. and 2 p.m., while private ECECs keep children until 4–5 p.m., allowing parents to work. Some parents seem to prefer private ECECs for their stronger focus on rote learning and discipline.[19]

23. **Interventions for the urban poor are a blind spot in current programming.** A blind spot in the current (although limited) ECD programming seems to be the urban poor. The two ECECs and one health center visited in Mahalaxmi Municipality in Lalitpur had a high

[16] Rabi et al. 2015.
[17] Budget Speech of Fiscal Year 2018/19 (paragraph 13).
[18] National Education Accounts in Nepal: Expenditure for Education 2009–2015, Table 1: Expenditure for education by level and source of financing, http://uis.unesco.org/sites/default/files/nepal-nea-report.pdf.
[19] Aryal et al. 2018.

concentration of service seekers who are not residents but children of migrants working in the local brick kilns or as daily wage laborers in the city. Demand for ECEC services was high, with four different sections in each of the two ECECs to accommodate the volume of preprimary children. Informants shared that almost all service seekers arriving at the public health and education centers are migrants to the city, with locals receiving these services from the private sector. Discussions with the LG representatives indicated a reluctance to lobby for additional resources or invest their own resources in facilities for 'nonresidents'. Unlike facilities in remote Chhayanath Rara, the centers in Mahalaxmi Municipality accommodated more children (and received the per head conditional grant) but were visibly underresourced, receiving little support from the LG or INGOs. Two major issues that came up during discussions included the inability of working parents to travel to their home districts to get birth certificates for enrollment in ECECs and the difficulty that local health service providers have in tracking or providing critical services such as immunization or vitamin supplementation to nonresidents. More research is needed into the complexities faced by the urban poor in accessing important ECD services provided by the health and education sectors, as well as key services such as birth registration.

Resource Allocation and Management

24. **Centrally allocated sectoral resources for ECD-related activities are reported to be inadequate for holistic, integrated ECD.** Municipality representatives and leaders interviewed emphasized resource constraints, especially financial and human resources allocated expressly for the ECEC agenda. In our field visit sites, UNICEF-supported programs have provided resource persons to train ECEC facilitators, organize PE programs, and enhance ECEC facilities, but these activities do not have sustainable funding beyond the end of the program.

25. Even where government funding is directly provided as conditional grants, for example, in ECECs, the LGs committed to achieving quality ECD outcomes have found government resources inadequate for this purpose. The practice of topping up salaries in Chhayanath Rara or inviting NGO support in enhancing ECEC quality both indicate that centrally allocated resources for ECECs are inadequate for quality services, requiring the LGs to tap into their own budgets or NGO partners to deliver on the ECD agenda.

26. The integrated ECD planning process for the LGs is another example. This UNICEF-supported planning process comes with a handbook to guide the planning workshop. However, the facilitation is done by UNICEF-supported ECD experts and is not resourced beyond program implementation. Coordination, integration, and exploration of new ideas are not funded by central conditional grants. The Parents' Fair in Chhayanath Rara is such an example where the UNICEF and MSNP resources and coordination capacity were mobilized to organize the event. While these new opportunities to mobilize and allocate resources are arising with local-level management, funding for exploring holistic, integrated activities such as awareness for parents or L&S for pre-ECEC-age children is harder to come by.

Skills and Capacity

27. There seem to be few ECD experts or resource persons at the local level. While ECD mentors supported by UNICEF support the ECEC facilitators, and the education coordinator also provides support to the ECEC agenda, both these roles have an education-heavy focus, with very low understanding of holistic, integrated ECD and little capacity to coordinate across sectors. In Chhayanath Rara, we met the district coordinator for the MSNP, who helped the municipality organize the Parents' Fair, together with UNICEF-supported ECD implementers. The lack of personnel and lack of capacity in existing personnel are both major challenges for the LG. Another gap that was also pointed out by development partners interviewed is the human resource gap on

ECD in the country. Even when an LG requests and is willing to pay for ECD resource persons to help in planning or implementation, they are not available in the country. This was also obvious in our desk review and field research: even NGOs working with a holistic, integrated approach to ECD in the country are few, and we relied heavily on the one organization doing much of this work in Nepal, National Seto Gurans.

Integration Potential

28. **The packaging of various interventions into one platform has been achieved in various degrees and modalities.** Some positive deviances are presented in the following paragraphs:

- In Kathmandu metropolitan city, Education, Health and Social Protection Units are collectively placed under the Social Development Section. Regular meetings are held on programs across the three areas, and harmonization is done at each of the planning, implementation, and monitoring stages. At the program level, efficient allocation of resources has been done, removing duplications. The budget is prepared for the Social Development Section, while program implementation is still done by individual units. Being part of the single division allows for flexibility and efficiency while planning and implementing multidimensional and holistic ECD interventions.

- Parental awareness programs conducted by ECEC facilitators and social mobilizers, with technical and financial support from UNICEF, had been instrumental in increasing ECEC enrollments and attendance. Parents have taken ownership and are implementing home-based activities and methods aimed at having stimulation and learnings as well as improving health and nutrition practices. PE programs effectively create demands for ECD services through the provision of knowledge on aspects of education, health, nutrition, sanitation, and protection pertaining to children. This program also teaches parents how to fill learning and developmental gaps using local materials and resources.

- ECEC facilitators and other local resource persons such as FCHVs indicated that they could become ECD champions, carrying messages on ECECs or L&S, as required. Some other things that FCHVs said they could do include working on detecting and helping with maternal depression (if trained); providing information to mothers of children ages 3–4 years with the option to send their children to ECECs; and delivering vitamin tablets, fortified flour, or other interventions at the ECEC if required, and if adequately compensated for their time.

- Some schools were found to have operated *poshan* garden 'Nutrition Garden', for providing day meals to children. The *poshan* garden was being looked after by members of the community, teaching staff, and the students, ensuring long-term sustainability of such efforts. This can be an effective way to combine nutrition and education through community participation using spare plots which are sometimes available in plenty in community schools.

- Child grants distributed by ward offices are intended as nutrition grants. The ward secretary who distributes these grants in Chhayanath Rara shared his experience of visiting every household with a child under five to invite them to a gathering where the grant would be disbursed and was enthusiastic about using that platform for providing information to parents on nutrition, stimulation, or preventing child abuse and neglect.

- In Mahottari, ECECs were also being used to administer Vitamin A supplements or polio drops, indicating the potential for health and education outposts to support each other to increase the coverage of their services and potentially create more avenues for joint or integrated interventions in the future.

Future Research Needs

29. **Some of the immediate future research needs are as follows:**

- Producing economic and fiscal space analyses for financing and operating integrated ECD activities.

- More research is needed into the complexities faced by the urban poor in accessing important ECD services provided by the public health and education centers in a city, especially in the federal structure where the LGs responsible for ensuring provision and quality of these services may not be accountable to service seekers, who are almost all migrants.

- Private sector service providers play a huge role in the health and education sectors, and thus in ECD service provision, but their contribution is rarely a part of policy discussions. While a comprehensive look at private sector service provision was outside the scope of this review, a closer look at the potential of leveraging private sector contributions for holistic ECD outcomes would be beneficial for informing local and national policies.

- Numerous maternal mental health pilot initiatives are under way, and a comprehensive look at the results and lessons from these would also help inform future initiatives to enhance caregiver mental health for better ECD outcomes.

Opportunities for Synergistic Investments in Early Years

30. Based on the synthesis of key findings from the literature review and key informant interviews (KIIs), in this section, we propose a three-part strategy for identifying, assessing, and designing opportunities. The step-by-step approach is particularly important because we must (a) ensure that we are guided by the science of childhood development so that we have a holistic understanding of goals to be achieved throughout the life course, (b) map and assess the gaps in quality and coverage of current interventions implemented to achieve such goals, and (c) design innovative programming and delivery mechanisms that can fill the gaps and increase efficiency of the overall governance and change ecosystem.

Part 1: Strategic Goals for Investing in Early Years (IEY)

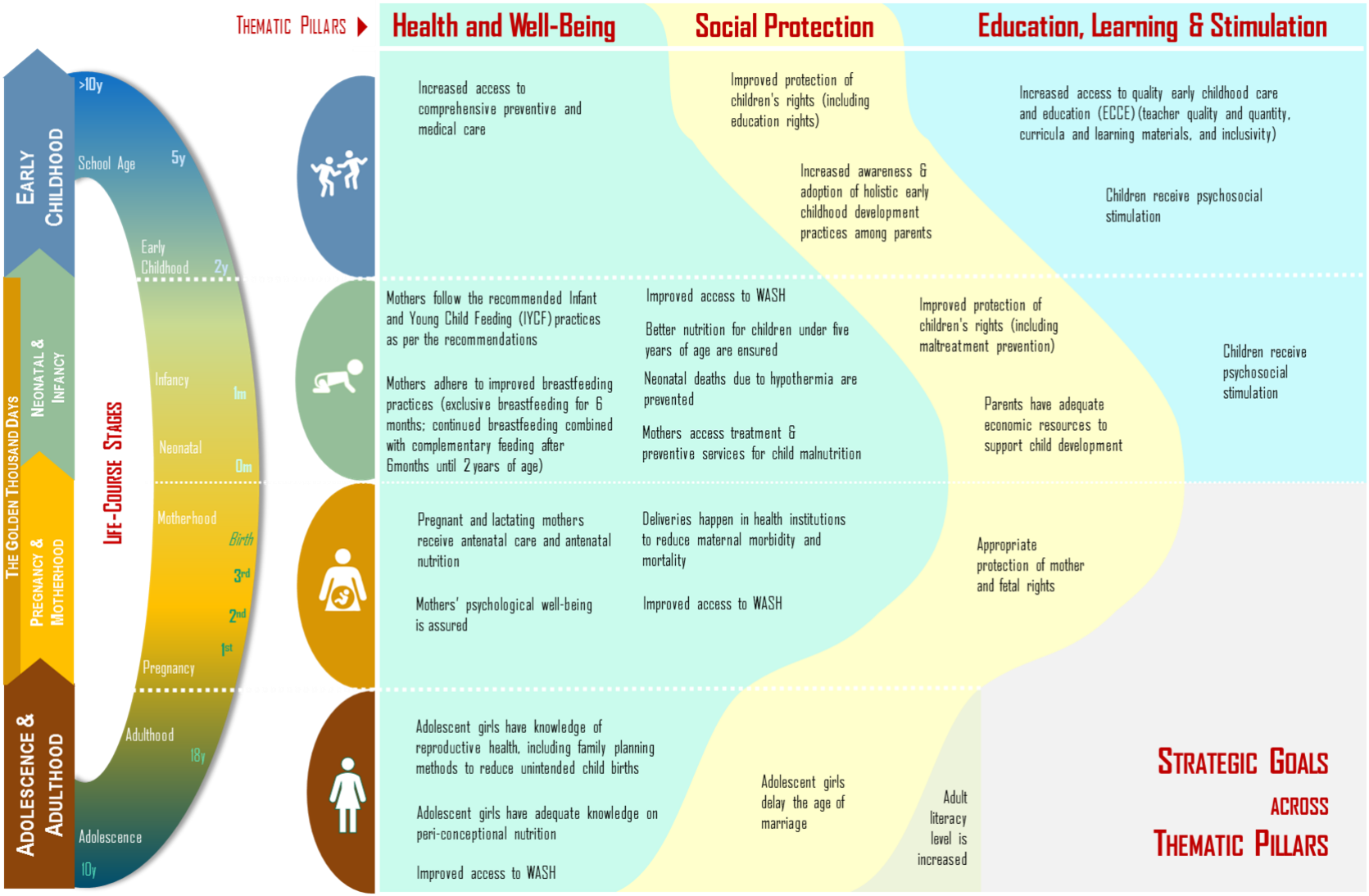
31. The first step in the process is to clearly define the strategic goals across the life-course stages, as illustrated in Figure 2, which is developed, based on the most recent scientific knowledge on the topic.[20] The life-course stages can be broadly classified in three stages.

	Adolescence and Adulthood	It is the period during which comprehensive sexual and reproductive health education and access to adolescent sexual and reproductive health (ASRH) services play a critical role in encouraging young people to delay the age of marriage; prevent unintended pregnancies; and prepare well for the task for childbearing and rearing with adequate knowledge of nutrition, rest, hygiene, and sanitation.
	The Golden Thousand Days	It is the period between conception and when a child is under the age of 2. It can be seen as a joint journey of mother and child. During pregnancy, a mother must be physiologically, psychologically, and physically prepared for birth and neonatal and infant care. During and after birth, a range of goals must be achieved by the public and private sectors to enable safe delivery, neonatal, and infant care. During the first two years, a child also must achieve specific development milestones to build a strong foundation for long-term cognitive, psycho-emotional, and behavioral skills.
	Early Childhood	It is the period between 2 and 5 years of the child, during which she or he must receive quality early childhood care and education, along with psycho-emotional L&S. As with other stages, access to comprehensive preventive and medical care, including timely nutritional assessment and malnutrition treatment, is critical. In addition, the role of parents in ensuring a nurturing environment is vital for the child's holistic development.

[20] Lancet 2016.

32. Along these life-course stages, the strategic goals are further categorized into three thematic pillar goals, which are geared toward improving (a) health and well-being; (b) social protection; and (c) education, learning, and stimulation.

FIGURE 2: THE STRATEGIC IEY OBJECTIVES ACROSS THE LIFE CYCLE AND IN RELATION TO THE THREE THEMATIC PILLARS



Part 2: Mapping and Assessment of Current Interventions during the Life Cycle

33. The second part of the process is to map and assess interventions that are being implemented by various organizations in Nepal. For each stage, we distilled key approaches leveraged to meet the goals. For each approach, we mapped various interventions being currently implemented. Then, we assessed the approach (and in some cases, specific interventions) across the dimensions of their coverage (demographical, geographical, and provincial) and quality (effectiveness, efficiency, relevance, sustainability, and accessibility). The assessment is presented in the charts in Annex IV.

34. The summary of the mapping and assessment charts are described below.

Adolescence and Adulthood	ASRH activities of the health sector are implemented at different places; sexual and reproductive health education has been incorporated into the school curriculum in Nepal; and various NGOs, as well as the government's Women Development Program (WDP), have been running resource centers, awareness programs, and livelihood interventions targeted toward adolescents. However, a few key gaps remain, which include the following: • Out-of-school, married, and migrant adolescents, who are the most vulnerable, are not reached by much of the current programming. • Teachers are not well trained on delivering comprehensive sexual and reproductive health education. • The future of adolescent girls' resource centers, livelihood grants, and skills training programs run independently by cooperatives promoted by the Women's Development Center is uncertain in the new federal structure.
The Golden Thousand Days	The coverage of at least four antenatal care (ANC) visits has increased to almost 70 percent in 2016 from 50 percent in 2011 (Nepal Demographic and Health Surveys [NDHS] 2011 and 2016). However, the quality and content of services are yet to catch up. More than half of the women do not receive counseling on all five critical components (NDHS 2016). The coverage is also particularly lower among women living in the midwestern mountain region and rural areas (Multiple Indicator Cluster Survey [MICS] 2014). The proportion of institutional deliveries increased from a mere 18 percent (2006) to 57 percent (2016),[21] surpassing the target of 40 percent of the Health Management Information System (HMIS). The coverage is particularly lower in Province 6 (36 percent), Province 2 (45 percent), and earthquake-affected districts (41 percent). However, health facilities are fraught with limited in-service training and provision of proper guidelines for health workers. Although skilled-birth attendant (SBA) deliveries have also increased by 22 percentage points (from 36 percent to 58 percent between 2011 and 2016), it has, however, failed to meet the target. Basic and comprehensive emergency obstetric and newborn

[21] NDHS (Nepal Demographic and Health Survey). 2016. Ministry of Health and Population, Government of Nepal.

	care (B/CEONC) services are concentrated in zonal and above hospitals (66 percent), with only 40 percent of the districts having at least one functional facility providing the services. However, referrals to such facilities during complications can become a nightmare because two-fifths of the facilities do not have emergency transport services. Health facilities also do not have adequate provision for auditory and visual privacy and confidentiality, in providing counseling services related to postnatal care (PNC) and family planning. Access to second trimester safe abortion services is poor, especially among the most vulnerable and socially disadvantaged groups. Likewise, preventing drug stock-outs in remote areas is a big challenge. Financial incentives and cash transfers have been a strong incentive for increasing institutional deliveries, but some fund flow inefficiencies exist. The key gaps include the following: the size of the benefit is not sufficient to achieve substantial impacts, particularly for child grants and irregular and partial payment to health facilities, usually because of slow disbursement from the center and nonuniform medium of payment (check, cash, and so on) has meant delayed payments to women; in some cases, particularly in the Terai, women still pay fees despite the provision for 'Free Delivery Care' under the Safe Motherhood Program (SMP).[22] FCHVs continue to play an important role in community-based delivery of services, such as in providing counseling in ANC, newborn care, nutrition surveillance and management, and infant and young child feeding (IYCF). However, because of the high fragmentation of services, FCHVs are overburdened and not mobilized efficiently. As such, it is important to identify ways to combine various tasks into one visit or event, through integrated and strategic planning of interventions.
Early Childhood	**The early childhood education development (ECED) sector in Nepal is marked by high achievements in access.** As of 2017, 36,093 ECED/PPE centers (30,448 community and 6,120 institutional) were providing education and stimulation care to almost 973,400 children from the ages of 3 to 4. Gross enrollment rate (GER) reached 82.9 percent. About 64.7 percent of the children being enrolled in grade 1 now have ECED/PPE experiences, up from only 10 percent in 2002 because of the impressive expansion of supply. The School Sector Development Program (SSDP, 2016–2022), a flagship education program of the MoEST, has ensured mainstreaming of the sector by integrating one year of ECED/PPE with basic education. Furthermore, the SSDP has taken on board an ambitious target of establishing ECED/PPE program in all basic schools to provide coverage to unreached children based particularly in remote and difficult areas and from economically disadvantaged families and marginalized and vulnerable communities. The SSDP's goal is consistent with the constitutional mandate of making basic education free and compulsory. **The SSDP focuses on various supply and demand activities to strengthen the sector.** Interventions on the demand side include the provision of PE;

[22] Nepal Health Facility Survey (NHFS) 2015.

	school day meals in selected areas; and scholarships to girls, marginalized ethnic groups, and communities including Dalits. On the supply side, the government is expanding accessibility by increasing the number of community school-based ECECs and enhancing quality by putting properly trained and qualified facilitators in ECECs, scaling up salaries and capacity of facilitators, and most importantly, by enhancing local-level monitoring and supervision. Alongside, ECECs have also been used as platforms for launching integrated efforts in WASH, social protection, and health in selected districts. **Compared to access, quality is far from commensurate.** Gains made in access are yet to be translated into quality. Of the four domains on Early Childhood Development Indicator (ECDI), literacy-numeracy, physical, socioeconomic, and learning, 64.4 percent children are developmentally on track in three domains. Far from adequate achievement has been made in the domain of literacy-numeracy, where only 28.8 percent are deemed to be developmentally on track.[23] Evaluation of the School Sector Reform Project (SSRP) reported that expansion took place with insufficient attention to quality.[24] Many ECECs have an inadequate supply of basic equipment and play material and possesses suboptimal classroom environments. Consequently, large proportions of ECECs fail to achieve even a small proportion of the national minimum standards. Likewise, the salary of ECEC facilitators seems to be very low. This has led to problems with retention and teacher motivation and reduced impacts in the classrooms. Other key gaps and challenges include low funding of the sector in general and high presence of underqualified facilitators.

[23] Aryal et al. 2018.
[24] Poyck et al. 2016.

BOX 1: CASE STUDY

The Promise of Parental Education: Working with Parents to Ensure a Successful Holistic, Integrated Approach to ECD

The primary caregivers of children have long been recognized as the first line of response to ensure that a child is well nourished and cared for and meets all development goals. Recognizing the need for PE packages to impart knowledge and skills to parents to help their children reach their full potential, PE interventions have been piloted in various areas of the country since 2006.

The earliest PE package, supported by UNICEF, Innovative Forum for Community Development, Save the Save the Children-US, Seto Gurans, and Plan-Nepal was delivered through the health system, by training FCHVs on the various learning modules. Anecdotally, the health-system-based PE package was quite successful, although the learnings from this pilot have not been captured.

To support comprehensive education on childhood development, UNICEF-Nepal, in partnership with SetoGurans National Child Development Services, developed a participatory PE program with 30 modules addressing various aspects of child development such as health, education, protection, or sanitation. The package was piloted from September 2016 to March 2017 in five (Achham, Bajura, Kalikot, Mugu, and Mahottari) districts. The ECEC facilitators were trained on the delivery of these modules, and parents could pick and choose from among the modules to learn about topics most relevant for themselves.

A Knowledge, Attitudes, and Practices Study conducted in November 2017 in three of the five program districts found that after the intervention, 59 percent of households have seen positive changes, especially in their knowledge of raising children.[25] After effective piloting, the package was handed over to the MoEST. The package is now being implemented by the LG in Achham, Bajura, Mugu, Kalikot, and Mahottari, with support from Seto Gurans.

While the PE package is a promising intervention, there are a few challenges that keep it from achieving its full potential. One of these is the delivery, which is solely through ECECs. Even where the implementer has mobilized mentors, trained facilitators, and delivered the PE package, our field visits show that delivery through ECEC will result in the package only being delivered to parents of children enrolled in that particular ECEC. Even though the package has been intended for all parents in the community, parents of children in private ECECs do not see the public ECECs as their space, and there was no evidence of any parents from outside the center participating. Another challenge is that by the time the children are in ECECs, it is too late for some of the health, nutrition, and L&S modules, information that parents require much early on. And a third challenge is that when parents can pick and choose, they do not choose certain important modules, such as violence against children, a known risk factor for poor early child development.[26] A final challenge is an overall one of keeping the quality intact when the program scales.

A multisectoral approach to delivering PE interventions could increase the value, coverage, and the effectiveness of this intervention. For example, the knowledge geared toward parents of younger children, on early learning, stimulation, and protection could be packaged with health and nutrition campaigns for mothers and newborns and taught either in health mothers' groups, health posts, cooperatives, or other community groups.

Parenting is one of the most important aspects of a child's life and is twice as predictive of a child's success in early learning as a family's socioeconomic status.[27] Working across sectors to support multidimensional parenting presents a great opportunity to achieve greater holistic, integrated ECD.

Part 3: Integration Opportunities for Increasing Delivery Efficiencies

Leadership for Integrating IEY Activities

35. With the devolution of responsibilities to local levels, the role of the LG in prioritizing, planning, implementing, and monitoring IEY has become substantial. As such, the LG can make a transformational and holistic IEY strategy the centerpiece of its contribution to human capital development. The head of the LG (such as Mayor or Chairperson) can offer strong executive

[25] UNICEF 2017b.
[26] Byambaa et al. 2012.
[27] UNICEF 2017a.

leadership and direction, under which various sectoral interventions can more holistically be integrated into the planning, budgeting, supervisory, and monitoring processes.

36. Building on the new organogram designed by the MoFAGA, one potential governance structure is presented in Figure 3 with the following key features:

- **Strong executive leadership:** The Chairperson of *Gaunpalika* or Mayor of the municipality should provide executive leadership, supported by operational leadership of the CAO. The proactive engagement of the Mayor creates a strong authorizing environment for the IEY agenda to be implemented with improved coordination, appropriate resource allocation, and timely resolution of issues and other constraints.

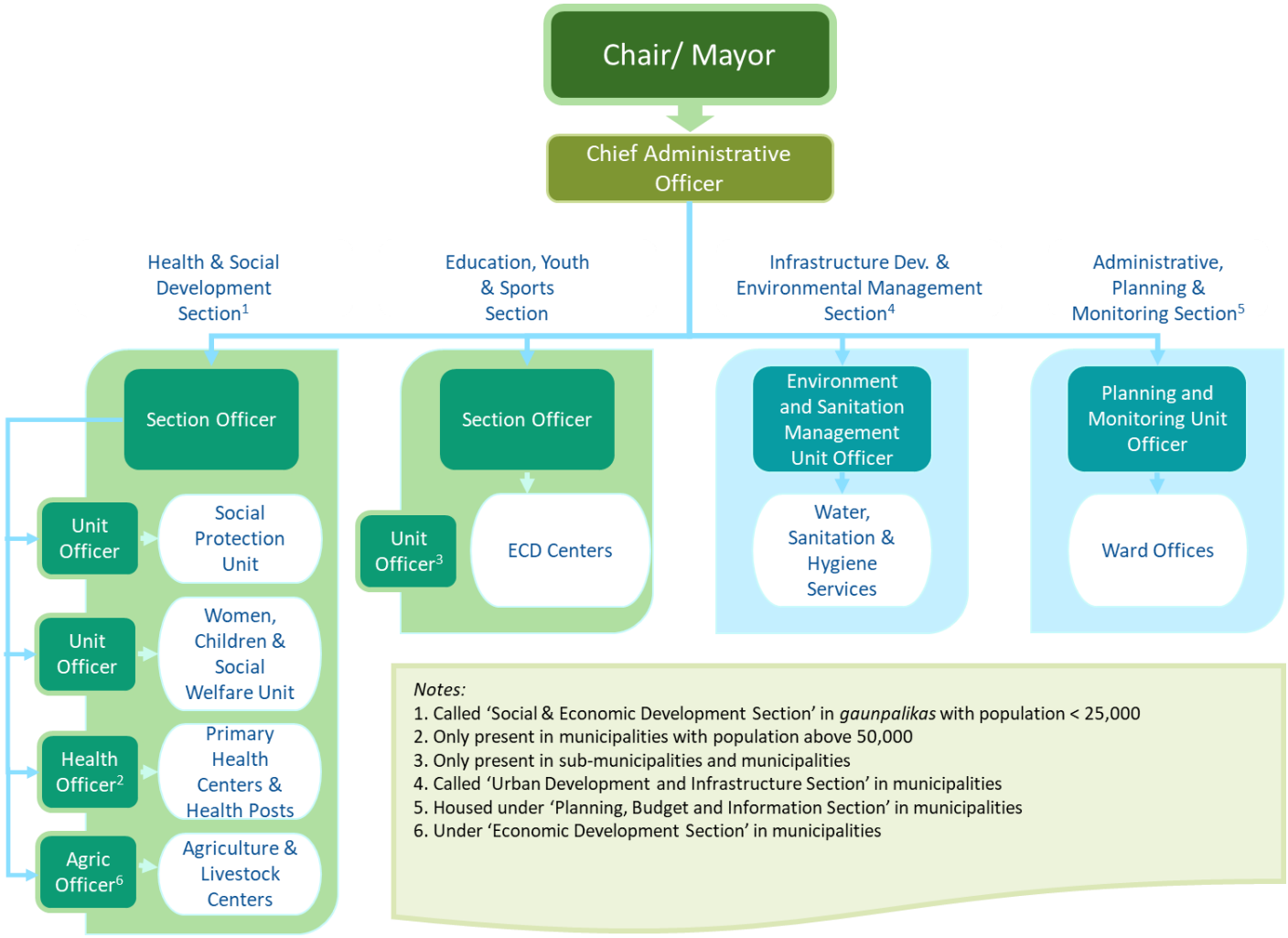
- **Operational partnerships among existing units:** The 'Health and Social Development Section' (or the Social and Economic Development Section in *Gaunpalikas*) can function as an 'umbrella section' with (a) **implementation leadership** of the section and unit officers of (i) Social Protection Unit; (ii) Women, Children, and Social Welfare Unit; (iii) Health/Public Health; and (iv) Education Section (that is, ECE officers in larger municipalities) and (b) **strategic planning** with the support of the Planning and Monitoring Unit. Other units and sections such as the Infrastructure Development and Environmental and Sanitation Unit can also play a critical role depending on the nature of interventions being implemented.

- **Resource optimization:** Through an integrated budgetary planning, facilitated by the Planning and Monitoring Unit, adequate resources can be allocated for optimizing investments across various interventions. Likewise, in smaller local bodies, where human resources are scarce, office staff (and physical space and other resources) can be shared among various units working on the IEY agenda.

- **A joint M&E framework:** The overall impact on child development and growth is contingent on optimum outcomes generated through a range of interventions, implemented through multiple sections and units. Thus, a holistic M&E framework is critical for tracking progress across sectors. The joint M&E framework must be developed by (a) clearly identifying activities, outputs, and outcomes for each section/unit; (b) synergizing field monitoring and supervision mechanisms; (c) establishing cross-referencing ability in information systems; and (d) organizing periodic results and progress review sessions to identify problem areas and introduce adaptive measures.

- **Cross-learning and creative problem solving:** Periodic learning events can be organized with a cadre of staff across the sections (such as ECEC facilitators, health workers, social workers, and so on) to encourage cross-learning and creative problem solving on some of the key issues identified during the review meetings or as reported by the staff.

FIGURE 3: LEADERSHIP FOR THE IEY AGENDA AT THE LOCAL LEVEL



37. While this is the desired modality for governance of how IEY activities can be adequately integrated at the local level, the study does find that not all local-level bodies may push the IEY agenda with the above-proposed proactive local leadership. The reasons may include poor sensitization to the importance of IEY, lower prioritization compared to other highly visible investments such as roads and so on, or weak leadership. Annex V presents a comparative analysis of the abovementioned modality along with other current and past modalities that can still offer adaptive solutions in these scenarios.

Integrated Implementation of IEY Interventions

38. The government, with the help of development partners and INGOs, is implementing various programs and services for childhood development. For instance, social protection programs ensure that children receive adequate support and care, ECECs provide L&S, and health programs provide maternal and child health services at health facilities and through FCHVs. However, these programs lack convergence and a child, born or unborn, may not receive the entire package of services needed for his/her development. It is important to identify and experiment with viable opportunities to integrate the interventions and investments for early years, particularly under the new LG structure. As a starting point, such integrated packaging of interventions must uphold some key principles, as presented as follows:

- Integration will increase efficiency.
- Integration will have high acceptance, ability, and authority to initiate the proposed change.
- Integration will not be substantially more expensive for the expected marginal efficiency gains.
- Integration will have a simplified process, for both messaging and managing.
- Integration will make calculated assumptions and consider all risks and mitigation measures.
- Integration will capitalize on the existing processes, systems, and financial resources.
- Integration will promote supportive governance and leadership at both the local and central levels.

39. Based on these principles of integration, the key 'Integration Dimensions' can be categorized as follows:

Integration of access to services	Integration mechanism that allows for multiple sectors to deliver services to same clients or beneficiaries, for example, providing services by health facility to ECD-enrolled children
Integration of human resources	Delivery of interventions of other sectors through existing human resources, for example, providing L&S services by FCHVs, who normally provide public health services
Integration of financial resources	Reallocating, consolidating, or 'topping up' financial resources between existing interventions, for example, additional monetary or in-kind incentives to FCHVs to carry out certain interventions in their communities
Integration of communication and outreach	Taking advantage of outreach events and communication channels used by one program or sector to promote activities and interventions of another program or sector, for example, ECED enrollment campaign

	event (*Abhibhabhak Mela*) used for collecting data on nutrition interventions in communities
Integration of information systems	Integration of digital or paper-based information systems to enable tracking of individual child, (through unique identification and cross-verification of reaching critical milestones), and easy analysis and aggregation of information for programmatic planning and M&E. For example, tracking whether a child has received necessary services over his/her life-course stages and using birth registration to estimate target ECECC enrollment level in a given year.

40. The study finds several examples of existing efforts for integration with valuable lessons for developing potential integration opportunities in the existing mechanisms. Hence, the opportunities for integration should be viewed with respect to the existing integration anchors, that is, infrastructure or programs that are already operational and can, therefore, provide a helpful foundation for integrating one or more of the Integration Dimensions. Three integration anchors (which are not mutually exclusive) are proposed below as models for integration of IEY activities.

INTEGRATION ANCHOR 1	LEVERAGING CHILD GRANT	The model capitalizes on the existing cash transfer, namely the cash grants given to all children under five in selected districts and all Dalit children elsewhere.
INTEGRATION ANCHOR 2	LEVERAGING ECECS	The model intensifies integrated ECD interventions to students enrolled in public ECECs (with provisions to require or recommend similar actions in private ECECs) by symbiotically interfacing with corresponding local service providers (such as health, social protection, and WASH services) and stakeholders (such as parents).
INTEGRATION ANCHOR 3	LEVERAGING COMMUNITY-BASED INVESTMENTS	The model streamlines delivery of services at (a) household or 'home' level and (b) at the community level, by leveraging the existing community mobilization channels or resources of the local institutions, such as FCHVs, social mobilizers/workers, and animal/agricultural workers, including microfinance and cooperative group members.

41. The models are described in detail, along with rationale, design, modalities, and assessments, in the following pages.

Integration Anchor 1: Leveraging Child Grant

CONTEXT

42. The first integration model capitalizes on the existing cash transfer, namely the child grants given to all Dalit children under five and all children under five in selected districts.[28] Such grants, when combined with other child-sensitive services and capacity building of service providers, are found to have a significant synergistic impact in reducing malnutrition.[29] The child grant requires birth registration of the child. In some districts, birth registration is further conditional on having visited a health facility (requiring parents to collect evidence of vaccination or weight measurement) to receive certification of birth and accessed postnatal checkup. The interviewees report that such cascaded requirements have contributed to the substantial increase in birth registration and visits to the health facility for or after delivery. Given that the government intends to roll out the child grant in other districts as well, this could prove to be an instrument with wider coverage.

DESIGN AND IMPLICATIONS

43. Learning from such achievements, we propose a potential 'Synergistic IEY in Social Protection Services' model, as shown in Figure 4 that primarily aims to enhance the social returns of existing child grant investments. The current child grant scheme for under-five children could be used to promote other IEY activities. Using this platform, we could encourage households/mothers of children less than three years for postnatal checkups, birth registration, and immunizations of children. We could encourage households/mothers of children between three and five years for enrollment of children into the ECED and primary schools and completion of vaccination. We could encourage expecting mothers for institutional deliveries. During the distribution of child grants, officials can provide such messages and information about sites to the households to access these services.

44. LGs can put soft conditions (for example, vaccination cards) to dispense cash grants so that the children receive other services. However, this should not be done at the risk of losing the beneficiaries who for other reasons may not be able to fulfill such conditions to meet the cash grants. For example, health facilities may be running out of vaccines. However, ward offices can 'top up' the grant for those who have vaccination cards and ECED enrollment certificates. On the other hand, health facilities while providing birth certificates can also encourage mothers to go to ward offices for birth registration. Some urban hospitals, such as Kathmandu Medical College, directly file birth registrations online. There is an interest in expanding such services to rural areas where there is good Internet connectivity, capability, and technological resources. The ECED centers can also help ward offices by submitting the names of the students to the local municipal office for automatic eligibility for any 'top-up' cash grants.

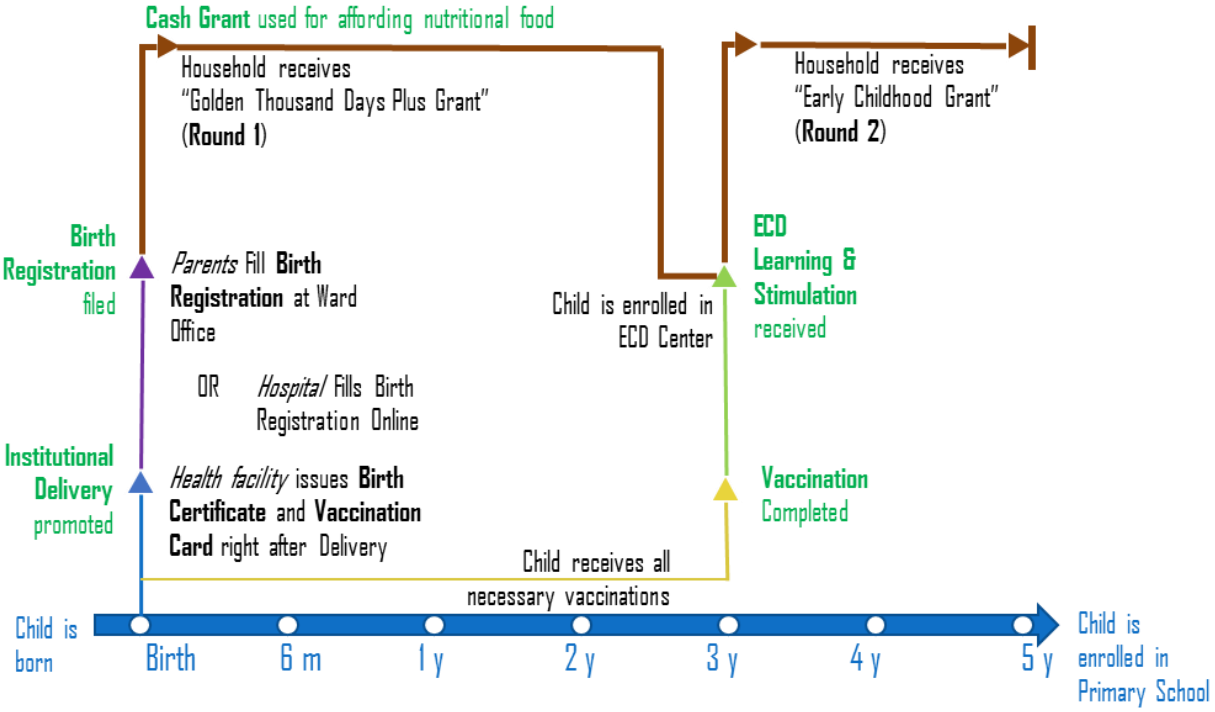
45. Ward officials can organize communications outreach on special days jointly with the ECED facilitators, health officials, and FCHVs to impart messages about service sites to avail different facilities for children's growth and well-being.

46. In this model, the LGs should create a coordination mechanism to ensure availability of various services and information flows between different institutions. Additional human resource may

[28] Currently in Kalikot, Jumla, Humla, Dolpa, Mugu, Achham, Rautahat, and Bajhang.
[29] Renzaho et al. 2017.

not be necessary, but ward offices will have an additional financial liability if they are to provide 'top-up' to the existing grants.

FIGURE 4: CONCEPTUAL PRESENTATION OF INTEGRATION ANCHOR 1: LEVERAGING CHILD GRANT



Integration Anchor 2: Leveraging ECEC-based Investments

CONTEXT

47. The second integration model seeks to intensify integrated ECD interventions to children enrolled in public ECECs, with provisions to require or recommend similar actions in private ECECs. The recently published *Guideline for the Local-level Integrated ECD* (hereafter referred to as 'the ECD Guideline') establishes the minimum requirements and recommendations for an ECEC.[30] For holistic early development of a child, the ECD Guideline calls for delivery of integrated interventions that enhance L&S, health and nutrition, WASH, and child protection and safety. Although this one-year window (ages 3–4) for intervention is small in comparison to the overall life-course stages, it is nonetheless seen as a critical period for building strong foundations for lifelong development of perceptual motor, cognitive, language, socioemotional, and self-regulation skills.[31]

DESIGN AND IMPLICATIONS

48. Using the ECD Guideline as the core guideline, we propose a potential 'ECEC-anchored IEY' model, as shown in Figure 5 that primarily aims to intensify the targeting of various sectoral interventions with a child-centric approach. Children in ECECs are provided care, learning, and psychosocial stimulation. These centers can act as good platforms to provide or link to additional childhood development services including nutrition services, vaccinations and health checkups, and WASH services. They can provide interface with communities and parents for protection of children's rights by showing them the right path toward the holistic well-being of children.

49. With coordination from health facilities, the ECECs can organize periodic health checkups, vaccination programs, and nutritional assessment of children. Health centers can train the ECEC facilitators for an early diagnosis of health needs of children for timely referral. The ECECs could also collaborate with agriculture extension workers for advice and support to establish kitchen gardens to provide nutritious midday meals to the children.

50. It is essential that ECECs meet the minimum standards including safe infrastructure, provision of playing materials, and adequate WASH facilities. The ECECs should have trained and well-incentivized facilitators to deliver quality services to the children.

51. Given the multisectoral nature of goals and interventions, the ECECs must symbiotically interface with corresponding line agencies and stakeholders. As such, the model proposes working on the following four interfaces:

Interface 1	Intra-ECEC
Interface 2	ECEC - Health Facilities/Services
Interface 3	ECEC - Community/Parental Services
Interface 4	ECEC - Local Institutions

- **Interface 1** constitutes improving the overall L&S service quality of the ECEC itself by ensuring that minimum standards set in the ECD Guidelines are met. This includes meeting requirements for (a) physical infrastructure (building/classroom specifications,

[30] Government of Nepal 2018 (b).
[31] Black et al. 2016.

physical space or environment for sitting, playing, and other activities); (b) qualifications and standard of care by teachers; (c) learning areas and their materials; (d) external playground and surrounding; (e) management committee; and (f) supervision and monitoring mechanisms. This would require interfacing with the local institutions.

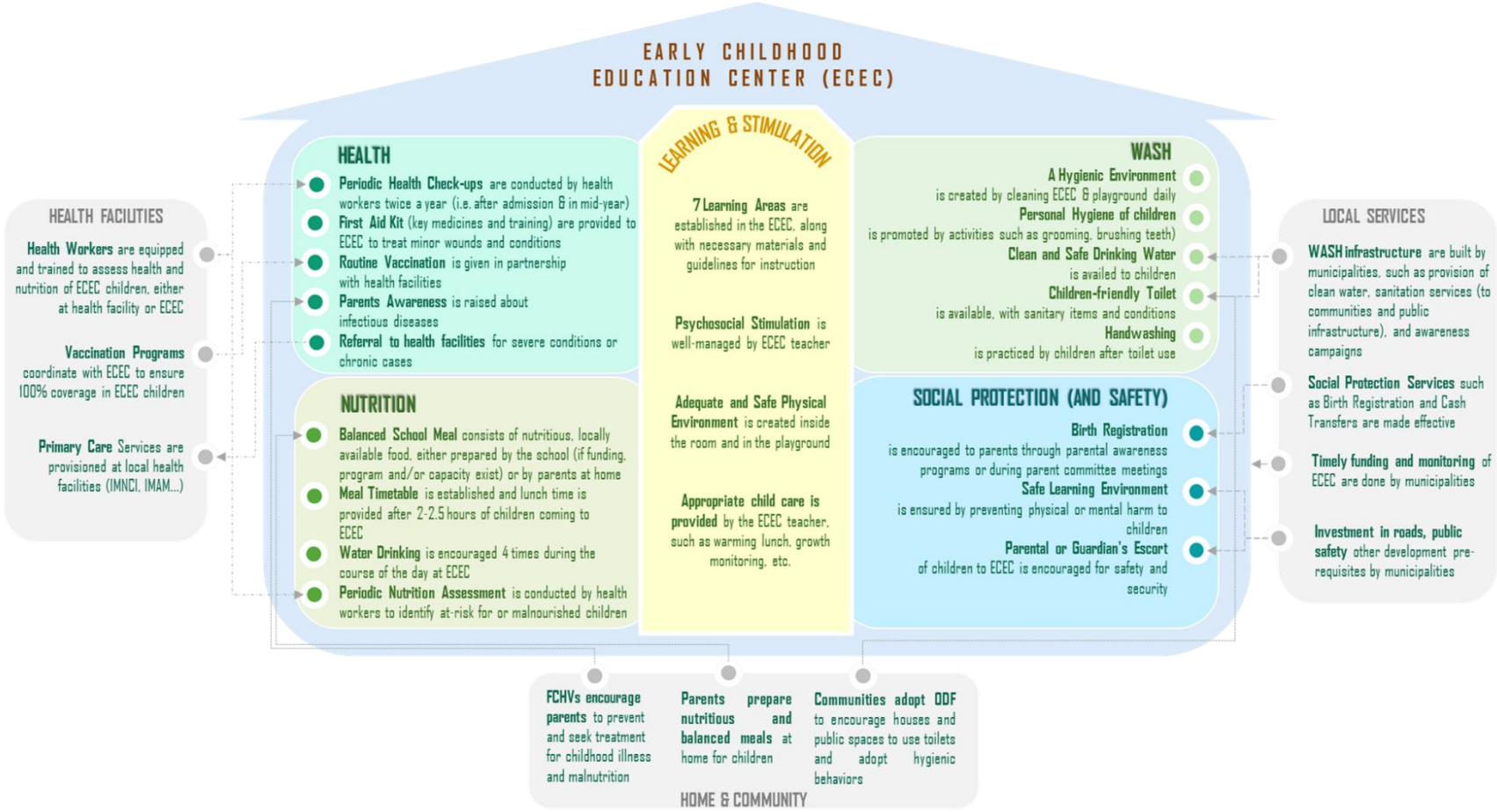
- **Interface 2** entails the links between local health facility and the ECEC to meet minimum standards. Such integrated activities include (a) provision of periodic health checkups to ECEC students after admission and midyear; (b) vaccination outreach; (c) the ECEC's referral of severe conditions, chronic cases, or cases of malnutrition; and (d) periodic nutritional assessments. The actual point of service can vary depending on the type of activity. For instance, (a), (b), and (d) can be done at the ECEC as an outreach campaign twice a year, while (c) can be done at the health facility after referral from the ECEC facilitator, who is given training to identify childhood illnesses.

- **Interface 3** pertains to the ECEC's efforts in engaging parents (and communities) to (a) ensure that children receive appropriate care and stimulation in their homes and communities by organizing parental awareness programs and (b) increase parental ownership of the ECEC by creating feedback loops, giving opportunity to support school-feeding program or kitchen gardens, and seeking guidance and participation in strategic decision making and budgeting through parent committees.

- **Interface 4** pertains to the ECEC's interface with local public system agencies to (a) advocate for infrastructure provision and investments (WASH, electricity, roads, and operational and capital costs, and so on); (b) help in advocating for and increasing utilization of social protection services among enrolled students; and (c) support timely supervision and monitoring by the relevant local agencies.

- This model could have both human resource and financial implications. Health facilities may not have adequate human resource to provide services at the ECECs and the ECECs' facilitators may not have the capacity to provide additional services like parental counseling and awareness. The ECECs may not have the required minimum infrastructure and facilities to provide care, support, and L&S activities to children. The LGs, with the help of federal and provincial governments, should ensure resources to provide the necessary services at the ECECs.

FIGURE 5: CONCEPTUAL PRESENTATION OF INTEGRATION ANCHOR 2: LEVERAGING ECEC-BASED INVESTMENTS



Integration Anchor 3: Community-Based Outreach Leveraging Health and Nutrition Services

CONTEXT

52. The third integration model presents the high potential opportunities for integrating the delivery of services surrounding all life-course stages at the community level and, ultimately, within individual homes. It emphasizes an ecological model, with three levels of integration. The core level is children's **home**, which consists of family members (that is, children, their siblings, parents, grandparents, and other relatives and caretakers), along with family values, socioeconomic status, propensity for child mistreatment, and risk factors for poor health, nutrition, sanitation, and L&S. The second level is the **community** or society, which comprises unique demographics, inequalities, social harmony and trust relationships, cultural practices and customs, and others. The third level consists of a range of service delivery **institutions**, including the LG or municipal office, health facilities, ECEC, agriculture/livestock/forest offices, women and child welfare offices, and private sector organizations such as microfinance institutions, cooperatives, private health and education service providers, and so on. This model particularly focuses on interventions that can be integrated at the first and second levels, while coordinating with upstream services or supervisory structures presented by the third level.

DESIGN AND IMPLICATIONS

53. We propose a potential 'community-based integrated IEY' model, as shown in Figure 6, that primarily aims to intensify the targeting of various sectoral interventions with a child-centric approach. The model has the widest touchpoints, in terms of (a) IEY goals related to health and nutrition, social protection, and L&S; (b) all life-course stages; and (c) MSNP interventions, such as health, WASH, women and children welfare, local body, education, agriculture, livestock, and forestry.

54. FCHVs, agriculture and livestock extension workers, and social mobilizers could be leveraged to provide additional services related to childhood development to households or communities. FCHVs have traditionally provided health counseling and surveillance services in areas such as ANC, PNC, newborn and IYCF, malnutrition identification, and disease surveillance. While they perform their regular tasks, FCHVs can potentially integrate components related to L&S counseling and identifying (and referring) children who are not enrolled in ECECs, particularly among marginalized and uninformed households in the communities. The FCHVs' program can potentially integrate components related to L&S counseling to provide households of children not attending ECECs. FCHVs could be trained to refer mothers with postpartum depression.

55. Similarly, social mobilizers can be trained to impart messages to the communities and households on WASH and nutrition. Social workers can provide community-based advocacy for women and child rights (and proper treatment), conduct interaction programs between mothers and mothers-in-law, and facilitate adolescence resource centers. Social mobilizers can also partner with community groups to provide community-based advocacy for women and child rights (and proper treatment), conduct interaction programs between mothers and mothers-in-law, facilitate adolescence resource centers, and raise awareness about maternal depression and provide psychosocial counseling.

Some institutions such as Women and Child Organizations might have social workers who have more specialized knowledge to carry out some of the activities. [32]

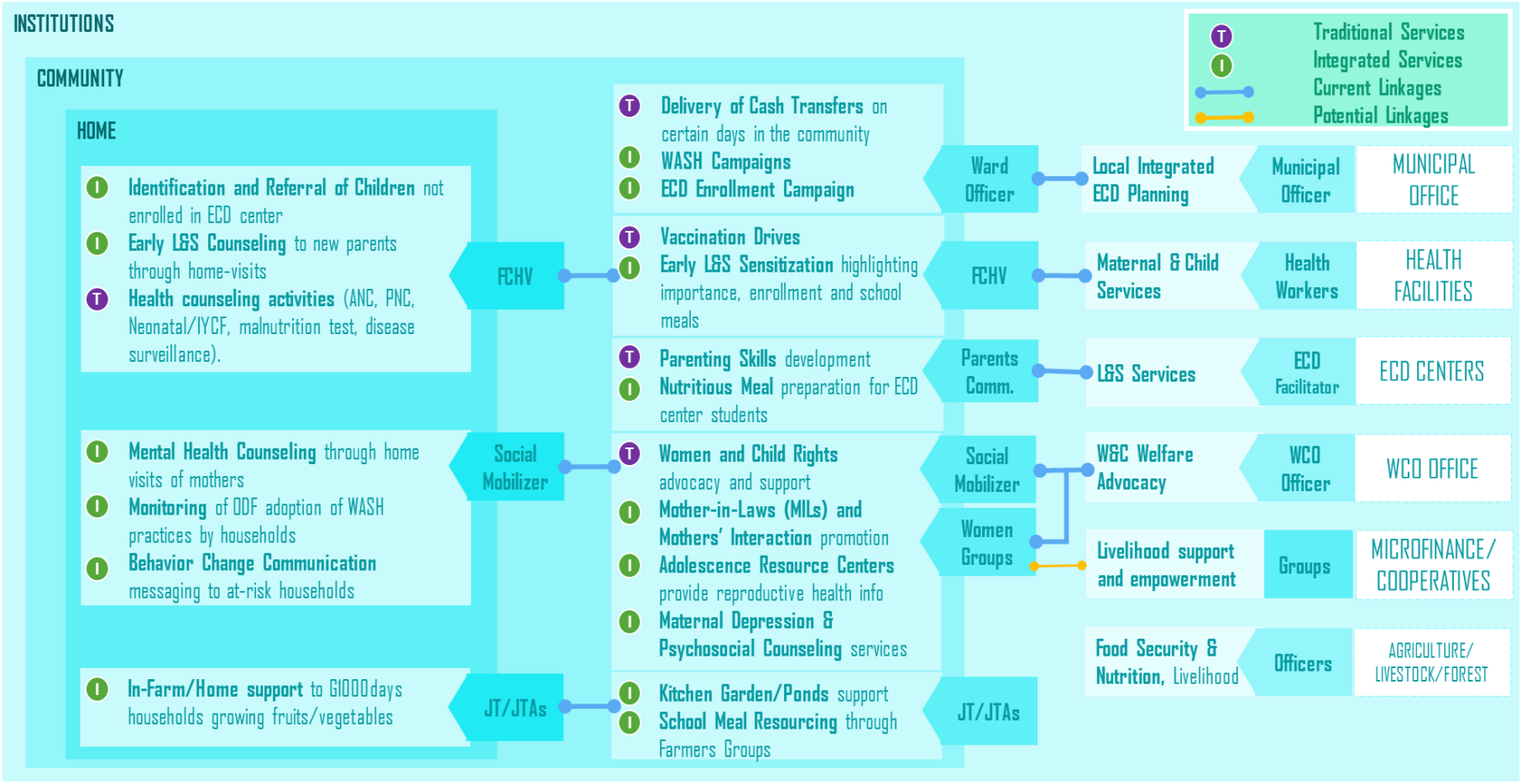
56. Agriculture and livestock extension workers could be trained to be more helpful to households for enhancing nutrition-sensitive agriculture practices. They can help in livelihood development and enhancing household food security through customized training and demonstration of best practices.

57. Microfinance and women cooperative groups can be other platforms where the future of children is discussed to identify and integrate childhood development activities.

58. The LGs can play key roles in the entire process. They can put in place performance benchmarks for each sectoral agency to build such activities in their work programs. This would mean additional work for the peripheral workers and their capacity needs to be strengthened with an addition of pecuniary or nonpecuniary incentive to motivate them.

[32] Oshima et al. 2017.

FIGURE 6: CONCEPTUAL PRESENTATION OF INTEGRATION ANCHOR 3: COMMUNITY-BASED INVESTMENTS LEVERAGING HEALTH AND NUTRITION SERVICES



59. Table 1 provides a matrix which consolidates integration opportunities across the three models based on various integration dimensions.

TABLE 1: IEY INTERVENTION OPPORTUNITIES MATRIX

Integration Dimension	CASH-TRANSFER APPROACH Leveraging SOCIAL PROTECTION SERVICES	ECD CENTER-BASED APPROACH Leveraging L&S SERVICES	COMMUNITY-BASED APPROACH Leveraging HEALTH AND NUTRITION SERVICES
	The model capitalizes on the existing social protection services, namely the 'child nutrition grants' given to all children under five, to incentivize households to ensure that their children meet critical development milestones (in health and education) from birth till five years of age.	The model supports ECECs to meet minimum standards, a process that necessitates adequate integration of various IEY interventions offered through different service providers (such as health, social protection, and WASH services) and in collaboration with a range of stakeholders.	The model streamlines delivery of services at (a) household or 'home' level and (b) at the community level, by leveraging the existing community mobilization channels or cadres of the such institutions (for example, FCHVs, social mobilizers/workers, and animal/agricultural workers).
INTEGRATION OF ACCESS TO SERVICES Integration mechanism that allows for multiple sector interventions to access and deliver services to same clients or beneficiaries	• Parents who come for birth registration of their children are encouraged to visit the health facility and show evidence of vaccination and health facility visit. • Children who come for enrollment in ECECs are also encouraged to complete vaccination.	• Provision of periodic health checkups to the ECEC students after admission and in the midyear period • Conducting periodic nutritional assessments of ECEC-enrolled children • ECEC's referral of children with various health conditions or malnutrition • Vaccination outreach to parents and children • Advocating birth registration and applying for child grant among the eligible enrolled students	• FCHVs can help identify (and refer) children who are not enrolled in ECECs to help ECEC increase its coverage, particularly among marginalized and uninformed households in the communities. • Psychosocial counseling skills of FCHVs can be integrated into the existing ANC and PNC services that they provide to pregnant and lactating mothers. • FCHVs can potentially integrate components related to L&S counseling in their PNC follow-up activities.
INTEGRATION OF HUMAN RESOURCE Delivery of interventions of other sectors through existing human resource	• Promotion of health facility visits (for institutional delivery, PNC, and vaccination) by ward officials during birth registration • Promotion of birth registration by health facilities/workers to mothers who come for ANC, delivery, or PNC	• The ECEC facilitator and community workers collaborate to ensure that children receive appropriate care and stimulation in their homes and communities by organizing parental awareness programs.	• Social mobilizers can potentially help monitor progress on local-level campaigns such as ODF and help coordinate BCC messaging to at-risk households in topics of nutrition, WASH, and social empowerment.

INTEGRATION OF FINANCIAL RESOURCE Reallocating, consolidating, or 'topping up' financial resources between existing interventions.	• Potential for the education sector to 'top up' current child grants for those children who are enrolled in ECECs or fund Round 2 of ECEC grants. • Budget sharing between units to launch joint community campaigns for encouraging institutional delivery, birth registration, vaccination, and ECE enrollment.	• Advocate for infrastructure provision and financial investments (WASH, electricity, roads, and operational and capital costs, and so on) with the LG to be able to meet the minimum ECEC requirements and increase quality of ECEC services.	• The municipal office can play a critical role in interfacing with the community to garner support from communities for local-level integrated planning, budgeting, and supervising implementation of the IEY interventions.
INTEGRATION OF COMMUNICATION AND OUTREACH Taking advantage of outreach events and communication channels used by a program or sector to promote activities and interventions of another program or sector.	• Joint community campaigns for encouraging institutional delivery, birth registration, vaccination, and ECE enrollment. • Vaccination days can be used to identify children who are not enrolled in ECECs and encourage parents to enroll such children. • During cash grant distribution days, ward officials can promote ECEC enrollment, especially to parents of children reaching 3 years.	• Increase parental ownership of ECEC by creating feedback loops, giving opportunity to support school-feeding program or kitchen gardens (in collaboration with junior technician/junior technical assistant , and seeking guidance and participation in strategic decision making and budgeting through parent committees (in collaboration with ward officials).	• Ward officials, while delivering cash grants at a public location, can promote WASH practices, vaccination, health checkups, and ECEC enrollments. • Vaccination drives in communities can be leveraged to sensitize the communities on concepts of L&S and meal preparation for schools and encourage ECEC enrollment. • Parents can be encouraged to participate in community-driven parenting awareness programs and in awareness programs related to preparing nutritious meals for their children. They can be organized through parent-teacher associations through ECECs. • Social workers can provide community-based advocacy for women and child rights (and proper treatment), conduct interaction programs between mothers and mothers-in-law, facilitate adolescence resource centers, and raise awareness about maternal depression and provide psychosocial counseling. • Women groups can be used as a platform to raise awareness on various topics. • Agriculture/livestock workers can also play an important role in supporting nutrition, food security, and livelihood development initiatives, such as kitchen gardens and ponds construction and school meal resourcing from the community.

INTEGRATION OF INFORMATION SYSTEMS Integration of digital or paper-based information systems for cross-tabulation, beneficiary identification, and cross-verification of beneficiary and aggregated information.	• Birth registration data can be used to estimate the target ECEC enrollment level in a given year and conduct outreach activities accordingly and allocate resources to operate ECECs. • Individual-level child tracking information system can be developed (such as local paper-based or database system or nationally by exploring interoperation with national identification and cash grant distribution information system).	• Support timely supervision and collection of monitoring data by the relevant local agencies, for both budget allocation and accountability purposes.	

Summary of Recommendations

60. **IEY Strategy:** At the strategic level, planning for IEY must begin with first identifying a range of IEY goals that best pertain to the existing needs across different stages of life-course and in areas including health/nutrition, L&S, and social protection. The clarity in the strategic goals will not only help determine interventions that are best suited to achieve them but also the integration opportunities for increasing delivery efficiencies, sustainability, and effectiveness. The national-level prioritization and agenda setting should be done by the central-level agencies, potentially under the coordination and supervision of the NPC, with executive roles of corresponding line agencies. In line with the national agenda and targets, the local level should prioritize and govern integrated programming as described in the next point.

61. **Integrated Local Governance:** The recent devolution of powers to the local level offers immense opportunities for holistic IEY planning and integrated governance of the IEY agenda at the municipal level. The most desirable governance mechanism to drive the IEY agenda is to, under the leadership of the LG head (Mayor/Chairperson), mobilize the 'Health and Social Development Section' or 'Social and Economic Development Section' for strategizing and implementing the IEY activities. The 'umbrella section' has advantages in leveraging its strong executive leadership for creating an authorizing environment for operational partnerships among the existing units, optimizing resource allocation, monitoring and evaluating programs using a joint M&E framework, and enabling cross-learning and creative problem-solving opportunities.

62. **Integrated Implementation:** To achieve the strategic IEY goals for holistic ECD, it is important to identify and experiment with viable opportunities to integrate the interventions and investments for early years, particularly under the new LG structure. A range of programs and services are currently being and can be implemented, from social protection programs providing cash transfers for nutrition, L&S interventions through ECECs, and maternal and child health services at health facilities and through FCHVs. It is critical to make sure that such integration increases efficiency while minimizing costs; will have high acceptance, ability, and authority to initiate the proposed changes with a simplified process; and leverages local leadership and existing systems and programs to increase effectiveness and sustainability. We recommend considering the below mentioned three potential integration models (not mutually exclusive), which can be further modified or assessed for actual project design and pilot-testing.

- **Leveraging child grant:** The model capitalizes on the existing social protection services, namely the cash grants given to all Dalit children under five and all children under five in selected districts.[33]

- **Leveraging ECEC-based investments:** The model intensifies integrated ECD interventions to students enrolled in public ECECs (with provisions to require or recommend similar actions in private ECECs) by symbiotically interfacing with the corresponding local service providers (such as health, social protection, WASH services) and stakeholders (such as parents).

- **Leveraging community-based investments:** The model streamlines delivery of services at (a) household or 'home' level and (b) at the community level, by leveraging the existing community mobilization channels or resources of the local institutions,

[33] Currently in Kalikot, Jumla, Humla, Dolpa, Mugu, Achham, Rautahat, and Bajhang.

such as FCHVs, social mobilizers/workers, and animal/agricultural workers, including microfinance and cooperative group members.

Conclusion

63. In recent years, Nepal has prioritized investments in the early years through multisectoral channels of health, nutrition, education, and social protection. With the new devolution of power to local-level governments, which can now plan, execute, and more closely supervise the progress on programs and interventions, some promising opportunities have surfaced in synergizing resources through greater integrated implementation of interventions.

64. Considering the growing interest and initiation (in some districts) of local-level integrated planning of early year interventions, the report identifies a strategy for developing synergistic investments to support this new movement. We propose that instead of taking a sector-specific approach, that is, beginning with the question of 'which sector can contribute where', we should take a child-centric life-course stage approach, beginning with identifying strategic goals that must be met so that the child can temporally achieve all developmental milestones. This is then followed by mapping the interventions already being provided, to get a clearer picture of what is missing. This creates an opportunity to identify the governance structure that best suits the overall management of the IEY agenda and also specific integration opportunities to increase delivery efficiency and effectiveness. We provided three examples of potential integrated implementation models, leveraging existing (a) child grant, (b) ECECs and programs through institution-based approach, and (c) health and nutrition services including L&S through a community-based approach. Further analysis and contextualizing of sample models can help in innovating existing programs or refining strategies for synergistic IEY in Nepal.

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Appendix

Annex I: Discussion Guides

The section presents the key instruments that were used in the study, particularly discussion guides for conducting national- and field-level discussions.

National-level Discussion Guide

The guide was used in structuring conversations with development partners and central-level government stakeholders.

1. Current role
    a. What are some of the policies you are working on (if applicable)? What policy gaps do you see in the effective implementation of integrated or multisectoral programs in ECD?
    b. What are major programs/projects that your agency is engaged in improving ECD outcomes?
2. Role/sector-specific information
    a. What is working?
    b. What are some of the critical challenges?
    c. What opportunities do you see?
    d. Intervention-specific discussions
        i. Are there specific quality and efficiency-related constraints?
        ii. What is the coverage of the mentioned interventions? What is the targeting strategy?
3. Inter-sectoral questions
    a. How are you currently coordinating with other sectors? Do you have examples of any successful coordination efforts? How about any failed attempts?
    b. What opportunities do you see for integrating interventions related to other sectors?
4. Do you have any recommendation for potential cases/informants for observation and further learning?

Field-level Discussion Guide

The guide helped in (a) focus group discussions (FGDs) with (i) intended beneficiaries (and non-beneficiaries) and (ii) service providers (associated with various line agencies, including health, education and social protection) and (b) consultations with associated stakeholders at the municipal or provincial level depending on the nature of the case chosen.

Beneficiaries consultation/discussion guide

Based on specific cases identified through national-level discussions and/or desk study for in-depth review, which included beneficiaries of both well-functioning and poorly functioning ECD centers, private ECD centers, and health posts. Various user groups such as mothers' groups and parents were also consulted for capturing perspectives. Likewise, vulnerable groups and nonusers were also consulted to understand potential barriers or dislikes leading to nonconsumption of services.

1. Please explain the types of services you have received in these areas:
    a. Maternal and child nutrition and health-related programs (awareness and clinical/nutritional services)
    b. Learning and stimulation (ECD center enrollment, mental health/psychosocial services, parenting, and caregiving)
    c. Cash transfers, child/social protection (security and safety)
    d. Birth registration
2. How did you learn about the mentioned services?
3. What constraints did you face in benefiting from those services (constraints related to physical access, financial affordability, inclusivity, trust, quality, time, and so on)?
4. What are the easiest services to access? Most difficult?
5. What would make it easier for you to access the services?
6. Do you have any suggestion for the service providers?

Service providers/implementers consultation/discussion

The beneficiary-level FGDs further shaped the guides to conduct FGDs with services providers (such as ECD facilitators, local-health facility staff, FCHVs, WDP cooperative focal person, and LG representatives). A basic structure of guide, nonetheless, was as follows:

1. What services do you currently provide?
2. What challenges in service delivery are you facing?
3. What kind of coordination do you have among service providers?
4. Our discussion with the community reveals ___. Where do you see some opportunities to address them?
5. Do you see any specific opportunities for packaging interventions (if resource constraint is not an issue)?

Municipal/Provincial consultation/discussion

The key findings from both FGDs, particularly with regard to the ideas and potential opportunities for better integrating services across the pillars, were discussed with stakeholders at the municipal and provincial level who are institutionally linked to the given service provision platform. These were open-ended discussions which sought to assess the operational and systemic constraints and opportunities for implementing any innovative ideas or potential solutions emerging from the FGDs. The basic structure of questions was as follows:

1. What is your current role in ensuring service delivery through the (platform discussed in the given case) platform?
2. What are your priorities and approaches in enhancing ECD outcomes in your (administrative unit)?
3. During our consultation with beneficiaries and service providers in (selected village) we found the following: (list and explain the 3–4 key findings). What are your thoughts on these findings and what steps have been taken/planned in these areas?
4. We asked the service providers to also come up with ideas to increase the delivery efficiency of the services across nutrition, education, and social protection. Some ideas that came about are as follows: (list and explain at least 1 idea that came from FGDs). What are your thoughts on such ideas? Do you also see potential? How feasible are these ideas? What key constraints do you foresee and what can be done to address them? Is it reasonable to further explore these ideas?
5. Do you have specific suggestions on how the World Bank should prioritize its development support to improve ECD outcomes in your (administrative unit)?

Annex II: List of Organizations Consulted at Central Level and Local Level

S. No.	Designation	Organization
1	Subcoordinator	District Coordination Committee
2	Treasurer	SetoGurans
3	Officer	Women and Children Office
4	Resource Person	Chhayanath Rara Muncipality
5	M&E Officer	MSNP
6	M&E Officer	SetoGurans
7	District Coordinator	SetoGurans
8	Accountant	SetoGurans
9	Mentor	SetoGurans
10	Mentor	SetoGurans
11	Mayor	Chhayanath Rara Muncipality
12	CAO	Mahalaxmi Municipality
13	Social Protection Officer	Mahalaxmi Municipality
14	Resource Person	Mahalaxmi Municipality
15	Deputy Mayor	Pipara Rural Municipality
16	Undersecretary	MoEST
17	Section Officer	Civil Registration Office
18	Director	Civil Registration Office
19	Joint Secretary	MoFAGA
20	Sr. Public Health Administrator	Department of Health Services
21	Education Advisor	Save the Children
22	ECD Specialist	UNICEF
23	Nutrition Specialist	UNICEF
24	Health and Nutrition Specialist	World Vision
25	Nutrition Specialist	World Food Program
26	Nutrition Specialist	World Food Program
27	District Coordinator	SetoGurans

Annex III: Research Methods

(a) Analytical Framework

PART 1: Dimensions

The primary dimension of analysis is a set of four **Life-Course Stages,** which are the critical entry points for interventions. The **Key Outcomes** to be achieved in each Stage form the second dimension of analysis. Given that a range of sectorial or cross-sectorial interventions may help produce those outcomes, the third dimension is the **Thematic Area**, which include, for the purposes of this study, divided into (a) nutrition (captures the "nourishment" and health aspects), (b) learning and stimulation, and (c) social protection (captures the "nurture" aspects).

PART 2: Mapping and Assessment of Interventions

The second part will build on the first phase by stocktaking/mapping interventions and assessing three specific aspects of each intervention, namely (a) organizations and agencies implementing/supporting/piloting those interventions (and existing collaborations and coordination activities between them), (b) quality of interventions and (c) coverage/ targeting of interventions across provinces, geographies, socio-economic groups and gender.

PART 3: Opportunities for Increasing Delivery Efficiency

The third part will build on the assessment from the previous part by examining how interventions can be better integrated or "packaged" for maximizing delivery efficiency and effectiveness given the financial, institutional and systemic challenges.

			MAPPING		ASSESSMENT					
LIFE-COURSE STAGES	KEY OUTCOMES	THEMATIC AREAS	INTERVENTIONS	TARGET GROUPS	ORGS INVOLVED	QUALITY	COVERAGE	PACKAGING PLATFORMS	INSTITUTIONAL MECHANISMS	BEST PRACTICES
Adolescence & adulthood		• Nutrition/ Health • Learning & Stimulation • Social Protection								
Pregnancy, Labor and Birth										
Neonatal and Infancy										
Early Childhood										

(b) Research Strategy

	Desk Study	National-level Discussions	Field-level Discussions	Evidence Synthesis and Dissemination
Purpose	• To develop a thematic background on key policy priorities, programs, and progress • To build an AF for leading systematic discussions and analysis	• To map interventions, projects, programs, and policy priorities of development partners and central-level government agencies in ECD • To identify deep-dive cases for field-level review and lessons gathering	• To conduct a field-level deep-dive discussion of selected cases of challenges, approaches, and positive deviances in packaging ECD interventions across the three pillars	• To consolidate the information gathered through the previous steps into a completed AF chart, a final report, and an executive PowerPoint report • To capture feedback from relevant stakeholders on the evidence captured for further refinement of the report
Approach	• Reviewed documents, data, and evidence from the three pillars • Identified key stakeholders to be consulted during the national-level discussions	• Conducted consultations with development partner stakeholders and central-level government stakeholders • Used the notes from the discussion to fill in the AF chart • Asked informants for their suggestions on specific cases that can be reviewed in-depth through field-level discussions	• Conducted FGDs with intended beneficiaries (those participating and not participating) • Conducted FGDs with service providers (associated with that particular platform) • Conducted consultations with municipal or provincial-level stakeholders (with institutional linkages to the selected cases) • Used the notes from the discussion to fill in the AF chart and to shape final report write-up	• Consolidated all information in the AF • Prepared a draft report • Collected initial feedback and the report internally • Revised report and prepared draft 2 • Prepared a presentation based on draft 2 • Collected feedback and comments from relevant stakeholders externally • Revised report and prepared the final draft • Disseminated findings through presentation and publication
Output	• AF was constructed • Gathered secondary information added in the AF chart	• 17 consultations conducted • AF was further revised with information • Additional notes were taken for framing the final report write-up	• 5 cases were identified for deep dives (about 9 field-level engagements were conducted) • AF was further revised, and notes were used for framing the final report	• Final report • PowerPoint presentation of key findings • Identification of future research areas • Identification of potential leads to project development

(c) Sampling Strategy

Pillar	Respondent Type	**Respondent Details** (Agency, Position, Possible Name, Email)	KIIs	FGDs
Nutrition/ Health	Development partners	UNICEF, Nutrition Team World Vision, Health and Nutrition Team (2)	3	0
	Central level	Nutrition Section, Family welfare Division, Department of Health Services	1	0
	Field level (cases)	Various individuals from Mahalaxmi Municipality, Lalitpur, Chhayanath Rara Municipality, Mugu, and Pipara Rural Municipality, Mahottari and Bardibas Municipality, Mahottari	1	3
Learning/ Stimulation	Development partners	UNICEF, ECD Specialist Save the Children, Education Team	2	0
	Central level	MoEST (2)	2	0
	Field level (cases)	Various individuals from Mahalaxmi Municipality, Lalitpur, Chhayanath Rara Municipality, Mugu, and Pipara Rural Municipality, Mahottari and Bardibas Municipality, Mahottari	2	3
Social Protection	Development partners	World Food Programme (2)	2	0
	Central level	MoFAGA, Department of Civil Registration (DoCR) (2) MoFAGA, General (2)	4	0
	Field level (cases)	Various individuals from Mahalaxmi Municipality, Lalitpur, Chhayanath Rara Municipality, Mugu, and Pipara Rural Municipality, Mahottari and Bardibas Municipality, Mahottari	2	3
		Total KIIs	19	9
Note: The list of FGDs and KIIs conducted also appears as Annex 2.				

Annex IV: Mapping of IEY Interventions

Stage 1: Adolescence and Adulthood

		MAPPING							ASSESSMENT		
STAGE 1: GOALS		**Approaches**		**Interventions**		**Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L& S			
1	Adolescence girls delay the age of marriage/pregnancy	1	School-based approach	• Incorporation of content in school curriculum • Awareness programs in school					(Limited information)		Out-of-school, married, and migrant adolescents, who are the most vulnerable, are not reached by much of the current programming.
		2	Community-based approach	• Resource centers for adolescent girls, providing reproductive health information and livelihood support.	Various NGOs						
		3	Financial support and incentivization	• Livelihood grants	Ministry of Women, Children, and Social Welfare (MoWCSW)		√				Program's budget and future is uncertain in the new federal structure.
2	Adolescent girls have knowledge of reproductive health, including family planning	1	School-based approach	• Incorporation of content in school curriculum • Awareness programs in school	MoEST	√			Response to previous gaps in teachers' ability to adequately convey reproductive health messages that	Five-day training module incorporated into Government of Nepal's curriculum for teachers, with	In early pilot stage, so coverage is limited. The intensive training module is yet to be rolled out nationwide,

		MAPPING							ASSESSMENT		
STAGE 1: GOALS		Approaches		Interventions		Pillars			Access/ Coverage	Quality	Key Gaps
				Interventions	Organization	Health	Social Protection	L& S			
	methods to reduce unintended childbirths			• Comprehensive sexuality education: teachers' resource material					are part of the school curriculum. Being rolled out in 10 districts to 200 teachers.	a shorter module integrated into 10-day long Teachers Professional Development training.[34]	so currently, most teachers are not well trained on delivering comprehensive sexual and reproductive health education.
		2	Health-center based approach	• Counseling, provision of contraceptives, and screening for sexually transmitted infections as part of the National Adolescent Sexual and Reproductive Health Programme (NASRHP)	Ministry of Health and Population (MoHP)	√			63 out of 75 districts have at least 13 adolescent-friendly services (AFS) health facilities. 1,144 health facilities are adolescent-friendly. Establishment of adolescent-friendly health services and AFS corners in health facility and schools	Lack of sufficient availability of information, education, and communication (IEC) materials, inadequately trained service providers, opening hours of AFS clinics.[35]	Out-of-school, married, migrant, and hard-to-reach rural adolescents were found to benefit less.
		3	Community-based approach	• Sensitization of stakeholders and service providers, including FCHVs and	MoH	√			See NASRHP coverage above	Good modality for reaching most community members	Services cannot meet the demand created by awareness.

[34] Comprehensive Sexuality Education: Teachers' Resource Material (2018).
[35] WHO 2017.

		MAPPING							ASSESSMENT		
STAGE 1: GOALS		Approaches		Interventions		Pillars			Access/ Coverage	Quality	Key Gaps
				Interventions	Organization	Health	Social Protection	L& S			
				mothers' groups.							
3	Adolescent girls have adequate knowledge of peri-conceptional nutrition				MSNP (Government of Nepal)				(Limited information)		
4	The literacy level of adolescent and adults is increased		Community-based approach	National Literacy Campaign launched in 2008 and aims to achieve full literacy of people between 15 and 60 years.	Non-formal Education Centre			√	More than 2,100 community learning centers have been established throughout the country; more than 10,000 volunteers training people.	Volunteer teachers and basic ability to sign one's name also considered 'literacy.'	Only 1.4% of the MoEST budget goes to the nonformal education, making full literacy an ambitious but underfunded goal.[36]
5	Improved access to WASH		Community-based approach	BCC on menstrual health management	Various I/NGOs				Small initiatives run by different NGOs in different parts	Intensive training and communication for involved communities.	Difficult to generalize or scale up impacts

[36] Hanemann 2017.

Stage 2: The Golden Thousand Days

		MAPPING							ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
1	Improvement in routine ANC and antenatal nutrition (of pregnant and lactating mothers)	1	ANC service provision (supply-side approach)	Provision of iron and folic acid (IFA) supplementation to pregnant and lactating mothers	MoHP	√			• Women with 4+ ANC visits increased from 50% (2011) to 69% (2016).[a] • Lowest provision of IFA in Terai (82%), compared to national average of 90%.[a]	• 98% of health facilities offer ANC.[c] • 90% had all essential ANC medicines. • Only 25% of health facilities have ANC guidelines. • Only 50% have soaps and running water. • Only 2% have all essential ANC items. • Long waiting times (12% cited as a major problem).[c]	• **Incomplete counseling on critical contents:** Only 49% of women received counseling on 5 critical components. • **Low nutrition counseling:** Only 50% receive nutrition counseling.[c] • **Poor sanitary condition** in health facilities.[c] • **Low coverage of health services** among Midwestern Mountains and rural women.
				Provision of deworming medication to pregnant and lactating mothers		√					
				Provision of iodized salt use		√					
		2	Knowledge, attitudes, and practice (KAP) (demand-side approach)	Promotion of utilization of ANC and antenatal nutrition services	MoH	√			• Women seeking ANC increased from 44% (2004) to 51% (2016) (target of 80% unmet).[a] • Only 42% of women in Midwestern Mountains and 65% of rural women seek ANC service.		
				Provision of birth preparedness package for behavior change through community	SMP	√					

		MAPPING							ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				health workers (CHWs)							
		3	Technology-assisted monitoring	Mobile phone-based health monitoring of pregnant mothers by CHWs and FCHVs to increase ANC coverage	Medic Mobile	√					
2	Reduced maternal morbidity and mortality by increasing the number of institutional deliveries (Specifically: Reduction of financial barriers to women seeking institutional delivery)	1	Maternal health services provision (supply-side approach)	Presence of skilled birth attendants (SBAs) during birth	MoHP	√			• SBA deliveries increased from 36% (2011) to 58% (2016).[a]	• Almost all districts hospitals and primary health care centers (PHCCs) offer normal vaginal delivery services (45% hospitals).[c] • Only 11% of health facilities have all medicines for delivery (70% zonal/above; 5% hospitals).[c] • Only 22% have guidelines on	• **Poor coverage of institutional deliveries in Terai** and earthquake-affected districts • **Much lower availability and quality of service in hospitals** compared to PHCCs and hospitals (infection control, medicines, services)
				Improving physical and human resources at health institutions for institutional deliveries	MoHP	√			• Institutional deliveries increased from 35% (2011) to 57% (2015) (target of 40% surpassed). • Lowest access in Terai (33%) and earthquake-affected districts (41%) and among women in the lowest wealth quintile (34%).[a]		

	MAPPING						ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood	**Approaches**	**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
		Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
								delivery and newborn care. • Only 33% have received in-service training.[c] • 85% of PHCCs, 71% of hospitals, and 90% of hospitals have handwashing supplies in delivery area.[c]	• **Limited in-service training** and provision of guidelines for health workers
		Management of birth complications through B/CEONC, including maternal infection prevention, diagnosis, and treatment	MoHP, Options Nepal	√			• 66% of zonal/above hospitals; only 3% of PHCCs provided B/CEONC services[c] • <10% of health facilities in Terai, <5% in hill and mountain areas[c] • Only 40% of districts offer *functional* B/CEONC services in at least one facility[c]	• B/CEONC criteria met by 4% of all health facilities and 68% of zonal+ hospitals.[c] • Only 60% of health facilities offer emergency transport.[c]	• **Functionality of B/CEONC** services is lower across districts. • **PHCCs have lower B/CEONC service provision** to zonal/hospital services. • **Poor availability of emergency transport** for complications.

	MAPPING					ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood	**Approaches**	**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
		Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
		Training of SBAs on ultrasound for identifying and referring obstetric complications (Rural Ultrasound Program)	SMP[37]	√			• 11 rural districts covered[c]		
		PNC services for immediate newborn care	MoHP	√			• 83% do not receive PNC immediately after birth[b] • Less likely to receive PNC: rural (53%), Midwestern (17%), home delivered (15%)[b]	• >90% of health facilities provide essential newborn care functions routinely.[c] • 49% of staff received any in-service training.[c]	• **Poor coverage** in rural areas, Midwestern Mountains, and among women who delivered at home • **Inadequate in-service training** for health workers providing newborn care services
		MNH activities at the community level (through CHWs)	SMP	√					
		Provision of family planning services		√			• Use of modern family planning methods increased from 35% (2001) to 47% (2014).[b]	• Only 16% of staff received in-service training.[c] • Only 6% of family	• **The poor environment for family planning counseling** in HFs with low

[37] SMP website.

	MAPPING						ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood	**Approaches**	**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
		Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
							• 97% of hospitals offer at least 3 modern family planning methods, regularly.[b]	planning consultations assured privacy and confidentiality.[c] • Only 13% have family planning guidelines.[c]	privacy and confidentiality. • **The content of counseling** less frequently includes Sexually Transmitted Infections (STIs), attitude toward family planning methods and side effects.
		Provision of safe abortion services (Medical abortion and comprehensive abortion care services)	MoHP, Marie Stopes, Family Planning Association of Nepal	√	√		• 25% of health facilities providing normal delivery services provide medical abortion (82% of zonal, 72% of district hospitals, and 55% PHCCs).[c] • 13% of health facilities provide Comprehensive Abortion Care (86% of zonal- and district-level hospitals and 41% of PHCCs).[c]	• Inadequate integration of abortion services (particularly second trimester) into the health care system and not tracked in HMIS • Limited awareness of the availability and location of safe abortion services	• **Poor access to second trimester services**, particularly among most vulnerable and social disadvantaged • **Prevention of sex-selective abortion cases** due to societal gender discrimination • **Preventing medication**

		MAPPING						ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
											stock-outs in remote areas[38]
		2	Incentivization of institutional deliveries and seeking maternal health services (demand-side approach)	Provision of cash transfers conditional to institutional delivery or birth with SBA	SMP (Aama Program)	√	√			• Delays in payment	
				Provision of transportation grants for women who do regular ANC checkups and deliver in health facilities	SMP (Aama Program)	√	√		• 89% of eligible mothers receive transportation grant in 1,000 health institutions.[39] • In some Terai areas, more husbands may receive the incentives (34% than in other regions.	• Difficulties in meeting the 4 ANC protocols, unavailability of funds, lack of awareness of scheme, lack of provision in private facilities	• **Delay in receiving payments** (25% of sampled women waited for more than 3 months).[40]
				Provision of cash incentives for health workers for deliveries and payment to health facilities		√	√		• Does not target women of low socioeconomic status because it is a blanket approach	• Health facilities may shorten hospital stay as the amount is given is on per case basis.	• **Slow disbursement from the center** caused a delay in health facilities

[38] Wu et al. 2017.
[39] Mehata et al. 2014.
[40] Upreti et al. 2013.

		MAPPING						ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				for providing free sick newborn care							receiving payments • **Nonuniformity** in how funds are received (check, cash, and so on)
				Removal of all user fees for all types of deliveries		√	√		• Terai health facilities are still having women pay for delivery services.	• 26% of health facilities received institutional unit cost payments in advance, but usually, receive sufficient budget by the end of the fiscal year. • Financial reporting by health facilities is poor and so is the internal auditing by the district.	• **Still paying fees** by some women despite health facilities are asked to comply with 'Free Delivery Care' • **Poor monitoring mechanism** to detect why women have to pay for deliveries in public and private health facilities, particularly in Terai despite the free care
3	Psychosocial well-being of mother is assured		Community-based approach	Training service providers such as ANMs and		√			• Limited coverage, early-stage pilots		Potentially huge need, and limited service provision,

		MAPPING							ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				FCHVs and select members of community institutions such as women's cooperatives in counseling							requiring further research
4	Increased access and adoption of WASH practices	1	WASH infrastructure building	Improved water sources, safe drinking water	Ministry of Water Supply (MoWS)	√	√		• 86.5% households using improved sources of drinking water	—	**Low equity in outcomes** especially across geographic regions and income groups
				Toilet construction	MoWS	√			• 60% of households have toilets.		**Uncertain utilization** of toilets by all members of the household
				Handwashing facilities	MoEST, MoWS	√			• 97.1% have handwashing facilities.		
				Distribution of water purifiers and filters	MSNP	√					
		2	WASH awareness and behavior change	WASH awareness programs	MoEST	√	√		• Limited coverage in selected districts	• PE is comprehensive and results oriented.	**Low coverage** in some of the districts

		MAPPING							ASSESSMENT		
STAGE 2A: Pregnancy and Motherhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
											Inadequate funding for PE
				ODF Campaigns	Department of Water Supply and Snitation	√	√				**Poor coordination structures** of WASH because of political transition and disturbances

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
1	Neonatal and infant disease prevention and treatment	1	Health service provision	The national newborn care package *(for example, NyanoJhola Program)*	MoHP	√			• Diarrhea is highest in 12–23 month children (19%).[b]	• >90% of health facilities provide essential newborn care functions routinely.[c] • 61% of health facilities have IMNCI guidelines.[c] • Only 22% trained in	**Limited FCHV mobilization** in classification and community-based management of neonatal infections **Unclear impact** of community-based newborn care package interventions.[41]
				Integrated Management of Newborn and Childhood Illness (IMNCI) to	MoHP	√					

[41] Paudel, Shrestha, and Siebeck. 2017.

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				improve case management skills, and family and community health practices						IMNCI, with a lower percentage in mountain regions (16%).[c] • Only 30% received in-service training on child health.[c]	
		2	Community-based approach	Community-based management of newborn infections *(Pilot: Morang Innovative Neonatal Intervention – MINI)*[42]	JSI/MoHP	√					
2	IYCF Practices	1	Health Service Provision	Enhancing IYCF counseling and support skills in pre-service and in-service training of health workers		√			• Mountain region has the lowest portion of trained staff on IYCF practices (10%).[b]	• Only 15% of staff had IYCF training.[c]	**Low level of trained staff** in providing IYCF counseling at health facilities, with mountain health facilities having the lowest level of trained staff
				Strengthening complementary feeding counseling		√					
				Strengthening counseling on maternal nutrition		√					

[42] Morang Innovative Neonatal Intervention Program (MINI-II).

		MAPPING						ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				during pregnancy and lactation							
		2	Community-based approach	Assessment, design and planning of community-based IYCF		√			• Only 49% of newborns are breastfed within 1 hour of birth, 57% exclusively breastfed, and 75% mostly had breast milk[b]	• Boys are more likely to be exclusively breastfed. • Mother's education level is inversely related to exclusive breastfeeding, indicating educated mothers, who are working fulltime, may not be able to exclusively breastfed.	**Gender disparity** in exclusive breastfeeding and complementary feeding to girl versus boy child. **Lack of awareness** about breastfeeding immediately after birth **Importance of frequent interactions between FCHVs and mothers** must be emphasized in designing FCHV-based delivery of IYCF counseling and micronutrient powders for KAP improvements.
				Promotion of exclusive breastfeeding in communities	MoHP	√					
				Mother-to-mother support through mothers' groups		√					
				Integrated IYCF and Baal-vita Community Promotion Program: Integrated IYCF with micronutrient powders, consisting of 15 micronutrients) delivered	MoHP-UNICEF	√			• 26 districts (as of 2016)	• Interventions successful in contributing to better some key IYCF knowledge/practices, such as timely introduction of complementary foods.	

		MAPPING						ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				through FCHVs and health workers[43]							
				Essential nutrition/ hygiene actions	Suaahara	√			• 41 districts		
		3	Integrated with cash transfer	Child Nutrition Grant NPR 400 per month	MoHA	√	√		• Covers around 20% of children in Nepal from Dalits and universally in 5 districts of Karnali and 3 other selected districts (Achham, Bajura, and Rautahat)	• The amount of transfer may not be adequate to produce necessary changes in behavior. • Utilization of grants may not be for purchasing nutritious food.[44] • Delays in payment.	**Size of the benefit** is not sufficient to achieve substantial impacts **Poor implementation** (irregular and partial payment)
		4	Agriculture-based approach	Promotion through Agriculture and Food Security Project	MoHP-World Bank-Food and Agriculture Organization	√			• 19 districts (selected based on severity of food security problem)		
		5	Communication	Designing and implementing BCC messages		√			• Most projects have BCC components		

[43] Locks et al. 2018.
[44] Adhikari, Hagen-Zanker, and Babjanian 2014.

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
									in different forms.		
3	Improved immunization coverage	1	Health center-based approach	Comprehensive child vaccination services 1–2 days a month at health facility		√			• 67% received all vaccines by the 12-month. (2014), which is below the target (90%) (MICS 2014) • 80% of health facilities run comprehensive child vaccination services	• Only 15% of health facilities meet the minimum national requirement of providing services 3–5 days a month. • Only 3% (mainly private) of health facilities provide >5 days. • Only 10% of health facility store vaccines on a routine basis. • Only 52% of health facilities have handwashing supplies.	**Limited monthly availability** of comprehensive immunization services in health facilities **Coverage gaps** in provision of child health cards
		2	Outreach clinics	Health facilities run 3–5 immunization clinics in a month		√					
		3	Intensified Campaign	National Immunization Days for polio eradication		√					
				Measles catch-up and follow-up campaigns		√					
4	Improved access to treatment and prevention of malnutrition	1	Using nationally established guidelines and strategies	Integrated Management of Acute Malnutrition (IMAM) – 11 districts	MoHP	√			• Severe acute malnutrition in 39 districts, 369 OTC[45]s, and 20	• 75% of health facilities have child health cards. • 66% have infant weighing scale;	**Governance uncertainty** because of the transition of roles to local level from districts

[45] Outpatient Therapeutic Center (OTC) are established to help identify and treat severe acute malnutrition (SAM) cases in a given locality.

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
				Maternal and Child Health Nutrition Program (MCHN)	MoHP	√			stabilization centers • 19,000 FCHVs and 8,000 health workers trained	29% have head circumference measuring equipment; 24% have mid upper arm circumference (MUAC) measuring facility. • 90% of health facilities offer zinc tablets, Oral Rehydration Solution (ORS), and Vitamin A. • Only 85% of Terai hospitals offer growth monitoring services (national average 93%).	
				Growth monitoring, promotion, and counseling	MoHP	√					
				Prevention of Iodine Deficiency Disorder	MoHP	√					
				Control of parasitic infestation by deworming	MoHP	√					
				Prevention, Control, and Treatment of Vitamin A deficiency	MoHP	√					
		2	Private sector based	Flour fortification through roller mills (Vitamin A, iron, and folic acid)		√			• 18 roller mills nationwide	• Quality of the intervention is not evaluated adequately, and the interventions	• **Low-scale impact** that can be increased through expansion and scale-up

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
										are limited in scale.[46]	
5	Improved protection of children's rights	1	Protective SP function	Provision of birth registration and certificate	MoHA	√	√		• Coverage in Province 2 is less reportedly because of custom/cultu re	• Only 6% of birth registration happen within 35 days.[47]	• **Implementation inefficiencies** in registration and delivery of grants need to be addressed. • **Awareness-raising strategies** need to be improved.
6	Promotion of early care and stimulation	1	Care skills training	CHWs provide weekly visits and teach parenting skills[48]		√		√	(Note: Currently, the strategy has not been tried in Nepal but is a best practice example from Jamaica)		• **Targeting** of children <3 is necessary to make the most of some of the modules in parental awareness programs • **An 'executive summary' module** may ensure that parents receive key messages from all the modules but then can make a more informed
		2	Stimulation promotion	CHWs provide weekly visits and encourage mothers and children to interact in a way that develops cognitive and socioemotional skills		√		√			

[46] Nepal National and District Nutrition Capacity Assessment 2012. paragraph 10.
[47] National KII - DoCR, Nepal.
[48] Gertler et al. 2014.

		MAPPING							ASSESSMENT		
STAGE 2B: Newborn and Infants		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps**
				Interventions	Organization	Health	Social Protection	L&S	*Source: (a) NDHS, (b) NMICS, and (c) NHFS of indicated years of publication*		
		3	Participatory PE programs	Parent groups can choose from 30 modules addressing various aspects of child development such as health, education, protection, or sanitation.	UNICEF - MoEST	√	√	√	• Only reaches public-ECDC enrolled children • Only covers children older than 3 years, which may be too late to introduce the content of some of the modules	• 59% of households have seen positive changes, especially in their knowledge of raising children. • Parents reportedly choose certain modules less such as violence against children.	decision on which modules to choose for deep dives.

Stage 3: Early Childhood (2–6 years)

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
1	Increased access to and quality of ECCE.	1	School based	High-quality early childhood care and education programs though school- and community-based 30,448 ECDs/PPCS and 6,120 institution-based ECDs/PPCs[49]	MoEST			√	• 68.5% children entering grade 1 have ECD experience • GER in ECD is 84.3%	• Only 28% are developmentally on track in literacy/numeracy (Aryal et al. 2018).	**Gaps in the quality of ECD centers**. (Only 1,500 [about 5%] ECD/PPCS meet National Minimum Standards)
				Improvement of teacher quality and quantity	MoEST			√	• High student-teacher ratio (STR) in many ECD centers	• Only 36% of ECD teachers have required qualifications.	**Majority of ECD teachers lack basic qualifications**
				Day meals	MoEST	√	√	√	• Districts in Karnali and 14 selected districts	• The cash support is only NPR 15 and may not be adequate for food.	**Ensuring financial sustainability**
		2	Community based	PE program	MoEST			√	• Limited coverage in selected districts	• PE is comprehensive and results oriented.	**Coverage is low.** Funding for PE is not adequate.
				Community-based ECDs	MoEST			√	• All linked for financial	• Under-resourced and running with	**Proper monitoring** of

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
				and link with community school					administration	minimal infrastructures	community-based ECDs
		3	Home based	Psychosocial stimulation care	NGOs			√	• Limited coverage, only in operation areas	• Well-designed programs with limited coverage	**Harmonization and scaling up** Institutionalization at the Government of Nepal-level
				Home visits	NGOs	√			• Sparingly available	—	**Comprehensive coverage**
				Parental awareness	MoEST			√	• Limited coverage in selected districts	• PE is comprehensive and results oriented.	**Coverage is low.** Funding for PE is not adequate.
2	Increased access to and quality primary education	1	School based	35,000 community and institutional schools located all over the country, residential schools are set up for children in extremely rural areas.	MoEST			√	• Net enrollment ratio is 97.2% • Net intake rate in grade 1 is 96%.	• Quality reflected in low learning achievement in National Assessment of Student Achievement	Ensuring quality basic education
				National Early Grade Reading Program	MoEST-United States Agency for International Development			√	• Implemented in 16 districts with a phased implementation plan to fully cover all community schools in at	• Early grade reading assessment results show significant gaps in reading abilities	**Low coverage** Financial sustainability

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
									least 38 districts by 2021		
				Midday Meal Program and Scholarships	MoEST	√	√	√	• Midday meal program in Karnali, food deficit, and malnutrition areas • Scholarship for all girls, Dalits, marginalized, and endangered castes (grades 1–8)	• The effectiveness of scholarships is limited.	**The scholarship amount** is low (NPR 400 per year) **Sustainability** for Food for Education Program
		2	Policy provisions	Constitutional provision of free and compulsory basic education and the SSDP Agenda	Government of Nepal, MoEST			√	• All children (ages 5–12)	• Quality agenda in the SSDP needs attention	**Unavailability of implementation directives** for free and compulsory basic education
3	Increased access to comprehensive preventive and medical care	1	Based on health facilities	Affordable and accessible care through 123 government hospitals, 200 PHCCs, 3,808 health post, 12,180 PHC/ORC	Ministry of Health and Population	√			• Health centers being built to ensure 1 unit per ward in the next two years	• Lack of medicine and equipment • Unavailability of doctors in rural areas	**Poor infrastructure** because many ward units do not have PHCCs **Lack of medical doctors** in health centers

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
				Health insurances at low costs and free surgery of selected fatal conditions for children below 15	MoHP	√			• Insurance coverage only in 24 districts	• Maximum of NPR 50,000 covered	**Lack of awareness** of health insurance and free care
		2	Community based	49,001 FCHVs actively promoting maternal and child health	MoHP	√			• Coverage is near universal	• Commendable work being done	**Poor benefits and incentives** for FCHVs
				Parental awareness	MoEST	√			• Limited coverage in selected districts	• PE is comprehensive and results oriented	**Coverage is low, inadequate funding** for PE
4	Improved provision of care	1	Based on under-5 child mortality	Vitamin A supplementation, de-worming and awareness	MoHP	√			• High coverage • Periodic and regularly administered	• Has been effective as a key driver of reduced under-5 child mortality rate	**Equity in coverage** particularly with reference to geography, location, and income status
				Community based-integrated management of childhood illnesses	MoHP	√			• High coverage		**Low funding** and sustainability
		2	Curative and preventive care	Full child immunization	MoHP	√			• 77.8% fully immunized	• Effective against the occurrence of major preventable diseases	**Achievement of universal** coverage

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
5	Reduction of maternal and child undernutrition	1	Multisector approach	Improve maternal and young child feeding and micronutrients status	MoHP	√			• Coverage of MNSP in 28, *Sunaula Hazar din* in 15, agriculture and food security projects in 19 and *Suaahara* in 40 districts	• Stunting reduced to 36% and waste to 10%	**Many districts outside the coverage** of targeted programs
				Manage severe acute malnutrition	MoHP	√					
		2	Community based	Parental awareness	MoEST	√			• Limited coverage in selected districts	• PE is comprehensive and results oriented.	**Low coverage, inadequate funding** for PE
6	Improved access to WASH	1	Promoting hygiene and sanitation-related behavior	Improved water sources, safe drinking water	MoWS	√	√		• 86.5% using improved sources of drinking water	—	**Equity in outcomes** especially across geographic regions and income groups
				Toilet construction	MoWS	√			• 60% of households have toilets.		
				Handwashing facilities	MoEST, MoWS	√			• 97.1% have handwashing facilities.		
				Awareness	MoEST	√	√		• Limited coverage in selected districts	• PE is comprehensive and results oriented.	**Coverage** is low, **inadequate funding** for PE
7	Improved protection of children's rights	1	Policy provisions	Constitutional rights, vital registration Act 1976,	Government of Nepal		√		• All children	—	**Effective implementation**

		MAPPING							ASSESSMENT		
STAGE 3: Early Childhood		**Approaches**		**Interventions**		**Thematic Pillars**			**Access/ Coverage**	**Quality**	**Key Gaps and challenges**
				Interventions	**Organization**	**Health**	**Social Protection**	**L&S**	*Sources: (a) Flash I 2017–18, (b) Flash II 2017–18, (c) Evaluation of National ECD Program*		
				Children's Act 2074 Child Friendly Local Governance 2068							
		2	NGOs/INGOs based	Promote a safe and enabling environment for growth and development of children	I/NGOs		√		• Low coverage, only in selected areas	• Well-designed program	**Harmonization in program** and resource allocation
8	Improved nutrition and reduced vulnerability	1	Cash transfers	Child grant for children of Dalits and all children in selected districts NPR 400 per month	MoHA		√		• Coverage of all children in 8 districts (including all of Karnali) and children from Dalit families in other districts	• Birth registration more than 90% in Karnali	**Low coverage sustainability** of the program
		2	Reduce vulnerability	Provide protection to abandoned children through orphanages	MoWCSW , I/NGOs		√		• Low coverage	• Quality varies substantially based on I/NGOs and centers	**Sustainability** of the program **monitoring and harmonization** of centers
Note: Actual implementation is being done by various arms of the mentioned ministries.											

Annex V: Comparative Analysis of Potential Variations in Governance Modalities

	Potential Variations in the Modality	Assessment		Key: Pros Cons	Conclusion
		Ability	Authority	Acceptance	
1	**Strategically (and physically) implemented under a Human Development Section of the municipality.** The Health, Education, and Social Protection Units are organized under the 'Social Development Section'. One of the core functional areas of the section is undertaking the IEY strategy. Key features of this modality may include the following: • **Leadership:** The Mayor *leads* the unit while unit heads direct each unit's IEY activities interdependently. • **Management:** All units reside in proximity, preferably in the same building, to help coordinate activities on a regular basis. • **Financial flows:** While financial flows may come to each unit from corresponding line ministries, budget planning and disbursements are made coherently through sectional discussions. • **Human resources:** The current human resource gaps are filled by sharing the administrative, field, and M&E staff across the units. • **M&E:** The section has a joint M&E framework to track key outputs and outcomes on a periodic basis. • **Learning:** Periodic joint staff meetings and cross-learning events are held with the engagement of staff across all three units.	**High** • Existing technical capabilities of units can be mobilized. • Sharing of office and field staff across the units can help address staff shortages, reduce costs, and increase efficiencies. • Financial resources can be better allocated locally to match the local-level needs in each sector. • Capacity to coordinate cross-unit activities needs to be increased. • Basic cross-unit knowledge needs to be enhanced within the section.	**High** • Strong leadership of the Mayor in section meetings can better mobilize and monitor actions. • Each unit head still retains the ability to direct one's portfolio and staff.	**High** • Ensuring accountability of elected officials (instead of bureaucrats) to the public can legitimize overall IEY efforts. • Allowing units to work with each other on a regular basis may help acknowledge each other's constraints and perspectives.	This is a good variation in areas where the LG, particularly the Mayor, is proactive and is driven to promote holistic planning and implementation of the IEY agenda. It offers a strong executive leadership and direction, under which various sectoral interventions can more holistically be integrated into the planning, budgeting, supervisory, and monitoring processes.
2	**IEY planning and implementation regularly supervised by the LG.** The IEY strategy implementing focal person participates regularly in the local municipality meetings and sessions chaired by the Mayor. (*The modality is somewhat like the previous mechanism of Local Development Offices [LDOs] leading District Development Committee meetings with representation from each sector, except, here the Mayor plays the LDO's role.*)	**Medium** • Existing technical capabilities of units can be mobilized. • Financial resources can be better allocated locally to match the local-	**Medium** • Less proactive leadership of Mayor means the unit heads must drive the agenda but get a buy-in from the Mayor.	**Medium** • The Mayor's supervisory role needs to be defined clearly to gain acceptance from the directors.	This variation is suitable in areas where the LG's leadership is strong, but the agenda of IEY may not be fully understood or proactively promoted.

	Potential Variations in the Modality	Assessment		Key: Pros Cons	Conclusion
		Ability	Authority	Acceptance	
	Key features of this modality may include the following: • **Leadership:** The Mayor *oversees* the work of units while unit heads lead each unit's IEY activities *independently*. • **Management:** Units operate separately but organize periodic joint meetings. • **Financial flows:** Financial flows come to each unit from the corresponding line ministries; budget planning and disbursements are made by each unit but under supervision of the Mayor. • **Human resources:** Human resources are allocated and mobilized by each unit separately. • **M&E:** Each unit has its own M&E framework but may track and review joint outputs and outcomes in a periodic basis. • **Learning:** Periodic joint staff meetings and cross-learning events are held with the engagement of staff across all three units.	level needs in each sector. • Capacity to coordinate cross-unit activities needs to be increased. • Basic cross-unit knowledge needs to be enhanced within the section.	• Each unit head still retains the ability to direct one's portfolio and staff.	• Allowing units to work with each other on regular basis may help acknowledge each other's constraints and perspectives.	The supervisory role of the Mayor ensures that autonomy to make decisions rests with sector heads, yet they have a suitable executive platform to integrate interventions and conduct joint planning, budgeting, and reporting activities.
3	**Periodically coordinated through a committee,** comprising technical representatives from each of the sectors. (*This modality is much like the functioning of district-level Nutrition and Food Security Steering Committee.*) Key features of this modality may include the following: • **Leadership:** The Mayor *chairs the committee* that meets per-need basis with representatives from each unit. • **Management:** Units operate separately but participate in planning and review discussions when committees meet. • **Financial flows:** Financial flows come to each unit from the corresponding line ministries, budget planning, and disbursements are made by each unit but under the supervision of the Mayor. • **Human resources:** Human resources are allocated and mobilized by each unit separately.	**Medium** • Existing technical capabilities of units can be mobilized. • Additional human resources might be required to help manage the logistics of having different sectors come together on a periodic basis.	**Low** • The limited executive and supervisory role can mean they would lack authority to take strong steps, without convincing the 'higher-ups', who might not be ambivalent about the IEY agendas.	**Low** • Because it is not driven by a politically elected body, the public might not find it as legitimate in prioritizing the IEY agenda. • As this committee will need to be formed at each local level,	This variation is suitable where the LG is not actively pursuing the IEY agenda. In such areas, technical experts will be the most suitable people to coordinate the activities across the sectors. While executive decisions may still rest with the political heads of the LG, the coordination function of the committee can still

	Potential Variations in the Modality	Assessment		Key: Pros Cons	Conclusion
		Ability	Authority	Acceptance	
	• **M&E:** Each unit has its own M&E framework but may track and review joint outputs and outcomes during committee meetings. • **Learning:** Periodic joint staff meetings and cross-learning events are held with the engagement of staff across all three units.			appropriate policy provision should back it up. Such policy does not exist and will need to be enacted for general acceptability to be high.	ensure that integration can occur at the programmatic level.