A case study on the factors which influenced a HiAP response to nutrition

Introduction

Despite good progress towards Millennium Development Goal's (MDGs) 4, 5 and 6, which focus on improving health, Nepal still has a way to go to achieve the first MDG of eradicating extreme poverty and hunger with poor nutrition among women and children in Nepal remaining a significant problem [1, p.163]. In 2011, 11 percent of children under five years were wasted, 41 percent were stunted (low height for age), and 29 percent were underweight (low weight for age) [1, p.163]. Essential infant and young child feeding practices that improve a child’s health outcomes are not followed; less than half of babies are breastfed within one hour of birth; only 65 percent are provided with appropriate complementary feeding and 24 percent of children between 6-23 months meet the minimum acceptable diet standard [1, p.163].

The multiple determinants of nutrition illustrate the complexity of the challenges inherent in addressing child hunger. For example, data from Nepal’s National Demographic and Health Survey (NDHS) 2011, identifies (as with stunting and wasting) an association between mother’s education and children being underweight, where the percentage of children who are underweight is highest (38 percent) among women with no education [1, p.168]. A similar relationship is identified between household wealth and the percentage of underweight children: “children in the poorest households are four times (40 percent) as likely to be underweight as children in the wealthiest households (10 percent)” [1, p.168]. Meeting such challenges goes beyond the influence and capacity of just the health sector and health policies.

The WHO Health in All Policies (HiAP) approach encourages the participation of all sectors (health, education, transport, and others) to take the health implications of their decisions into account and to work collaboratively towards developing
public policies which improve population health and health equity, and in this case, also nutrition related outcomes. It also recognises that many of the determinants of health, such as gender inequality, housing, and environment, go beyond the direct influence of the health sector and health policies and require support from other if not all sectors. A multi-sector approach to health, therefore, is HiAP in action.

Nepal (2013) provides a detailed observation of Nepal’s multi-sector response to nutrition. It includes historical information about the initial emergence of this response to nutrition in the 1970s and 1980s, and the most recent Government of Nepal (GON) Multi-sector Nutritional Plan (MSNP), 2012. Through this historic comparison, Nepal (2013) identifies the main factors which influence the emergence of a multi-sector response to nutrition as well as the factors which influence its sustainability. It does not cover implementation at a programmatic level of the GON’s MSNP 2012 which had been planned for roll-out in selected districts between 2012-13 and scaled-up to other districts by 2016.

**Background - the beginning of a multi-sector approach to nutrition in Nepal**

A multi-sector response to health in Nepal emerged as early as the 1970’s through several Integrated Rural Development (IRD) projects such as Rasuwa Nuwakot IRD and Mahakali IRD. A National Nutrition Survey in Nepal conducted in 1975 raised awareness of the extent of stunting and wasting among under age 6 children in Nepal [4, p.149]. The results paved the way for the National Nutrition Strategy Workshop in 1978 which drew up a multi-sector strategy for improving nutrition and resulted in the Pokhara Declaration, where nutrition focal points were created in 4 ministries (health, education, agriculture and Panchayat), and a nutrition section was created within the Department of Health to coordinate among them [4, p.150]. A Joint Nutrition Support Program (JNSP) operationalizing this multi-sector relationship was established, with support of WHO/UNICEF, to “bring a positive change in nutritional status” in 5 districts [5, p.10]. JNSP, however, was discontinued midway because of poor results. Some of the factors that influenced those results were: inadequate country capacity; lack of political will or formal coordinating mechanism; lack of civil society engagement; fluctuating donor policies and financial support. Nonetheless, JNSP provided a policy and structural basis for the future emergence of a multi-sectoral response to nutrition in Nepal.

**The emergence of the current Multi-Sector Nutrition Plan (MSNP)**

International and national commitment to the MDGs has brought nutrition, and maternal and child health into focus once again. The Nepal Nutrition Assessment and Gap Analysis (NAGA), started in 2007 and completed in 2009, recommended “specific, evidence-based, feasible, interventions across the relevant sectors – health, agriculture, education, local development, gender, social welfare, and finance” [6, p.1]. In addition, central to its recommendations is “establishing the architecture for this approach through NPC” [6, p.8].

In 2012, the MSNP (2013-2017) was finalized. Led by the National Planning Council (NPC), the plan was prepared by five government sectors, in collaboration with development partners, and endorsed by the Prime Minister. The plan was developed following a series of consultative meetings, and involved “the National Nutrition and Food Security Steering Committee (NFSSC) and Coordination Committee (NFSCC) members, the key line ministries, sector reference and working groups, and representatives from various
development partners including donors, academia, and civil society organizations (CSOs)” [7, p.8].

The goal of the MSNP is to enhance human capital, especially among the poorer segments of the society. Its purpose is to improve maternal and child nutrition by accelerating the reduction in maternal and child undernutrition. MSNP uses a multi-factoral nutrition determinants model to address the causes and consequences of malnutrition especially among infants, young children, adolescent girls and women through nutrition specific and nutrition sensitive interventions. Nutrition specific interventions improve feeding and care practices mainly through the health sector. Nutrition sensitive interventions address food availability, affordability, access, quality and are implemented through non health sectors such as agriculture, education, local development and water supply and sanitation. The multi-sectoral planning framework (figure 1) highlights the strategic objectives for each sector, their respective expected results (R) and their collective outcomes.

A multi-sector response putting HiAP into action

A WHO HiAP Framework for Country Action published in January 2014, describes six key components that need to be addressed in order to put the HiAP approach into action (see figure 2).

The components do not have to be carried out in a particular order but countries can adopt and utilise them in the order that works for their specific circumstance [8, p.1]. Nepal (2013) does not directly assess progress in using these components. Nevertheless, the following section highlights a few examples of where some of these components have been carried out. A detailed analysis would require further study.

**Figure 1:**

![Multi-sectoral Nutrition Planning Framework](image-url)
Key factors for a multi-sector response to nutrition in Nepal

A HiAP approach to public policies is still relatively new in South East Asia. Nepal (2013) shows that a multi-sector response to nutrition, as an example of a HiAP in action, has emerged in Nepal over the last 40 years. More than that, Nepal (2013) analysed the factors which influenced the decision to discontinue JNSP, and assessed the factors which influenced its most recent re-emergence (MSNP 2012).

Using the findings of Nepal (2013), the following section sets out six key factors which influence a multi-sector response to nutrition (see figure 3), including those which ‘trigger’ initiation, and those which influence the sustainability of a multi-sector approach to nutrition in Nepal. Whilst we cannot show a causal relationship between these factors and the success of a multi-sector response to nutrition, can also be seen as a factor which has influenced the sustainability of this response to nutrition. Furthermore, in contrast to the 1980s when JNSP was started with the support of WHO, UNICEF and the Italian Government, the current MSNP 2012 has much wider donor support which will hopefully enable its sustainability beyond its planning process.

2. Compelling evidence

Nepal (2013) identified that the presence of scientific data from the first National Nutrition Survey (1975) about the level and effects of malnutrition, was a key influence which triggered the response to under-nutrition in the 1970s and 1980s. However, what has helped drive and also sustain a multi-sector response to nutrition in Nepal in recent years has been the acceptance of compelling evidence by multiple sectors that the consequences of stunting are and fluctuating donor policies meant there was a lack of political will to prioritise nutrition and sustain a multi-sector approach. In contrast, in the last 10-15 years there has been a ‘policy change window’ where political will to prioritise nutrition has been obtained at an international and national level and which has driven a multi-sector response to nutrition in Nepal. Thus, with the active support of international donors and renewed efforts by countries to scale-up nutrition (such as the SUN Initiative), the GON reassessed its commitment to addressing nutrition and achieving the MDGs. Also at this time Nepal became a federal republic, a window of opportunity perhaps for a renewed focus to improving nutrition and maternal and child health? The interim constitution of 2007, for example, recognises every citizen’s right to food sovereignty.

Political commitment by the GON and in particular by the NPC, which has taken a lead role in generating support among sectors for a multi-sector response to nutrition, can also be seen as a factor which has influenced the sustainability of this response to nutrition. Furthermore, in contrast to the 1980s when JNSP was started with the support of WHO, UNICEF and the Italian Government, the current MSNP 2012 has much wider donor support which will hopefully enable its sustainability beyond its planning process.

1. Political commitment and international influence

In the 1980s other more immediate priorities, such as reducing Nepal’s very high mortality rates as a result of communicable diseases...
“profound and irreversible” [3, p.12], and that a more effective policy and strategy was needed which recognised the determinants of nutritional status which go beyond nutritional specific interventions [3, p.17]. Evidence from NDHS 2011, for example, identifies a number of determinants of undernutrition including food insecurity, such as inadequate access to food, and a mother’s level of education [1, p.165]. The GON accepts that for Nepal to achieve MDG targets on nutrition ‘specific’ as well as nutrition ‘sensitive’ interventions need to be introduced with the involvement of all sectors [3, p.2].

3. Mechanisms for coordination and consultation

A consultative approach with mechanisms for multi-sector coordination, provided important opportunities for sustaining a multi-sector dialogue and identifying sector roles and responsibilities. After the publication of NAGA in 2009, a consultative approach which involved all sectors through reference groups and sector reviews was adopted in the development of the initial MSNP. The NPC was responsible for garnering sector involvement and is responsible for coordinating MSNP. Various horizontal mechanisms were set up for cross-sectoral linkages at reference group meetings and for experts from other bodies, such as the private sector and academia, to also be consulted through a technical committee.

A number of challenges during the consultative stage of MSNP, 2010-2012 hindered progress towards a multi-sector plan for nutrition. They included difficulties in getting sectors to accept collaborative ways of working; time consuming
processes of consultation and non-health sectors unfamiliar with working with donors through a sector wide approach.

Various vertical coordination mechanisms were also put in place at the district and village levels through the inclusion of different sectors in steering committees. Their role, defined in the MSNP 2012, was to incorporate nutrition into their periodic and national plans and monitoring framework [3, p.10]. However, while a key informant noted that a coordination mechanism existed at the district and village level, a number of interviewees emphasised dissatisfaction with the process which has led to poor accountability. In particular, given that the terms of locally elected representatives have expired and new elections have not taken place, informal and formal structures have determined the implementation of some plans and policies. Another pointed out that certain political influences at a local level were posing a significant challenge to developing health programmes. These concerns underline the need for defined roles and responsibilities as well as governance-related monitoring and evaluation structures which can identify challenges and progress of Nepal’s MSNP.

4. Active involvement of civil society

For HiAP to be put into action it was essential to identify opportunities for engagement with key groups and the wider community to seek their views on the health benefits and impacts of, in this case, a multi sector response to nutrition, and to promote awareness of the planning process [8, p.9]. A number of opportunities were incorporated into the MSNP 2012 for the voices of local communities to be heard. For example, Citizens Awareness Centres and Wards Citizens Forums would be tasked with raising awareness of nutrition and including nutrition in their Terms of Reference [3, p.49]. Wards Citizens Forum’s would also be represented at the District Level: Food Security Steering Committee; and an NGO would be present on the Village Level: Food Security Steering Committee. However, interviews with key informants found mixed experiences of the role of civil society in influencing the agenda for HiAP in Nepal. Some saw civil society as weak and felt that policies were made without consulting civil society. In contrast, another key informant commented that at the district level, civil society played a role in accessing the local community and helping them to take ownership of a plan or policy and make it sustainable.

5. Infrastructure and building capacity

Building capacity for the implementation and sustainability of a HiAP is a key component of the WHO’s framework for putting HiAP into action (component 6) and was a central element of the MSNP 2012. The plan recognised that non-health sectors may have little nutrition capacity which takes time to build and consequently each sector had to set out opportunities in their sector reviews for capacity building including partnerships with local government. Furthermore, the existence of a core planning cell in each of the 5 ministries, highly trained human resources involved in planning, and previous experience of coordinating efforts between sectors, such as health and education, are factors which contributed to the success of building the 2012 MSNP.

JNSP lacked local health infrastructure and formal mechanisms to support JNSP implementation, such as District Development Committee and Village Development Committee. This hindered the planning and coordination of community resources. In contrast, in recent years better public health, education and agricultural infrastructure even at the community level, could go some way to supporting
the sustainability of the MSNP 2012. At the same time, the reliance on donors to provide substantial capacity building support in the first few years [3. p.21], underlines the vulnerability of MSNP.

6. Ensuring funding

The HiAP framework recognises that to enhance implementation beyond the health sector, frameworks should bring ‘mutual accountability and shared responsibility’ with ‘adequate and sustainable financing’ [9, p.15]. In the 1980s, JNSP discontinued when donor funding ceased. In contrast, the MSNP 2012 framed a plan of action which aimed to ensure adequate funding for agreed program areas. As such, a ‘Basket Fund’ was proposed in which the GON and development partners would make their committed financial contribution. Donors would normally make a 3 year commitment. The various sectors were given responsibility for mapping the financial resources that they would need and the plan recognised a need for a coordinated framework for funding allocation [3. p.51]. Although the presence of a funding plan is an example of the HiAP component 2 (see figure 2), key informants highlighted concerns that the budget was inadequate and that in the longer-term it could become a barrier to implementation.

Conclusion

Nepal’s MSNP is an exciting example of HiAP in action. Strong political will at the international and national level to achieve MDGs as well as compelling scientific data supporting a multi-sector approach to nutrition, have been important in driving the development and acceptance, among sectors, of a multi-sector response to nutrition in Nepal. A participatory process with strong engagement mechanisms involving ministries, technical experts, civil society and local government bodies at district and village level, provided opportunities for an array of views to be heard and to build acceptance of the MSNP 2012 among the wider community. The sustainability and implementation of MSNP is more challenging. Whilst roles and responsibilities among ministries have been clearly defined and agreed, weak governance at the local level as well as infrastructure and capacity building have the potential to hinder progress. Nevertheless, the experience of Nepal’s multi-sector approach to nutrition demonstrates that HiAP can be put into action and is an important example for other countries in South-East Asia Region to consider. A future study evaluating progress of the first phase of implementation of the MSNP would be useful to policy makers and programme managers.

References


Note: The information for this article is based on the case study commissioned by WHO-SEARO, which was written by Dr Suniti Acharya, Executive Director, Centre for Health Policy Research and Dialogue, Kathmandu, Nepal, March 2013. The case study included information from a literature review and interviews with 16 key informants from various ministries in Nepal as well as international organisations, NGOs and academia. The case study (hereafter Nepal 2013) was presented at a WHO meeting in Helsinki in June 2013.

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