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SUAAHARA
Building Strong & Smart Families

SUAAHARA II

Good Nutrition Program

Monitoring, Evaluation, and Research (MER) Plan

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List of Abbreviation

CB-IMNCI	Community Based Integrated Management of Newborn Childhood Illnesses
CHSB	Community Health Score Board
CHW	Community Health Worker
COP	Chief of Party
CVCA	Climate Vulnerability and Capacity Analysis
DAG	Disadvantaged Group
DCOP	Deputy Chief of Party
DDC	District Development Committee
DHIS	District Health Information Systems
DHO	District Health Office/r
DHS	Demographic and Health Surveys
DQA	Data Quality Audit
DRR	Disaster Risk Reduction
DRR	Disaster Risk Reduction
EA	Equal Access
ENA	Essential Nutrition Actions
ENPHO	Environment and Public Health Organization
EPI	Expanded Programme on Immunization
FCHV	Female Community Health Volunteer
FLW	Frontline Worker
FP	Family Planning
GESI	Gender Equality and Social Inclusion
GMP	Growth Monitoring and Promotion
GoN	Government of Nepal
GPS	Global Positioning System
H4L	Health for Life
HFP	Homestead Food Production
HKI	Helen Keller International
HMG	Health Mothers' Group
HMIS	Health Management Information Systems

HTSP	Healthy Timing and Spacing of Pregnancies
ICT	Information Communication Technology
IFPRI	International Food Policy Research Institute
IMAM	Integrated Management of Acute Malnutrition
IPO	Implementing Partner Organization (i.e., local NGO)
IPTT	Indicator Performance Tracking Table
IT	Information Technology
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
KISAN	Knowledge-based Integrated Sustainable Agriculture and Nutrition
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MICS	Multiple Indicator Cluster Survey
MIS	Management Information Systems
MIYCN	Maternal Infant and Young Child Nutrition
MMC	Market Management Committee
MNCH	Maternal Newborn Child Health
MPS	Minimum Program Standards
MSNP	Multi Sector Nutrition Plan
NACS	Nutrition Assessment Counseling and Support
NAS	Network Attached Storage
ND	Newcastle Disease
NFSSC	Nutrition Food Security Steering Committees
NGO	Non-Government Organization
NIL	Nutrition Innovation Lab
NTAG	Nutrition Technical Assistance Group
ODF	Open Defecation Free
ODK	Open Data Kit
OFSP	Orange-fleshed Sweet Potato

PAHAL	Promoting Agriculture Health and Alternative Livelihoods
PHC/ORC	Primary health care/outreach clinic
PIRS	Performance Indicator Reference Sheet
PNGO	Partner Non-Governmental Organization
QA	Quality Assurance
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SBCC	Social Behavior Change Communication
STA	Senior Technical Advisor
USAID	United States Agency for International Development
USG	United States Government
VDC	Village Development Committee
VDRC	Vijaya Development Resource Center
VMF	Village Model Farmer
WASH	Water, Sanitation and Hygiene
WSP	Water Service Point

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1. PROGRAM AIMS AND APPROACH

Suaahara II is a five-year USAID-funded program (April 1, 2016-March 31, 2021) that will continue, and improve upon, the multi-sectoral approach of *Suaahara I*. The ultimate goal of the program is to reduce the prevalence of low birth weight, stunting, wasting, and underweight among children under 5 years of age; underweight among women of reproductive age; and the prevalence of anemia among these categories of women and children. The program will incorporate a specific focus on adolescent girls and other household members as well. *Suaahara II* will promote greater gender equality and social inclusion (GESI), in part by targeting women and disadvantaged groups (DAGs). *Suaahara II* activities will take place in 40 districts, 38 of which were part of the *Suaahara I* program, and 17 of which have been implementing the *Suaahara* program since 2012.

The program will be delivered through:

- Targeted and intensive social and behavior change communication (SBCC);
- Universal and intensive coverage of 1,000-day mothers and households by frontline workers (FLWs);
- The strengthening of existing health systems and service points that address nutrition-specific and nutrition-related causes of under nutrition; and
- Mass media to raise awareness of and increase demand for these services.

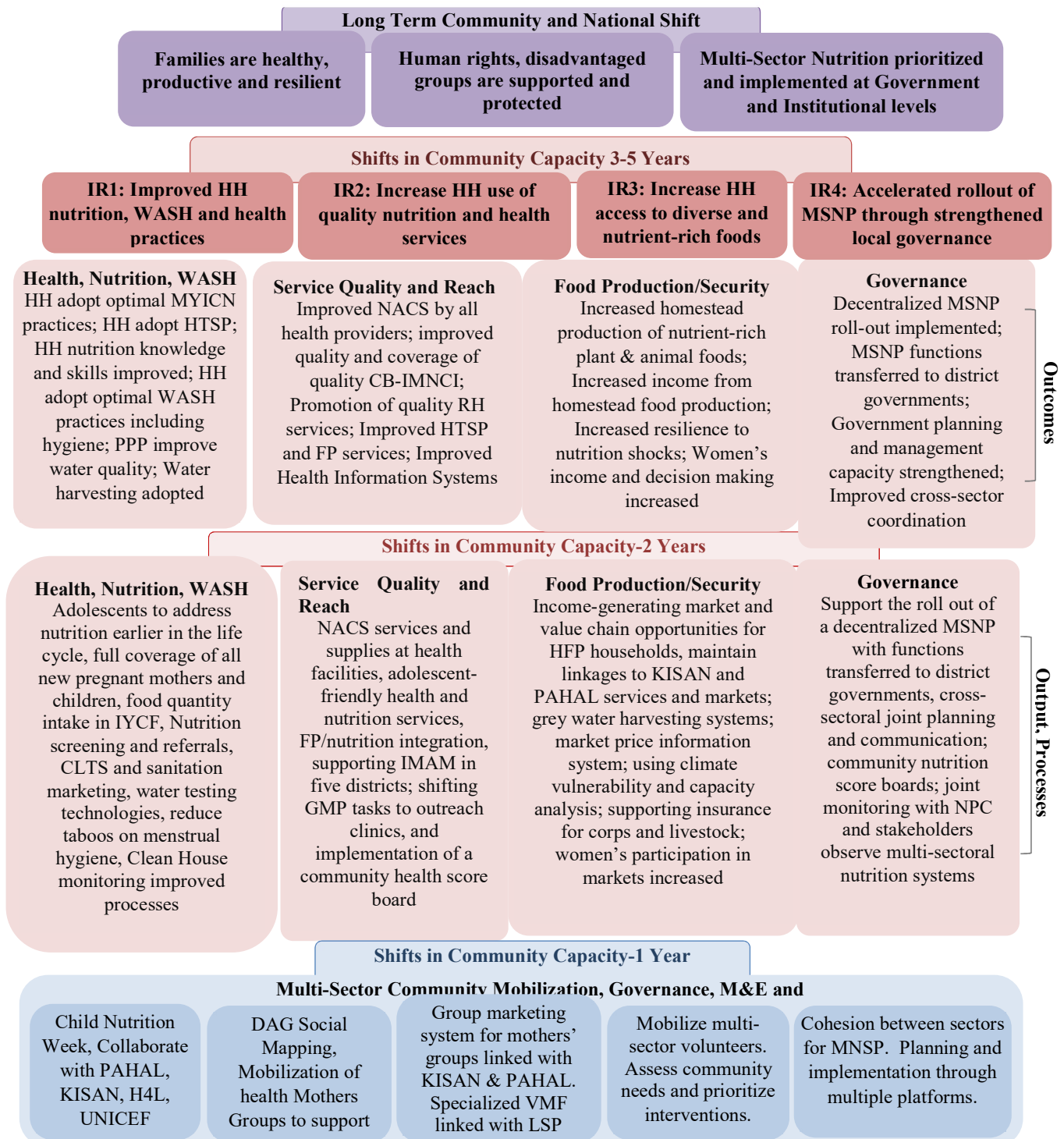
The program will build government capacity to deliver high quality services, strengthening governance, coordination, and delivery structures and standards that support sustainable nutritional improvements among women and young children.

Suaahara II consortia partners include Helen Keller International (HKI), CARE, Equal Access, Environment and Public Health Organization (ENPHO), FHI360, Vijaya Development Resource Center (VDRC), and Nutrition Technical Assistance Group (NTAG). HKI will be leading all monitoring, evaluation and research activities (MER), with the expectation that all partners will provide input into the design and implementation of the MER and information management systems.

Figure 1 shows *Suaahara II*'s Theory of Change, including the activities, outcomes, and preconditions that are needed to drive improvements in the nutritional status of women of reproductive age and children under 5 years of age in Nepal.

Figure 1: Suaahara II Theory of Change

GOAL: IMPROVED NUTRITIONAL STATUS OF WOMEN AND CHILDREN IN NEPAL



An extensive SBCC strategy will lead to improved health, nutrition, and WASH behaviors by households. For nutrition, we will improve infant and young child feeding (IYCF) practices, including increasing the proportion of mothers that are exclusively breastfeeding their children aged 0-6 months the proportion of children 6 to 24 months consuming diverse diets . We will also increase the proportion of women of reproductive age with dietary diversity. For WASH, more households with young children will be using safe sanitation services, fewer will be practicing open defecation, hand washing at critical times will be the norm, and more households will be using safe water storage and treatment technologies on a regular basis.

We will bring about these changes through a trained cadre of FLWs, most notably FCHVs and *Suaahara II* field supervisors, delivering SBCC through interpersonal communications, health mothers group sessions, and household visits throughout the 1,000-day period, targeting 1000-day women and their family members. This will be supported through mass media, using the *Bhanchhin Aama* broadcasts and listener groups to reinforce messages. The private sector will also be leveraged to increase access to the products and services that support improved WASH behaviors.

Intermediate Result 2: Increased use of quality nutrition and health services by women and children

Household-level behavior change activities will aim to increase demand for health services and will be supported by activities to improve the quality of health services, particularly those that play a critical role in improving nutritional status: growth monitoring program (GMP), prevention and treatment of severe acute malnutrition (SAM), nutrition counselling, community based integrated management of childhood illness (CB-IMNCI), and family planning counselling and services. High-quality services and their regular use by households would combine to support improvements in the nutritional status of young children and women of reproductive age.

We will bring about these changes through building the capacity of health service providers, introducing quality standards for nutrition counselling and family planning, strengthening referral mechanisms, and targeting demand creation for high quality services that support nutritional improvements.

Intermediate Result 3: Improved access to diverse and nutrient-rich foods by women and children

A targeted enhanced homestead food production program (EHFP) will increase the proportion of households with access to diverse and nutrient rich foods. As a result, more households will be practicing agriculture with improved techniques and technologies to deliver higher levels of production of a more diverse range of nutrient rich fruits and vegetables. The number of households practicing poultry farming will also increase, as will the number of eggs produced by poultry farmers. More families will be employing effective post-harvest techniques to safeguard and add value to their crops. The total value of crops and animal produce will increase and a greater proportion of households will be converting surplus produce into income through increased access to markets, and an increase in their business and marketing

acumen. Women will play a greater role in the production process and a greater number of women will be involved in decision-making about the use of household income generated from EHFP activities.

We will bring about these changes through establishing and strengthening village model farms (VMF) as a community resource, and using these to deliver high quality inputs to build the technical capacity of households in crop production and poultry raising. This will complement nutrition activities, including those promoting the consumption of nutrient-rich foods among women and children in the 100-day period. More households will be implementing climate smart farming, a greater number of those with poultry will be vaccinating their chickens appropriately, and the business acumen of farmers, particularly female farmers, will be strengthened. Linkages to livelihood programs, such as KISAN and PAHAL, will be made where appropriate, enabling VMFs to benefit from these programs as well.

Intermediate Result 4: Accelerated rollout of Multi-Sector Nutrition Plan (MSNP) through strengthened local governance

The program will work with the Government of Nepal (GoN) and other stakeholders to strengthen the governance structures that support sustainable improvements in the nutritional status of women and young children. There will be enhanced facilitation, coordination, and collaboration for effective implementation of the MSNP through joint planning between sectors. MSNP-related technical, management, and operational capacity and knowledge will improve among government and civil society stakeholders. There will be an increase in the number of districts with functioning Nutrition and Food Security Steering Committees (NFSSC).

Management of nutrition services will be transferred to the GoN in 15 districts in year 3 of *Suaahara II* and the quality and coverage of the services delivered will be maintained. We will work closely with the Department of Health Services (DOHS) at the central level to develop a systematic, phased approach, based on mutually agreed criteria, for this handover process, including the development of performance standards. *Suaahara II* will support DOHS to conduct performance assessments and management capacity analysis in the handover districts in years one and two. Context-specific capacity development plans will then be developed in accordance with the program sustainability plan (see Annex A) to strengthen the capacity of the DHO and health facilities to lead and manage the planning, budgeting, monitoring, and assessment in order to maintain quality nutrition services in their district.

Suaahara II will support the districts to regularly monitor progress towards handover status. The direct implementation of services, including the following, will be transferred in phases by the end of year 3: Health Mothers Group (HMG) meetings, primary health care/ outreach clinic (PHC/ORC) functioning, food demonstration; WASH; Celebration of Child Nutrition Week; NACS and Growth monitoring, CB-IMNCI; District NFSSC activities; HFP Marketing Linkages; Resilience; VDC NFSSC activities. After year 3, a small technical team will stay in the districts to provide on-site technical support and monitoring. Ideally, the district teams will be located at the DHO, if space is available for a District Coordinator with the added responsibility of M&E and small-scale grant management and a MNCH-GESI officer.

2. MONITORING, EVALUATION, AND RESEARCH AIMS AND APPROACH

2.1 MER system overview

The primary purpose of *Suaahara II* data collection activities is to track programmatic activities and inputs, identify implementation gaps, and facilitate learnings and feedback. This MER plan, developed in partnership with *Suaahara II* consortia partners, provides a detailed description of:

- How *Suaahara II* will be monitored, so that changes in intervention areas can be assessed over the life of the program and how monitoring data will be used for learnings and to identify areas for programmatic improvement
- How *Suaahara II* will be evaluated, so that assessment can be made re: *Suaahara*'s contribution to any improvements over time seen in *Suaahara* areas;
- How *Suaahara II* research studies will be designed so that deeper learnings and insights on specific thematic and sub-thematic topics can be gleaned; and
- What arrangements will be put in place to ensure that all data collection, management, and analysis is of a high quality and relevant to program objectives.

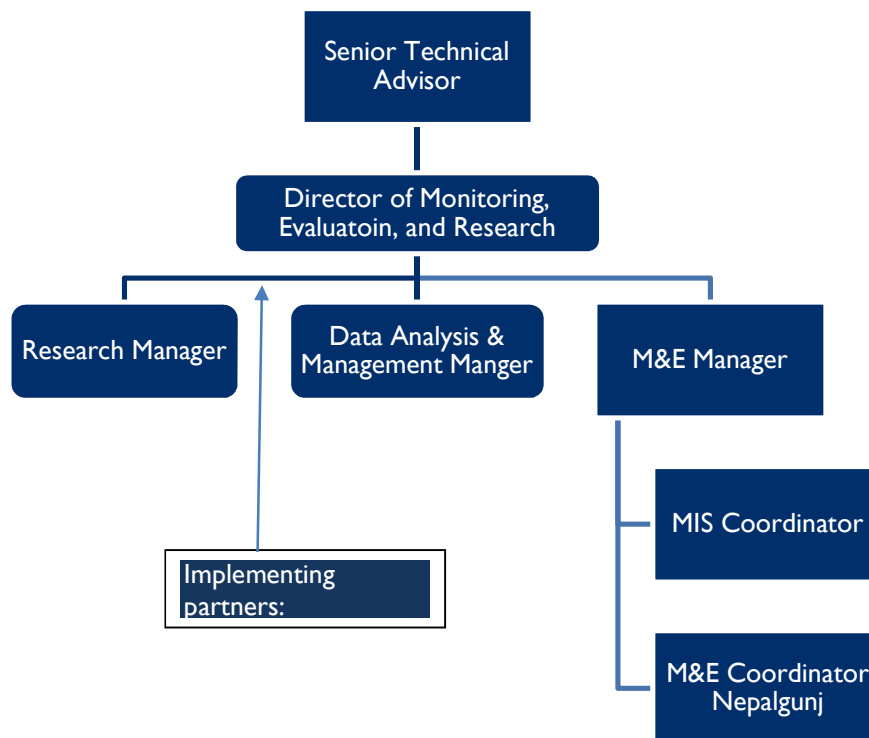
Furthermore, this MER plan will serve as a reference tool, specifically aiming to:

- Provide a framework for the MER system that will enable the systematic collection, aggregation, analysis, and interpretation of data that support performance-informed decision-making;
- Identify the core indicators to be used to assess progress towards achieving planned results and impacts;
- Describe the main data tools, sources, and methods used to collect data;
- Describe roles and responsibilities associated with M&E;
- Establish a clear information flow and reporting and aggregation structure;
- Define data quality assurance measures and data management procedures to provide transparency and ensure data quality;
- Align with USAID's strategies and processes;
- Outline strategies to inform decision-making through monitoring results; and
- Facilitate participation among USAID/Nepal and consortia partners

2.2 MER team structure, roles, and responsibilities

This section describes the structure and functions of the central MER team, and how this links with the MER functions of implementing partners. Figure 2 displays the organizational structure of the MER team.

Figure 2: Structure of the Monitoring, Evaluation, and Research Team



Senior Technical Advisor (STA)

The STA provides overall MER guidance, including the application of MER data to management decisions that will improve program performance and ensure that MER systems are functioning and are high-quality. The STA will also provide guidance on statistical analysis and reporting of MER data collected. The minimum job requirements include a Masters of Public Health/Social Sciences and fifteen to twenty years of experience in implementation and MER of health, nutrition and food security programs. The STA will work closely with *Suaahara IIs* COP and DCOP, as well as HKI's Regional M&E Advisor.

Director of MER

The Director of MER will have overall responsibility for all components of the MER system. They will be responsible for the timely implementation of data collection, ensuring data quality, and that all data is reported in a timely manner using approaches that will facilitate decision-making about the program based on the data. They will have overall responsibility for the design and implementation of surveys, including the commissioning of agencies and/or consultants to deliver elements of those surveys. Finally, they will ensure that MER reporting meets the expectations of all key stakeholders. To deliver against the above, they will work closely with the Chief of Party, Deputy Chief of Party, Senior Technical Advisor, and HKI's Regional M&E Advisor. The Director of MER reports to the STA. The minimum job requirements include a Master's degree in Public Health/Demography/Population studies and statistics or related field (knowledge and experience in Public Health and Nutrition related M&E preferred). The Director of MER must have at least ten years of relevant experience in monitoring and evaluation, including development of data

flow maps, data collection tools, reporting forms, project databases and management information systems.

Research Manager

The Research Manager assists the Director for MER in all research activities including research design, development of scopes of work for research studies, selection of researchers and/or research firms; relationship management with external researchers and firms, day-to-day oversight of all ongoing research, direct field research (in some cases), data management, data analysis, and reporting. S/he is also responsible for assisting the M&E Manager with all MER data collection and analysis needs. S/he will ensure that pre-established statements of work, study protocols, and ethical requirements are followed for all *Suaahara II* research efforts. S/he will also oversee recruitment of study participants and consult with investigators on appropriate management of participant problems and concerns, including data security and informed consent. The Research Manager reports to the Director of MER. The minimum job requirements include a Master's degree in Public Health, International Development or other relevant discipline preferred and at least seven years of experience in similar position/organizations.

Data Analysis and Management Manager

The Data Analysis and Management Manager will serve as the focal person for statistical analysis, verification, and storing of all *Suaahara II* data and information. S/he will report to the designated supervisor and support overall improvement of *Suaahara II*'s quality information system and sharing of its results and findings. S/he will support the district coordinators and their partner NGOs and will build capacity of the district level teams engaged in MER activities to ensure quality of data collection, analysis, validation, reporting, and use of findings. The Data Analysis and Management Manager reports to the Director of MER. The minimum job requirements include a Master's degree in statistics or relevant field and at least seven years of experience in advanced statistical analysis, by using statistical software packages, and managing large datasets related to development.

M&E Manager

The M&E Manager will serve as the main focal person for all M&E activities for the program. S/he will assist and report to the Director of MER. The M&E Manager is responsible for guiding data collection, ensuring that USAID requirements are met in a high quality, timely manner, establishing the project monitoring system for tracking indicators, developing procedures and tools, identifying capacity building needs, providing technical assistance to staff and partners, and organizing data collection to ensure quality and consistency. S/he will also lead on the development of management information systems (MIS) to facilitate decision making by supplying information and data to the managers on time and in a usable form. The M&E Manager reports to the Director of MER. The M&E Manager will have a minimum of seven years experience of designing and implementing high quality M&E systems for public health programs in Nepal.

Management Information System (MIS) Coordinator

The MIS Coordinator is responsible for ensuring that data collection tools are fit for purpose and link smoothly with the MIS. The MIS Coordinator will be an administrator of CommCare, which requires working with the M&E Manager to

ensure training of all end users in CommCare mobile systems. S/he will develop and ensure a data security system for MIS and provide periodic and timely backup of all MIS data in collaboration with thematic managers and partners. Lastly, s/he will ensure all data and information from districts, line agencies, and stakeholders are compiled for regular reports. S/he will report to the M&E Manager and will work closely with district teams to coordinate use of mobile technology for monitoring activities of field supervisors, as well as work with relevant IT staff and partners to advise on the development of data dashboards for improved supervision and quality improvement schemes. The minimum job requirements include a bachelor's degree in information technology (Bachelor's in Information Management (BIM), Bachelors in Science for Information Technology (BSCIT), Bachelors Computer Applications (BCA), and Bachelors Engineering and Information Technology (BEIT) and at least five years' of relevant experience in MIS development and maintenance. Candidates should have experience of working with the DHIS2 information system.

M&E Coordinator

The M&E Coordinator will work closely with the M&E Manager, in establishing the M&E system in all *Suaahara II* districts. S/he will help the MER team to develop and field test data collection tools and ensure monitoring data are collected according to the PMP. S/he will also conduct regular district-level monitoring visits to verify data and support local partners in high-quality data collection and use for decision making. S/he will ensure all data and information from districts, line agencies, and stakeholders are compiled for regular reports; and maintain close liaison with the district officers responsible for district data collection and reporting. S/he will also play a role in documentation and reporting, capacity building of PNGOs, and other MER activities as required. The M&E Coordinator will have a Bachelor's degree in public health/social science and at least five years of experience in designing and implementing high quality M&E systems for public health programs in Nepal.

Implementing partners (IPs)

All implementing partners have their own structures and functions to deliver high quality M&E data. Implementing partners will contribute a large proportion of the data that will be used for M&E of the *Suaahara* program, and, regardless of the individual structures of each implementing partner, will work together to ensure that there is a single, harmonized, M&E system supporting the *Suaahara* program. Three IPs (Care, FHI360 and VDRC) will have fulltime M&E Specialist to support *Suaahara* program. Other IPs will have M&E staff for partial support to *Suaahara* program.

In addition to this core staff, at the district level there will also be MER support staff. First, the DMDOs, hired by the PNGOs in each of the 40 districts, are the main link between the PNGO and *Suaahara II* district teams for data management and documentation. DMDOs are responsible for supervising a team of hired *Suaahara II* Field Supervisors in each district, reviewing and verifying data collected by Field Supervisors and holding monthly meetings to review all *Suaahara II*-related work including targets, achievements, and compliance. Field Coordinator of PNGO will assist DMDO for all data management and monitoring activities. Field Coordinators hold responsibility for submission of all PNGO-level data to *Suaahara II* district teams.

Second, *Suaahara II* will have DMDOs, supported by district coordinators, manage MER activities, whereas the PNGOs will be responsible for monitoring data collection. The Data Analysis and Management Manager will support the district teams and their partner NGOs to build MER-related capacity and to ensure data quality. The minimum qualifications are a Bachelor's degree in Public Health/Social Sciences and at least five years of experience in health, nutrition and food security.

2.3 Key indicators and targets

A detailed description of indicator types, 2016 estimates, and annual and life of program targets are included in the Indicator Performance Tracking Table (IPTT) in **Annex 1**. The indicators that we have chosen to track progress over the life of the program reflect the overall aims of the project – improving the nutritional status of women and young children –, as well as the hypothesized pathways to impact and the activities that will be implemented along those pathways.

Although impact measures will be collected through the DHS 2016 and later in the DHS 2021, we are also proposing to collect anthropometric and anemia (in mothers and children) data in the first and last annual surveys for *Suaahara II* for a number of reasons:

- The DHS are not powered to measure changes in the *Suaahara II* impact indicators over the duration of the program. The sample of women with children under 5 years of age in *Suaahara II* intervention areas may vary and the DHS may not be sufficiently powered to track changes in impact with the required precision to draw conclusions about whether targeted reductions in stunting, wasting, underweight and anemia have been met.
- Collecting impact level indicators in the baseline and endline surveys will allow us to explore the relationship between these impact indicators, program coverage indicators, and indicators along the hypothesized pathways to impact. This would not be possible if impact level indicators and measures of program exposure are collected in different surveys.
- The major cost component of conducting baseline surveys will be getting data collection teams out to the VDC/wards and able to collect high quality data. Once enumerator teams are at the VDC/ward, the costs of collecting anthropometric and hemoglobin data, in addition to outcome level data, is not substantial, and is likely to be a fairly small proportion of the overall costs.

In consideration of the above, we think that there is a strong case for including impact level indicators in the first and last *Suaahara II* annual surveys.

The targets that we have set are challenging but achievable over the life of the program. They are based on achievements from *Suaahara I* and evidence from other similar programs that work towards a similar set of impacts and outcomes. We have used a number of data sources as estimates against which to set targets. For impact level measures, we have used the 2014 UNICEF MICS and the DHS 2011 datasets. For population based outcome measures, we have also used a range of data sources - UNICEF MICS 2014, DHS 2011, and the *Suaahara I* end of project survey (Year 5, LQAS) - for our estimates of current prevalence and to set program targets.

All measures and targets will be reviewed and revised once *Suaahara II*'s first round of annual survey data is available.

The first and last annual surveys will be powered to assess the extent of change in all population based indicators over the life of the program. The annual surveys will be designed so that the findings can be disaggregated and are representative of 'mature' and 'new' program districts. Mature districts are *Suaahara I* districts that received intervention activities for several years (phase 1 and phase 2 *Suaahara* districts). New districts are *Suaahara I* districts that received intervention activities for no more than 1 year and the two new *Suaahara II* districts (phase 3 and phase 4 *Suaahara* districts).

As a minimum, it will be possible to disaggregate all household-level data by age, sex, and caste/ethnicity (Dalit, Muslim, Brahmin/Chhetri, Newar, Janajati, and other), and, where appropriate by DAG v non-DAG. Age disaggregation for adolescents will be 10-14 years and 15-19 years. Age disaggregation for adults will be by five-year groupings (e.g. 15-19, 20-24, 25-29, 30-34). For child nutrition indicators, we will use the standard age categories from Nepal DHS.

As a large scale, multi-sectoral program, *Suaahara II* will draw upon data from a wide range of sources to monitor implementation and achievements. Each data collection activity will be developed in the context of the entire MER package – cognizant of all other data collection activities operating across the program – ensuring efficiency in the collection of information from different levels – household, community, health facility, VDC, and district – reducing duplication, and maximizing data utility. Broadly, our data collection activities are grouped into monitoring, evaluation, and research and greater information on each is provided below.

2.4 Data for monitoring

For monitoring, the following categories of data will be collected: 1) activity reporting/logging; 2) routine monitoring data from households, frontline workers, and health facilities; and 3) annual surveys. For the first two categories, field supervisors and district teams will be responsible for collecting data electronically via CommCare on mobile devices and on web-based CommCare and DHIS2 platforms. For annual surveys, an external survey firm will be contracted to collect data electronically.

1. **Activity reporting:** All program activities, such as events and trainings, will be monitored on a per activity basis. Data will be entered using standard online forms and stored in a single database. Activities and achievements will be monitored against annual and monthly work plans for each implementing partner. Activities will be reported monthly by each district. Implementation data will be used to assess the extent to which activities of appropriate scope and scale, required to drive behavior change, are being delivered.

Reporting would include a host of basic information such as number of people trained, topic(s), and trainees' role, sex, and ethnicity/caste. All training activities will be monitored for the quality of implementation and will record pre/post-test training scores and Quality Standard checklists for quality in the

delivery of training and capacity building efforts. Future activities will draw upon lessons learned and look to the continual improvement of training delivery. All training data will be reported into the USAID TRAINET system.

District-level staff and partner NGO officers will be responsible for entry of some of the monitoring data, particularly activity logging. Field supervisors and district teams will enter data directly into electronic systems. The systems will have drop down menus, conditional entry, filters and scripts that will be able to report data entered which is outside reasonable parameters. Any data that is not automatically loaded into the *Suaahara* information system will be entered manually within a maximum of 3 days from the day of collection. This will allow for routine verification of data, reduce pressure on data entry staff, and allow time for data verifications as necessary.

2. **Routine monitoring:** This will include monthly monitoring data from the household and frontline worker levels, as well as from the health facilities. Field supervisors will collect routine monitoring data, using checklists, on mobile devices, based on CommCare's mobile applications and forms. The forms will be uploaded and aggregated centrally in near real time. GPS points will be recorded for each household allowing tracking at multiple levels of aggregation – household, village, ward, VDC, district, project. About 600 field supervisors will collect checklist data. Each month field supervisors will collect data from 5 households, 2 VMFs (where available), and 2 FCHVs in their supervision area. In aggregate, we will have data on more than 36,000 household visits annually.

Monthly household-level data collection will provide data on program coverage of services being delivered by FLWs. Household checklist data will allow us to formulate a district level picture of coverage of interventions and services being delivered to, and accessed by households. They will provide data on:

- Exposure to and participation in key program interventions, such as monthly meetings, home visits, PHC/ORC activities, health facility services
- Frequency and intensity of contacts with FLWs including female community health volunteers (FCHVs) and *Suaahara* Field Supervisors.
- Adoption of key program-promoted practices, based on annual programming.

In HFP-intensive districts, a checklist will also be used for HFP surveillance activities to provide data facilitating a better understanding of the extent to which HFP interventions are driving improvements in horticulture and livestock management practice, and, critically, whether these are resulting in the substantial improvements in production needed to deliver changes in diets and income, which will contribute to improvements in nutritional status. The surveys will track the training, products and services that are received by households, production yields, consumption/diets, food security, and other factors along the pathway from agricultural inputs to health and nutrition.

Monthly FCHV and VMF data collection will provide data on program coverage in their respective areas and also allow us to formulate a district level picture of up-to-date strengths and weaknesses of program implementation. This district, and even VDC-level, picture will facilitate supervisory discussions with real time data and enable context-specific programmatic improvements based on evidence and identification of gaps.

Data will be reported into *Suaahara II's* CommCare and DHIS2 information systems and indicator dashboards will be created. These dashboards will be a key data source for managers both in districts and centrally to understand the extent to which interventions and services are reaching households and to inform decisions on where additional resources or alternative approaches may be required. They are also a critical data point in assessing key elements in our theory of change, and the extent to which behavioral outcomes are being delivered as envisaged through the activities proposed.

For health facilities, periodic audits will be conducted to assess the quality of service delivery in the area of nutrition assessment counseling and support (NACS), family planning, CB-IMNCI in terms of health worker knowledge, human resources, equipment, and supplies. The quality of health provider services will be tracked against agreed standards and will be reported back to program managers on a regular basis to guide decisions on capacity building and use of program resources. Client exit interviews will be used to routinely assess client perceptions of quality. In selected communities, Community Health Score Boards will enable community members to assess service providers and to rate their services/performance using a community defined grading system. District based MCHN/GESI officers and/or DMDOs will visit health facilities on a quarterly basis to monitor the delivery of quality health and nutrition services and the availability of key MCHN/GESI commodities. The MCHN/GESI officer will also provide information to health facilities and district health offices for appropriate actions. These data on health provider quality and performance will be shared with the District Health Officers and Health Facility in-charge during review and reflection meetings at the District Health Office. These data will also be a systematic way of monitoring the progress of handing over nutrition and health services to the GoN.

- 3. Annual surveys:** This aspect of our monitoring system will track progress towards targets and identifying whether the outcomes required to deliver changes in nutritional status are being achieved. Together with routine monthly monitoring data and activity reports, these annual surveys will inform project management decisions on program strategy. They will allow for an ongoing assessment of our theory of change, and whether the preconditions we think are necessary for change to take place hold true, or whether alternative approaches may be needed. Annual surveys will primarily be done among 1000-day women, but other household level respondents include a primary male household decision-maker, a mother/mother-in-law of the 1000-day woman, and adolescent girls. Anthropometric and hemoglobin assessment of women of reproductive age, children under 5 years of age, and adolescent girls will also be done. In addition to household-level surveys, annual FCHV and health facility surveys will also be carried out. Survey data

will be held in a database that can be downloaded into Excel for data checks and cleaning. Survey data will be analyzed and reported within 3 months of the completion of data collection. These surveys will be conducted electronically by an externally hired survey firm to ensure independent reporting of program progress and data collection will happen in the same season each year to avoid seasonal influences on agriculture, health, WASH, and nutrition indicators. The first annual survey will serve as a baseline survey for *Suaahara II* monitoring.

2.5 Data for evaluation

Annual surveys in the first and last years of *Suaahara II* will serve as baseline and endline surveys as they will capture all population level impact and outcome indicators listed in the IPTT. They will be designed to measure change in indicators over the life of the program, comparing this change to the targets set for each indicator. The surveys will be powered such that data can be disaggregated, and indicators tracked, by 'mature' and 'new' districts. In years between the baseline and endline, annual surveys will assess the extent to which anticipated changes in population level outcome indicators required to improve nutritional status are taking place. These annual surveys will also be powered such that the data can be disaggregated into at least two strata of 'mature' and 'new' districts. For the baseline survey, we estimate a sample of about 3,600 households. Baseline prevalence of key indicators, desired minimal detectable change over time, a design effect, power, and alpha will all be taken into account.

Although the annual surveys will show changes over time in *Suaahara* areas, the lack of a counter-factual in the design will make it challenging to attribute these changes to the intervention. To facilitate the highest likelihood of attribution of changes seen over time to the *Suaahara* program, an endline impact evaluation survey is planned for rainy season of 2020. This survey will follow the same quasi-experimental impact evaluation design, set up by IFPRI in 2012, will be used. Since the endline for 2015/2016 was canceled, this same design can be used at the end of *Suaahara II* to evaluate the effect of *Suaahara* on health and nutritional changes between 2012 and 2020. This study design involved matched pairs of 8 intervention districts and 8 comparison districts; within each district, 5 VDCs and 3 wards per VDC were randomly selected using probability proportional to size techniques. The original plan was a double matching: matching of districts at the time of design and matching of households at the time of analysis. Given natural disasters, political turmoil, and the reselection of some comparison districts as intervention districts, the matching will need to be reassessed and econometric techniques used to ensure the highest likelihood of attribution of changes in behaviors and health and nutritional status to *Suaahara*.

To complement the annual surveys, a qualitative mid-term evaluation will be done to evaluate the program in terms of relevance, effectiveness, efficiency, and sustainability, and progress towards meeting program objectives:

- **Relevance:** To what extent are the *Suaahara II*'s objectives and methods still appropriate to the improvement of nutrition outcomes among women and children in intervention areas?

- **Effectiveness:** What are the major factors that have contributed to or prevented progress to date?
- **Efficiency:** Are project resources being used efficiently or could the same results have been achieved with fewer resources or alternative approaches?
- **Sustainability:** To what extent is the program bringing about sustainable changes? To what extent are the approaches being integrated into GoN systems, and/or have GoN buy-in to continue their operation beyond the life of the program? What are the key risks longer-term sustainability and what can be done to reduce these risks over the remainder of the program?

2.6 Data for research

Formative research will be conducted to inform the development of new and revised interventions, including SBCC messages and strategies. A full formative research plan is being drafted with implementing partners, but an indicative list of the themes and areas to be covered are as follows:

- Knowledge, attitudes and motivating factors relevant to adolescent nutrition and reproductive health, to inform the development of adolescent friendly health services
- Rapid assessments of hard to change practices in *Suaahara 1*, such as sick child feeding, animal source food consumption, hand washing and water treatment, and post-partum care-seeking
- Barrier analysis to identify the determinants that affect seeking of health and nutrition services by the different household members and adoption of key practices.
- Research to gain insights on gender inequalities particularly around decision-making on health, nutrition, agriculture, use of household income and resources, and workload distribution.

Several Operations Research activities are planned over the life of the program, w to answer key operational questions that will both shape future program delivery in Nepal and contribute to global evidence around the implementation of health and nutrition programs at scale. This will be done in partnership with the International Food Policy Research Institute (IFPRI), a group of global leaders in the delivery of high quality research around nutrition, agriculture and health systems.

An Operations Research Steering Group, chaired by the *Suaahara II* STA and consisting of representatives from GoN, USAID, IFPRI, HKI, implementing partners and others with relevant expertise in agriculture, nutrition, and health, will oversee the development and implementation of the Operations Research Strategy. This group will shape the specific questions to be answered through the research; review and support the development of study protocols; support and provide input to analysis of research data; and lead the dissemination of study findings.

Indicative themes to be explored through operations research are as follows:

1. What impact does a targeted package of adolescent health and nutrition interventions (micronutrients, nutrition SBCC, menstrual hygiene) have on nutrition behaviors and nutritional status of adolescent girls (10 to 19 years of age)?

2. What sustainable innovations and performance incentives can be introduced to drive improvements across health and nutrition services?
3. What indicators can be used to assess health system readiness and quality of health services?
4. What are effective social behavior change strategies in terms of number of points of contact with 1000 days women; number of family members involved and supporting her; a simplified package of messages with doable actions)

The Operations Research Strategy will be further developed in year one and will be included as an Annex to an updated version of this MER plan.

In addition to the formative research and operations research activities, several other research activities are planned, particularly focused on GESI (e.g. time diaries to understand women's workload); agriculture (e.g. linkages with anemia; program impact pathways from inputs to outcomes, including the income pathway; and Kyangkong and OFSP specific studies); and WASH (e.g. water treatment, marketing of WASH products).

2.7 Data limitations and ethics

All data sources will have some standard, known threats to their validity. Surveys will be subject to social desirability biases – i.e. where respondents say what they know to be the 'right' answer, rather than providing an answer that reflects the reality of a situation. Monitoring data may contain inaccuracies that result from human error or, in some cases, from attempts to deliberately misrepresent a situation. However, the data quality checks (see relevant section of this document) will greatly reduce these risks and ensure that data collected and used is of high quality.

All data collected for *Suaahara* will uphold the highest ethical standards, including but not limited to applying for and receiving ethical clearance from the Nepal Health Research Council (NHRC), informed consent prior to data collection, and anonymity. Several measures will be taken to ensure that data management and safeguards are maintained to the highest level.

Strategies to Safeguard Participant Confidentiality

The program will aim to ensure confidentiality and protect personal identity information, both in hard copy and digital files. Manual records (paper files) collected from the field will be kept in file cabinets and clearly labelled or coded with the date, place of data and name of the responsible person name. Access to these original/hard data records will be limited to *Suaahara* personnel responsible for the processing of monitoring data. For digital files, the database will only have ID-based look-up functions rather than by beneficiary name; sensitive information will be de-identified and stored outside of the routine monitoring database in a separate database; and digital data collection devices will be password protected with user access restrictions where data collectors cannot access the data after uploading.

System Storage of Information

Databases will be backed up regularly, with multiple copies kept in safe locations. Automated back-ups will be scheduled and managed by HKI's Information Technology (IT) Manager. Raw data will be permanently deleted at the end of the

award. Methods, frequency and locations of file and database backup will be as follows:

- Database backup will be weekly onto a network attached storage (NAS) drive;
- Back-up tools will be used for weekly digital data backups;
- All project staff in district offices with computers will be backed-up to the central drive weekly; and
- Staff with computers in other field offices without regular internet connectivity will back-up to a *Suaahara II* external hard disk using Second Copy software on a weekly basis.

The *Suaahara II* MIS Coordinator will have the primary responsibility of keeping the DHIS2 database secure. The *Suaahara II* MIS Coordinator and M&E Manager will be responsible for editing and keeping the database up to date. Users will be granted different levels of access to track changes. All DHIS2 dashboards will be password protected, with access controlled centrally.

ICT Equipment/System Security

Some of the measures HKI takes in ensuring safety and security of the ICT equipment are listed below:

- All computers will have the latest antivirus installed and updated with the latest definitions;
- All laptop users are supplied with back packs, which are suitable for carrying the laptops as they are equipped with padding to prevent damage if accidentally dropped;
- A cleaning kit is in place for physical cleaning of computer hardware;
- Installation of non-HKI approved software is restricted;
- Windows and other software updates are enabled on all computers to prevent malware infections; and
- Staff are advised to always keep their offices locked when they leave the office.

2.8 Data quality assurance

All M&E data will conform to five principles of high quality data: validity, precision, reliability, integrity, and timeliness. To ensure these principles are met, data quality audits will be conducted at least twice each year. Procedures will be put in place check the quality of survey data and a monthly data verification process with field supervisors, will be used to review their submitted data and identify areas for improvement.

Data quality audits

We will conduct data quality audits (DQA), in collaboration with all implementing partners, for various aspects of our MER system at least twice per year of implementation. In each DQA, we will focus on a selection of indicators, based on their relevance to each partner. The DQA process will assess data collection tools, the skills and capacities of those collecting data, the consistency with which

definitions and protocols are followed, and how data is managed, aggregated, and reported.

Each DQA will begin at the lowest level of aggregation of the indicator being assessed, and will review the forms and tools used to collect data. A small sample of field staff will be interviewed on their understanding of the indicator and the data elements needed to calculate the indicator. A selection of field supervisors will be interviewed to establish data quality issues on an ongoing basis. Where, appropriate, roles further up the reporting chain (e.g. at the District level) will be interviewed to understand how data is received, stored, aggregated and reported.

A summary of the DQA process to be followed is provided in the table below.

DQA Process Steps	Indicative Areas of Inquiry
1. Review recommendations from any previous DQA conducted.	<ul style="list-style-type: none"> · Have recommendations been actioned? · Which recommendations have not been actioned and why? · Is there a clear plan and timeline in place to action these? · Are there clear lines of responsibility for taking the actions recommended?
2. Assess the data collection systems and processes	<ul style="list-style-type: none"> · Does a reporting calendar exist? · Is there evidence of data quality discussions within the organization? · Does data collection process align with indicator definition(s)? · Is data appropriately transferred from the field to first level of aggregation, second level and so forth? · Does a random sample of data collected centrally align with the found in the field office?
3. Assess qualifications of staff assigned to data collection, analysis and storage	<ul style="list-style-type: none"> · Who are the key people in the M&E team that have direct or indirect relationship with the data collected? · Are people assigned to each task appropriately trained for the role? · Are M&E staff aware of official data collection methodology as described in the PIRS?
4. Assess the data storage systems	<ul style="list-style-type: none"> · Are key data files password protected? · Who has authorized access to the data and is this access appropriate to their role(s)? · How clearly are files stored and archived? · How vulnerable are the electronic systems to breaches of confidentiality and/or major loss of data?
5. Conduct a field visit	<ul style="list-style-type: none"> · What are the field based challenges that data collectors/providers face? · How are these challenges being met? · Are there solutions to those challenges from other sites or implementing partners that can be applied to this context?
6. Review data compliance	<ul style="list-style-type: none"> · To what extent does the data collected meet the standards of: <ul style="list-style-type: none"> * Validity

DQA Process Steps	Indicative Areas of Inquiry
7. Complete the DQA checklist for each indicator	<ul style="list-style-type: none"> * Integrity * Precision * Reliability * Timeliness ·Ensure that self-assessment form is completed by implementing partner. An indicative DQA checklist is at Annex 5.
8. Debrief on main findings to implementing partner office	<ul style="list-style-type: none"> ·Clarify any outstanding issues ·Provide initial verbal report back on key findings of DQA
9. Write up DQA report, recommendations and action points for improvement	<ul style="list-style-type: none"> ·Identify all areas that need attention ·Make clear and actionable recommendations ·Agree a timeline with implementing partner for implementation of recommendations

All DQAs will result in a report and action plan, detailing steps that the implementing partner needs to take to strengthen their monitoring data. A follow up assessment will be conducted within 3 months to assess the extent to which the action plan agreed with the implementing partner has been put into place.

Quality assurance through data collection mechanisms

Household checklist data and all survey data will be collected digitally, using pre-programmed applications loaded onto tablets and/or mobile devices. Pre-programmed applications greatly limit the risk of data entry errors and incomplete data through controls placed on the data at point of entry. They record start and end times of data collection and GPS points for data collection sites, reducing risk of enumerator falsification. Finally, digitally collected data allows for the pre-establishment of possible ranges and skip patterns, decreasing errors in data collection.

Quality assurance through checks on data collection procedures

In addition to the quality assurance checks that will be a compulsory part of all data collection contracts issued by HKI, all survey data will be subject to monitoring by the project M&E team. The *Suaahara* monitoring team will ensure that:

- All routine DQA checks are being followed correctly;
- Enumerators are following study protocols and that there is no falsification of data;
- Study instruments are used correctly; and
- That data meets the quality standards

Where conduct and/or data is not found to meet agreed quality standards, data collection agencies will be required to repeat data collection.

The MER and district teams will make spot check visits to households from which Field Supervisors are providing monitoring data to verify the information provided and to help understand the accuracy of household monitoring data.

Data verification process

Data verification processes will include a monthly review of data from field supervisor reports, field books, and monitoring checklists. A data verification log will be used to record data quality issues, aiming to improve program reporting from the districts. The data verification findings will be shared regularly during staff and review meetings.

2.9 Data analysis and reporting

Key data points gathered will be analyzed and synthesized appropriately for various types of reporting, including the semi-annual progress reports and annual performance reports for USAID. *Suaahara II* will also report final annual performance monitoring results each year into the USAID AID tracker system. These key data points on program implementation and monitoring data will be collected through various sources. All of the data will be reported through, the DHIS2 information system. **Table 1** summarizes the data flow for routine monitoring data.

Table 1. Monitoring Data Flow

Program Level	Process and Responsible Person(s)	Reporting Tools
PNGO to District	At first cross verification of monthly reports among Field Supervisors will be done and Field Coordinators will verify reports submitted by Field Supervisors prior to data entry.	Routine Monitoring Training Supervision Checklist HFP Input Database Data Verification Log Integrated Home Visit Checklist Activity Monitoring Tools Beneficiary Profile Quality Standards Quarterly Reporting template
	After submission of monthly data by PNGO, thematic persons at district level will verify respective theme wise data at PNGO and will maintain data verification log and report to DC.	Reporting Tools Case Study Data Verification Log Program Quality Standards Checklist
Data Submission and Verification	PNGO to District: 28 th of each month: Complete data entry. 30 th of each month: data submission to district. 3 rd of next month: Data verification by thematic person at PNGO level	
District to Center	District Coordinators will verify data entered by thematic persons. Thematic persons will collect data periodically	Reporting Tools Project Activity Reports Case Study Data Verification Log Progress Report Exit Client Interview Checklist Training Supervision Checklist HFP input database Health Facility Monitoring Checklists

Program Level	Process and Responsible Person(s)	Reporting Tools
		DQA Findings HMIS/LMIS Indicators Beneficiary Profile Quality Standards Quarterly Reporting template
Data Submission and Verification	District to Center: 4 th of next month: District data verification by District Coordinators 7 th of next month: District data verification by thematic person and M&E Manager 10 th of next month: Data submission district to center	
Central	M&E Manager and MIS Coordinator will verify district level data entered by District Coordinators.	Reporting Tools MIS Case Study HFP Input database Partner Progress Report DQA Findings HMIS/LMIS Indicators Beneficiary Profile Quality Standards

Monitoring data

Dimagi, will expand the use of smartphone technology to improve service delivery and monitor program implementation for prioritized activities. Dimagi will use the most mature and rapidly expanding mobile platforms, CommCare (www.commcarehq.org) that will be installed on smart phones, used by Field Supervisors. The CommCare platform includes registration forms for tracking beneficiaries by sector. Monitoring data from each user will be sent to a central cloud server, where it will be privacy-protected and accessible only to relevant users. Real time data on coverage and services will include GPS coordinates of households. Reports will be automatically generated on the activity level of FLWs and the coverage of 1000-day households. In each district, the DMDOs and Field Coordinators will review and cross-verify FS activities on a monthly basis when the FS submit their activities via CommCare and paper tools to their respective PNGOs. This is essential to monitor program coverage and can assist the project team in better targeting visits to improve integrated nutrition behaviors. CommCare will be integrated into DHIS2 using the application interface called MOTECH.

All routine monitoring data, including but not limited to that collected via CommCare, will be held in DHIS2, which allows data to be aggregated and disaggregated at various levels. DHIS2 is an open source, web-based, information system that promotes the use of monitoring data through bringing key data points together in a dashboard format using engaging visuals and graphics to facilitate interpretation and use. Multiple dashboards will be created for different aspects of the program and for different audiences including *Suaahara* II Kathmandu-based staff, PNGO staff, GoN partners, and so on. In DHIS 2, data can be aggregated, disaggregated, and presented at various levels (e.g. national and district). DHIS2 is being rolled out as the national HMIS in Nepal from in 2017. We will work with the GoN to identify how the DHIS2 system for *Suaahara* II may be designed to complement and/or to allow for eventual integration with the HMIS system in the 15 handover districts. All

PNGOs and district teams, particularly the DMDOs and DCs, will be responsible for providing all district-specific data from their districts, as needed for the DHIS 2. DHIS2 also allows for the combination and overlaying of data sources to facilitate insight and interpretation. Data will be presented through a number of bespoke program dashboards, including a series of pre-programmed charts, graphs, and tables. These dashboards will form the basis of monthly program reviews and will facilitate data driven decision-making.

DHIS2 dashboards are web-based and accessed via a password protected portal. USAID, GoN, and other stakeholders can be granted access to dashboards to view real time monitoring of program performance. Capacity will be built among *Suaahara II* partners so that dashboards can be updated, refined, and improved. Data can be presented in different formats, new data can be introduced, and data points can be combined and aggregated/disaggregated in different ways, according to needs identified. **Figure 3** provides an example of a program dashboard created through DHIS2, and is indicative of project dashboards that will be created for *Suaahara II*.

Figure 3: Example DHIS2 Program Dashboard



Data from annual surveys and HFP surveillance surveys will be analyzed by the *Suaahara II* M&E team. Survey data will be analyzed and reported on within three months of the completion of data collection. Prior to data collection for each survey, a detailed analysis plan will be developed. Findings will first be shared among implementing partners and then reported to USAID, GoN, and other stakeholders, through presentations and learning workshops. These workshops will be used to identify key trends, areas for follow up, and programmatic action points. It will also be used to identify where further analysis may of value, and to develop any additional data points that should be collected in future rounds of annual surveys.

The program will follow the Government of Nepal's reporting period, i.e. July to July. The program will report to USAID as follows:

Semi-Annual Progress Reports

The Semi-Annual Progress Report will contain information on actual accomplishments against targets set for the period; reasons for deviation (if any); anticipated future problems, delays, or conditions that may affect implementation; management; security; and the status of finance and expenditures; and so on. These reports will be submitted within 30 days of the completion of the reporting period.

Annual Performance Reports

The Annual Performance Reports will contain results from analysis of quantitative monitoring data including information on progress toward meeting the targets, reasons for deviations (if any) and data quality concerns (if any). The report will also include information on management issues, lessons learnt and success stories, major challenges and constraints faced during the reporting period, an overview of the next year's programs, the status of finance and expenditures, and so on. These reports will be submitted within 45 days of the end of the reporting period. After finalization of annual performance reports, *Suaahara II* will report performance results in USAID AIDtracker system in coordination with AOR as appropriate.

Performance Plan Report

The Performance Plan Report is an indicator data collection template, which includes information on the type of indicator, indicator title, definition, calculation of indicator, primary use of the indicator, data source, data availability, who will likely use the data, known data limitations, and explanations. The project will submit to USAID a performance plan report by mid-October each year.

Final Report

The Final Report will include the overall program strategy, history and operating context, reach, scale, activities, and outputs under each intermediate result, cross cutting program activities, program targeting, and impact. Lastly, the report will include annexes that include the IPTT, site visits during evaluation, evidence-based recommendations and tables of accomplishments per intermediate results and budget and cash expenditures by year. The program will submit this Final Report within 90 days following the award completion date.

2.10 Stakeholder coordination

The program will actively participate in the GoN's multi sector working groups, Sajedhari Governance program, Swachchhata Project, POSHAN, and other USAID programs such as KISAN, PAHAL, Sabal, and Health for Life to share information and learnings generated by our monitoring, evaluation, and research activities.

Additionally, the program will jointly organize semi-annual consultative meetings with key technical staff from each project and with key stakeholders at the district level to share implementation successes, challenges, and best practices. Key stakeholder consultations at the district level will optimize communication and coordination.

PAHAL research will also be of value to the program in similar locations, particularly findings from their market assessment/knowledge, attitudes, and practice (KAP) study on GESI-related barriers to goods, services, and employment opportunities; and mapping and review of technical training service providers in business development of private sector and government services at the district level. Learning

from their on-farm research will also be extremely useful—‘Market assessment of crop and livestock potential’; mapping of existing and potential agriculture traders, aggregators, processors and exporters; and farmer and business-focused assessment on key market infrastructure needs and constraints.

The program will also closely work with USAID’s Feed the Future Nutrition Innovation Lab (NIL). HKI is a key in-country partner of Tufts University, the NIL’s management entity, and closely collaborates with Johns Hopkins University (JHU), which leads the nationally representative population-based panel studies as part of the NIL-supported POSHAN activities. HKI will continue this partnership to conduct analyses of POSHAN data, examining trends over time in exposure to interventions; nutrition, WASH, and agricultural practices; agricultural production; and nutritional status and to apply learnings from NIL research to strengthen the program approaches. The program will also work with the NIL to examine differences in key indicators by *Suaahara* vs. non-*Suaahara* districts. POSHAN data have also identified institutional and individual capacities needed to support complex programming aimed at accelerating national nutrition gains and the importance of focusing on reinforcing engagement and coordination at the regional and district levels. There will be two more rounds of the policy and population based studies, in 2016 and 2018, and data will be analyzed for additional programmatic lessons. These data will continue to provide information on the gaps in knowledge, coordination and effective nutrition programming among multi-sector line ministries, and nongovernment organizations.

The results of the food safety component (mycotoxin contamination of the food supply) of the NIL’s mycotoxin study will significantly enhance the program’s understanding of risks from food-borne contaminants in farming, food processing, and household and community storage practices, and how these can be mitigated by *Suaahara II* field.

At the national level, the program will collaborate with the National Planning Commission, Child Health Division and Family Health Division to develop performance tools to assess the capacity of districts to deliver quality nutrition services in the handover districts in years one and two. At the District level, the program will coordinate with Government health staff in the assessment and handover process. Government health staff include Public Health Nurse, Family Planning Supervisor, Nutrition focal person, IMNCI focal person, Expanded Program for Immunizations (EPI) and the District Health Officer (DHO). The Maternal Newborn Child Health/Gender and Social Inclusion (MNCH/GESI) Officer, Deputy Chief of Party and Senior Technical Advisor will be responsible for coordinating the process.

Additionally, we will jointly organize semi-annual consultative meetings with key technical staff from each project and key stakeholders and Government stakeholders to share research, implementation successes, challenges and best practices.

2.11 Capacity building

This MER plan outlines the framework for the implementation of a complex MER system that serves all implementing partners. As such, all implementing partners

need to be equipped with the skills, knowledge, and ability to deliver against objectives and to understand and interpret the data that comes from the M&E system.

Part of this will be delivered through the collective development of tools, data collection procedures, and quality arrangements, ensuring that all implementers have a good understanding of the range of data being collected and their role in the process. An initial workshop was held with all implementing partners at the end of May 2016 to establish data needs and review and refine the program logical framework, which is the basis for monitoring activities throughout the life of the program. MER-related capacity gaps will be identified and addressed through staff mentorship and supervision. Additional training and capacity building will be done based on needs and challenges. New staff that join the MER team (across all implementing partners) throughout the life of program will receive formal orientation on the MER system, procedures and all reference documents.

At the community level, *Suaahara II* will improve the record keeping by FCHVs to track pregnancies and referrals during health facility and outreach clinic visits, thereby improving the HMIS system. This information will be used to monitor the number of contacts and type of service utilized during the 1,000-day period. At the district level a formal list of criteria and best practices in nutrition service delivery and quality standard tools for all activities will be developed.

A key priority in year 1 of the program will be to build DHIS2 capacity across implementing partners. This will be done through intensive training of a few core MER team members through attendance at DHIS2 'academy' training (held periodically throughout the year in various locations across south and southeast Asia), conducted by the University of Oslo and partners. This will be supplemented through on the job training by a DHIS2 consultant, throughout the design and implementation of the DHIS2 information system. The interim data management strategy will be done through excel from August 2016 to January 2017.

This core expertise will serve as a resource for all implementing partners, providing support and training on the use of DHIS2, data entry procedures, creation of dashboards, and other routine adaptations of the system. At the district level, where NGO partners will need to be trained on data entry into DHIS2, we will look to partner with GoN offices, each of which has a Statistical Officer trained in data entry into DHIS2 for the HMIS system. We will also supplement this with formal training, when and where required.

2.12 Learning and adapting

The scale and scope of the *Suaahara II* program offers an unprecedented opportunity for learning about the implementation of multi-sector health and nutrition programs and innovations to drive improvements in health outcomes, both in Nepal and across low and middle income countries. The consortium values analytical thinking to drive our understanding of program performance and where program activities can be adjusted to improve health outcomes. As such, we envisage routinely asking questions to improve the program such as:

- i. What is the coverage of FCHVs and other contact points that are hypothesized as driving behavior change? Who is being reached, where, how and why?
- ii. Where do we continue to see gaps between DAG and non-DAG populations, and where is there evidence of this gap being closed?
- iii. Which behaviors do we seem to be impacting upon, and which appear to be proving more resistant to change, and why?
- iv. Are targeting strategies proving successful in directing program activities and inputs to populations most in need?
- v. Where is there scope for greater efficiency in implementation?
- vi. For HFP households, what are production patterns and what is driving these? How are households using produce, what income is being generated and how is that income being used?
- vii. What are differences between mature and new districts and between food secure and food insecure areas in terms of health, nutrition and WASH behaviors and agricultural production outcomes?
- viii. What are the factors that seem to be facilitating or working as barriers to behavior change?
- ix. What is the capacity of health systems to deliver NACS, CB-IMNCI and Family Planning services in regards to skills and knowledge?
- x. How are those districts where implementation will be handed over to GoN performing, and what are the areas where further capacity and support is needed, prior to handover?
- xi. What are appropriate methods to reach adolescent girls attending schools and peers to reach out of school adolescents? What information needs is there among the adolescent girls? Which messages are more important and observed by the adolescents? What are the factors associated with the knowledge transfer from school adolescent girls to the out of school adolescent?
- xii. What organisms present in stool tests and hand swap tests cause diarrhea?
- xiii. How are health facilities improving water, sanitation and hygiene (WASH) services in health care facilities in order to ensure clean and safe facilities for staff and patients?
- xiv. What are potential cost implications to Government of Nepal in taking on the component parts of the program and which areas of intervention are driving costs?
- xv. What are the motivations and barriers to use of VDC block grants for community nutrition activities targeting women and children?

The senior program management group will review data on an ongoing basis and hold quarterly meetings with implementation partners to review monitoring data, with a view to identifying opportunities for innovation and areas where program strategies and activities can be strengthened. The DHIS2's ability to combine different data

sources into dashboards in real time and visually display this information addresses key barriers to learning from program monitoring data, i.e. access to data in a format, and with the required timeliness, that facilitates analytical thinking about program activities.

2.1 Monitoring, Evaluation and Learning budget

	Key M&E Tasks	Tentative Budget					Total
		Y1	Y2	Y3	Y4	Y5	
1	Tools and templates design & printing						\$8,000
2	Data Quality Audits						\$20,000
3	Annual surveys and Endline evaluation*						\$1,200,000
4	Programming assessments and data quality audits in 15 handover districts						\$30,000
5	DHIS-2 Consultant						\$70,000
6	Training and roll out of CommCare, DHIS2 and MIS						\$220,000
7	Formative Research (literature reviews and data collection/analysis (e.g. adolescent nutrition and reproductive health; sick child feeding, animal source food consumption, hand washing and water treatment, and post-partum care-seeking; care seeking; GESI)						\$50,000
8	Qualitative Mid-Term Assessment (to complement the annual surveys)						\$50,000
9	Field Costs for research studies (Field Researcher Travel Allowance/Daily Service Allowance, Human Resources, Travel, Training of field enumerators, translation)						\$250,000
10	Stata, SPSS, GIS, etc.						\$13,000
11	Mobile phones for data collection (650)						\$64,000
Sub-total (HKI)							\$1,975,000
1	CommCare Consultant (Dimagi)						\$500,000
2	Operations research (IFPRI) - Adolescent health & nutrition - Health services - Handover standards - TBD (e.g. WASH interventions and diarrheal episodes; effective SBCC strategies)						\$2,000,000
Sub-total (Sub awards)							\$2,500,000
TOTAL							\$4,475,000

* The endline evaluation costs will be based on study design and may require additional funds; the budget will be updated and adjustments made to accommodate this requirement to evaluate *Suaahara*.

3. ANNEXES

3.1 Annex 1: Summary of Indicators Performance Tracking Table (IPTT)

Notes relevant to reading the IPTT:

- i. Baseline figures and subsequent targets for *Suaahara* II will be revised once DHS 2016 results are published.
- ii. Baseline and endline surveys will be powered to measure change between those two points in time, whereas annual surveys will be primarily used for monitoring to track indicative changes in intervention areas.
- iii. Baseline estimates taken from the 2015 *Suaahara* (1) survey are indicative and apply only to districts surveyed in 2015, and not to the full range of districts where interventions will be implemented from 2016. We will revise baselines for both 'mature' and 'new' districts once baseline data has been collected in 2016.
- iv. Where values are TBD, baseline values will be set through the *Suaahara* II baseline survey, unless otherwise specified in the Data Source column.
- v. Where reference is made to 'mature' and 'new' districts, mature districts are those that participated in the initial roll out of *Suaahara* I and where implementation has been in place for a number of years. New districts are those where implementation began towards the end of *Suaahara* I, and new districts for *Suaahara* II

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
1	Impact 1	Prevalence of stunted children under 5 years of age	Impact	Gender, Age	MICS 2014; Suaahara II annual surveys	37.4%					29.9%
2	Impact 2	Prevalence of underweight children under 5 years of age	Impact	Gender, Age	MICS 2014; Suaahara II annual surveys	30.1%					< 20%
3	Impact 3	Prevalence of wasted children under 5 years of age	Impact	Gender, Age	MICS 2014; Suaahara II annual surveys	11.3%					<5%
4	Impact 4	Prevalence of anemia among children 6-59 months of age	Impact	Gender, Age	DHS 2011; Suaahara II annual surveys	46.2					41.2
5	Impact 5	Prevalence of low birth-weight	Impact	Gender, Age	MICS 2011; Suaahara II annual surveys	24.2%					<19.4%
6	Impact 6	Prevalence of underweight among women of reproductive age	Impact	Age, Pregnancy status, Caste /Ethnicity	DHS 2011; Suaahara II annual surveys	18.2%					13.0%
7	Impact 7	Prevalence of anemia among women of reproductive age	Impact	Age, Pregnancy status, Caste /Ethnicity	DHS 2011; Suaahara II annual surveys	35.0%					30.0%
IR1: Improved Household Nutrition and Health Behaviors											
Outcome 1.1: Households adopt essential nutrition actions including maternal nutrition, infants and young child feeding											
8	IR 1.1.1	Prevalence of exclusive breastfeeding of children under six months of age	Outcome	Gender, Age, Wealth quintile	MICS 2014; Suaahara II annual surveys	56.9%	61.0	65.0	69.0	73.0	77.0%
9	IR 1.1.2	Prevalence of children 6-23 months of age receiving minimum acceptable diet	Outcome	Gender, Age, Wealth quintile	MICS 2014; Suaahara II annual surveys	31.9%	36.0	40.0	44.0	48.0	52.0%

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
10	IR 1.1.3	Percent of children 6-23 months of age receiving foods from 4 or more groups during the previous day	Outcome	Gender, Age, Wealth quintile	MICS 2014; <i>Suaahara</i> II annual surveys	37.0%	42.0	47.0	52.0	57.0	62.0%
11	IR 1.1.4	Percent of children 6-23 months of age consuming iron-rich foods during the previous day	Outcome	Gender, Age, Wealth quintile	DHS 2011; <i>Suaahara</i> II annual surveys	24.1%	28.1	32.1	36.1	40.1	44.1%
12	IR 1.1.5	Percent of sick children 6-23 months of age fed more during and after their illness	Outcome	Gender, Age, Wealth quintile	MICS 2014; <i>Suaahara</i> II annual surveys	10.6%	12.5	14.5	16.5	18.5	20.5%
13	IR 1.1.6	Women's Dietary Diversity: Mean number of food groups consumed by women of reproductive age	Outcome	Wealth quintile, Urban/Rural	<i>Suaahara</i> 1 LQAS data 2016; <i>Suaahara</i> II annual surveys	4.9	5.0	5.1	5.2	5.3	5.4
14	IR 1.1.7	Percent of women consuming all 180 tablets of IFA during pregnancy	Outcome	Age, Caste/Ethnicity	MICS 2014; <i>Suaahara</i> II annual surveys	41.1%	45.0	49.0	53.0	57.0	61.0%
15	IR 1.1.8	Percent of adolescent girls (10-19 years) eating iron rich foods in the previous day (MSNP)	Outcome	Age, Caste/Ethnicity	N/A; <i>Suaahara</i> II annual surveys						
16	IR 1.1.9	Number of people trained in child health and nutrition through USG supported programs	Output	Gender, health and nutrition training separately	N/A; Training Records		37171	27756	19232	0	0

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
17	IR 1.1.10	Number of pregnant women reached with nutrition interventions through USG supported programs (in thousands)	Output	IFA supplementation, age	N/A; Activity Reports		351.6	351.4	351.1	351.0	350.90
18	IR 1.1.11	Number of children under five (0-59 months) reached by USG supported nutrition programs (in thousands)	Output	Gender, Vitamin A received,	N/A; Activity Reports		1275	1275.1	1275.2	1275.3	1275.4
19	IR 1.1.12	Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs (in thousands)	Output	Gender,	N/A; Activity Reports		516.1	516.3	516.6	516.8	517
Outcome 1.2: Households adopt essential WASH actions											
20	IR 1.2.1	Percentage of children under age five who had diarrhea in the prior two weeks	Outcome	Gender, Urban/Rural, Access to improved WASH	MICS 2014; Suaahara II annual surveys	12.0%	11.6	11.2	10.8	10.4	10.0%
21	IR 1.2.2	Percent of households using an improved sanitation facility	Outcome	Urban/Rural,	MICS 2014; Suaahara II annual surveys	60.1%	64.1	68.1	72.1	76.1	80.1%
22	IR 1.2.3	Percent of households using an improved drinking water source	Outcome	Urban/Rural	Suaahara 1 LQAS data 2016; Suaahara II annual surveys	86.0%	87.0	88.0	89.0	90.0	91.0%
23	IR 1.2.4	Percent of households in target areas practicing correct use of recommended household water treatment technologies	Outcome	Urban/Rural Technology types	MICS 2014; Suaahara II annual surveys	18.2%	22.2	26.2	30.2	34.2	38.2

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
24	IR 1.2.5	Percent of households with soap and water at a handwashing station commonly used by family members	Outcome	Urban/Rural	<i>Suaahara</i> 1 LQAS data 2016; <i>Suaahara</i> II annual surveys	57.0%	61.0	65.0	69.0	73.0	77.0%
25	IR 1.2.6	Percent who practices handwashing at 6 critical times	Outcome	Urban/Rural	<i>Suaahara</i> 1 LQAS data 2016; <i>Suaahara</i> II annual surveys	31.0%	35.0	39.0	43.0	47.0	51.0%
26	IR 1.2.7	Number of communities (VDCs) certified as 'open defecation free' (ODF) as a result of USG assistance	Output	None	N/A; Activity Reports		20	27	30	9	0
27	IR 1.2.8	Number of individuals trained to implement improved sanitation methods	Output	Gender	N/A; Training Records		2180	4100	1100	0	0
28	IR 1.2.9	Number of schools with girl friendly facilities	Output	None	N/A; Activity Reports		0	240	240	240	120
29	IR 1.2.10	Number of cases of child diarrhea treated in USG-assisted program (in thousands)	Output	Zinc and ORS, ORS only	HMIS HMIS	1,265.3	1,240.0	1,215.2	1,190.9	1,167.1	1,143.8
30	IR 1.2.11	Number of people educated on tools, approaches, and /or methods for water security, integrated water resource management, and /or water source protection as a result of USG assistance.	Output	Gender	N/A; Training Records		0	700	700	0	0

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
31	IR 1.2.12	Number of action plan implemented for water security, integrated water resource management, and /or water source protection as a result of USG assistance.	Output	None	N/A; Activity Reports		0	20	50	50	0
IR2: Increased Use of Quality Nutrition and Health Services by Women and Children											
Outcome 2.1: Improved capacity of health service providers to do nutrition assessment, counseling and support											
32	IR 2.1.1	Percent of pregnant women weighed in most recent ANC visit	Output	Caste/ Ethnicity, Urban/ Rural	DHS 2011; Suaahara II annual surveys	58.0%	62	66	70	74	78.0%
33	IR 2.1.2	Percent of children under two years of age weighed in the past month	Output	Caste/ Ethnicity, Urban/ Rural	Suaahara II annual surveys		TBD	TBD	TBD	TBD	TBD
34	IR 2.1.3	Percent of health service providers knowledgeable regarding accurate assessment of weight gain during pregnancy	Output	Level of health service provider	Health facility survey		TBD	TBD	TBD	TBD	TBD
35	IR 2.1.4	Percent of health service providers knowledgeable about accurate diagnosing of growth faltering (inadequate weight gain) in children under two years of age	Output	Level of health service provider	Health facility survey		TBD	TBD	TBD	TBD	TBD
36	IR 2.1.5	Percent of health service providers knowledgeable about accurate diagnosis of severe and moderate acute malnutrition (SAM/MAM) in children under five years of age	Output	Level of health service provider	Health facility survey		TBD	TBD	TBD	TBD	TBD

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
37	IR 2.1.6	Number of health facilities, including NRCs, who received training in management of acute malnutrition (SAM/MAM), in the previous year.	Output	None	N/A; Activity Reports		5	5	4	0	0
Outcome 2.2: Increased accessibility and quality of outreach nutrition and health services for women, children, adolescent girls and disadvantaged group											
38	IR 2.2.1	Percent of births attended by a skilled birth attendant	Outcome	Caste/Ethnicity, Ecological zone	MICS 2014; <i>Suaahara</i> II annual surveys	55.6%	60	64	68	72	76.0%
39	IR 2.2.2	Percent of newborns receiving postnatal health check within 24 hours of birth	Outcome	Caste/Ethnicity, Urban/ Rural	MICS 2014; <i>Suaahara</i> II annual surveys	58.0%	62	66	70	74	78.0%
40	IR 2.2.3	Number of newborns receiving postnatal health check within 24 hours of birth	Outcome	None	HMIS HMIS	159,071	167,025	175,376	184,145	193,352	203,019
41	IR 2.2.4	Percent of births receiving at least 4 antenatal care (ANC) visits during pregnancy	Outcome	Urban/rural	MICS 2014; <i>Suaahara</i> II annual surveys	59.5%	63.5	67.5	71.5	75.5	79.5%
42	IR 2.2.5	Percentage of 1000-day households who had contact with the FCHV in the previous month	Outcome	Caste/ Ethnicity	N/A; <i>Suaahara</i> II annual surveys		TBD	TBD	TBD	TBD	TBD
43	IR 2.2.6	Number of districts with CB-IMNCI programs scaled up, supported by USG	Output	None	N/A; Activity Reports		2	4	4	0	0
44	IR 2.2.7	Number of HFOMCs who have been engaged in a QI process	Output	None	N/A; Activity Reports		0	400	140	0	0
45	IR 2.2.8	Number of children under five years of age with suspected pneumonia	Output	None	HMIS HMIS	419,327	410,941	402,722	394,667	386,774	379,038

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		receiving antibiotics by trained facility or community health workers in USG-assisted programs									
46	IR 2.2.9	Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs	Output	None	HMIS HMIS	18,106	19,917	21,908	24,099	26509	29160
Outcome 2.3: Improved healthy timing and spacing of pregnancy through promotion and more accessible family planning outreach services											
47	IR 2.3.1	Percent of reproductive age women in union who are currently using a modern method of contraception	Outcome	Caste/Ethnicity, Urban/Rural	MICS 2014; <i>Suaahara</i> II annual surveys	47.1%	48	49	50	51	52.0%
48	IR 2.3.2	Percent of USG-assisted service delivery points (SDPs) that experienced a stock out at any time during the defined reporting frequency of any contraceptive methods that the SDP is expected to provide.	Outcome	None	LMIS LMIS	20%	19	18	17	16	15.0%
49	IR 2.3.3	Number of people trained in FP/RH with USG funds	Output	Gender	N/A; Training Records		0	400	400	0	0
50	IR 2.3.4	Number of health facilities with FP micro plans	Output	None	N/A; Activity Reports		121	364	83	0	0
51	IR 2.3.5	Percent of USG-assisted service delivery points providing family planning (FP) counseling and/or services	Output	Urban/ Rural	<i>Suaahara</i> 1 LQAS data 2016; <i>Suaahara</i> II annual surveys	85%	86	87	88	89	90.0%

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
52	IR 2.3.6	Percent of audience who recall hearing or seeing a specific USG-supported FP/RH message	Output	Urban/Rural	<i>Suaahara</i> II annual surveys		TBD	TBD	TBD	TBD	TBD
53	IR 2.3.7	Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information, referrals, and/or services during the year	Output	Gender	N/A; Activity reports		2271	2631	3101	TBD	TBD
54	IR 2.3.8	Couple years protection in USG supported programs (in thousands)	Output	None	HMIS HMIS	731	765	799	833	867	901
55	IR 2.3.9	Average stock out rate of contraceptive commodities at family Planning service delivery points	Output	None	Health facility survey		TBD	TBD	TBD	TBD	TBD
IR3: Improved Access to Diverse and Nutrient-rich Foods by Women and Children											
Outcome 3.1: Increased and sustained homestead production of nutrient-rich foods											
56	IR 3.1.1	Percent of households with homestead gardens meeting minimum criteria	Outcome	None	<i>Suaahara</i> 1 LQAS data 2016; <i>Suaahara</i> II annual surveys	19.0%	23	27	31	35	39.0%
57	IR 3.1.2	Mean number of nutrient dense vegetables cultivated by household, in the previous year	Outcome	None	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	2.2	2.5	2.7	3.1	3.3	4
58	IR 3.1.3	Percent of households with chickens	Outcome	None	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	63.0%	66	69.5	73	76.5	80.0%
59	IR 3.1.4	Mean number of eggs produced in the previous month by household	Outcome	None	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	16	16	17	18	19	20

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
60	IR 3.1.5	Percent of households who vaccinate their chickens against Newcastle disease (ND), in the previous year	Outcome	None	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	3.0%	5	9	15	20	25.0%
61	IR 3.1.6	Percent of new 1000 days household who received HFP inputs from VMFs and/or graduated HFP beneficiaries	Output	None	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	25.0%	28	34	39	45	50.0%
62	IR 3.1.7	Number of people trained in homestead food production (HFP)/agriculture (Dhading and Panchthar) (in thousands)	Output	Gender	N/A; Training Records		2	4	7	10	15
63	IR 3.1.8	Number of chicken distributed	Output	None	N/A; Activity reports		52,160	120,000	0	0	0
64	IR 3.1.9	Number of households benefited by chickens	Output	None	N/A; Activity reports		10,216	24,000	0	0	0
Outcome 3.2: Strengthened linkages to KISAN services and to markets for selling surplus homestead											
65	IR 3.2.1	Percent of households with surplus HFP sold (vegetable/egg production) in the past year	Outcome	HFP intensive and non-intensive, Season	<i>Suaahara</i> 1 HFP surveillance; <i>Suaahara</i> II HFP surveillance	12.0%	14	17	20	23	26.0%
66	IR 3.2.2	Percent of households that used revenue earned by selling HFP surplus to purchase nutrient dense food, in the previous years	Output	Food secure, Food insecure	<i>Suaahara</i> II HFP surveillance		TBD	TBD	TBD	TBD	TBD

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
67	IR 3.2.3	Number of VMFs included in KISAN and PAHAL Market Management/ Project Committees	Output	None	N/A; Activity reports		20	20	20	20	20
68	IR 3.2.4	Number of VMFs/households with access to KISAN collection center/MMC (market management committee), Business literacy program	Output	None	N/A; Activity reports		60	60	60	60	60
Outcome 3.3: Increased resilience of communities and households to potential nutrition											
69	IR 3.3.1	Number of VDCs with DRR preparedness plans that include building resilience to nutrition shocks	Output	None	N/A; Activity reports		0	78	0	0	0
70	IR 3.3.2	Number of vulnerable (DAG) VDCs that are benefiting directly from USG assistance based on DRR plan	Outcome	None	N/A; Activity reports		0	78	0	0	0
71	IR 3.3.3	Number of vulnerable VDCs using CVCA tool	Output	None	N/A; Activity reports		0	78	0	0	0
72	IR 3.3.4	Number of DAG VDCs that received training on drought resistance vegetables, (as part of HFP training)	Output	None	N/A; Training Records		216	0	0	0	0
73	IR 3.3.5	Number of small grants made to test innovation to build resilience to nutrition shocks	Output	None	N/A; Activity reports		0	10	15	20	0
IR 4: Accelerated Rollout of Multi-Sector Nutrition Plan (MSNP) through Strengthened Local Governance											
Outcome 4.1: Decentralize MSNP implementation defined and strengthened											

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
74	IR 4.1.1	Number of districts with functioning Nutrition and Food Security Steering Committees that met at least twice in the past per year (MSNP)	Outcome	None	N/A; Activity reports	38	39	40	40	40	40
75	IR 4.1.2	Number of districts meeting program standard performance benchmarks (technical/managerial) for 15 handover districts	Outcome	None	N/A; Activity Reports and/or Operation Research		0	0	15	15	15
76	IR 4.1.3	A national multi-sectoral nutrition plan or policy is in place that includes responding to emergency nutrition needs	Output	None	N/A; Activity Reports		Yes	Yes	Yes	Yes	Yes
77	IR 4.1.4	Percentage of national budget invested in nutrition	Output	None	MoH MoH	6.6%	6.2%	>6	>6	>6	>6%
Outcome 4.2: Nutrition services in 15 Suaahara districts transferred to GON management on services											
78	IR 4.2.1	Number of districts transferred to GoN management per year after year three	Outcome	None	N/A; Activity Reports and/or Operation Research		0	0	15	0	0
79	IR 4.2.2	Number of handed over districts maintaining performance benchmarks in years 3 to 5	Outcome	None	N/A; Activity Reports and/or Operation Research		0	0	0	15	15
80	IR 4.2.3	Number of people trained to assess, plan and manage the MSNP at district level (in thousands)	Output	Gender	N/A; Activity Reports	120	130	170	215	0	0
Outcome 4.3: Improved coordination between sectors, and between GON and MSNP stakeholders											

S.N.	No.	Indicators	Type	Data Disaggregation	Sources of data (BL; annually)	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
81	IR 4.3.1	Number of knowledge sharing activities, exchange visits and dissemination activities among GoN and MSNP-related stakeholders, organized by districts	Output	None	N/A; Activity Reports		5	15	20	25	31
82	IR 4.3.2	Amount of targeted DDC and VDC funds leveraged for health, agriculture, environment, education, and/or GESI activities (in thousands)	Output	None	N/A; Activity Reports	\$591	\$100	\$100	\$100	\$100	\$1,591

(Note: Bold denotes the USAID mandatory indicators) Available sources are used as baseline source. We will update all population level indicators after *Suaahara* II baseline survey results are available.

3.2 Annex 2: Logical Framework

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
IR1: Improved household nutrition and health behaviors			
Outcome 1.1: Households adopt essential nutritional actions including Maternal Nutrition, infant and young child feeding			
	<ul style="list-style-type: none"> • Prevalence of exclusive breastfeeding of children under six months of age • Prevalence of children 6-23 months of age receiving minimum acceptable diet • Percent of children 6-23 months of age receiving foods from 4 or more groups during the previous day • Percent of children 6-23 months of age consuming iron-rich foods during the previous day • Percent of sick children 6-23 months of age fed more during and after their illness • Women's Dietary Diversity: Mean number of food groups consumed by women of reproductive age • Percent of women consuming all 180 tablets of IFA during pregnancy • Percent of adolescent girls (10-19 years) eating iron rich foods in the previous day (MSNP) • Number of people trained in child health and nutrition through USG supported programs (in thousands) • Number of pregnant women reached with nutrition interventions through USG supported programs (in thousands) • Number of children under five (0-59 months) reached by USG supported nutrition programs • Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs (in thousands) 	<ul style="list-style-type: none"> • DHS, 2016 & 2021 • Baseline survey • Annual survey • Endline survey • Training records • Activity reports 	<p>An assumption covering all outcomes under this IR is that there is not a high turnover of FLW staff such that it jeopardizes our ability to build sustainable capacity among this cadre.</p>
<p>Activities:</p> <ul style="list-style-type: none"> • District consultative meeting to health sector stakeholders on MIYCN activities and training planning meeting • Orientation on MIYCN to PNGO staff • MYICN Adolescent Nutrition MTOT 	<ul style="list-style-type: none"> • Number of meetings with health sector stakeholders • Number of people trained in child health and nutrition through USG supported programs (USG OP) • Number of data quality audits • Number of orientation workshops on HMIS recording • Number of participants attending workshop 	<ul style="list-style-type: none"> • Training records • Activity records 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> • MTOT on MIYCN • Village level training on MIYCN (2 new districts) • Community level training on MIYCN (2 new districts) • Refresher training on MIYCN to FCHVs (23 districts) (3 days) • Training on NACS to FCHVs • Training to HMG members and decision makers by FCHV and Field Supervisor (2 new districts) • Data quality audits on nutrition indicators in 15 districts of 5 development regions • Orientation on HMIS recording and reporting (Nutrition and Health Indicators) to health workers and FCHVs 			
<p>Activities:</p> <ul style="list-style-type: none"> • Ongoing support to community level frontline workers to identify and invite new 1000 days' women, adolescents, including DAG, to attend SBCC activities and health services • Radio program with messages on adolescent health and nutrition • Adolescents girls' leadership training 	<ul style="list-style-type: none"> • Number of messages disseminated to adolescent girls • Number of interpersonal counseling sessions with adolescent girls • Numbers of Bhanchhin Aama episodes aired • Number of audience responses received through IVR, SMS, email • Number of adolescent girls trained • Number of trainings held • Number of participants in the training • Increased score of post-test than pre-test • Number of follow up activities carried out by trained adolescents' leaders 	<ul style="list-style-type: none"> • Activity records 	
<p>Activities:</p> <ul style="list-style-type: none"> • Support to Vitamin A Supplementation (monitoring, supervision, logistics, follow up) • Ensure FCHVs have adequate supply 	<ul style="list-style-type: none"> • Number of monitoring visits • Number of districts that received adequate supply of Vitamin A before supplementation dates 	<ul style="list-style-type: none"> • Activity records 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
of Vitamin A capsules			
Outcome 1.2: Households adopt essential WASH actions			
	<ul style="list-style-type: none"> • Percentage of children under age five who had diarrhea in the prior two weeks • Percent of households using an improved sanitation facility • Percent of households using an improved drinking water source • Percent of households in target areas practicing correct use of recommended household water treatment technologies • Percent of households with soap and water at a handwashing station commonly used by family members • Percent who practices handwashing at 6 critical times • Number of communities (VDCs) certified as 'open defecation free' (ODF) as a result of USG assistance • Number of people trained in WASH through USG supported programs (in thousands) • Number of schools with girl friendly facilities • Number of cases of child diarrhea treated in USG-assisted program (in thousands) • Number of people educated on tools, approaches, and /or methods for water security, integrated water resource management, and /or water source protection as a result of USG- assistance. • Number of action plan implemented for water security, integrated water resource management, and /or water source protection as a result of USG assistance. 	<ul style="list-style-type: none"> • Baseline survey • Annual survey • Endline survey • Training records • Activity reports 	
<p>Activities:</p> <ul style="list-style-type: none"> • Refresher MTOT training to central level training on WASH to District WASH officers • Central level training on post ODF/Total Sanitation/SWASTHA community to 	<ul style="list-style-type: none"> • Number of District WASH officers trained on SWASTHA/Clean House approach • Number of District WASH officers training on Planning and Monitoring of SWASTHA/Clean House approach • Number of PNGO staff trained on WASH and 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> • District WASH officers • Central level training on Planning/Monitoring and Evaluation to District WASH officers • PNGO training on WASH/post ODF to WASH Officers • Multi-sectoral consultation and coordination meetings to D/M/V-WASHCC • District level training on Water Safety Plan (WSP) and Water Quality (WQ) testing to District Water User Network and multi-sector stakeholders • Cluster level training on WASH to FCHVs and Youth Volunteers • D/M/V-WASH CC orientation on WASH • VDC level TOT on Total Sanitation to Trigger for Social Mobilizers • Train local stakeholders on fecal sludge management • VDC level orientation on WASH to Head Master, Focal Teach, School Management Committee and Parent and Teacher Association. 	<ul style="list-style-type: none"> • SWASTH/Clean House approach • Number of consultative meetings with D/M/V-WASH CC • Number of trainings on WSP • Number of participants attending training on WSP • Number of trainings for FCHVs and Youth Volunteers • Number of FCHVs and Youth volunteers on WASH/SWASTHA/Clean House approach • Number of D/M/V WASH CC orientation events on WASH/SWASTHA/Clean House • Number of VDC level triggering events on total sanitation • Number of trainings on fecal sludge management • Number of persons attending fecal sludge management training • Number of VDC level orientations on WASH to Head Master, Focal Teach, School Management Committee and Parent and Teacher Association. 		
<p>Activities:</p> <ul style="list-style-type: none"> • Training and exchange visits on fecal sludge management to local stakeholders • Provision of materials (pan, cement, pipes, corrugated galvanized iron sheet) toilet construction for DAG (includes biogas and eco-san toilet) • Promote MUS of water for grey water management 	<ul style="list-style-type: none"> • Number of exchange visits • Number of mass awareness campaigns 	<ul style="list-style-type: none"> • Activity reports 	
<p>Activities:</p> <ul style="list-style-type: none"> • Promote awareness on household 	<ul style="list-style-type: none"> • Number of promotion campaigns on water treatment • Number of water quality testing 	<ul style="list-style-type: none"> • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<p>water treatment options for DAG</p> <ul style="list-style-type: none"> • Water Quality Testing, monitoring and Research activities (research activities will focus on water quality of DAG and non-DAG) • Community level Triggering and sensitization events on water quality (PA vial for presence of fecal matter and water field testing for iron, arsenic, etc.) • Training on cost effective techniques of rainwater harvesting RWH systems and its treatment in water scarce areas • Capacity building on Water Safety Plan for Water User Committees 	<ul style="list-style-type: none"> • Number of triggering activities on water quality • Number of trainings conducted on safe water • Number of participants in training • Number of households with RWH system installed and people benefited • Number of water safety plans developed • Number of Water User Committees trained on water safety plans 		
<p>Activity:</p> <ul style="list-style-type: none"> • Community level Triggering and sensitization events on hygiene • Organize WASH Days • Conduct Hygiene Campaigns 	<ul style="list-style-type: none"> • Number of triggering activities on hygiene behavior change • Number of key WASH Celebration Days • Number of Hygiene Campaigns 	<ul style="list-style-type: none"> • Activity reports 	
<p>Activity:</p> <ul style="list-style-type: none"> • Advocate space and adequate water for washing sanitary pads and personal hygiene and a place for pad disposal • Provide technical support for designing, planning and managing girl friendly toilets in schools • Child Club orientation on WASH and Menstrual Hygiene 	<ul style="list-style-type: none"> • Number of meeting with D-WASH on girl friendly facilities at schools • Number of school with girl friendly toilets • Number of Child Club orientation sessions on menstrual hygiene 	<ul style="list-style-type: none"> • Activity reports 	
<p>Activity:</p> <ul style="list-style-type: none"> • District level training on Sustainable Sanitation to local entrepreneur • District level training on WASH marketing to private sector • Support to communities to establish linkages with service providers on biogas, biosand filters, etc. 	<ul style="list-style-type: none"> • Number of trainings on WASH marketing • Number of WASH technicians and entrepreneurs with improved knowledge of toilet construction and WASH marketing 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> Support local WASH technicians and entrepreneurs for proper construction of toilet and marketing of WASH products and services 			
IR2: Increase use of quality nutrition and health services by women and children			
Outcome 2.1: Improved capacity of health service providers to do Nutrition Assessment, Counseling and Support			
	<ul style="list-style-type: none"> Percent of pregnant women weighed in most recent ANC visit Percent of children under two years of age weighed in the past month Percent of health service providers knowledgeable regarding accurate assessment of weight gain during pregnancy Percent of health service providers knowledgeable about accurate diagnosing of growth faltering (inadequate weight gain) in children under two years of age Percent of health service providers knowledgeable about accurate diagnosis of severe and moderate acute malnutrition (SAM/MAM) in children under five years of age Number of health facilities, including NRCs who receives training in management of acute malnutrition (SAM/MAM) in the previous year 	<ul style="list-style-type: none"> Baseline survey Annual survey Endline survey Health facility assessments Training records Activity reports 	Government of Nepal is willing to lead on the roll out NACS implementation
<p>Activities:</p> <ul style="list-style-type: none"> Review existing National training package in consultation meeting with CHD, NHTC, UNICEF, Care Nepal and other stakeholders 	<ul style="list-style-type: none"> Number of review sessions of national training package Number of consultative meetings with stakeholders 	<ul style="list-style-type: none"> Activity reports 	
<p>Activity:</p> <ul style="list-style-type: none"> Job aid development workshop in consultation meetings with CHD and NHTC 	<ul style="list-style-type: none"> Number of job aid development workshops 	<ul style="list-style-type: none"> Activity reports 	
<p>Activity:</p> <ul style="list-style-type: none"> Consultative meeting for NACS Performance Standard Package Development 	<ul style="list-style-type: none"> Number of consultative meetings held 	<ul style="list-style-type: none"> Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<p>Activities:</p> <ul style="list-style-type: none"> • Masters Training of Trainers (TOT) on NACS District level training for NACS • District level training to health service providers on NACS • NACS Referral Service Development Workshop at National Level • Onsite support and supervision (including GMP) 	<ul style="list-style-type: none"> • Number of people trained in child health and nutrition through USG supported programs • Number of referral development workshops • Number of persons attending workshop • Number of onsite support visits 	<ul style="list-style-type: none"> • Training records • Activity reports 	
<p>Activities:</p> <ul style="list-style-type: none"> • Support to DOHS, NUTEC, UNICEF, other stakeholders to integrate NACS in community based GMP System • Supportive supervision of GMP sessions 	<ul style="list-style-type: none"> • Number of support meetings with stakeholders on integration of NACS into CB GMP systems • Number of GMP session supervision 	<ul style="list-style-type: none"> • Activity reports 	
<p>Activities:</p> <ul style="list-style-type: none"> • Integration of NACS into FCHV Curriculum Workshop • Community level training on NACS for FCHVs (NTAG) 	<ul style="list-style-type: none"> • NACS is integrated into FCHV curriculum • Number of curriculum development workshops • Number of persons attending workshops • Number of community level trainings on NACS 	<ul style="list-style-type: none"> • Activity reports 	
<p>Outcome 2.2: Increased accessibility and quality of outreach nutrition and health services for women, children, adolescent girls and disadvantaged group</p>			
	<ul style="list-style-type: none"> • Percent of births attended by a skilled birth attendant • Percent of newborns receiving postnatal health check within 24 hours of birth • Percent of births receiving at least 4 antenatal care (ANC) visits during pregnancy • Percentage of 1000-day households who had contact with the FCHV in the previous month • Number of districts with CB-IMNCI programs scaled up, supported by USG • Number of HFOMCs who have been engaged in a QI process 	<ul style="list-style-type: none"> • Baseline survey • Annual survey • Endline survey • Training records • Activity reports 	<p>Government of Nepal is willing to lead on the roll out CB-IMNCI implementation</p>
<p>Activities:</p> <ul style="list-style-type: none"> • MTOT to the district resource persons. TOT at district level for health supervisors and managers, facility in- 	<ul style="list-style-type: none"> • Number of districts with CB-IMNCI programs • Number of health facility assessments for HR, equipment and supply 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
charge. <ul style="list-style-type: none"> • Cascade CB-IMNCI training in 10 districts to all the health workers and FCHVs. • Supply of essential equipment for the health facilities under CB-IMNCI and NACS • Assessment of HR and equipment (health facility assessment). • Provide basic necessary equipment in collaboration with DHO and referral hospital • Orientation on CB-IMCI to pharmacy, private practitioners, traditional healers, school teachers etc. 	<ul style="list-style-type: none"> • Number of supplies for CB-IMNCI provided to health facilities • Number of pharmacy, private practitioners, traditional healers, school teachers trained on CB-IMNCI 		
Activities: <ul style="list-style-type: none"> • Conduct orientation of health service providers/FCHVs at the health facilities on the process and expected benefits of SATH 	<ul style="list-style-type: none"> • Number of orientations to health service providers/FCHVs on the SATH approach • Number of health service providers/FCHVs trained on the SATH approach 	<ul style="list-style-type: none"> • Training records • Activity reports 	
Activities: <ul style="list-style-type: none"> • HFOMC capacity need assessment • Health Governance Training to HFOMC members and prepare action plan for improvements • Assessment of HR and equipment (health facility assessment) situation for NACS, FP related services • Provide basic necessary equipment in collaboration with DHO and referral hospital • Conduct orientation of health service providers/managers at the district level on the process and expected benefits of Community Health Score Board (one event at district level for DHO staff) 	<ul style="list-style-type: none"> • Number of HFOMC capacity needs assessments • Number of trainings to HFOMC members • Number of persons attended training • Number of health facility assessments • Number of equipment provided (by type) • Number of orientations to health service providers/managers on CHSB • Number of health service providers/managers trained on CHSB 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> Conduct orientation of health service providers/FCHVs at the health facilities on the process and expected benefits of Community Health Score Board (at the facility level) and implementation of CHSB 			
<p>Activities:</p> <ul style="list-style-type: none"> Design school health education curricula. Conduct TOT for teachers to enhance knowledge and skills on adolescent nutrition, FP/RH. Conduct school health outreach sessions in selected schools 	<ul style="list-style-type: none"> Number of curricula developed Number of trainings Number of participants in the training 	<ul style="list-style-type: none"> Training records Activity reports 	
Outcome 2.3: Improved healthy timing and spacing of pregnancy through promotion and more accessible family planning outreach services			
	<ul style="list-style-type: none"> Percent of reproductive age women in union who are currently using a modern method of contraception Percent of USG assisted service delivery points (SDPs) that experienced a stock out at any time during the defined reporting frequency of any contraceptive methods that the SDP is expected to provide Number of people trained in FP/RH with USG funds Number of health facilities with FP micro plans Percent of USG-assisted service delivery points providing family planning (FP) counseling and/or services Percent of audience who recall hearing or seeing a specific USG-supported FP/RH message Number of additional USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year Couple years protection in USG supported programs (in thousands) Average stock out rate of contraceptive commodities at family Planning service delivery points 	<ul style="list-style-type: none"> Baseline survey Annual survey Endline survey LMIS/HMIS Health facility survey Training records Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
Activities: <ul style="list-style-type: none"> Update guideline and training package for Micro Planning of FP FP Referral System Improvement Workshop 	<ul style="list-style-type: none"> Number of FP referral improvement workshops Number of persons attending workshops Number health care providers with knowledge of FP micro planning 	<ul style="list-style-type: none"> Activity reports 	
Activity: <ul style="list-style-type: none"> TOT on USG abortion and FP requirements – District level 	<ul style="list-style-type: none"> Number of people trained on USG abortion and FP requirements Number of trainings on USG abortion and FP requirements 	<ul style="list-style-type: none"> Training records 	
Activities <ul style="list-style-type: none"> Broadcast Banchhin Aama radio series Broadcast Hello Banchhin Aama Produce Banchhin Aama magazine Broadcast of Nepali Hello Series Public Service Announcements (PSA) production Develop and distribute Comic Book FM producers' training (under radio program production heading) Push messaging Conduct voxpop and interviews Web-platform monitoring of responses Interactive Voice Response (IVR) SMS Conduct CAG meetings for consortium members and stakeholders Radio Listening Session (40 Dist x 5 group) Develop and produce Comic Book 	<ul style="list-style-type: none"> Number of Banchhin Aama episodes broadcast Numbers of Hello Banchhin Aama radio episodes on direct beneficiaries' concerns Number of Banchhin Aama magazines distributed Broadcast monitoring (spot checks through field visits), through district offices Number of PSA Number of IVR SMS sent Number of local partner FM producers' trained/Number of participants trained Number of voxpop and interview (content focused) collected web-platform monitoring (Facebook responses, twitter responses) audience responses received (through IVR and SMS, Email, and SMS polls) Numbers of CAG meetings held among consortium members/stakeholders Number of Radio Listening Sessions Number of comic books distributed Numbers of Critical Listening and Feedback Session (CLFS) to ensure radio program quality Number of Radio Listening Group (RLG) formed/ community discussion sessions around the radio drama 	<ul style="list-style-type: none"> Training records Activity reports 	
Activities: <ul style="list-style-type: none"> Conduct listening and feedback 	<ul style="list-style-type: none"> Number of home visits Number of health mother group meetings 	<ul style="list-style-type: none"> Training records 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
sessions <ul style="list-style-type: none"> • Establish Radio Listening Group • Train Radio Listening Group's Facilitators • Conduct home visits • Conduct key life events • Facilitate health mothers group meetings • Conduct food demonstrations at health mothers group meetings 	<ul style="list-style-type: none"> • Number of food demonstrations • Numbers of local RLG facilitators trained • Number of participants in the training 	<ul style="list-style-type: none"> • Activity reports 	
IR3: Improved Access to Diverse and Nutrient-rich Foods by Women and Children			
Outcome 3.1: Increased and sustained homestead production of nutrient-rich foods			
	<ul style="list-style-type: none"> • Percent of households with homestead gardens meeting minimum criteria • Mean number of nutrient dense vegetables cultivated by household, in the previous year • Percent of households with chickens • Mean number of eggs produced in the previous month by household • Percent of households who vaccinate their chickens against Newcastle disease (ND), in the previous year • Percent of new 1000 days household who received HFP inputs from VMFs and/or graduated HFP beneficiaries • Number of people trained in homestead food production (HFP)/agriculture (Dhading and Panchthar) (in thousand) 	<ul style="list-style-type: none"> • Baseline survey • HFP surveillance • Endline survey • Training records • Activity reports 	An assumption across all IR3 outcomes is that there is no major outbreak of diseases such as bird flu.
Activities: <ul style="list-style-type: none"> • Roll out 2 days HFP training for mothers of 1000 days, FCHVs and Family members • Organize HFP TOT for frontline extension workers • Conduct agriculture and food fair to sensitize community about importance of HFP for dietary diversity 	<ul style="list-style-type: none"> • Number of household engaged in HFP • Number of household with poultry rearing in semi intensive coop • Number of people (including agriculture and livestock extension workers per new structure) trained in homestead food production • Number of agriculture and food fair conducted in coordination with stakeholders • HFP TOT 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> • Support in regularization of HFPB group meeting led by VMFs • Conduct refresher training on Homestead Food Production • Support in distribution of vegetable seeds to households • Support in distribution of eight week brooded chicks to beneficiary households • Chicken coop assembly material support to DAG households • One-day refresher on backyard poultry rearing practices including importance of vaccine • HFP supervision and monitoring by ASC and LSC 	<ul style="list-style-type: none"> • Number of HFPB group meetings • Number of households received vegetables seeds • Number of households received chicks • Number of DAG households provided chicken coop assembly support • Number of households received refresher on backyard poultry rearing including importance of vaccine • Number of VDCs monitored by ASC and LSC 		
<p>Activities:</p> <ul style="list-style-type: none"> • VMF profile assessment and maintain database for SP1 districts in coordination with ASC, LSC and VDC • VMF capacity building training (5 days) for selected Village Model Farmers • VMF strengthening planning meeting with district stakeholders • Local Resource Person development training for selected VMFs to promote HFP model at community • Support in establishment of poultry brooding center • Vegetable Seed Production Training for VMFs to develop VMFs as seed producers in consultation with KISAN • Support in regularization of HFPB group/VMF network and link with KISAN groups • Agriculture and livestock Advisory Group meeting-KISAN, SABAL, PAHAL 	<ul style="list-style-type: none"> • Number of VMF network established at VDC • Number of VMF trained as Local Resource Person (Village Agriculture Workers-Grahmin Krishi Karyakarta), Village Animal Health Workers (VAHWs) • Number of VDCs assessed for VMF potentials as change agents on HFP • Number of participants trained in Village Model Farm Concept • Number of VMFs trained as Local Resource Person for promotion of homestead food production • Number of brooding center established for promotion of improved chickens • Number of HFPB group registered at DADO and DLSO • Number of coordination and planning meeting with district stakeholders • Number of VMFs trained in seed production techniques • Number of participants attended in Agriculture and livestock advisory group meeting • Number of people from private sector (agro vets, 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
and <i>Suaahara II</i>	<ul style="list-style-type: none"> community animal health workers) trained in HFP Number of brooding center established 		
Outcome 3.2 Strengthened linkages to KISAN services and to markets for selling surplus homestead			
	<ul style="list-style-type: none"> Percent of households with surplus HFP sold (vegetable/egg production) in the past year Percent of households that used revenue earned by selling HFP surplus to purchase nutrient dense food, in the previous years Number of VMFs included in KISAN and PAHAL Market Management/Project Committees Number of VMFs/households with access to KISAN collection center/MMC (market management committee), Business literacy program 	<ul style="list-style-type: none"> Baseline survey HFP surveillance Endline survey Training records Activity reports 	<ul style="list-style-type: none"> National tax policy remains same for agriculture commodities (No transport tax) KISAN maintains collection center Market Management Committee facilitated by KISAN/DADO/DLS O is functional
<p>Activities:</p> <ul style="list-style-type: none"> Quarterly Review and Planning Meeting with KISAN, PAHAL, AFSP, and AG-Livestock Stakeholders Review and Planning Meeting with VMF in coordination with KISAN (with plan of VMF linking LSP) VMF training on LSP One-day orientation on HFP for Local Service Providers to promote HFP and Garden to Plate approach VMFs' exposure visit to KISAN demonstration site/collection center and interaction meeting with Local Service Providers/Leader Farmers (16 +4 far western districts) Support in strengthening Market Management Committee for promotion of HAAT BAZAR (weekly market) 	<ul style="list-style-type: none"> Number of review and planning meeting with KISAN, PAHAL, AFSP and district government stakeholders Number of local service providers oriented on HFP (Garden to plate approach) Number of VMF/households trained as Local Service providers (LSP), Community Business Facilitator(CBF), Peer KISAN Farmer Number of VMFs attended exposure visit to KISAN demonstration/collection center Number of market management committee meeting facilitated by project to strengthen Haat Bazar (Non KISAN districts) Number of barter shop initiated in remote districts Number of HHs who traded surplus produces (eg. eggs, chickens, vegetables) 	<ul style="list-style-type: none"> Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> Support in establishing barter shop for nutrient dense foods in remote districts <p>Activities</p> <ul style="list-style-type: none"> Market assessment of crop and livestock potential including mapping of existing and potential agriculture traders, aggregators, processors, and key market infrastructure needs and constraints VMF orientation program (5days) on business plan, gender friendly enterprise and financial literacy linking with financial institutions Organize training on institutional development (saving, credit, account keeping, risk management) for HFPB group led by VMFs Training on improved processing and preservation of HFP produces for nutrition value chain Collective Marketing training for VMFs to manage surplus produces of HFPB groups Training in marketing and small scale enterprise development 	<ul style="list-style-type: none"> Number of districts with market potential assessment Number of VMFs trained on business plan and gender friendly enterprise development Number HFPB group trained in institutional development including saving and credit Number of participants attended in improved processing and preservation training Number of participants trained in collective marketing approach to generate supplementary income from surplus homestead produces at household level Number of people trained in marketing and small scale enterprise development 	<ul style="list-style-type: none"> Activity reports 	
<p>Activities</p> <ul style="list-style-type: none"> Promote Village Model Farmer Approach to develop female as a leader farmer in community HFP training for mothers of 1000 days (what nutrient rich crop should be cultivated) Engage male member/family member in HFP activities (training, meeting, orientation) Collective marketing training for management of surplus produces 	<ul style="list-style-type: none"> Number of female VMFs developed in districts Number of female member of HFP intervention households trained for marketing skill Number of 1000 days mothers who have access to homestead area what to produce Number women with control over the use of supplementary income generated from selling HFP 	<ul style="list-style-type: none"> Training records Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> Home-economics training for mothers 			
Outcome 3.3 Increased resilience of communities and households to potential nutrition			
	<ul style="list-style-type: none"> Number of VDCs with DRR preparedness plans that include building resilience to nutrition shocks Number of vulnerable (DAG) VDCs that are benefiting directly from USG assistance based on DRR plan Number of vulnerable VDCs using CVCA tool Number of DAG VDCs that received training on drought resistance vegetables, (as part of HFP training) Number of small grants made to test innovation to build resilience to nutrition shocks 	<ul style="list-style-type: none"> Training records Activity reports 	
<p>Activities</p> <ul style="list-style-type: none"> Conduct participatory vulnerability and capacity assessment at district level to reduce nutrition shocks Orient Community Disaster Management Committee (CDMC) to incorporate nutrition issues in emergency Formulate DRR and CCA plans at community level to reduce nutrition shocks Coordination meeting with food security cluster and Nutrition emergency cluster Training on DRR and nutrition 	<ul style="list-style-type: none"> Number of CDMC oriented on nutrition and WASH in emergency Number of DRR and CCA plans with nutrition and WASH activities in emergency Number of VDC with vulnerability and capacity assessment Number of coordination meeting with food security cluster Number of people trained in DRR with content of nutrient resiliency 	<ul style="list-style-type: none"> Training records Activity reports 	
<p>Activities</p> <ul style="list-style-type: none"> Four days training on CC adaptation and DRR for DAG vulnerable households Promotion of drought/climate resilient vegetable crops Training/orientation on improved post-harvest management techniques including storage of food crops 	<ul style="list-style-type: none"> Number of DAG households trained on CC adaptation and DRR measures Number of HHs growing drought/climate resilient crops Percent of households practicing improved post-harvest management Number of households oriented on crop and livestock insurance Number of households benefitted from small 	<ul style="list-style-type: none"> Training records Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> Support to increase access to crop and livestock production insurance for large scale producers Provide support to adapt climate change adaptation and disaster risk reduction measures increasing resilience to produce nutrient rich foods 	grants/innovation fund (water harvest tank, seed storage bins, processors, solar dryer etc.)		
IR 4: Accelerated rollout of multi-sector nutrition plan (MSNP) through strengthened local governance			
Outcome 4.1: Decentralize MSNP implementation defined and strengthened			
	<ul style="list-style-type: none"> Number of districts with functioning Nutrition and Food Security Steering Committees that met at least twice in the past per year (MSNP) Number of districts meeting program standard performance benchmarks (technical/managerial) for 15 handover districts A national multi-sectoral nutrition plan or policy is in place that includes responding to emergency nutrition needs (Yes=1, No=0) Percentage of national budget invested in nutrition 		The government will continue MSNP implementation with high priority engaging all stakeholders
Activities: <ul style="list-style-type: none"> Orientation on Multi-Sector Nutrition plan (MSNP) District Coordinator and Local Governance Officer Orientation on integration of INP indicators in DPMASS (District Poverty Monitoring and Analysis System) Update district DAG mapping in collaboration with DDC Organize Monitoring Field Visit for Child Health Division (CHD)/ MoH 	<ul style="list-style-type: none"> Number of orientation session on MSNP Number of orientation sessions on integration of INP indicators in DPMASS Number of districts that incorporate nutrition in periodic plans Number of districts with updated DAG maps Number of monitoring field visits 	<ul style="list-style-type: none"> Activity records 	
Activities <ul style="list-style-type: none"> Update training guidelines on MSNP Support establishment and functionality of Regional and District Level Nutrition and Food Security Steering Committees Training of trainers for MSNP for 	<ul style="list-style-type: none"> Number of people trained to assess, plan and manage the MSNP at District and VDC level Number of districts that incorporate nutrition in periodic plans Number of established and functional Regional and District NFSSC Number of training of trainers on MNSP 	<ul style="list-style-type: none"> Training records Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<ul style="list-style-type: none"> regional GoN focal person in collaboration with NPC • Conduct MSNP Refresher training to field level staff and DDC • Support to DDC/VDC NFSCC for social audits and public hearing on MSNP activities 	<ul style="list-style-type: none"> • Number of refresher trainings to field staff and stakeholders • Number of social audits conducted at VDC/DDC 		
Outcome 4.2: Nutrition services in 15 Suaahara districts transferred to GoN management on services			
	<ul style="list-style-type: none"> • Number of districts transferred to GoN management per year after year three • Number of handed over districts maintaining performance benchmarks in years 3 to 5 • Number of people trained to assess, plan and manage the MSNP at district level (in thousands) 	<ul style="list-style-type: none"> • Training records • Activity reports 	MSNP architecture will be institutionalize and advocacy and communication strategy will create enabling environment for ownership
<p>Activities</p> <ul style="list-style-type: none"> • Support NPC-led High level Nutrition and Food Security Steering Committee (HLFNSSC) for bi-annual meetings • Support NPC-led National Nutrition Coordination Committee meetings • Organize advocacy workshops focusing on local government and civil society ownership (Parliamentarian, stakeholders, EDPs, Media personnel, Chamber of Commerce/ Federation of Nepalese Chambers of Commerce and industry) • Organize joint review and planning meeting with government and external development partners (EDPs) at National Level • Participate and organize Civil Society Alliance for Nutrition Nepal (CSANN) – led meetings • Organize district level consultative and planning workshop 	<ul style="list-style-type: none"> • Number of meetings • Number of workshops • Number of meetings • Number of workshops 	<ul style="list-style-type: none"> • Training records • Activity reports 	

Narrative Summary	Indicators	Means of Verification	Risks/Assumptions
<p>Activities</p> <ul style="list-style-type: none"> Organize meeting with MoH, MoFALD and NPC for preparing Transferring Guideline and Post Transferring guideline Organize performance assessment according to Transferring Guideline Organize workshop for internalizing the roles and responsibilities according to Transferring Guideline Organize Transferring Ceremony through District Level Nutrition and Food Security Steering Committee 	<ul style="list-style-type: none"> Number of meetings Number of performance assessments Number of workshops 	<ul style="list-style-type: none"> Activity reports 	
Outcome 4.3 Improved coordination between sectors, and between GoN and MSNP stakeholders			
	<ul style="list-style-type: none"> Number of knowledge sharing activities, exchange visit and dissemination activities among GoN and MSNP related stakeholders organized by districts Amount of targeted DDC and VDC funds leveraged for health, agriculture, environment, education, and/or GESI activities (in thousand) 	<ul style="list-style-type: none"> Activity records 	
<p>Activities</p> <ul style="list-style-type: none"> Training to D/M/V Officers and Secretaries on coordination, joint monitoring and resource sharing Organize exchange visit for WCF Member, VMF/LRP, program staff and government official (between districts) Organize joint field visit for district level stakeholders Organize monitoring field visit for media personnel 	<ul style="list-style-type: none"> Number of trainings Number of participants attended training Number of exchange visits Number of consultative and planning workshops Number of joint visits Number of monitoring visits 	<ul style="list-style-type: none"> Training records Activity reports 	

3.3 Annex 3: MEL Tasks Calendar

	Key MEL Tasks	Frequency	Responsible person	Tasks Calendar																			
				Year 1				Year 2				Year 3				Year 4				Year 5			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Monitoring																						
1	Tools preparation, translation, and printing/programming	Ongoing																					
2	Monthly 1000-day household-level monitoring with CommCare checklists	Monthly																					
3	Monthly FCHV and VMF monitoring with CommCare checklists	Monthly																					
4	District-level activity reporting																						
5	HFP surveillance	Bi-monthly																					
6	Annual surveys, including baseline	Annual																					
7	Assessment of 15 handover districts	Quarterly																					
8	Data Quality Audits	Bi-annual																					
10	DHIS2/MIS trainings (KTM and District teams)	Once	HIS P																				
	Evaluation and Research																						
11	Formative Research	Once																					
12	Mid term assessment	Once																					
13	Endline for Suaahara (I/II)	Once																					
14	Handover	Ongoing	IFP RI																				
15	Health systems	Ongoing	IFP RI																				
16	Adolescent health and	Ongoing	IFP																				

	Key MEL Tasks	Frequency	Responsible person	Tasks Calendar																			
				Year 1				Year 2				Year 3				Year 4				Year 5			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	nutrition		RI																				
17	TBD	Ongoing	IFP RI																				
	Other																						
18	GESI, such as <ul style="list-style-type: none"> Time diaries adolescent girls 	Once	CARE																				
19	HFP, such as: <ul style="list-style-type: none"> Ag/anemia linkages Pathways including income women's empowerment and time use OFSP and Kyankong 	Once	HKI																				
20	WASH, such as <ul style="list-style-type: none"> WASH Mart status, knowledge and behavior, affordability and education etc. WASH FIT Water quality assessments 	Once	ENP HO																				
21	Photo database	Ongoing																					
22	Intervention database	Ongoing																					

3.4 Annex 4: Performance Indicator Reference Sheets

(see separate folder)

3.5 Annex 5: Data Quality Assessment Checklists

Activity Name:	
Implementing Organization:	
Title of Performance Indicator: <i>[Indicator should be copied directly from the Performance Indicator Reference Sheet]</i>	
Data Source(s): <i>[Information can be copied directly from the Performance Indicator Reference Sheet]</i>	
Period for Which the Data Are Being Reported:	
Is This Indicator a Standard or Custom Indicator?	<input type="checkbox"/> Standard Foreign Assistance Indicator <input type="checkbox"/> Custom (created by the Activity; not standard)
Data Quality Assessment methodology: <i>[Describe here or attach to this checklist the methods and procedures for assessing the quality of the indicator data. E.g. Reviewing data collection procedures and documentation, interviewing those responsible for data analysis, checking a sample of the data for errors, etc.]</i>	
Date(s) of Assessment:	
Assessment Team Members:	
<i>Activity Implementation Partner Verification of DQA</i> Team Leader Officer approval X _____	

		YES	NO	COMMENTS
VALIDITY – Data should clearly and adequately represent the intended result.				
1	Does the information collected measure what it is supposed to measure? (E.g. A valid measure of overall nutrition is healthy variation in diet; Age is not a valid measure of overall health.)			
2	Do results collected fall within a plausible range?			
3	Is there reasonable assurance that the data collection methods being used do not produce systematically biased data (e.g. consistently over- or under-counting)?			
4	Are sound research methods being used to collect the data?			
RELIABILITY – Data should reflect stable and consistent data collection processes and analysis methods over time.				
1	When the same data collection method is used to measure/observe the same thing multiple times, is the same result produced each time? (E.g. A ruler used over and over always indicates the same length for an inch.)			
2	Are data collection and analysis methods documented in writing and being used to ensure the same procedures are followed each time?			
TIMELINESS – Data should be available at a useful frequency, should be current, and should be timely enough to influence management decision making.				
1	Are data available frequently enough to inform program management decisions?			
2	Are the data reported the most current practically available?			
3	Are the data reported as soon as possible after collection?			
PRECISION – Data have a sufficient level of detail to permit management decision making; e.g. the margin of error is less than the anticipated change.				
1	Is the margin of error less than the expected change being measured? (E.g. If a change of only 2% is expected and the margin of error in a survey used to collect the data is +/- 5%, then the tool is not precise enough to detect the change.)			
2	Has the margin of error been reported along with the data? (Only applicable to results obtained through statistical samples.)			
3	Is the data collection method/tool being used to collect the data fine-tuned or exact enough to register the expected change? (E.g. A yardstick may not be a precise enough tool to measure a change of a few millimeters.)			

		YES	NO	COMMENTS
VALIDITY – Data should clearly and adequately represent the intended result.				
INTEGRITY – Data collected should have safeguards to minimize the risk of transcription error or data manipulation.				
1	Are procedures or safeguards in place to minimize data transcription errors?			
3	Is there independence in key data collection, management, and assessment procedures?			
3	Are mechanisms in place to prevent unauthorized changes to the data?			

SUMMARY	
Based on the assessment relative to the five standards, what is the overall conclusion regarding the quality of the data?	
Significance of limitations (if any):	
Actions needed to address limitations prior to the next DQA (given level of USG control over data):	

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being taken to collect and report these data as soon as possible?	
When will data be reported?	