Municipal budget allocation and utilisation for nutrition in Nepal

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Introduction

Nepal’s government structure

The 2015 Constitution of Nepal specifies three tiers of government (federal, provincial and local (municipality and ward)) (Figure 1) and promotes social democracy at municipality and ward levels. Municipal governments have power to prepare and implement long-term and short-term periodic plans, including annual, strategic and sector-wide plans for local development, with direction from federal government towards meeting the Sustainable Development Goals.

There are 753 local government units in Nepal that govern municipalities in remote, rural locations (with populations of <25,000) through to urbanised, metropolitan areas (with populations of >300,000), under which are 6,743 wards. Budget is allocated by municipalities with over four years of experience in project management and research in several areas mainly in nutrition.

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Nutrition situation in Nepal

Nepal faces a triple burden of malnutrition: undernutrition, micronutrient deficiency and overnutrition. According to the 2016 Nepal Demographic Health Survey, 36% of children under five years of age are stunted, 10% are wasted and 27% are underweight. Eleven per cent of women aged 15–49 are short (less than 145 cm) and 17% are thin (body mass index (BMI) less than 18.5). Twenty-two per cent of women are overweight or obese (BMI greater than or equal to 25.0). Among men, 17% are thin and 17% are overweight or obese. The Government of Nepal (GoN) acknowledges the problem of malnutrition, particularly undernutrition, and the need for multi-sector efforts to improve the nutrition of its citizens.

The Nepal Multi-sectoral Nutrition Plan (MSNP) II for 2018-2022 takes a multi-sector approach to tackling malnutrition and sets out guidance for the integration of both nutrition-specific and nutrition-sensitive interventions. Several national nutrition programmes are implemented country-wide by the Ministry of Health (MoH), funded by conditional budget1 allocated from federal and provincial levels, including programmes on ma-

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1 Conditional budget is the budget received for national programmes that cannot be spent on anything else.
ternal, infant and young child feeding; integrated management of acute malnutrition (IMAM); and adolescent iron and folic acid (IFA) supplementation. In addition, guided by the MSNP, the Partnership for Improved Nutrition (‘Poshan Ko Lagaat Haatemalo’) project, which is government-owned and funded by the United Nations Children’s Fund (UNICEF) and the European Union (EU), conducts nutrition-specific programmes through Nepal’s MoH, and nutrition-sensitive programmes through the Ministry of Federal Affairs and General Administration (MoFAGA), in coordination with relevant ministries. This programme is currently implemented in 28 districts of Nepal, with a view to wider phased rollout across Nepal.

To tackle the problem of undernutrition in Nepal, it is crucial that local governments take ownership and mobilise existing budgets to complement national- and provincial-level nutrition efforts and those of external development partners (EDPs). The MSNP-II mandates that integrated nutrition is included in local, provincial and federal government policies and plans, guided by Nutrition and Food Security Steering Committees (NFSSCs) that meet regularly at national, provincial and local government (municipality and ward) level. Municipal-level NFSSCs bring together nutrition stakeholders to advocate and lobby for needs-based nutrition activities with the community and local governments to encourage the allocation and proper utilisation of local budget for nutrition.

Suahahara II – working with municipal governments for integrated nutrition

Suahahara II (SII) (2016-2021) is a USAID-funded, multi-sector nutrition programme that works to improve the nutritional status of women and children through a multi-sector approach in all municipalities (389) and wards (3,353) of 42 of Nepal’s 77 districts, in line with MSNP II. Led by Helen Keller International (HKI), SII is implemented by a consortium of seven organisations: HKI; Cooperative for Assistance and Relief Everywhere, Inc. (CARE); Family Health International 360 (FHI 360); Environmental and Public Health Organization (ENPHO); Digital Broadcast Initiative Equal Access (DBI EA); Nepali Technical Assistance Group (NTAG); and Vijaya Development Resource Center (VDRC). At the district level, SII partners with 40 local non-government organisations (NGOs) technically supported by SII district sub-offices. At the community level, SII activities are implemented through SII frontline workers in close coordination with government female community health volunteers (FCHVs), Nepal’s cadre of community health workers, which is particularly active in maternal and child health.

The SII programme has four intermediate aims: 1) improved household nutrition and health behaviours; 2) increased use of quality nutrition and health services by women and children; 3) improved access to diverse and nutrient-rich foods by women and children; and 4) accelerated rollout of the multi-sector nutrition plan through strengthened local governance.

SII has several cross-cutting themes, including gender equality and social inclusion (GESI); social and behavior change communication (SBCC); public-private partnerships (PPP); monitoring, evaluation and research (MER); and disaster preparedness and emergency preparedness and response plan (EPRP). Under intermediate aim 4, the SII team coordinates with national and sub-national actors to create a favourable policy environment, increase investments in nutrition and support the formation and functioning of NFSSCs at all levels.

**Objectives of the study**

In 2018, internal monitoring data revealed that, across 30 SII districts, 173 out of 277 (62%) municipalities reported allocating USD 8.46 million to implement integrated nutrition activities for women and children, utilisation of budget was only USD 3.5 million; not even half (41%) of total allocated funds (SII, 2018). Suahaara is interested in ensuring that activities it has initiated in the communities are sustained by local governments to ensure continuous progress in nutrition, even after SII phases out. Therefore, SII planned a qualitative study to explore the factors affecting allocation and utilisation decisions of local budgets, particularly those which affect investments for nutrition, to gain insight for project improvements in future.

**Study methodology**

The study was carried out in four geographically diverse districts of Nepal: Achham (mountain), Dang (plain), Nuwakot (hill) and Sindhupalchowk (mountain). Seven municipalities (one in Nuwakot and two in each of the other three districts) and seven wards (one ward per municipality) were purposively selected. Seven focus group discussions (FGDs) and 46 in-depth interviews (IDIs) were undertaken with municipality and ward-level government stakeholders, community informants and EDP representatives working on nutrition at local level. In addition, 12 non-participant observations (NPOs) were undertaken of budget allocation and utilisation-related meet-
ings that took place during the data collection period, and key documents related to budget allocation and utilisation were collated from municipality and ward levels and analysed. Audio-recordings of FGDs and IDIs were transcribed verbatim and observation notes from NPOs elaborated into detailed transcripts, which were later translated into English, coded in NVivo 12 and analysed using thematic analysis approach.

Findings

Budget allocation process

Nutrition plans can be proposed to municipalities either via community members during public community meetings; the Health Facility Operation Management Committee (HFOMC)\(^\text{5}\), which can propose needs-based health (and nutrition) related plans directly to the ward or municipal health committee; or via wards or municipal sector committees, which can propose health or nutrition plans that they feel are important or needed. The GoN guideline is clear that all municipalities must follow a seven-step planning process for the allocation of budget (Figure 2), ending in approval by the municipal assembly if successful.\(^\text{3}\)

Budget utilisation process

As per the GoN guideline, an integrated implementation plan is prepared by municipalities after approval by the municipal assembly. Regarding health and nutrition plans, municipal health sections formulate and implement programmes via HFOMCs. Required documentation, including a workplan, expenditure bills and programme-completion reports, are forwarded to the municipality for payment. Nutrition-specific activities are implemented by the health section, while nutrition sensitive-activities are implemented by the respective sections (e.g. distribution of vegetable seeds by agriculture section). Health plans are monitored periodically by municipalities and wards. This process is described in Figure 3.

Facilitators of budget allocation and utilisation in nutrition

An important facilitator of budget allocation identified was good coordination within the municipality, between municipality and ward, and between municipality and international and national non-governmental organisations (NGOs), leading to integrated planning. Other important facilitators were a sense of responsibility among ERs towards their community; national/municipality guidelines and acts outlining the allocation and utilisation process; and awareness and participation among the community regarding the planning process. Facilitators of implementation/budget utilisation identified were capacity-enhancement trainings on budget utilisation, and adequate monitoring and supervision of plans during implementation. Facilitators of budget allocation and utilisation for nutrition specifically were awareness among municipality and ward leaders of the importance of health and nutrition, as well as involvement of Suahara in advocacy and lobbying for allocation of budget to nutrition, technical support and joint monitoring with municipalities. A best-case scenario of budget allocation and utilisation for nutrition was observed in Achham. Findings triangulated from FGDs, IDIs, NPO and document review showed that the strongest facilitator for Achham was the government-led MSNP (Poshan ko laagi haatemalo) programme (See Box 2)

Barriers to budget allocation and utilisation for nutrition

Barriers to budget allocation and utilisation processes identified were: insufficient experience and skills of ERs in the new context of municipal planning; insufficient staff in municipality and ward offices; no or less involvement of sector committees; insufficient community awareness and participation; insufficient coordination between stakeholders (within government, such as ERs/government staff/thematic committees and wards). This process is described in Figure 3.

- Periodic monitoring is conducted

Government had opened forms for proposal and requested for demands for agricultural materials, vegetable blocks, etc. When we received this information from the municipality, we [SII] immediately informed them [community groups] and gave them instructions as well. At that time, only two groups were registered. I facilitated this process. I registered the groups myself and filled the grant form on the same day for one group. We received a grant amount of 19 lakhs (USD 19,000). I am very happy.

Suahara Field Supervisor, Nuwakot

We ‘launched’ a programme named ‘Flag in the house and eggs in the hands of pregnant women’. We launched the programme ... we conducted municipality-level orientation in the presence of all ERs, other stakeholders, different NGOs working in the field of nutrition like Suahara.”

Municipality health staff, Nuwakot

4 Each government health facility has an HFOMC consisting of health workers, community leaders and government leaders.

5 Municipal assembly is the most powerful municipal body, consisting of all elected leaders from municipality and ward levels. The municipal assembly’s decision on budget allocation is final.
A few participants cited perceptions among ERs that the conditional budget for nutrition (under health) is enough as another barrier. Speaking about specific barriers to utilisation in nutrition, some participants mentioned budget being allocated from government MSNP activities, like other districts, needs-based demands from community and ward levels were also lacking in Achham. Some participants in Achham explained how delayed conditional budget from EDP for the MSNP programme had impacted implementation of nutrition programmes, whereas others reported that budget was transferred from one heading to another due to political influence.

**Discussion**

There is a huge potential for Nepal to reduce undernutrition through the addition of municipality programmes to national to meet the specific needs of citizens in local contexts. Realising the significant roles that local governments could play, this study was conducted to explore how the newly assembled local governments are allocating and utilising budget in general and for nutrition in particular.

As reported by municipality and ward participants, EDPs such as Suahara have helped sensitise local government on the importance of investing in nutrition. However, while awareness is there, other barriers to budget allocation and utilisation are present, such as the perception that conditional budgets are enough, political motivations to invest only in programmes that show “immediate effects”, and lack of plans proposed by lower levels, in part due to lack of knowledge on how to develop nutrition-related plans. In the light of these findings, we suggest that awareness activities continue, but with revised content to address identified barriers, covering general allocation and utilisation process, analysis of community nutrition needs, and the formulation of plans to address them.

For budget allocation in nutrition, one of the most critical findings is the need to sensitise/orient health stakeholders at municipal and lower levels (health coordinators, HFOMC members, health workers, FCHVs, and HMG members and the community in general), as the analysis shows that few nutrition plans are demanded. Although health stakeholders are expected to be the strongest advocates of nutrition for budget allocation and are in the right position to put forward nutrition demands, they are not currently doing so. Nutrition-sensitive planning also needs to be strengthened in agriculture, livestock and other related sectors; therefore coordinated efforts with all these sectors is important. Other recommendations are to ensure timelines in releasing authority and budget for implementation, and adequate monitoring and supervision of budget utilisation.

Suggestions or action points that EDPs could consider to support budget allocation and utilisation for nutrition include the provision of technical assistance to municipal and ward levels to formulate nutrition-sensitve, long-term strategies and plans; technical assistance for better and more accountable utilisation; development of strategies to increase the visibility of nutrition and advocate to ERS to invest in nutrition; and to formulate, test and recommend nutrition plans that government can replicate. Finally, EDPs such as Suahara should gradually take a step back to increase accountability and ownership by municipalities.

**Findings**

Findings of this study have been circulated to all study districts. Our field teams are now targeting efforts towards health stakeholders at different levels and conducting sustainability workshops in all 389 SII municipalities where the study recommendations are being implemented. For more information, please contact Shraddha Manandhar at SManandhar@khi.org