

Evaluation of the National Early Childhood Development Program

Final Report

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Executive summary

Overview of the evaluation

Early childhood development (ECD) is key to the future wellbeing of children. This importance has been recognised globally over time, and this has been cemented through the adoption of ECD targets and goals as part of the 2030 Agenda for Sustainable Development, which itself is part of the United Nations' (UN) global development goals.

Studies show that ECD is the foundation of lifelong learning, and if all children receive quality early childhood care to support their development and achieve age-appropriate development and learning outcomes in the early years, then they can participate more effectively and efficiently in the subsequent stages of learning.

Amidst the political, social, and educational transformation that Nepal is undergoing, there has been a renewed focus on ECD, with evidence showing progress is being made, albeit slowly. In 2004, the ECD Strategy Paper was developed under the leadership of the Ministry of Education (MoE) with elaborate plans/strategies to expand ECD services in the country. Indeed, Nepal has developed various plans, programmes, strategies, and projects related to ECD services in education, health, nutrition, water, sanitation and hygiene (WASH), and protection sectors to develop this vision.

This evaluation sought to evaluate Nepal's National Early Childhood Development Program (2004–2015) to identify potential ways of enhancing coordination among key ministries, demonstrate the linkages between early childhood education (ECE) and other sectoral interventions of ECD, and identify the gaps between policy and implementation. The focus of this evaluation was on the five sectors touched on above and considered central to ECD provision: education, health, nutrition, WASH, and protection.

As agreed with UNICEF and the National Planning Commission (NPC) at the start of the assignment, the evaluation did not focus on any particular set of interventions to assess the performance of the ECD strategy against the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) criteria. Instead, we assessed the whole milieu of activities in the ECD sector to determine their contribution to the ECD strategy and its objectives.

Evaluation objectives and intended audience

The main objectives of the evaluation are to:

- Reconstruct a theory of change (ToC) for the ECD Strategy 2004–2015;
- Assess the existing services available for ECD across the sector;
- Assess how the ECD strategy (2004–2015) was integrated in key sectoral strategy/policy documents, programmes and budgets;
- Assess the implementation linkages with key ministries in Nepal, especially the ministries of Education, Health, Federal Affairs and Local Development (MoFALD), and Women, Children and Social Welfare in implementing ECD programmes at national and subnational levels; and
- Assess the extent to which the interim outcomes/results of the ECD strategy were achieved.

The purpose and objectives of the evaluation are reflected in the four key research questions, which underpin the findings of this evaluation:

1. How successful was the implementation of the current national ECD programme in line with the national ECD vision?
2. How efficient were the sectoral resources allocated to ECD in meeting national and subnational needs?
3. How were the implementation of ECD programmes and achievements perceived by key stakeholders in the intervention districts?
4. What learning can be drawn to inform the new ECD strategy development and implementation?

The findings from this evaluation are expected to contribute to provide strategic guidance during the elaboration of the new ECD strategy (2017–2030), and the findings and recommendations will support the government in policy making and national and subnational planning.

The main audiences of this evaluation are the NPC, the Ministry and Department of Education, the Ministry of Health (MoH), the MoFALD, the Ministry of Women, Children and Social Welfare (MoWCSW), the ECD council, the ECD network, the ECD caucus, UN agencies, development partners, international and local non-government organisations (NGOs), and other stakeholders in ECD.

Evaluation methodology

The evaluation questions have been addressed through primary qualitative research, complemented by an analysis of secondary quantitative data and existing documents. We have used a mixed-methods approach to consolidate the findings from qualitative and quantitative evidence gathered from multiple sources to cover the breadth and depth of the evaluation in a comprehensive and rigorous manner.

Secondary data sources were used to provide descriptive statistics of the national context on selected indicators of ECD services in the education, health, nutrition, WASH, and protection sectors. These informed the design of the primary data collection and provided insights into and a source of triangulation for the information collected through qualitative research. However, the lack of availability of critical data in some areas, including the lack of disaggregated data by age, limited the level of secondary analysis.

Selection of districts: As suggested in the Terms of Reference (ToR), we selected seven districts covering all ecological belts and seven provinces of the country, based on a range of variables of interest.

Selection of ECD centres: ECD centres were sampled purposively based on variables of interest such as existence of community-based ECD centres, number of households in the community where an ECD centre is located, and the number of children aged under five in that community. The evaluation team visited at least one school-based ECD centre in each of the seven provinces, as well as one community-based ECD centre in each of the four sites where these were present.

Selection of respondents: We identified school- and community-based ECD centres in our selected sampling units in each district, and then carried out interviews and focus group discussions (FGDs) with a wide range of stakeholders to inform and triangulate our findings.

The evaluation team faced several challenges. In particular, we were trying to carry out a retrospective evaluation of an ECD strategy with a timeframe of over a decade, which had technically ended several ago (in 2015). This is a serious limitation, as there is a mismatch between when the strategy was devised and implemented versus when we were carrying out our evaluation.

Key findings

Although the ECD strategy is explicit about a holistic approach to ECD, the provision of ECD services has in reality taken place in sectoral terms. Relevant line ministries have been responsible for providing specific services to children between conception and five years of age, but these have not been integrated meaningfully to ensure that each child has received each of the services necessary to support the holistic development of the child.

The MoE provided the leadership to draft and deliver Nepal's ECD strategy. In practice, Nepal's ECD strategy has remained largely an ECE strategy. To the extent that other ministries provide services to children till the age of five, their relationship to ECD has been largely incidental, with limited coordination and integration in terms of the design and delivery of relevant services in education, health, nutrition, WASH, and protection.

Given this sectoral approach to programme design and delivery, our evaluation has also had to follow a similar pattern for the summative component, with the evaluation and report also relying on sectoral findings to assess ECD in Nepal. These sectoral approaches were rarely linked directly to the ECD strategy, even if they were servicing children under the age of five, so it was difficult to ascertain the impact of ECD programmes in line with the national vision.

Education

There have been some significant improvements in the provision of ECE in Nepal, although disparities remain. Enrolment in ECD centres increased from 512,151 in 2004 to 977,365 in 2015. The average time taken to reach ECD centres has decreased to 19 minutes, as the number of ECD centres increased from 4,032 in 2004 to 35,991 in 2015. While only 28.9% of children aged 36–59 months are receiving ECE in the Far Western Hills, this proportion is 78.2% in Central Hills, demonstrating the significant disparity based on geography. This disparity can also be observed in terms of wealth: while 41.2% of children of this age attend ECE among children from the poorest quintile of households, this proportion more than doubles to 83.5% for the children from the richest quintile of households.

The quality of ECE also remains a challenge, particularly because the remuneration for facilitators is very low. This has led to low retention and low motivation, which has limited the impact of the various trainings these facilitators have received.

The percentage of children with ECD experience in Grade 1 increased from 10.9% in 2004 to 62.4% in 2014. Although 64.4% of children are considered to be developmentally on track in three of the four domains of literacy/numeracy, physical, socio-emotional, and learning, only 28.8% of children are developmentally on track in literacy/numeracy. This proportion is as low as 7.7% for children from Far Western Hills, compared to 75.1% for Kathmandu Valley, denoting almost a ten-fold difference. Only 12.3% of children from the poorest quintile of households are developmentally on track for this component, whereas this proportion is five times more, at 65.1%, for the richest quintile of households. The performance of girls (66.6) is slightly higher than boys (62.4) in terms of being developmentally on track.

The education sector budget for ECD has been increasing in nominal trends, with a significant proportion of these funds being used for the salary of facilitators. However, the salary of each facilitator remains low, which has affected the quality of the provision of ECD services. The overall ECD education budget execution rate is high in Nepal, at over 95%. However, although there is limited data on this issue, it is clear that the current level of financing falls short of providing access to high-quality services for all children.

Health

There has been an overall increase in safe motherhood practices across Nepal. The proportion of deliveries facilitated by skilled birth attendants increased from 12.7% in 2001 to 40% in 2017, and deliveries at institutions have increased from 9% to 22% during the same period.

Nepal achieved its Millennium Development Goal (MDG) of reducing under-five mortality rate from 54 to 34 per 1,000 live births. A range of new interventions to promote exclusive breastfeeding and immunisation, among others, have helped to reduce child mortality in Nepal. Similarly, significant emphasis on community-based approaches to the delivery of maternal and child health promotion services has contributed to declining trends in child mortality. However, there is a big difference between the rich and poor, with this rate at 22 per 1,000 live births for the richest quintile and at 57 per 1,000 live births for the poorest quintile of households.

The percentage of children vaccinated against polio3 has remained similar in the last 11 years, at around 79%. The target of taking DPT (diphtheria, pertussis, and tetanus) vaccine coverage to 90% was not reached, and coverage is not uniform throughout the country in any case.

Budget allocation in health increased by almost four times between 2004 and 2015, which is a significant increase, even accounting for the expected increase in the total population. However, the expenditure is not as efficient compared with the allocation of the budget. In 2004/05, only about 54% of the allocated budget was utilised in the health sector. This figure increased to about 87% in 2015/16, but this still represents underspend of 13%. Disaggregated data to analyse the specific implications for ECD-related activities were not available.

Nutrition

The percentage of children who had growth monitoring visits increased from 54.4% in 2004 to 78.2% in 2015. Nepal has made significant progress in reducing the prevalence of stunting, wastage, and emaciation between 2006 and 2016. For instance, the rate of stunting has decreased from 57% to 36% in the last 10 years, although the MDG target to reduce it to 28 by 2015 was missed. The rate of wastage has decreased from 12% to 10% in the last 10 years, while the underweight rate decreased from 39% to 27% during that period.

There is a significant gap between budget allocation and budget spend in nutrition. Only 32% of the funds were used in 2004/05. While this proportion increased to almost 50% in 2015, there is still a significant gap between allocated budget and fiscal expenditure.

WASH

Access to improved water sources increased from about 82% in 2006 to 95% of households in 2016.

Although the ECD strategy had expected facilitators would work on soft parts of WASH to initiate behaviour change among children attending ECD centres through curriculum

implementation and collaboration with local health workers, the availability of WASH facilities has been limited and behavioural change has not been observed extensively either.

The proportion of the population using improved sanitation facilities increased from 39% in 2005 to 82% in 2015. Some positive changes were also observed in the practice of safely disposing of children's stools.

Several different agencies and institutions have been involved with delivering WASH-related services, so it has been difficult to ascertain the exact amount spent on these activities. There are no data available that are disaggregated to reflect the amount or proportion used on ECD activities, although government records show that there is a funding gap in WASH.

Protection

A number of sectoral interventions are associated with ensuring the protection of children under the age of five, but a lack of coordination and linkages between different aspects of the development rights of children continues to diminish this agenda. For instance, both birth registration and the provision of child grants can contribute to the protection of children, but these have not been aligned sufficiently with children who attend ECD centres.

The focus of the ECD strategy is also on children who attend ECD centres, but support is extremely limited, if available at all, for children who are not attending ECD centres or in alternate care (such as in orphanages or prisons). Such children might be the most vulnerable in terms of their ability to access and use ECD services, but their needs remain largely hidden to the system.

The focus of child protection services appears to be on children of school-going age, and there was no disaggregated information on either the services or the funding and budgeting associated with serving children under the age of five.

Conclusion

The findings from this evaluation suggest that the provision of ECD services has generally improved during the timeframe of the ECD strategy (2004–2015). However, despite these improvements, significant geographical and wealth variations remain and these have profound implications for access to and quality of ECD services. To the extent that ECD services are being provided, there is minimal evidence to suggest that all children are receiving all the key services they should receive to ensure their all-round, holistic development.

Recommendations

These findings point to several key recommendations for the next ECD strategy as well as the provision of ECD services in the future.

The ownership of the entire ECD strategy, beginning from the conceptualising and designing phase, must be shared by each of the relevant sectoral and intersectoral ministries in a defined way. A representative from each of the relevant government bodies should be assigned the responsibility to both draft the ECD strategy and to align all their relevant department programmes and policies related to children under the age of five with this ECD strategy. An intersectoral body (such as the NPC), rather than a sectoral body (such as the MoE), should coordinate these activities.

The fact that Nepal is undergoing an extensive decentralisation process under the new federal set-up presents a unique opportunity to ensure the holistic development and delivery of ECD. Since most local governments will not have experience of doing this before, there is a risk of extreme variation in the provision of ECD services based on the priorities of different local governments, which could contribute toward exacerbating rather than addressing the various disparities in ECD provision. Local governments should thus receive support to deliver the ECD strategy and provide services in a holistic and equitable way.

The ECD strategy should clearly spell out minimum ECD services that all children from conception to the age of five should receive. Such a service mapping should account for both chronology (that is, the services that a child should receive based on their age) *and* theme (that is, the services a child should receive in each of the five key sectors relevant for ECD). Responsibility should be clearly assigned to the officials and/or institutions who are supposed to provide these services.

From the perspective of monitoring and evaluation (M&E), once the key services have been identified some key indicators should be agreed to provide guidance on the success (or failure) of the programme from the beginning of the strategy period. Each ministry as well as relevant local authorities should then regularly collect disaggregated data on those indicators through the Management Information System (MIS) to ensure that this information can be analysed to assess and evaluate the performance of the programmes as well as to inform the design and delivery of future programmes.

The minimum ECD services spelled out in the ECD strategy should be backed by a credible resource plan as well. There should be a strong political commitment to allocate the required resources to deliver this ECD strategy.

There should be a special focus on deprived children, and the ECD strategy should clearly outline both supply-side and demand-side initiatives to enhance access for these children.

The next ECD strategy should explicitly address the quality of ECD services to be made available to children.

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List of abbreviations

ARI	Acute Respiratory Infection
CBOs	Community-based organisations
CSSP	Child Sensitive Social Protection
DAC	Development Assistance Committee
DEOs	District education offices
DoE	Department of Education
DPT	Diphtheria, pertussis, and tetanus
ECCD	Early Childhood Care and Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECDI	Early Childhood Development Index
ECE	Early Childhood Education
ECEC	Early Childhood Education and Care
EDPs	External development partners
EFA	Education For All
ELDS	Early Learning and Development Standards
EMIS	Education Management Information System
EPI	Expanded Program of Immunization
FCHV	Female community health volunteer
FGD	Focus group discussion
GDP	Gross domestic product
GEM	Gender Empowerment Measure
GER	Gross Enrolment Rate
HMIS	Health Management Information System
ILO	International Labour Organization
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
KII	Key informant interview

LBW	Low birth weight
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MCPC	Municipality Child Protection Committee
MDG	Millennium Development Goal
MIS	Management Information System
MoE	Ministry of Education
MoF	Ministry of Finance
MoFALD	Ministries of Education, Health, Federal Affairs and Local Development
MoH	Ministry of Health
MoWCSW	Ministry of Women, Children and Social Welfare
MSNP	Multi-Sector Nutrition Plan
MToT	Master Training of Trainers
NDHS	Nepal Demographic and Health Survey
NEWAH	Nepal Water for Health
NGO	Non-government organisation
NMICS	Nepalese Multi-Indicator Cluster Survey
NPC	National Planning Commission
ODF	Open defecation free
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
PCF	Per Child Fund
PEM	Protein-energy malnutrition
PPC	Pre-Primary Class
RP	Resource Person
RUTF	Ready-to-use therapeutic food
SBA	Skilled Birth Attendant
SCI	Save the Children International
SDGs	Sustainable Development Goals

SLC	School Leaving Certificate
SMC	School Management Committee
SSDP	School Sector Development Program
SSRP	School Sector Reform Plan
TABUCS	Transaction Accounting and Budget Control System
ToC	Theory of Change
ToR	Terms of Reference
ToT	Training of Trainers
UN	United Nations
UNCRC	UN Convention on the Rights of the Child
VCPC	Village Child Protection Committee
VDC	Village Development Committee
WASH	Water, sanitation, and hygiene

1 Introduction

ECD is key to the future wellbeing and learning of children. UNICEF refers to ECD as a comprehensive approach to policies and programmes for children, their parents, and caregivers (UNICEF, 2014). These policies aim to protect the child's rights to develop their cognitive, emotional, social, and physical potential. The goal of the services is to meet the vital needs – such as health, nutrition, education, water, and sanitation – of infants and young children (UNICEF, 2014).

Different terms have been used to describe the services for young children, such as ECD, Early Childhood Care and Education (ECCE), Early Childhood Education and Care (ECEC), and Early Childhood Care and Development (ECCD). These different terms reflect the variations in the focus of services and the age group covered (UNESCO and WCECCE, 2010).

The ECD strategy rose to prominence globally in 1989 at the Convention on the Rights of the Child (CRC). This Convention established that young children have the right not only to survive but also to thrive and develop to their fullest potential. This, in 1990, was expanded to 'learning begins at birth' in the Education For All (EFA) framework adopted in Thailand. In 2000, the goal to 'expand and improve comprehensive ECCE, especially for the most vulnerable and disadvantaged children', was adopted as the first EFA goal at the World Education Forum in Dakar, Senegal (World Education Forum, 2000).

While ECD was not explicitly addressed as an MDG, the commitment to EFA Goal 1 was reaffirmed at the World Conference on ECCE in Moscow in 2010 (UNESCO Bangkok, 2013). The importance of ECD was recognised in 2015 when it was adopted into the 2030 Agenda for Sustainable Development, as part of the UN's global development goals. ECD is addressed in the Sustainable Development Goals (SDGs) as Goal 4 to 'ensure inclusive and equitable education and promote life-long learning opportunities for all'. Target 4.2 of the SDGs discusses ensuring that, 'by 2030, all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education' (UNESCO Bangkok, 2013). Studies show that ECD is the foundation of lifelong learning and if all children receive quality early childhood care to support their development and achieve age-appropriate development and learning outcomes in the early years, then they can participate more effectively and efficiently in the subsequent stages of learning (UNESCO Bangkok, 2013). International evidence on the long-term social and economic benefits of ECD programmes, including reduced dropout, increased primary school completion, and investment returns, are well established (see, for instance UNICEF (2017) and Neuman and Devercelli (2013)).

1.1 Context

The focus of ECD is on every child being physically healthy, mentally alert, emotionally sound, socially competent, and ready to learn. ECD is also concerned with the moral and spiritual development of children. Various studies focused on improving ECD offer evidence that high-quality interventions can produce substantial benefits later in life in areas such as communication and cognitive development, school enrolment and completion, health status, earnings, and self-sufficiency (Engle *et al*, 2007; Young and Richardson, 2007; Love *et al*, 2005).

Amidst the political, social, and educational transformation that Nepal is undergoing, there has been a renewed focus on ECD and the evidence shows that progress is being made, albeit slowly. The Constitution of Nepal (2015) in Article 31 clearly guarantees the right to education: 'Every citizen shall have the right to compulsory and free basic education'. The Constitution lays down the

directive principles of the federal state, provinces, and local bodies on education and the right to education (Ministry of Education, 2016).

ECD programmes are known by various names in Nepal (UNESCO, 2008). There has been a shift in emphasis from ECE to ECCE, and from ECCE to ECD (UNESCO, 2008). The term ECE is used to emphasize the focus on educating children at an early age, and ECCE refers to taking care of children and educating them during the absence of parents. ECD implies the overall development of children (UNESCO, 2008).

ECD activities undertaken by the Government of Nepal are well aligned with national goals and priorities. ECD became a formal part of the national educational policy in 2000, when Nepal adopted the goals and strategies of the EFA Dakar Framework for Action (UNICEF, 2011). The School Sector Reform Plan (SSRP), adopted in 2009, discusses concrete steps to incorporate ECD into the national education system (UNICEF, 2011). The School Sector Development Plan (2016) aligns with Nepal's international commitment to the SDGs, as adopted by the UN in September 2015. Building upon the lessons learned and the gains made in the ECD sector, the School Sector Development Program (SSDP) aims to ensure the achievement of the SDG 4 target of ensuring equitable and inclusive quality of education (Ministry of Education, 2016).

The key organisations responsible for the implementation of early childhood programmes can be divided into three categories: government ministries; UN agencies, international and local NGOs; and the private sector (UNESCO, 2008). The ministries of Education, Federal Affairs and Local Development, Health, and Women, Children and Social Welfare are primarily responsible for ECD programmes. The MoE, through its Department of Education (DoE), implements many ECD programmes as a part of its EFA programme components (UNESCO, 2008). The MoH under its various programmes, especially its Mother and Child Health (MCH) programme, provides health services to pregnant women, lactating mothers, and young children, and monitors the nutritional status of children below three years in some districts (UNESCO, 2008). At the local level, municipalities and village development committees (VDCs) have administrative and logistical responsibilities, including financing and monitoring of schools to ensure quality of education (Government of Nepal, 2016). The SSDP seeks to enhance their capacities and responsibilities (Government of Nepal, 2016). UN agencies such as UNICEF and UNESCO not only support the government and other agencies in the development and implementation of ECD programmes but also implement ECD programmes through their regional offices (UNESCO, 2008).

There is a lack of equitable access to early childhood services for all in Nepal. Access to essential health and protection interventions for pregnant women and young children and access to essential nutrition interventions in Nepal are adequate for some but not for others. Stunting and infant mortality are still prevalent. Data show that 42% of children under five suffer from moderate to severe stunting, demonstrating that children in Nepal are not receiving their essential nutrition requirements (World Bank, 2013). Only about a third of children have access to pre-primary school in Nepal (World Bank, 2013). ECD services are not equitably accessible between socioeconomic levels or geographic locations. Evidence shows that children living in rural areas are less likely to have access to essential health and sanitation services (World Bank, 2013). It also shows that, of the children in the richest quintile, 61% were attending pre-primary or ECD centres; however, only 14% of children from the poorest quintile were doing the same (World Bank, 2013).

Quality ECD services are essential for better cognitive and social development in children. Standards for service providers exist in Nepal; for example, preschool teachers are required to have formal education at least till grades 9 and 10 (World Bank, 2013). Pre-primary teachers are also required to complete in-service training on health, cognitive, social, and emotional development (World Bank, 2013). However, studies show that training of teachers and facilitators

is particularly challenging in Nepal due to high teacher turnover at the ECD centres (See, for instance, van Raven (2009)).

Although quality standards for ECD services are established in Nepal, the enforcement of regulatory mechanisms needs strengthening (UNESCO, 2015). According to van Raven, funding problems make follow-up monitoring a challenge. Private providers of ECD centres also face challenges regarding quality of services (van Raven, 2009). According to van Raven (2009), private ECD centres lay more emphasis on academics and teaching English with the objective of optimising cognitive performance. As a result, children do not receive holistic development (van Raven, 2009). Thus, ensuring quality standards is a serious concern and challenge.

Nepal has been promoting and expanding ECD services since the 1950s because of their importance as well as the country's needs, with sectoral-driven ECD programmes in health, nutrition, protection, and education. Nevertheless, the ECD concept still focuses most on education (ECD centres), as evidenced by several government documents on ECD.

The ECD Strategy Paper (2004) was developed under the leadership of the MoE with elaborate plans/strategies to expand ECD services in the country. The ECD strategy was developed to speed implementation of the National Policy on ECD and ensure it is in line with the EFA programme. It is a statement of intent underlining what should be done to ensure that Nepali children are given a fair chance to survive, grow, develop, and participate. The strategy envisioned that quality services with specific criteria for all stakeholders – including ECD children, parents, facilitators, and the centres – would be achieved by 2015. The paper also provides ECD projections and targets to be achieved by 2015.

The ECD Strategy paper (2004) places emphasis on ensuring coordination among ECD providers and tries to create synergies in the planning, management, and operational aspects of the ECD programme. The ECD Strategy Paper's focus was on ECE, but efforts were also made toward making it more holistic by integrating aspects of health and nutrition. The Strategy Paper does not focus explicitly on WASH and protection issues, which should be addressed in the next strategy.

With the NPC and Ministry of Finance (MoF) providing the overarching framework for the resurgence of the ECD programme in Nepal, the MoE, MoH, MoWCSW, and MoFALD are involved in ECD implementation. The EFA National Plan of Action (2001–2015) stipulates three types of ECD programmes in Nepal: (a) school-based programmes including pre-primary classes (b) community-based programmes for children aged 3–5; and (c) parental programmes for children under three.

The vision document for ECD in Nepal sets out four target areas to be developed by 2015: those related to children, the ECD facilitator, ECD centres, and parents. These are described in detail below:

- More than 80% of children aged 3–5 are attending ECD programmes, irrespective of their sex, caste, ethnicity, and location.
- More than 90% of the children attending ECD programmes will transit to primary education equipped with basic competencies to study and grasp the primary level curricula.
- Children below three years of age will receive enough and appropriate attention from their parents and communities so that they will be provided with adequate care through health and nutrition services.
- There should be an ECD facilitator of the ECD programme (at the child development centre and in the pre-primary class) who is competent to take care of the child.

- The ECD facilitator should have a minimum qualification of a Class 8 pass certificate to be recruited as facilitator. Moreover, the facilitator should have opportunities for professional growth.
- In terms of the infrastructure, the ECD centre should be an enabling environment for children's learning.
- The parents of children attending the ECD programme have basic knowledge and skills on learning and the developmental needs of children. The parents should come to the ECD centre and help the facilitator in relation to care-giving and educational activities.

Nepal has developed various plans, programmes, strategies, and projects related to ECD services in the education, health, nutrition, WASH, and protection sectors to develop this vision. Periodic revisions have been made to policy documents to incorporate commitments made by Nepal in international forums and to account for emerging needs in relation to ECD services. Ministries and departments in these sectors are responsible for implementation of ECD programmes related to their sector. The table below lists documents, implementation activities, and strategies related to ECD services.

Table 1: ECD-related strategies, programmes, and projects in Nepal

SN	Programmes/ projects/ activities/ strategies	Implementation strategies	Targets, if any
Education			
1	EFA National Plan of Action (2001–2015 and EFA (2004–2009)	<ul style="list-style-type: none"> • Coordination, networking, and partnership • Decentralised management • Community involvement • Human resource development • Use of communication and mass media • Development of national ECD curriculum, training package, and networking of ECD-related organisations 	2000 ECD centres
2.	Tenth Plan (2002–2007)	<ul style="list-style-type: none"> • Prepare children for enrolment to the primary level of education • Holistic development • Training of teachers/facilitators • Awareness programmes for parents and guardians 	
3	Ten-Year National Program of Action for Children	<ul style="list-style-type: none"> • Intersectoral implementation and coordination • Community participation 	Universal access to basic education
4.	SSRP (2009–2015)	<ul style="list-style-type: none"> • ECED Council chaired by Secretary of MoE • Coordination Committee of NPC • DoE implementing ECED programme in collaboration with international and local NGOs • Foster children's all-round development, laying a firm foundation for basic education • Expand access to quality ECED services for children of four years of age to prepare them for basic education • Fund a year-long programme for children of 4-5 years • Ensure access to the ECED programme for disadvantaged populations • Expand the ECED programme with a greater focus on qualitative improvement and maintaining an equitable 	<ul style="list-style-type: none"> • Gross enrolment of 99% • 87% of four-year-old children gain ECED experience • Minimum standards for the ECED are met by all ECED centres

		<ul style="list-style-type: none"> balance between needs and demands of children and communities Ensuring state support for the establishment, operation, and sustainability of ECED centres Implementing ECED operational guidelines 	<ul style="list-style-type: none"> 64% of children entering Grade 1 have ECED experience
5	The 11 th Plan of Nepal	<ul style="list-style-type: none"> Continue community-based child centres, and provide more centres based on the demand for the operation of one-year pre-primary centres Make programmes in schools comprehensive Main responsibility for operating the Community Child Center with local bodies, who will mobilise local level organisations and institutes such as mothers group, youth group, users' group, and saving group 	<ul style="list-style-type: none"> Establish 9,000 new pre-primary education/ primary child development centres Establish 4,000 community-based ECD centres
6	13 th Plan of Nepal	<ul style="list-style-type: none"> Expansion of ECD programmes in an integrated approach Institutional growth of community- and school-based ECD programmes, increase access to ECD, empowerment of facilitators and management committee members, quality enhancement and work collaboratively with community to increase the access of disadvantaged groups of people to ECD 	
Health and nutrition			
7	Population Policy 2071 BS	<ul style="list-style-type: none"> Collaborate to integrate reproductive health within the curriculum 	
8	National Health Policy 2071 BS	<ul style="list-style-type: none"> Initiate midwifery education to develop human resources for the safety of mothers and children Implement multi-sector nutrition policy and food safety programmes with the aim of improving nutrition status Establish a vaccination fund to ensure an uninterrupted vaccination programme 	

9	Health Strategy Improvement Plan 2004	<ul style="list-style-type: none"> • Prioritised areas include safe motherhood, family planning, child's health, control transferrable disease, and strengthened outpatient care • Prioritise the access for poor and deprived communities
10	National Nutrition Policy and Strategy 2004	<p>Objective 1: To reduce protein-energy malnutrition (PEM) in children under five and women of reproductive age</p> <p>Target</p> <p>1. To reduce the prevalence of PEM among children to half of the 2000 level by 2017</p> <p>2. To reduce the prevalence of low BMI in women to half the 2000 level by 2017</p> <p>Objective 2: To reduce the prevalence of anaemia among women and children. Target 1: To reduce the prevalence of iron deficiency anaemia to less than 40% by 2017</p> <p>Objective 3: To virtually eliminate iodine deficiency disorders and sustain the elimination</p> <p>Target 1: To virtually eliminate iodine deficiency disorders by 2017</p> <p>Objective 4: To virtually eliminate vitamin A deficiency and sustain the elimination Target 1: To virtually eliminate vitamin A deficiency</p> <p>Objective 5: To reduce the infestation of intestinal worms among children and pregnant women</p> <p>Target 1: To reduce infestation of intestinal worms to less than 10% by 2017</p> <p>Objective 6: To reduce the prevalence of low birth weight (LBW)</p> <p>Target 1: To reduce the prevalence of LBW to 12% by 2017</p> <p>Objective 7: To improve household food security to ensure that all people can have adequate access, availability and utilisation of food needed for healthy life</p> <p>Target 1: To reduce the percentage of people with inadequate energy intake to 25% by 2017</p>

		<p>Objective 12: To reduce the critical risk of malnutrition during exceptionally difficult circumstances</p> <p>Objective 13: To strengthen the system for analysing, monitoring, and evaluating the nutrition situation</p>
11	Golden Thousand Days 2070 implementation	<ol style="list-style-type: none"> 1. Ensure appropriate weight and food 2. Increase use of animal food 3. Breastfeeding (right ways and frequently) 4. Safe and clean drinking water 5. Late marriage and conception for adolescent girls 6. Regular deworming and iron tablets for adolescent girls 7. Adolescent education 8. Family planning 9. Handwashing habits (regularly and appropriately) 10. Ensure vaccination for young children 11. No open defecation 12. Ensure health services 13. Reduce work load for pregnant women 14. Improve school hygiene and cleanliness 15. Reduce smoke
12	Tenth five-year plan (2060–2064)	Children are supported with various health programmes at health posts and health centres in VDCs and municipalities. Priority given to children at risk, and for the improvement of the services activate local government
13	Thirteenth plan (2070–2073)	<ul style="list-style-type: none"> • Safe motherhood, antenatal care (ANC) and child's health-related programmes are prioritised • Ensure adequate care and nutrition from conception to birth • Implement programme for child's physical, cognitive and mental capacity development
14	Fourteenth Plan (2073–2076)	<ul style="list-style-type: none"> • Increase access to vaccines, vitamin A, polio, and basic health care facilities
Protection		

15	10 th Plan 2002–2007	<ul style="list-style-type: none"> • Increase in birth registration, reduce child marriage, and monitor the situation of adopted children, • Necessary measures will be taken to encourage birth registration and control child marriage • Refinement of acts to ensure children's rights and development of necessary laws and of national action plan related to children's rights • Grant and economic support to Nepalese children's organisations including NGOs involved in children's rights for launching programmes related to protection and development of children's rights • In 2009/10 with the objective of specifically improving the nutrition of children, the Child Grant Program was introduced starting from Karnali Region (Jumla, Humla, Kalikot, Dolpa and Mugu) and all Dalit children across the country
16	11 th Interim Plan 2007/08– 2009/10	<ul style="list-style-type: none"> • Resource centres will be used to collect different information related to children and birth registration, and the process of recording details, carried out by local bodies, will be made more effective • Special programmes will be run through education and other service-providing institutes related to children for their physical, emotional, and moral development • Child-friendly campaigns for childcare, child welfare, development, participation, and protection will be institutionalised in local bodies • Encourage changes in people's food habits to match food available in the local areas. Increase feeding practices like 'a little and many times a day', especially for infants. Increase awareness of balanced diet and its practices • Promote the sale and distribution of local production and decrease prices in food-deficit areas • Conduct M&E activities in relation to ECD services

17	12 th Interim Plan 2010/11–2012/13	<ul style="list-style-type: none"> • Create a conducive environment for children's physical, mental, cognitive, and intellectual development by eliminating all forms of exploitation, discrimination, abuse, violence, risks, and their reasons • Promote programmes aiming at rehabilitation and alternative care mainly targeting children without family and at risk • Improve monitoring and distribution system; register births, enhance and implement child social protection activities including school nutrition and day meals, linking with programmes of local body, community and NGOs; enhance children's home/orphanage; establish and expand child-friendly ward in every hospital; and establish nutrition centres
18	13 th Interim Plan 2014/15–2016/17	<ul style="list-style-type: none"> • Current nutrition-related programmes will be upgraded and adjusted to meet the objective set by the multi-sector nutrition plan. • ECD process will be well managed by making children's birth registration mandatory. • Ensure the management of required care and nutrition from the antenatal to the postnatal phase. • Implement programmes necessary for children's physical, mental, and intellectual capacity development. • Trace and rehabilitate disappeared children; emergency service, rescue and rehabilitation of children at risk; effective operation and expansion of integrated service with free help line phone service 1098 for immediate rescue and protection of children affected by child right violation; orientation and monitoring for effective implementation of the guideline for operation and management of children's home. • Establish child welfare fund and implement programmes to rescue, protect, and promote rights of marginalised children and children at risk.

WASH			<ul style="list-style-type: none">• Implement family sensitisation support programme to promote children's right to grow under parental care.
19		10 th Plan	<ul style="list-style-type: none">• Assist in reducing the child mortality rate by controlling water-borne and water-induced diseases and thereby helping to increase income generation through opportunity of utilising saved labour from illness

The total number of community- and school-based ECD centres and pre-primary classes (PPCs) is 35,991, of which 5,543 PPCs are in institutional schools and the remaining 30,448 are either community schools or community-based ECD centres (Ministry of Education, 2015). The Plan of Action for Children and Development has emphasised the need for providing pre-primary education to all under-age children enrolled in Grade 1 in government-aided schools. This would be done by a gradual expansion of ECD programmes depending upon the availability of resources.

According to the strategy document (2004), a major aspect of the ECD programme is the need for coordination, networking, and partnership with communities for ECD implementation. Moreover, coordination among various ECD programmes is required so that there is optimal use of resources and duplication of services is minimised. However, the strategy was not specific enough on how this coordination and networking would take place in terms of implementation. As such, it was not clear with whom or how this would function.

Community participation, too, is crucial for efficiency in ECD implementation and sustainability in the programmes. For instance, ECD training packages, curricula, and learning materials will be developed by coordinating with and catering to local needs and those that address children's diversity.

Parents and caregivers play an important role in the rearing of and caring for children. However, due to financial constraints and livelihood pressure, parents might have limited time for nurturing their children and are thus not able to support the children as needed. To this end, the Tenth Five-Year Plan encourages NGOs and other societal organisations to launch parental education programmes that expand the knowledge base and skills of fathers and mothers, surrogate parents, guardians, and caretakers of children aged 0–5 years, particularly those in low-income and marginalised groups.

For the holistic development of children, health and nutrition targets have also been integrated into the ECD strategy. At the ECD centres, the health and nutrition programme packages were to be developed at the local level in consultation with potential partners and local stakeholders including health clubs, user groups, schools, and community user groups. Local people will be trained as ECD facilitators and resource persons to follow an integrated approach that includes health and nutrition.

The main aim of the Early Childhood Development Index (ECDI) is to determine the developmental status of children. According to the Nepalese Multi-Indicator Cluster Survey (NMICS) of 2014, the ECDI indicates that only 64.4% of children aged 36–59 months are developmentally on track in at least three of the four domains of literacy/numeracy, physical, socio-emotional, and learning (NMICS, 2014). As we discuss later in the report, the disparity between regions varies: the highest proportion of children developmentally on track was in the Central Hills region (84%) and the lowest proportion was in the Mid-Western Mountains (43%). Out of a total of 75 districts, 19 districts in Nepal had a low ECDI score range of 42 to 55.

With respect to the health indicators that NMICS 2014 covered, the infant mortality rate was 33 deaths per 1,000 live births and the under-five mortality rate in Nepal was 38 deaths per 1,000 live births. Moreover, the stunting and wasting rate was reported at 37% and 11% respectively among children under five. Childhood diseases such as pneumonia and diarrhoea remain a threat to the most disadvantaged populations where care-seeking practices, community and facility-based care, and treatment are inadequate. Additionally, the survey notes that there has been a declining trend in neonatal mortality at the national level. Neonatal mortality decreased from 29 deaths per 1,000 births during the 5–9 year period before the survey to 23 deaths per 1,000 births in the most recent five-year period. Other child-related issues of child labour, child marriage, exposure to violence, abuse, and harmful traditional practices also affect a substantial number of children in Nepal.

NMICS 2014 states that children attending an ECE programme were much more likely than those not attending to be developmentally on track according to the ECDI (80% compared to 49%).

1.2 Programme overview

The purpose of the assignment was to conduct an evaluation of Nepal's National Early Childhood Development Program (2004–2015) to identify potential ways of enhancing coordination among key ministries, demonstrate the linkages between ECE and other sectoral interventions of ECD, and identify the gaps between policy and implementation. The evaluation is expected to contribute to provide strategic guidance during the elaboration of the new ECD strategy (2017–2030), while the findings and recommendations will support the government in policy making and national and subnational planning.

We have aimed to provide a comprehensive evaluation of the ECD programme. The evaluation did not focus on any particular set of interventions to assess the performance of the ECD strategy against the DAC criteria. Instead, we assessed the whole milieu of activities in the ECD sector to determine their contribution to the ECD strategy and its objectives.¹

ECD, MoE, and governance/ownership

There is widespread agreement among all respondents that Nepal's ECD strategy (2004–2015) is really an ECE strategy. Although the language of the strategy is more inclusive, and calls for the holistic development of children, the actual drafting of the strategy, the ownership over the process, and the ultimate implementation of key policies fell under the primary purview of the MoE. Our evaluation thus explored in greater detail the reasons why this was the case and proposes recommendations on how this could be addressed in the future.

In particular, ECD fell under the purview of the MoE because of the obvious emphasis on ECD within the school system in the Nepali context, particularly given the growing importance and relevance of EFA in 2000, which had an explicit ECD component. In practice, then, the sector under the purview of MoE was called ECD, even though in effect MoE focused primarily on ECE.² Although the MoE pursued a collaborative, consensus-based agenda to develop the strategy, the participation of representatives from other ministries (such as Health) was not consistent. In theory, representatives from key ministries always attended these drafting meetings, but they were not always the same representatives who attended the previous meetings. In addition, these ministry representatives were not always able to relay the information from the consultative meetings effectively to other officials in their own ministries. They were also not always senior or influential enough to direct the agenda of their ministries based on the consultations on ECD that were taking place in these meetings. As a result, even though most ministries participated in these consultative processes in theory, the cumulative effect was not necessarily a consultative, shared agenda that was owned by all ministries equally.

The culture of portfolio management within the ministries also appears to have made it difficult to implement an integrated ECD strategy across different ministries. Each ministry has its own plans, policies, and mandates based on their own priorities, and since the MoE was seen to be taking the lead on the drafting of the ECD strategy the other ministries did not take the same ownership over it. Further, although the strategy itself was comprehensive and integrated, other ministries were not always willing to implement a policy that was seen to have been led and directed by the MoE, which they considered to be a parallel rather than superior ministry. According to an MoE official,

¹ This approach was agreed with the NPC and UNICEF during the inception phase.

² We note that the Ministry of Education previously used the term 'ECED' but has been using the term 'ECE' since the Eighth Amendment of the Education Act.

'We [i.e. the MoE] made a mistake because we drafted the policy, and no matter how good the policy, the other ministries felt that they did not have any reason to follow that policy. So, it did not matter how good the policy was in the end.'

This issue was most pronounced in the allocation of business between the MoE and MoFALD. The MoE had hoped that it would provide the technical input and support for the ECD strategy, while MoFALD would be responsible for a significant portion of the resourcing and implementation of the strategy on the ground. However, stakeholder interviews suggest that, since the MoE was seen to have drafted and taken ownership of the strategy, MoFALD staff did not feel that they were responsible for the delivery of the strategy in the same way. They thus fulfilled the minimum expectations placed on them, without taking overall responsibility or ownership over the processes. As an example, MoFALD was expected to approve ECD centres at the local level, and even though it had been expected that it would assess the need and appropriateness of ECD centres based on their quality, MoFALD approved all requests to establish centres if they had received funds from the MoE for those centres. Our informants noted that MoFALD did not necessarily carry out checks regarding requirements and quality control for these centres, but simply acted as a disbursement body. Further, it did not carry out assessments regarding where these centres were most needed and did not provide MoFALD resources to support new or existing centres. This lack of ownership seriously undermined the implementation of the ECD strategy as envisioned, as the MoE was left to not only provide technical support but also became the only major institute providing resources for these centres.

One of the implications of this dynamic was that even when the strategy talked about the holistic component of ECD, the emphasis of this 'holistic' approach still remained limited to children of ECE age, i.e. 3–5 years old.³ In other words, to the extent that the strategy is explicit about holistic development, the focus is still on children of pre-primary school age but remains silent on the key ECD services children are expected to receive before they turn four. This is problematic not only because all such services in other sectors (such as health and nutrition) are important in their own right, but also because those services could have a direct impact even on the ability of the same children to then attend ECD centres and receive ECE, and also because 0–3 is a critical age group with lifelong impact. The capacity of children to learn would also be affected, as they could face more disadvantages than children with better health and nutrition. The undue ownership of the MoE over ECD in Nepal has thus had a significant impact on how 'holistic development' has been envisioned and ECD policy has been developed and understood in the country.

Provision of ECD services

Our preliminary findings hinted that the ECD strategy has not been integrated effectively within the policies, programmes, and budgets of the major programmes concerned with ECD. In this evaluation, based on consultations with different stakeholders, the team focused on five sectors as being critical to ECD: education, health, nutrition, WASH, and protection. A cursory assessment of the key policies and programmes of all the other sectors besides education make no direct reference to the ECD strategy. It appears clear, then, that there is a significant divergence between policy and practice when it comes to the ECD strategy.

Having said that, it is also clear that all of these sectors provide specific services targeted to children from conception or birth to 60 months.⁴ For instance, the MoH and its constituent

³ Although the age group was 3–5 years within the strategy period, it is now considered to be 4–5 years.

⁴ There is significant debate on whether ECD should focus on 0–5 or 0–8. In recent years, UNICEF has revised its emphasis from 0–8 to 0–5 for ECD target age. This has been done for three key reasons, according to a UNICEF source. First, since the years 5–8 are clearly within the mandate of the school system, many stakeholders believe that

organisations and institutions provide a number of services to ensure the health and wellbeing of children. Their programmes prioritise 0–2 years in the form of vaccinations, immunisations, and health check-ups. All these services can be considered integral parts of ECD.

At the same time, our conversations with different ministries made it clear that, while these services are provided, they are not delivered together through a holistic, integrated framework of ECD. While each sector provides services as per its sectoral plans and policies, there is a clear need for better integration to ensure that the same child receives each of the necessary inputs of education, health, nutrition, WASH, and protection. Even for children who do receive most of these services, it is not clear whether the quality of the services is good enough to support the overall development of the children.

Our understanding, then, of the provision of ECD services in Nepal is of segregation, not integration. We thus provide a clear understanding of the segregated services that children are supposed to receive from the five key sectors, and then assess the reach and quality of those services as they relate to ECD.

The following table lists the services that are being provided by various ministries, targeting children of ECD age.

Table 2: Services provided by various ministries

Age group	MoH	MoFALD	MoWCSW	MoE
Conception to birth	Safe motherhood Vaccination of mothers Nutrition support to mothers and children	Activities under the Child-Friendly Local Governance programme (CFLG) Child Grant Birth registration Activities under the Multi-Sector Nutrition Plan (MSNP) Golden thousand days	Provide protection to abandoned children Orphanages	Parenting education
Birth to 2 years	Vaccination Nutrition support Golden thousand days support Treating children if they get sick Curing acute malnutrition in children	Activities under CFLG Child Grant Activities under Golden thousand days Day care centres Preschools Montessori education	Provide protection to abandoned children Orphanages	Parenting education

this age group could be assigned within the education ecosystem, rather than as part of ECD. Second, since resources are finite, organisations like UNICEF increasingly believe that they need to target resources to the age groups that are currently not being targeted, and reducing the total age group from 8 years to 5 years will allow institutions to better target their funds and programmes. Third, UNICEF claims that the returns to the investment between 0–5 years are much higher, and the returns thereafter decrease.

2 to 3 years	Nutrition support Treating children if they get sick Curing acute malnutrition in children	Activities under CFLG Child Grant for children of Dalits and children in selected districts Day care centres Preschool Montessori education	Provide protection to abandoned children Orphanages	Parenting education
3 to 5 years	Nutrition support Treating children if they get sick Curing acute malnutrition in children	Activities under CFLG Child Grant for children of Dalits and children in selected districts ECD centre support Day care centres Preschool Montessori education	Provide protection to abandoned children Orphanages	ECD centres / PPCs

The evaluation considered the ‘programme’ to include all ECD-related activities associated with the five key sectors. Thus, when we refer to ‘ECD-related activities’ we mean all services provided by these sectors targeting pregnant women and children up to the age of five, regardless of whether these programmes were directly linked to or part of an explicit ECD strategy or programme. In the education sector, then, the focus was on school- and community-based ECD centres. In health, the focus was on prenatal and neonatal care, safe delivery, vaccination and immunisation, and preventative and curative health check-ups for mothers and children. In nutrition, the focus was on feeding programmes, nutrition supplement provisions, and malnutrition programmes. In WASH, the key services included provision of safe water (particularly in schools), provision of WASH-related goods (such as toothbrushes, toothpaste, and soap), and behavioural approaches (such as information on handwashing). Finally, in protection, the focus was on social protection cash transfers to families with vulnerable children, counselling to parents and children, and activities concerning punishment of children. As the report shows, we have more information and findings for some sectors over others, which was reflective of the reality of the situation concerning the provision and integration of ECD-related services by various sectors in Nepal.

1.3 Purpose and objectives of the evaluation

This evaluation consists of both a summative component (assessing the current ECD strategy) and a formative component, which will focus on informing the new ECD strategy development and implementation. The evaluation has three key purposes:

- Identify possible ways of enhancing coordination among key ministries;
- Demonstrate the linkages between ECD and other sectoral interventions of ECD; and
- Identify the gaps between policy and implementation.

The main objectives of the evaluation are to:

- Reconstruct a ToC for the ECD strategy 2004–2015;
- Assess the existing services available for ECD across the sector;
- Assess how the ECD strategy (2004–2015) was integrated in key sectoral strategy/policy documents, programmes and budgets;
- Assess the implementation linkages with key ministries in Nepal, especially the ministries of Education; Health; Federal Affairs and Local Development; and Women, Children and Social Welfare in implementing ECD programmes at national and subnational levels; and
- Assess the extent to which the interim outcomes/results of the ECD strategy were achieved.

The purpose and objectives of the evaluation are reflected in the four key research questions, discussed in more detail in the next chapter. The report addresses the purpose and objectives by responding directly to the research questions, which also provides guidance for the structure of the report.

1.4 Scope of the evaluation

The evaluation covered the period 2004–2015 of the ECD strategy as the reference document, as outlined in the ToR. The evaluation not only relied on the ECD strategy but sought to assess other sectoral plans and policies related to ECD as well.

The emerging picture regarding ECD is a complex one, where at the central level, and in the form of the ECD strategy, the ownership and ultimate emphasis of the agenda has been largely centred on education. ECD centres, which have been established as the primary sites for the provision for ECD services, are also essentially ECE centres. At the same time, at the local level a number of sectoral services are being provided by specific ministries that could come under ECD in theory but are not being provided as such. In structuring this evaluation, then, the research team assessed why and how the ECD strategy has not been integrated at the central and local levels. At the same time, we assessed what services that can be considered to be part of ECD are being provided to children in the key sectors, even if they are not provided under an integrated ECD agenda. Given the methodological complexity of this situation, where our initial unit of analysis is ECE, our primary focus on the summative component of the evaluation is on education (as this is where most work has been done so far). However, at the same time, our formative component focuses on ECD as a whole, so we have tried to provide learnings and lessons by evaluating the nature and quality of ECD services as a whole, even if they have been provided in a segregated fashion.

Geographically, the evaluation has covered all three ecological zones and at least one district from each province, as agreed with the ECD evaluation technical committee. The evaluation sought to include gender, human rights, and equity dimensions.

1.5 Structure of the report

After this introduction, Section 2 presents our evaluation design. This includes our evaluation framework, questions, methodology, limitations, gender, equity and human rights perspective, and our ethical considerations. Sections 3, 4, 5, and 6 present our key research findings, structured as a response to the four key evaluation questions on the successful implementation of the national ECD programme in line with the national ECD vision, efficiency of the allocation of sectoral

resources to ECD in meeting national and subnational needs, implementation of ECD programmes and achievements perceived by key stakeholders in the intervention districts, and learning to inform the new ECD strategy development and implementation respectively. Section 6 presents the key lessons learned and recommendations together, while sector-specific recommendations are provided in the annexes. Section 7 concludes by summarising these findings in relation to the DAC criteria for evaluations, focusing on relevance, effectiveness, efficiency, interim outcomes, sustainability, and gender and equity.⁵

⁵ We note that the structure of the report has been amended from the report outline noted in the original ToR. This change was made to ensure that the findings were presented in a manner that would be most useful to key stakeholders, and because presenting the findings according to the DAC criteria might not have been useful for a report that was not evaluating a specific, singular intervention. This change was agreed with UNICEF in November 2017. We have also made changes to the structure to try to manage the length of the report by avoiding repetition.

2 Evaluation design

2.1 Evaluation framework

The ToR provide a clear mandate for this evaluation to be carried out using the DAC criteria, with some adjustments. First, this evaluation is not meant to determine the impact of the ECD strategy or other ECD services. Instead, as noted explicitly by NPC, this is meant to be a process evaluation. Second, in addition to the standard criteria of relevance, effectiveness, efficiency, and sustainability, the evaluation is also expected to contribute to a greater understanding of gender, equity, and human rights issues in relation to ECD in Nepal. The key research questions, disaggregated by OECD criteria, are presented in the next subsection. The findings from the research will be organised in relation to the four research questions. The results will be disaggregated by sector as well. A summary of the findings in relation to the DAC criteria including gender and equity is also presented.

In addition to these criteria, the ToR are also explicit about reconstructing a ToC for Nepal's ECD strategy 2004–2015. Key stakeholders, including at NPC and UNICEF, appreciate that this is not an easy task, and the accuracy and reliability of reconstructing a ToC for a strategy that was developed more than a decade ago cannot be confirmed with great confidence. Nonetheless, based on a close reading of the ECD strategy as well as some key conversations with experts involved with drafting the strategy, we present below a draft reconstruction of the ToC for the ECD strategy.

Figure 1 provides an overview of the overall ToC for the ECD strategy. Please note that this is meant to give a visual representation of the reconstructed ToC. However, this is separated into five more components, where the ToC for each component is explained further.

In this section, we have added a dimension to the 'usual' ToC. Each section below has a 'Process' component as well, linking inputs to outputs to help understand the ECD strategy as well as provision of ECD services better.

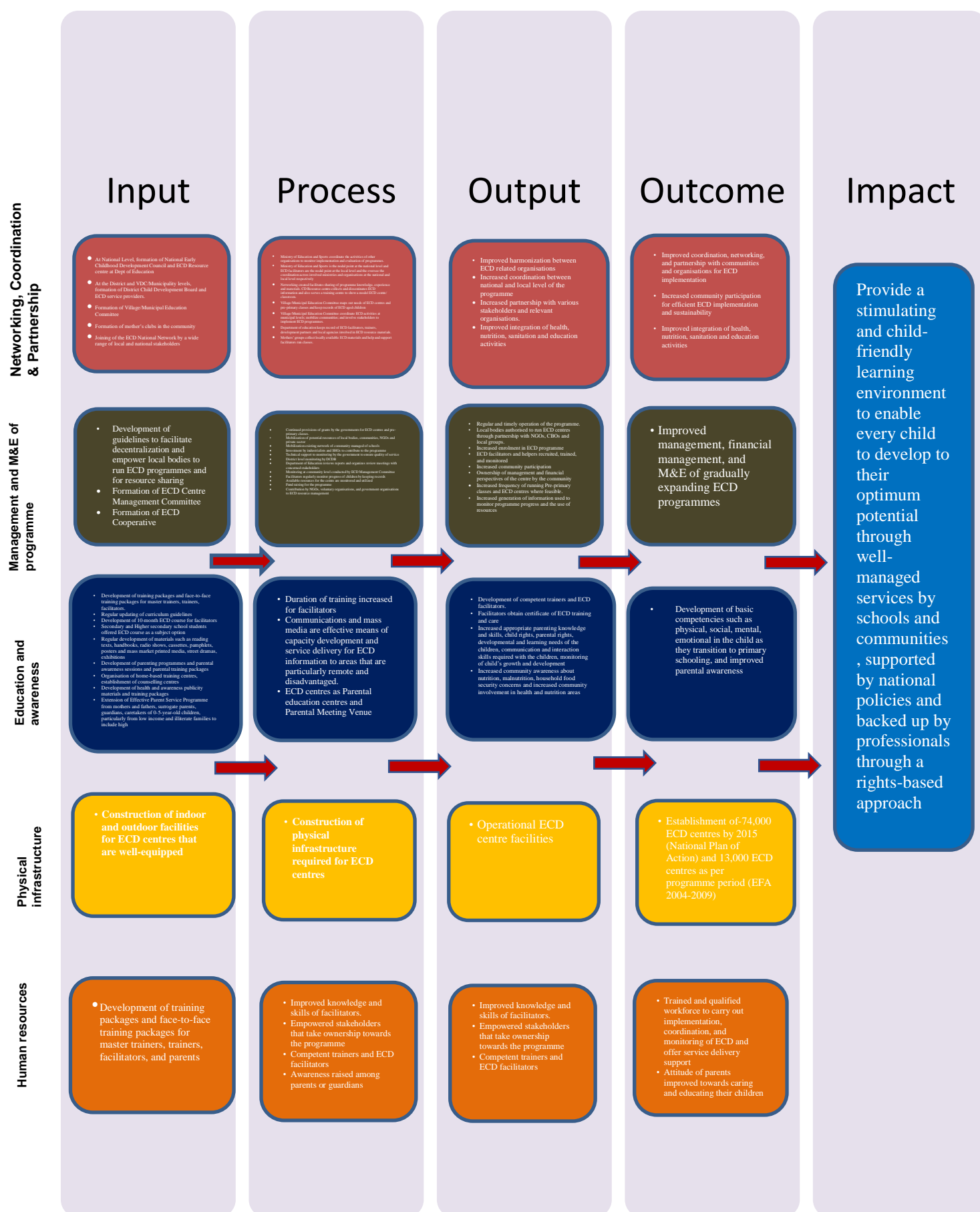
Figure 1: Composite ToC for ECD Strategy 2004–2015

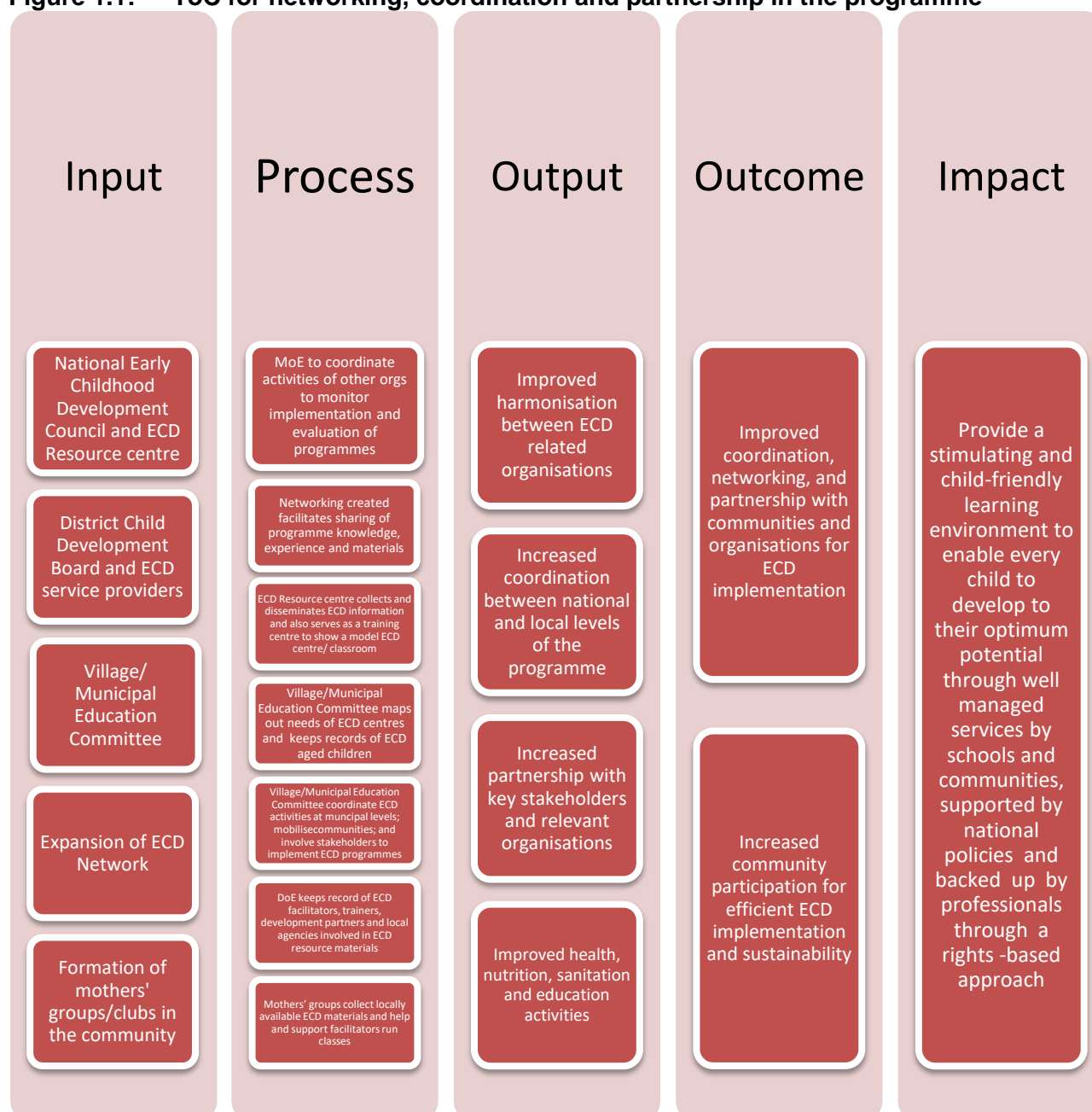
Figure 1.1: ToC for networking, coordination and partnership in the programme

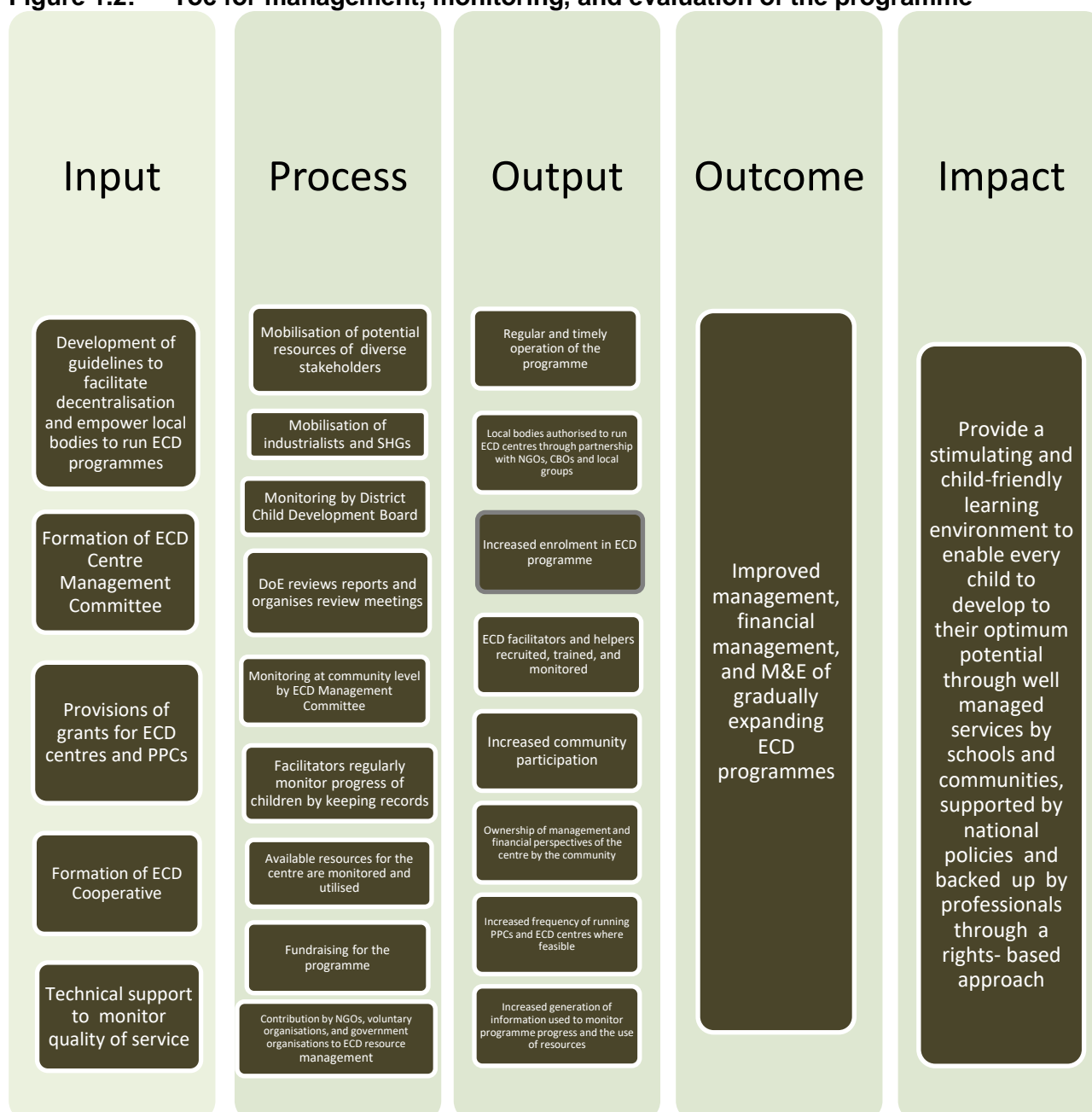
Figure 1.2: Toc for management, monitoring, and evaluation of the programme

Figure 1.3: ToC for physical resources for the programme

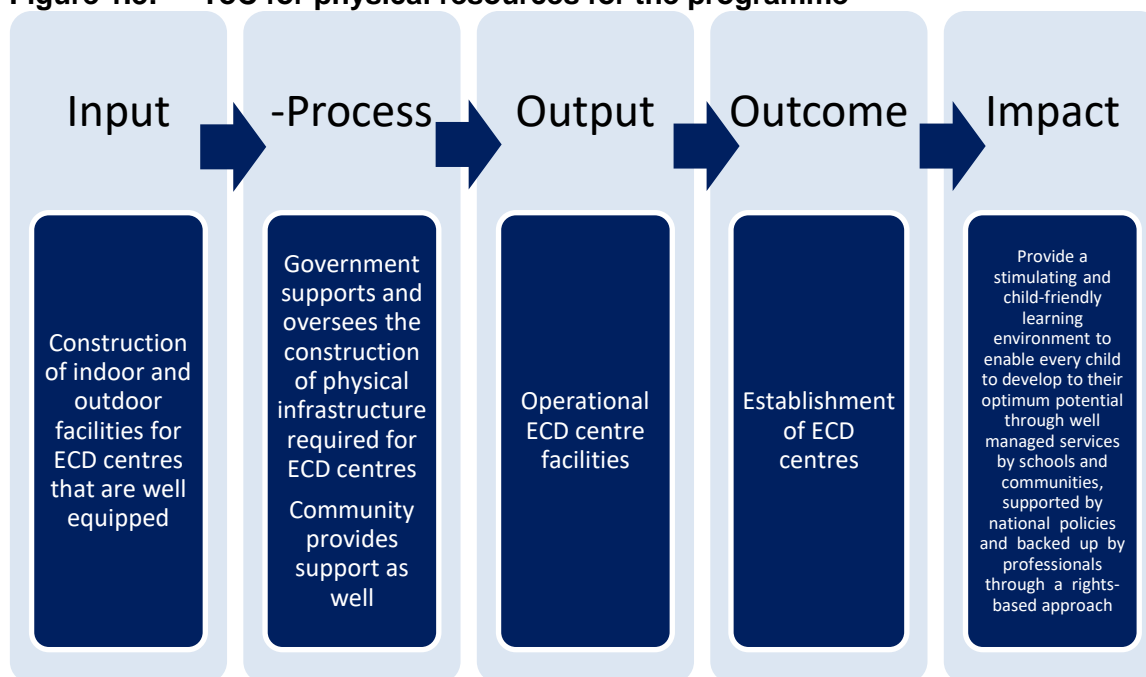


Figure 1.4: ToC for development of human resources for the programme

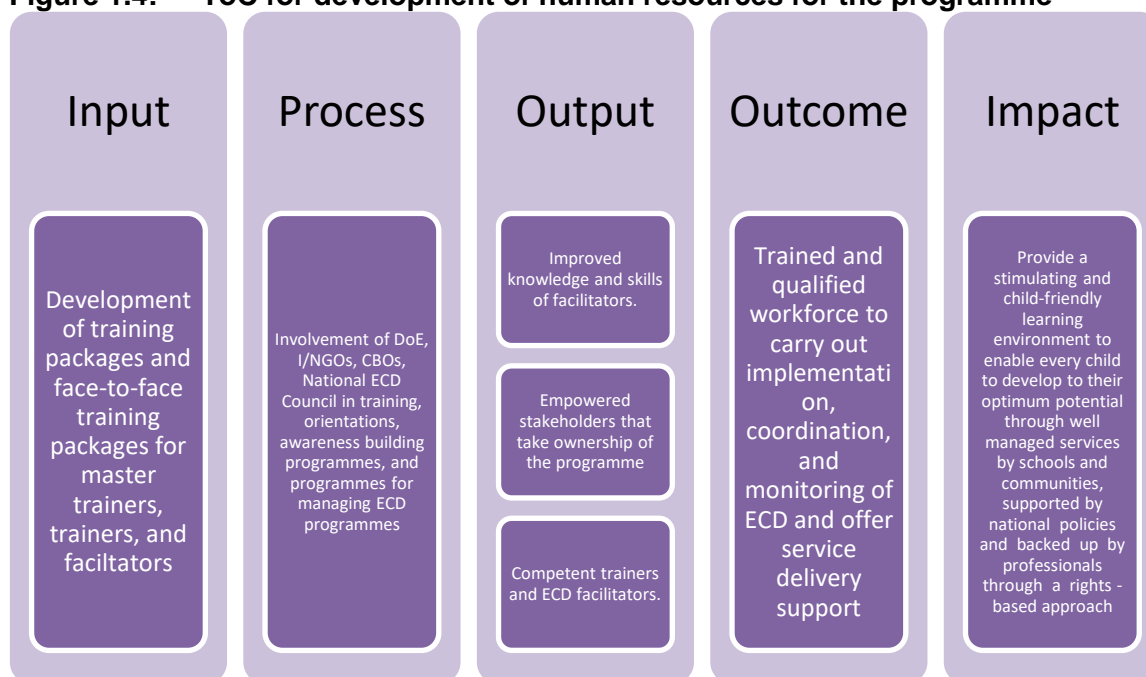
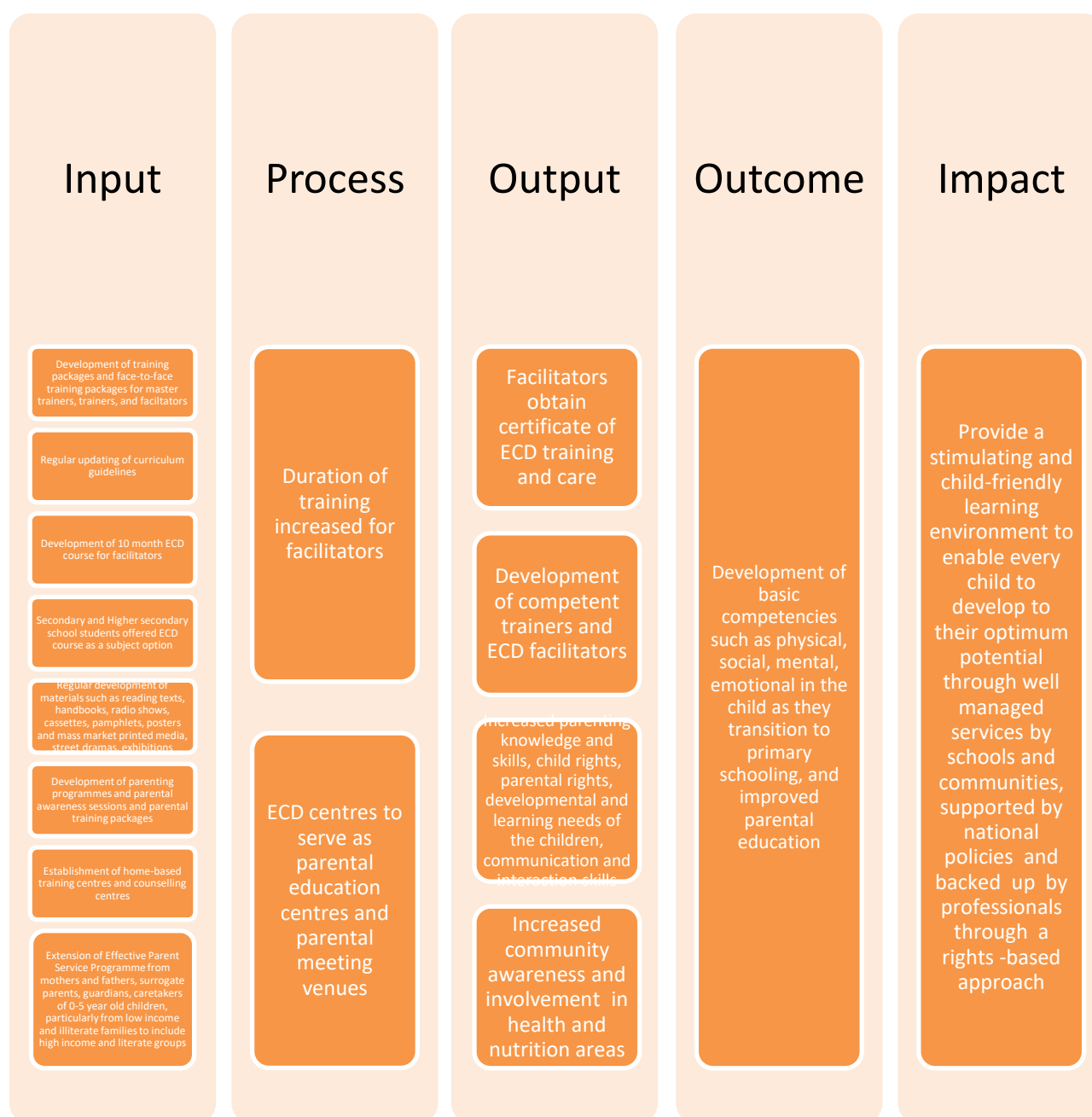


Figure 1.5 ToC for ECD Education and Awareness

In each of these ToCs, a number of the processes listed above could also be considered to be assumptions, as the successful functioning of these processes are critical to ensuring that the inputs lead to the desired outputs, outcomes, and ultimately impact.

In addition to these specific processes, a number of other, wider assumptions were in place in relation to the design and delivery of the programme. These are listed below:

- Continued political will to attain the vision and mission of the ECD strategy;
- Increased decentralisation of authority leading to improved access and uptake of ECD services;
- Well-integrated and coordinated ECD programmes contribute to the holistic development of the child;
- Parental education is crucial in ECD programmes because children's wellbeing and development depend on their relationship with others and their surroundings; and

- Well-trained facilitators and helpers efficiently contribute to the implementation, monitoring and service delivery of the ECD programmes.

2.2 Evaluation questions

As outlined in the ToR, we sought to address evaluation questions on the relevance, effectiveness, efficiency, intermediate outcomes, and sustainability of the National Early Childhood Development Program 2004–2015. In addition to the adapted DAC criteria, the evaluation also focuses on gender, human rights, and equity.

The ToR presents four overarching questions:

- How successful was the implementation of the current national ECD programme in line with the national ECD vision?
- How efficient were the sectoral resources allocated to ECD in meeting national and subnational needs?
- How were the implementation of ECD programmes and achievements perceived by key stakeholders in the intervention districts?
- What learning can be drawn to inform the new ECD strategy development and implementation?

Adopting the OECD DAC evaluation criteria to disaggregate these questions, the key evaluation questions are summarised in the table below.

Table 3: Evaluation questions

Criteria	Evaluation questions
Relevance	<ul style="list-style-type: none"> How have sector programmes met the ECD needs in the regions (now provinces)? How were key sector outputs linked to the key ECD strategy outputs? How was the ECD strategy developed? Was the ECD strategy relevant in itself?
Effectiveness	<ul style="list-style-type: none"> How has the ECD strategy been reflected in key sectoral strategies and/or policies, sectoral programmes, planning documents, and activities? What were the gaps? What were the gaps in the coordination amongst key Ministries and Departments at the central and local level support in holistically delivering ECD services?? What model can best support a stronger collaboration and coordination? To what extent were local bodies and other local actors involved in the planning and management of ECD services? How were the sector ECD implementation strategies effective in contributing to the overall outcome of the strategy and/or sectoral ECD programmes?
Efficiency	<ul style="list-style-type: none"> How much of key sector programme budgets were allocated and spent on ECD activities? What is the cost-effectiveness of community- and school-based intervention approaches (compare per unit cost, which should include government and other sources of funding such as corporate social funding)? How was the financial progress tracked and monitored to improve on programme management?
Interim outcomes	<ul style="list-style-type: none"> What immediate results were achieved by ECD sectors during the period 2004–2015? What were the unintended, positive, or negative effects of the programme? What was the annual performance of the ECD programmes with respect to annual targets and achievements?

Sustainability

- What were the different sectoral ECD services provided and how sustainable are these services in the communities (this includes mapping of ECD services and the quality of the different services)?
- What is the sustainability of ECD services in the communities once development partners or other funding support phases out?
- How can the design and implementation of the new ECD strategy contribute in achieving Nepal's SDGs?

Gender and equity

- How equitable is access to ECD services for the most vulnerable (male and female), excluded (M/F) and marginalised children (M/F), such as children in remote areas, migrants, children from ethnic minority groups, and children living in institutions, among others?
- How has gender equality been incorporated into sector ECD programmes (from the design to the implementation including targeting)? Were the sector programmes guided by international conventions such as the CRC (1989) and convention on the elimination of all forms of discrimination against women (CEDAW, 1979)?

2.3 Evaluation methodology

The evaluation questions are being addressed through primary qualitative research, complemented by an analysis of secondary quantitative data and existing documents. We have used a mixed-methods approach to consolidate the findings from qualitative and quantitative evidence gathered from multiple sources. This integrated mixed-methods analysis has sought to cover the breadth and depth of the evaluation in a comprehensive and rigorous manner.

The next sections detail our approach to collecting and analysing primary data, and how we make use of existing data to contextualise and support the primary research findings.

As discussed, primary data collection was qualitative in nature. It included interactions with a range of respondents associated with the programme in varying capacities at the central, district, and village/municipality levels to gather responses to address the research questions.⁶

2.3.1 Research sites

As the primary data collection was qualitative in nature, the focus of the exercise was to collect in-depth information. As suggested in the ToR, we selected seven districts covering all ecological belts and seven provinces of the country. Research districts were purposively selected in consultation with key stakeholders, based on a range of variables of interest, such as geography, population, average number of children per ECD centre, percentage of Grade 1 students with ECD experience, and Gross Enrolment Rate (GER) for ECD. We classified each district along the variables of interest based on Flash Report 2016 provided by the DoE and on interviews with key stakeholders we met during the inception period. A meeting was held between UNICEF, NPC, Oxford Policy Management (OPM), and ECD experts to discuss our inception report, including sampling. The meeting agreed on the sampling proposal presented in Table 4 below.

⁶ The administrative structure of Nepal has changed in the new federal system, with local units now being organised into either rural or urban municipalities. For the purposes of the evaluation, we will continue to use the administrative structures that are relevant to the timeframe of the ECD strategy (2004–2015), so we will use terms such as VDC and district.

Table 4: District selection matrix

District	Ecological belt			Average number of children per ECD centre		GER		Notes
	Mountain	Hill	Terai	High	Low	High	Low	
Province One	■			■			■	In the headquarters
Province Two			■	■			■	In a Mushahar community
Province Three		■			■		■	In a rural municipality
Province Four		■			■	■		Kundule (model centre)
Province Five			■	■		■		In a madrassa
Province Six		■			■		■	In the headquarters
Province Seven	■		■		■	■		In the headquarters; priority district of UNICEF

The districts were selected to ensure as broad a balance as possible across the relevant variables. This enabled us to make useful comparisons across research sites. The sample was thus balanced across selection variables as outlined below:

- We selected two districts from Terai, three districts from Hill, and two districts from Mountain ecological belts. This selection provides the best balance and included an inner terai valley district.
- District A was selected to ensure a district where ECD centres are performing well was included. This district has a high GER for ECD and low average number of children per ECD centre.
- District B is one of the priority districts for UNICEF, and we expected the district to be useful to understand the dynamic in an area with limited ECD services.
- District C was selected to learn about ECD centres that operate in madrasas. This is also a district with a high average number of children per centre.
- District D was selected to understand the provision of ECD services in an extremely disadvantaged community (in this case, a Mushahar community). This district has high GER for ECD and high average number of children per ECD centre.
- District E was selected to understand the provision of ECD services in an inner terai valley district.
- District F was selected because it is a hill district with a low GER for ECD, to balance the selection of another hill district with a high GER.
- District G was selected because it has a high number of ECD children per centre, to balance another district with a low number of ECD children per centre.

We believe such a selection allowed for comparison across extreme cases, in terms of disadvantaged districts, disadvantaged communities, and rural areas.

2.3.2 Selection of ECD centres

ECD centres in selected districts were sampled purposively based on variables of interest such as the existence of community-based ECD centres, number of households in the community where the ECD centre is located, and the number of children aged under five in that community. According to district education offices (DEOs) in the selected districts, most of the community-based ECD centres have been merged with schools, so that schools are now responsible for the functioning and management of these merged community-based centres. We were able to find community-based ECD centres in four districts. The sampling of centres is presented in Table 5 below.

Table 5: Centre selection matrix

District	School-based ECD centres	Community-based ECD centres
Province One	One primary school with ECD centre and one lower secondary school with ECD centre	

Province Two	One primary school with ECD centre in Mushahar locality	
Province Three	One secondary school with ECD centre	One centre
Province Four	One higher secondary school with ECD centre	One NGO-led centre
Province Five	One madrassa ECD centre	One centre
Province Six	One lower secondary school with ECD centre	
Province Seven	One primary school with ECD centre	One centre

We visited more school- and community-based ECD centres than was proposed in the inception report.

2.3.3 Selection of respondents

After extensive consultations with key stakeholders, we came to the agreement that the qualitative component of this evaluation would take a child-centric approach. In each of the selected primary sampling units, in the seven provinces, the evaluation team first mapped all the ECD services available to people living in that community. The research team visited school-based ECD centres in the sampled areas. If the community-based ECD centres existed in the same community, then the research team visited these centres as well. This enabled the team to understand provision of ECD services in both community- and school-based centres in the research sites visited. In places where there was more than one ECD centre in the area, the evaluation team picked a school-based centre at random as the primary basis. The evaluation team took the views of respondents related to other ECD centres as well (as discussed below).

Table 6: Relevant stakeholders

Respondent level	Key respondent(s)	Tools used
ECD centre	ECD facilitator	Key informant interview (KII)
	Mothers of ECD children	KII * 4
	School principal	KII
	ECD Centre Management Committee (or School Management Committee)	FGD
	Social mobiliser	KII
Community	Female community health volunteer (FCHV)	KII
	Village health motivator or health facility worker	KII
	Mothers of out-of-school children	KII * 2
	Mothers of children attending other ECD centres in the area	FGD

District	ECD facilitators in other ECD centres in the area	FGD
	District ECD Committee	FGD
	District education focal person	KII

From the selected centre, we carried out in-depth interviews with the ECD facilitator as well as the principal of the school where the centre is based. We also randomly selected four pupils (two boys and two girls) between four and five years old to explore their ECD experience, from their conception and birth to their journey to the ECD centre. This approach allowed us to select respondents who have had the opportunity to experience all the possible interventions within ECD. Once we selected the children, we interviewed the mothers of each of these selected pupils. We decided to interview mothers because they are more likely to be available and are also more likely to know about the entire ECD experience of their children, including the health and nutrition services they might have received in their infancy. If any mother was not available, we interviewed either the father or another primary caregiver (such as a grandparent) instead. We carried out a FGD with either an ECD centre management committee or the School Management Sub/Committee in its absence.

Moving beyond the ECD centre, we interviewed the FCHV who serves the area. We also interviewed either a village health motivator or another health official at the health post. These respondents not only provided us with information about the provision of health services but also gave us a broad understanding of the provision of nutrition, WASH, and possibly protection services relevant to a holistic ECD experience. We also interviewed the social mobiliser for the community, as our experience suggests that they are extremely well informed about most issues and programmes in their communities.

To make our evaluation as extensive as possible, we held an FGD with randomly selected mothers from all ECD centres in the area. These included mothers of pupils who attend community-based centres as well as private centres in the area. Similarly, we carried out an FGD with the ECD facilitators of all the centres to capture a broader range of perspectives and experiences from the area.

We explicitly enquired about any pupils of ECD age (4–5 years) who might not be attending any centres. Where possible, we carried out interviews with two mothers or caregivers of such children to ensure that we captured the perspectives of out-of-school ECD children and their families as well.

We supplemented these activities at the local level by interviewing the district education focal person and carrying out an FGD or KII with the District ECD Committee. These interviews provided us with a more detailed understanding of ECD services and their provision at the local as well as district levels.

2.3.4 Evaluation tools

We employed multiple qualitative research methods during the course of our research. In our experience, respondents tend to differ greatly in terms of the information they have, how comfortable they are interacting with the evaluation team, and how much time they have to dedicate to the research process. As such, the methods adopted for data collection must be appropriate to the particular respondent or group of respondents. The table below summarises the evaluation methods we use for different types of respondents, along with their particular contribution to this research.

Table 7: Summary of research tools

Method	Purpose
Informal observations: including observations at the district coordination committee, rural municipality, and municipality, and especially community level	<ul style="list-style-type: none"> To build rapport with respondents To assess the general situation in our research sites To develop an informal understanding of programme plans, operational quality, and efficiency To verify the findings gathered through more formal research processes
FGDs: <ul style="list-style-type: none"> District ECD Committee ECD Centre Management Committee/ School Management Committee Mothers of ECD children ECD facilitators of other ECD centres 	<ul style="list-style-type: none"> To understand multiple viewpoints and capture differential experiences and perceptions To increase research coverage To allow for internal verification of information through the participation of multiple respondents To gauge degree of agreement and disagreement on key themes
Interviews: <ul style="list-style-type: none"> In-depth interviews with government personnel involved in ECD programming (centre, district, and village levels) and mothers of children of ECD age not attending ECD centres 	<ul style="list-style-type: none"> To obtain in-depth information from individual respondents To provide respondents with privacy and freedom to respond openly without the presence of other group or community members

We developed research tools at the national, district, and community levels by contextualising these research questions to ensure that each tool is relevant and appropriate for each respondent. This semi-structured questionnaire was designed to structure the research but also to be flexible and adaptive so that emerging or unanticipated areas of enquiry that develop during the research can be explored as well. All the tools were piloted during the training of field researchers, and adjustments were made to improve the tools based on the experience of this piloting exercise.

2.3.5 Research considerations

The evaluation team has significant experience in undertaking qualitative research and we were mindful of the strengths as well as potential challenges associated with conducting interviews. We constantly assessed the importance of positionality in the research, and strived to be both adaptive and reflexive in our approach to qualitative research. We paid attention to the following factors during the evaluation:

- Identifying and gaining access to the most appropriate informants, drawing on our initial mapping exercise and first-hand knowledge of the organisations concerned;
- Selecting an appropriate range of interviews based on sampling strategies to ensure key and divergent views are captured and findings sufficiently triangulated;
- Application of semi-structured interview guidelines to ensure systematic data collection and optimal use of time, while allowing for new emerging findings; and
- Adherence to all ethical considerations and appropriate personal conduct during the interview process (see also Section 2.6 below).

Two evaluation teams carried out the field-level research. Each evaluation team consisted of a team of three local researchers. Local researchers spent seven days with the core evaluation team in Kathmandu prior to the fieldwork in a rigorous and interactive training session. Researchers were trained on the general methods and best practices of qualitative research, the purpose of this evaluation, specific research questions, and the research tools. During the training, in-field piloting was also conducted to ensure that researchers were adequately prepared for data collection. The pilot session was also used to finalise our research tools

The research team employed purposive sampling techniques to ensure that there is a good mix of respondents. The team attempted to ensure that different groups are adequately represented in the research and that data were gathered with due regard to principles of ethical research such as confidentiality, anonymity, and informed consent. These tenets are discussed in detail in Section 2.6.

2.3.6 Ensuring rigour in our work

A major methodological challenge in qualitative-led research is the definition and achievement of 'rigour'. Qualitative research is sometimes accused of being open to research bias or anecdotal impressions, as being impossible to reproduce, and as difficult to generalise (Mays and Pope, 1995). Methodological rigour in this research is not given through a statistically representative sample but rather through a 'systematic and self-conscious research design, data collection, interpretation and communication' (Mays and Pope, 1995, p. 2). This evaluation was guided by a number of key considerations:

- A clear sampling strategy was developed that explained the justification for the identification of research sites, key informants, and individuals for FGDs, highlighting any limitations. These were carried out in consultation with key stakeholders, including the NPC and UNICEF.
- Each field researcher was required to write up their notes after each interview or discussion. The research training also covered notetaking to ensure consistency across researchers.
- At the end of each day, the field team met to discuss the key findings from the day using a daily debrief form. These forms were thematically structured, and the team would begin to synthesise and analyse the findings in the field itself. Such an approach also allowed team members to discuss inconsistencies and develop strategies to investigate further data needs for the ongoing research.
- The research teams transcribed all the interviews and discussions after the fieldwork.
- The quantitative and qualitative teams spoke regularly to discuss emerging findings, to ensure appropriate mixing of methods.
- The evaluation team also carried out a comprehensive peer review process including internal and external reviewers during design, implementation, analysis, and report production.

2.3.7 Secondary data analysis

Secondary data sources were used to provide descriptive statistics of the national context on selected indicators of ECD services in the education, health, nutrition, WASH, and protection sectors. These informed the design of the primary data collection and provided insights into and a source of triangulation for the information collected through qualitative research. Demographic health surveys and MICS for various years were used to provide context as well as to see the progress on key indicators such as rates of stunting and malnutrition. The Nepal National Population and Housing Census was used to provide context on key indicators for WASH such as access to safe drinking water and access to improved toilets. These survey data were used to triangulate the information obtained from administrative data such as the Education Management Information System (EMIS) or Health Management Information System (HMIS).

Before the training for qualitative researchers, we conducted secondary data analysis. The analysis was structured around the research questions. This helped in refining research instruments and the areas to focus on while in the field.

HMIS and EMIS data on the ECD experience of Grade 1 children, number of ECD centres, number of trained ECD facilitators, fully immunised children, number of children provided with health services, and number of children receiving nutrition supplement were analysed for all visited districts.

The key datasets we analysed are as follows:

Education

- Annual Strategies Implementation Plan and Annual Work Plan and Budget, SSRP, FY 2004/05–2015/16, Ministry of Education, Government of Nepal.
- Additional Issues: 2004/05, 2006/07–2011/12, 2016/17.
- School Level Educational Statistics of Nepal, Consolidated Report, FY 2005/06–2015/16, Department of Education, Ministry of Education, Government of Nepal.
- Flash Report I, FY 2004/05–2015/16, Department of Education, Ministry of Education, Government of Nepal.
- Flash Report II, FY 2004/05–2015/16, Department of Education, Ministry of Education, Government of Nepal.
- Status Report on School Sector Reform Program (SSRP), FY 2010/11–2015/16, Department of Education, Ministry of Education, Government of Nepal.
- SSDP thematic plan.
- EFA National Work Plan.

Budget

- Annual Development Programme, FY 2010/11–2015/16, NPC, Government of Nepal. Source: www.npc.gov.np
- Estimates of Expenditure (Red Book), FY 2004/05–2015/16, Ministry of Finance, Government of Nepal. Source: www.mof.gov.np
- Economic Survey, FY 2004/05–2015/16, Ministry of Finance, Government of Nepal. Source: www.mof.gov.np
- Transaction Accounting and Budget Control System (TABUCS) Database 2017. Ministry of Health, Kathmandu, Nepal. Source: <https://tabucs.mohp.gov.np/login.asp>

Health, nutrition, WASH, and protection

- Ministry of Health, Nepal, New Era and ICF (2001, 2006, 2011, 2017). Nepal Demographic and Health Survey (NDHS) (2001, 2006, 2011, 2016). Kathmandu, Nepal: Ministry of Health, Nepal.

- Central Bureau of Statistics, 2015. Nepal Multiple Indicator Cluster Survey (NMICS) 2014, Final Report. Kathmandu, Nepal: Central Bureau of Statistics and UNICEF Nepal.
- Central Bureau of Statistics, 2012. Nepal Multiple Indicator Cluster Survey (NMICS) 2010, Mid- and Far Western Regions, Final Report. Kathmandu: Central Bureau of Statistics and UNICEF Nepal.
- Department of Health Services, (2003/04–2015/16). Annual Report (2003/04–2015/16). Teku, Kathmandu, Nepal: Department of Health Services.
- Central Bureau of Statistics, 2012. National Report, National Population and Housing Census 2011. Kathmandu, Nepal: Central Bureau of Statistics
- National School Health Nutrition Strategy Nepal 2006
- Golden Thousand Days Operation Guidelines
- Nutrition Policy and Strategy 2004

2.4 Limitations

The evaluation team faced a number of challenges during fieldwork and, although the team sought to address them through an iterative research process, some limitations remain. These limitations are acknowledged here, while some of their implications will be discussed in greater detail in the substantive chapters.

Space and timing of KIIs and FGDs

The research team sought to conduct all interviews and FGDs in private to ensure a safe space for the respondents. However, this was not always possible at either the government offices or during community visits, for a number of reasons.

The issue of space was particularly relevant in the community context, as we had to rely on spaces such as tea stalls, open fields, and halls in public buildings to speak with beneficiaries and non-beneficiaries of the programme. Given the nature of our field sites, it was never really possible to ensure fully that non-participants were not within earshot of our interviews or discussions. Although respondents did not seem too hesitant about engaging with researchers in these communal spaces, they would presumably have been more comfortable in a different setting, without these disturbances.

The timing of our interactions also posed some problems for us. Government officials were often very busy, and so we had to schedule (and sometimes reschedule) our conversations with them to fit their needs. Many of the interviews and conversations were interrupted by other officers as well as people visiting the offices, and their work often took priority. The conversations with local counterparts had made it clear that officials were most likely to be in their office in the mornings, but this also meant that we were essentially competing for their time, given their multitude of responsibilities.

Sampling difficulties

Although the evaluation team had developed a clear sampling strategy for the evaluation, it was not always possible to follow this plan to interview our selected respondents. For instance, the

team wanted to speak with members of the District ECD Committee but, in some districts, these members were not available or were too busy with election activities (see next section).

We faced similar challenges with our sampling at the community level. In one district, we wanted to use the attendance file from an ECD centre to randomly select children to assess their attendance. However, the facilitator told us that the attendance file had been torn up by children in the last month, so we did not get an updated attendance list. We had to list ECD children, and then use that as the basis for selecting our respondents.

We faced similar challenges in engaging with respondents who were sampled as potential participants for the evaluation. Because of the harvest season, many mothers were busy working in the fields, so it was not always possible to meet with mothers who had been randomly selected.

As these examples demonstrate, we could not always follow our sampling plan for engagement as part of the evaluation. Nonetheless, the evaluation teams were flexible and adaptive on the ground, implementing alternative strategies to ensure that the evaluation could be conducted properly.

Election disturbances

The timing of our evaluation field visits coincided with election preparations in a number of districts. Although we were aware of this in advance, the tight timeline of this project meant we were unable to make any adjustments to the field schedule, which had already been agreed before the election dates were confirmed.

The fervour of election preparation affected our fieldwork in a number of ways. First, many respondents at the district level were busy preparing for the election, so they were not readily available to meet with us and discuss ECD service provision. We were not able to conduct FGDs in all the districts with the ECD committees for this reason. Second, extensive election-related activities affected the planning and preparation of our field teams in their place of residence. For instance, activists and supporters of different political parties were busy discussing their plans and programmes, with these mass gatherings being loud and disturbing. Third, and perhaps most importantly, some respondents and community members also enquired why and how the field teams were authorised to be carrying out this study when the Election Commission's code of conduct had already been implemented because of the impending elections. Although we clarified that we were not from any government organisation or political party, and even though they accepted this explanation, they were still surprised and somewhat suspicious of our presence in the field. We carried all our relevant paperwork, and explained in detail the nature of our fieldwork, which was enough to allow us to continue our work, but nevertheless suspicions appeared to remain.

Timeframe, turnover, and recall problems

We were trying to carry out a retrospective evaluation of an ECD strategy with a timeframe of over a decade, which had technically ended a few years ago (in 2015). This is a serious limitation of this evaluation, as there is a mismatch between when the strategy was devised and implemented versus when we were carrying out our research. It was difficult to trace an obvious link between the design of the ECD strategy, its implementation, its relationship with actual projects and programmes at the grassroots level, and its relevance to ECD programming in 2017. We have had to therefore assume that the findings of our fieldwork are consistent with, and are an extension of, what our findings would have been had we conducted the evaluation throughout the lifecycle of the ECD strategy (i.e. between 2004 and 2015). At a theoretical level, the disparity in the timing of the ECD strategy against the actual evaluation thus poses a significant challenge in terms of linking

the strategy to ECD activities as well as achievements (and missed opportunities) observed and assessed as part of this assignment.

This problem manifested into administrative and logistical challenges as well. Given a system of administrative and bureaucratic shuffles and reshuffles, where government officials are regularly moved from one department to another, it was difficult to identify and track specific officials who had been involved in implementing ECD programmes. In most cases, these officials were no longer working in the same district. When they were available, most of them had very limited recollection about the ECD strategy, how it was formulated, or what the experiences were of implementing these ECD programmes. As such, although we were able to gauge the current state of ECD service provision and delivery in our target districts, we have had to assume that these findings are also consistent with, and extensions of, ECD services during the period covered by the ECD strategy.

2.5 Gender, equity, and human rights perspectives

The evaluation sought to explicitly address concerns related to gender, equity, and human rights. In practice, we did this in a number of ways. Wherever possible, we have tried to disaggregate the data by gender so that we could observe any differences in service provision and delivery based on gender. At an epistemological level, we have sought to design the entire evaluation, and especially the fieldwork, to account for gender concerns. Our evaluation team is gender balanced, with three female experts in the core team, including a gender, equity, and human rights specialist, providing guidance on addressing gender concerns. Similarly, six of the eight local researchers we trained for the qualitative fieldwork were female, as we felt that women would be better suited to engaging with ECD facilitators (who are predominantly female) and mothers to collect gender-sensitive data concerning ECD. In terms of our respondents, we prioritised mothers as our key respondents because we felt they were more likely to be primary caregivers and so could provide more comprehensive information about ECD services. As such, our process as well as our findings have been formulated to account for gender differences.

This approach has also been extended to account for equity considerations throughout the data collection and analysis. We have disaggregated the findings in a number of ways, including by administrative unit (such as districts) as well as by geography (by ecological belt, as expected by the ToR). The evaluation sought to assess school- and community-based ECD centres to ensure greater representativeness of the beneficiaries served by the programmes. We have collected information on the cost of accessing various ECD services to assess whether there are equity considerations concerning ECD provision. We would have ideally liked to assess service provision and quality of service delivery based on factors such as wealth and caste, but the availability of secondary data was a key constraint in carrying out such an analysis.

In terms of the perspective of human rights, our evaluation has started with the guiding principle that all children (and their mothers) have an equal and unequivocal right to good quality education, health, nutrition, WASH facilities, and basic protection services. These should thus not be considered privileges and all children should be receiving a set of minimum standard of services, so that they have an equal chance to grow and prosper in a healthy and effective way. As such, every child – regardless of caste, class, geography, gender, age, or any other category – who is denied basic ECD services should be regarded as disadvantaged in their wellbeing.

We tried to use diversity as one of our analytical lenses so that we could assess the situation of girls and boys in different regions and by wealth quintile. For example, in relation to protection we analysed gender-disaggregated information related to birth registration practices. However, a major challenge here was that most of the available information regarding protection situations was

neither disaggregated by age nor by gender. Moreover, birth registration data were reported in totality. In other words, information regarding the registration of children born in the reported year was not disaggregated. This made it difficult to understand the extent to which the right to identity and citizenship of female and male infants as well as ECD children has been ensured. The ECD Strategy Paper did not have specific strategies or measures to address issues related to gender and social equity in relation to ECD children either. Where possible, we have tried to disaggregate the data and present analysis that accounts for gender and equity, as will be discussed in the forthcoming chapters.

2.6 Ethical considerations

Conducting qualitative fieldwork of this nature requires high ethical standards to ensure that false expectations are not raised among respondents, confidentiality is maintained, and respondents are never forced to participate or encouraged to speak about subjects that may be upsetting. We drew on our experience of qualitative fieldwork in humanitarian settings to ensure that these standards were met. Ethical considerations influence the entire evaluation process, including evaluation design, composition, recruitment, and management of the evaluation team, as well as consultations and interviews with informants and data storage and use.

All members of the evaluation team were briefed on guidelines for ethical research involving vulnerable adults (drawing, for example, on OPM's code of conduct).

In conducting our fieldwork, we followed a set of ethical principles that we have developed based on our own experience as well as adapted from the Young Lives research ethics guidelines (Young Lives, 2011), which draw from existing literature on the governance of social research (ESRC, 2010):

- **Ensuring the safety of participants:** We were mindful that the environment in which research was conducted was physically safe, and that there were at least two facilitators present at all times.
- **Recognising that participants are vulnerable:** All researchers were made aware of local conditions and we made sure that the exercise and interactions were carried out in a manner respectful to all respondents.
- **Ensuring that people understand what is happening at all times:** This was ensured through the use of local enumerators, so that research was conducted in the appropriate language and dialect through fieldworkers who were familiar with local customs and terminology.
- **Clarifying the purpose:** The research team set out and communicated clear parameters for the interviews to the respondents, which included clearly stating the purpose, the limits, and what the follow-up would entail. Each engagement started with a clear introduction to ensure that all participants were aware of these parameters.
- **Informed consent:** We ensured that potential respondents were given enough information about the research. All researchers were trained to ensure that there was no explicit or implicit coercion so that potential respondents could make an informed and free decision on their possible involvement in the fieldwork. Respondents were informed that they could choose to not respond to all or any of our questions at any time. We took explicit oral consent from each respondent before carrying out any research activity.

- **Anonymity:** Given that research respondents could share considerable amounts of personal information with us, it is our responsibility to ensure that their confidentiality is maintained and personal information is protected. This has been operationalised by ensuring that all datasets are anonymised, in the sense that all names of people are removed before any data is shared publicly.

All efforts were made to protect children, adults, households, and communities against any form of harm, manipulation, and malpractice following established ethical guidelines on the subject.

3 The national ECD vision and success of ECD programme implementation

This chapter discusses the success of the implementation of the current national ECD programme in line with the national ECD vision as it was outlined in the ECD strategy. We assess this alignment for each of the five key sectors in turn.

3.1 Education

ECE is regarded as being instrumental for the physical, intellectual, social, and emotional development of children. As such, it helps to improve the internal efficiency of primary and basic education. ECE is also considered one of the main strategies to achieve the EFA goals. Therefore, the MoE led on the establishment of ECD centres to ensure access for the most vulnerable and marginalised children.

3.1.1 Vision

Nepal's ECD strategy was prepared with the aim of ensuring the holistic development of each child in the country. The vision aims to:

provide stimulating and child friendly learning environment to enable every child to develop their optimum potentials through well managed services by the schools and communities, supported by national policies and backed up by professionals through a rights based approach. (Department of Education, Nepal, 2004)

The vision of ECD as outlined in the ECD strategic paper was based on the vision set out in the core document *Education For All (2004–2009)* (Department of Education, Nepal, 2004). The strategy outlines the desired characteristics of ECD children, ECD centres, facilitators (teachers), and parents by 2015. Subsequent strategies, work plans, and annual budgets have been formulated to implement the national ECD programme. This subsection outlines programme implementation and achievement of results in terms of access to and quality of ECE. As will be discussed throughout the report, Nepal's ECD strategy was in effect an ECE strategy, and to the extent that health and other services are being provided to children between the ages of three and five this is usually incidental.⁷

Early childhood is a crucial period in human life. Early intervention and investment during this period has long-lasting impact for the all-round development of the child. Learning experiences during early childhood – especially from birth to five years of age – represent the foundation for later human life. Early learning experiences help a child to acquire learning desires, explore their environment, and enhance his/her skills for learning and all-round development. Access to ECD helps ensure the right of the child.

3.1.2 Legal and policy provisions

A number of legal provisions demonstrate the strong support for ECD programmes from the Government of Nepal. The Constitution (2015), through Article 31, guarantees that 'Every citizen

⁷ As a result of this situation, sometimes the terms ECD and ECE have had to be used interchangeably, to reflect the fact that the evaluation of the programme required the team to use the terms used by the programme. For instance, all pre-primary centres could be considered ECE centres, but they were always referred to as ECD centres in the context of Nepal.

shall have the right to compulsory and free basic education'. Similarly, in Article 39, ECD is considered a fundamental right of every child. The Constitution lays down the directive principles of the federal state, provinces, and local bodies on education and the right to education (Ministry of Education, 2016). Similarly, the development of the 2011 National Plan of Action is another important step toward achieving universal high-quality ECD for all children (Neuman and Devercelli, 2013).

The Eighth Amendment of the Education Act included ECE within the structure of school education in Nepal, so ECE is now part of the education system, whereas it used to be a separate project for the government in the past. The Constitution gives authority over school education to local-level government. The government set its plan to strengthen access to and improve the quality of ECE services through its EFA core document (covering 2004–2009), the SSRP (2009–2015), and the SSDP (2017–2022).

Clear ECD policies are vital for sustainable and effective ECD activities in the country. Establishing an enabling environment is the foundation for effective ECD policies, providing the mechanisms and means to design and implement ECD policy, deliver services, and monitor outcomes (Neuman & Devercelli, 2013). In Nepal, the ECD programme is being operated through MoE/DoE to run ECD centres for children between 3 and 5 years of age. These centres are supported by local government, international and local NGOs, and communities. There are centre-based ECE services implemented through community-based ECD centres, school-based PPC, preschools, day care centres, Montessori schools, madrasa, kindergartens, and other centres.

3.1.3 Access to ECE

The GER for ECD increased to 81% in 2015 from 39.4% in 2004. However, there are a number of children below the age of four and above the age of five in school-based ECD centres. There is no reliable data on the age and number of children in ECD centres. While observing the ECD centres in schools, we found that public schools operate three to four classes (playgroup, nursery, lower kindergarten and upper kindergarten) under the name 'ECD class'.

Nepal has been able to surpass the target GER of 80% set out in the ECD Strategy Paper. The number of children enrolled in ECD increased to 977,365 in 2015 from 512,151 in 2004 (see the table below for more information) (Department of Education, Nepal, 2004) (Department of Health Services, 2015). A combination of demand- and supply-side initiatives has helped Nepal achieve this target. On the supply side, the percentage of ECD centres within 30 minutes of households increased to 88.8% in 2011.⁸ The average time taken to reach ECD centres has decreased to 19 minutes (NLSS, 2011). This has been possible as a result of the phenomenal increase in ECD centres from 4,032 in 2004 to 35,991 in 2015 (Department of Education, Nepal, 2004) (Department of Health Services, 2015). Nonetheless, this number is still below the target of 74,000 centres. According to a former MoE official:

The plan was to establish an ECD centre in each VDC. The original idea was that the children aged between three and five years would be enrolled into the ECD centres. Later on it was decided that children aged between four and five would be enrolled into ECD centres.

⁸ Using the usual means of transportation.

Although it is not clear why this decision was made, it appears that officials see ECD centres as grounds to prepare children for formal school, especially for enrolment in Grade 1, so the focus is now only on children between the ages of four and five.

Table 8: Children attending ECE in Nepal

	Percentage of children aged 36–59 months attending ECE
Total	50.7
Sex	
Male	51.9
Female	49.4
Region	
Eastern Mountains	37.6
Eastern Hills	64.2
Eastern Terai	49
Central Mountains	70.7
Central Hills	78.2
Central Terai	29.3
Western Mountains	(67.2)
Western Hills	80.3
Western Terai	58.6
Mid-Western Mountains	36.7
Mid-Western Hills	41.8
Mid-Western Terai	39.3
Far Western Mountains	44.4
Far Western Hills	28.9
Far Western Terai	44.2
Area	
Urban	78.3
Kathmandu Valley	85.3
Other urban	75.9
Rural	46.5

Source: NMICS, 2014

The table shows that a slightly higher percentage of male than female children aged 36 to 59 months was attending any form of ECE by 2014. As the table also makes clear, the highest percentages of children were found enrolled in Western Hills, followed by Central Hills and Central Mountains. Furthermore, more children are enrolled in urban areas (78.3%) than in rural areas (46.5%). This indicates that there is a disparity in access to ECD for children in different development regions.

There is uneven distribution of the ECD centres in the districts and the VDC/municipality level, as per the DoE records. Although the trend shows an increase in numbers of ECD centres/PPCs (Department of Health Services, 2015), fair access is still out of reach. The population of children aged under five years decreased from 2,755,213 in 2001 to 2,567,963 in 2011 (CBS, 2001; National Population and Housing Census, 2011). Furthermore, the number of additional ECD centres needed to ensure all Nepal's children access ECD centres seems to be around 9,000 centres, based on the assumption that about 36,000 ECD centres are currently catering to about 80% of children.

The results of household surveys show a lower percentage of children enrolled in ECD when compared to data from the EMIS. According to EMIS data, the percentage of children attending ECD was 77.7% in 2014, while NMICS 2014 data give a lower attendance rate of 50.7%. However, the discrepancies could have resulted from the different methodology used to obtain the information, as EMIS is a school census that collects information from all districts whereas NMICS is a household survey that collects information on enrolment of ECD children from households. Such discrepancies could also be a result of enrolled children not actually attending ECD centres.

Table 9: Enrolment, ECD centres, and GER

Year	Number of children enrolled	Number of ECD centres	GER
2004	512,151	4,032	39.4
2015	977,365	35,991	81
Change	465,214	31,959	41.6

Source: DoE 2004, DoE 2015

As the table shows, Nepal has been able to increase ECD access tremendously during the strategy period, although at least 19% of children have still not even been enrolled. It should also be noted that this information is only about ECD enrolment and does not capture ECD attendance. We do not have data available that confirms the actual level of ECD participation for these children.

The Flash Report 2015/16 notes that total enrolment of the ECD/PPC for four year-olds is 81% (girls: 80.9%; boys: 81.2%). Similarly, the enrolment of three-year-olds is 91% (girls: 90%; boys: 92%) (Ministry of Education, 2015). Although it is not clear why there is a difference in the age of enrolment of three and four year-olds, it is possible that this is because, after a year of habit formation, parents are enrolling four-year-old children in private schools.

According to the NMICS data for 2014, the percentage of children aged 36 to 59 months attending ECE is 83.5% for the richest 20% of households but only 41.2% for the poorest 20% of households. This represents a difference of 42.3 percentage points between the richest and the poorest, highlighting the disparity between income groups.

GER and Net Enrolment Rate (NER)

GER is an indicator relating to enrolment in ECD centres. It explains the total number of new entrants in the ECD centres, regardless of age, expressed as a percentage of the population of four-year age children (the official age of children who should be attending ECD centres). This rate

indicates the capacity of the education system to accommodate new enrolled children in ECD centres. Likewise, Net Enrolment Rate (NER) relates to new entrants in ECD centres who are four to five years of age, expressed as a percentage of the population of the same age. It shows the level of access to primary education of the eligible population of children of primary school-entrance age.

The tables below show the GER in ECD centres in the school year 2013-2014 to 2015-2016 by gender.

Table 10: Projected Population, GER, and NER

SN	Age	FY 2015/16 [2015]			FY 2014/15 [2014]			FY 2013/14 [2013]		
		Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total
1	3 Years Enrolment	99,661	99,126	198,787	122,658	120,458	243,116	124,173	123,309	247,482
2	4 Years Enrolment	217,816	229,700	447,516	210,592	223,480	434,072	208,219	221,170	429,389
3	5 Years Enrolment	107,312	118,982	226,294	107,321	120,098	227,419	120,546	138,503	259,049
4	>5 Years Enrolment	45,731	59,037	104,768	48,057	61,675	109,732	48,350	62,847	111,197
5	Total of all age group	470,520	506,845	977,365	488,628	525,711	1,014,339	501,288	545,829	1,047,117
6	3-4 Years Projected Population	522,828	550,799	1,073,627	524,316	551,173	1,075,489	546,846	572,477	1,119,323
7	4 Years Projected Population	269,172	283,015	552,187	272,440	286,031	558,471	273,408	286,367	559,775
8	% of 4 Years' Enrolment (NER)	80.9%	81.2%	81.0%	77.3%	78.1%	77.7%	76.2%	77.2%	76.7%
9	Enrolment Rates (GER)	90.0%	92.0%	91.0%	93.2%	95.4%	94.3%	91.7%	95.3%	93.5%

Based on the total number of new enrolments and the total number of age appropriate children, the overall GER for ECD in 2013/14 was 93.5%, with this proportion being 91.7% for girls and 95.3% for boys. Similarly, GER was 94.3 %, with 93.2% for girls and 95.4% for boys, in 2014/015 and 91.0 % in 2015/16, with 90.0% for girls and 92.0% for boys. The overall NER in ECD centres in 2013/2014 was 76.7%, with 76.2% for girls and 77.2% for boys; in 2014/15, NER was 77.7%, with 77.3% for girls and 80.9% for boys; and in 2015/16, NER was 81%, with 80.9% for girls and 81.2% for boys.

DoE publishes Flash Reports every year, through which they provide detailed information on the status of children in ECD centres. The flash reports claim that the enrolment of children is age appropriate, and so the reported gross enrolment rate is also the NER. However, this view is contested, and the calculations above demonstrate that there is a sizeable difference between NER and GER in Nepal.

The difference between GER and NER can be interpreted to mean that there are many underage and overage children attending ECD centres. This situation raises concerns about both access and quality. For instance, about 20 percent of children between the ages of 4 and 5 appear to not be attending ECD centres. Similarly, providing ECD services to a wider age range of children (both under- and overage children) is more difficult for facilitators in ECD centres, as they have to conduct multi-grade and multilevel interactive activities in the classroom, but they do not always have the appropriate training and support to deliver such activities.

3.1.4 Quality of ECD services

Quality of input

The ECD curriculum guidelines were developed by the DoE in 2005/06, for the holistic development of children aged three and four. This curriculum has been used as an instructional base in community-based ECD centres, has been partially followed in school-based ECD centres in community schools, and not entirely followed in the ECD centres of institutional schools (Seto Gurans, 2010). Indeed, in the study conducted by Seto Gurans in seven districts it was found that 83.3% of the observed community-based and school-based ECD centres have not followed the ECD curriculum guideline as per the intent of the guidelines prescribed by the DoE (Ibid.).

The ECD strategy aims to provide a child-friendly learning environment in ECD centres. The strategic paper also mentions that families (parents) and facilitators will monitor the holistic development of children, which includes their social, physical, emotional, language, and cognitive development. It also underscores the role of ECD facilitators, ECD centres, and guardians.

Human resources represent a crucial aspect of ECD and facilitators, parents, helpers, teachers, trainers, and coordinators are central to the quality of ECD centres. It is important to support and empower ECD facilitators to ensure the effectiveness of these centres.

Facilitators play a crucial role in ensuring the quality of ECD activities. However, frequent changes of facilitators may create problems regarding the quality of ECD programmes and ECD facilitators leaving was a common issue in most school- and community-based ECD centres. Low recognition and low pay were the major reasons for facilitators leaving their jobs. Similarly, a number of ECD facilitators also aspire to and become primary school teachers (Seto Gurans NCDS, 2011). This is often the aspiration of these facilitators because of higher pay opportunities and perceived greater importance of teaching at higher levels and in school-based centres. However, this transition can be a serious problem for ECD provision.

The number of ECD facilitators reached 47,086 in 2015, which is commensurate with the increase in the number of ECD centres. The percentage of trained facilitators stood at 88.4% in 2015 (DoE, 2015). Around 36% of facilitators have academic qualifications higher than the School Leaving Certificate (SLC). From qualitative data, it emerged that ECD facilitators received training to understand child development and psychology and to shape their work accordingly. However, this training was not regular, only taking place once or twice a year. The facilitators believed that training sessions should be held more often, which would refresh and improve their teaching skills. Besides the DoE, various organisations such as UNICEF and Seto Gurans have also offered training.

The qualifications, skills, and dedication of facilitators, as well as a caring and loving attitude toward children, help make the ECD learning and experience of children better and more effective. A case study noted that facilitators (observed by the research team) in community-based ECD centres were knowledgeable and skilful, and enjoyed working and playing with children (Seto Gurans NCDS, 2015). The same study noted, however, that school-based ECD facilitators were not motivated to work with parents. Facilitators also complained about their low remuneration to head teachers. Moreover, head teachers were not enthusiastic about monitoring the performance of the facilitators, as they were conscious that the facilitators were getting paid a very small sum for their services. There were no clear guidelines to the head teachers for the monitoring either. Some of the head teachers also mentioned that the facilitators did more work than perhaps what they should be expected to do, based on their low pay. This implies that they were sympathetic regarding facilitators' low honorarium. In the case of community-based ECDs, the facilitators were found to be more responsible in terms of their conduct and day-to-day activities in the centres, especially as they did not have the same institutional support that school-based ECD centres received. They were also found coordinating with parents closely (Ibid).

Interviews conducted with district officials highlight that the low salaries of ECD facilitators led to low teacher retention and low motivation to work in ECD centres, as ECD facilitators looked for better opportunities.

Quality of training

Facilitators' (teachers') competency

The qualification level required for an ECD facilitator is a Grade 8 pass with pre- and in-service training (ECD Operation Guideline, 2004/05). There was a provision of 16-day (90 hours) basic and three-day refresher training for facilitators. The training was provided by trained human resources from DEOs and from NGOs such as Seto Gurans. Apart from this training, various international NGOs also have provided short training sessions for facilitators. However, such training was not reported as a required qualification for facilitators. Moreover, despite the training, most facilitators were found to be struggling to perform their daily work effectively with their current level of knowledge and skills. Based on consultation with ECD facilitators from various districts (during various programmes), if facilitators/teachers have been trained at all most have attended only short courses and such training is not adequate for the development of productive competencies.

A study by Seto Gurans explored that the DoE conducted Master Training of Trainers (MToT) and Training of Trainers (ToT) to develop ECD human resources (trainers) in districts. Both MToT and ToT were found to be effective in producing ECD trainers and practitioners in all districts (Seto Gurans, 2015). It was also observed that various ECD-related training sessions for facilitators helped them organise ECD classes effectively. However, there were difficulties and constraints in regard to translating the knowledge and skills provided by the training into local ECD contexts. Different training packages were developed to enhance the ability of facilitators to run ECD centres

effectively. The study suggests that the Basic and Refresher Training equipped the facilitators with general content on ECD required to conduct the ECD class as well as to manage the day-to-day activities of the ECD centre. Similarly, the Peace Education Training provided the ECD facilitators with knowledge of child psychology and the importance of a peaceful environment for the learning and development of children, while the Local Material Construction Training helped facilitators prepare instructional materials fitted to the interests of children.

After the inclusion of ECD centres within the school structure, National Centre for Educational Development (NCED) has taken responsibility for training and developed an ECD teacher training module. It is a 30-day package divided into two modules, each consisting of 10-day face-to-face training and five-day project-based training at the respective ECD centres. At present, only the first module has been introduced, and training has started based on it.

Teaching pedagogy

Teachers of school-based and private school early childhood classes prefer using books and printed materials and reciting content. A number of key stakeholders such as ECD facilitators and parents as well as ECD experts confirmed this in our interviews. Moreover, classroom teaching and learning activities are more formal and structured. The teachers and facilitators of these classes tend to adopt the same classroom-based methods in ECD classes, and such methods are often against the child-friendly approach, as verified by several practitioners during our interactions at the inception stage. There is a need to adapt ECD pedagogy to support teaching and learning in ECD centres. On the other hand, community-based ECD centres face the problem of a lack of physical infrastructure and instructional materials (Seto Gurans NCDS, 2011:27).

Quality of outcomes

The percentage of children with ECD experience in Grade 1 had increased to 62.4% in 2015 from 10.9% in 2004. Moreover, researchers attribute the decrease in repetition and dropout rates at the primary level to the provision of ECD services. A study conducted by CERID found that students with ECD experience performed better than their non-ECD counterparts in final examinations. Similarly, the attendance rate of students at the primary level was higher for students who had ECD experience (CERID, 2004; Children's Environment Research Group, 2003). The introduction of ECD has also led to a positive impact on attendance and the retention of girls, as they did not have to stay at home looking after their younger siblings. This has further freed up poorer parents to pursue income-generating activities.

The percentage of children aged 36–59 months who are developmentally on track for literacy/numeracy is 28.8%. According to NMICS 2014, a child is said to be developmentally on track for literacy/numeracy if they can perform at least two of the activities outlined below:

1. Identify at least 10 letters of the alphabet;
2. Read at least four words;
3. Recognise the symbols of numbers from 1 to 10.

In contrast to these low results, the percentage of children who are developmentally on track in the physical domain is high (96.4%). The percentage of children who are considered to be developmentally on track has been pulled higher by the fact that almost all children are developmentally on track in the physical domain, even as the performance on other domains is much worse. A child is considered to be developmentally on track in the physical domain if he or she is sometimes not reported to be too sick to play and can pick up a small object with two fingers from the ground (NMICS, 2014).

The percentage of children who are on track in the socio-emotional domain is 68.8% (NMICS, 2014). A child is said to be track in this domain if any two of the following are true:

- (i) The child gets along with other children;
- (ii) The child does not kick or bite others;
- (iii) The child does not get distracted.

The percentage of children who are developmentally track in the learning domain is 81.6%. A child is said to be developmentally track here if he or she can follow simple directions toward completing a given task.

Finally, the ECDI score for Nepal is 64.4% (NMICS, 2014). The ECDI is calculated as a percentage of children who are developmentally on track in any three of the literacy/numeracy, physical, socio-emotional, and learning domains.

Table 11: ECDI score and development track indicators

	Percentage of children aged 36–59 months who are developmentally on track in the indicated domain				ECDI score
	Literacy/numeracy	Physical	Socio-emotional	Learning	
Total	28.8	96.4	68.6	81.6	64.4
Sex					
Male	27.5	96.1	65.8	81	62.4
Female	30.2	96.6	71.4	82.2	66.6
Region					
Eastern Mountains	25.2	92.8	80.9	68.8	60.6
Eastern Hills	37.9	95.3	80.1	78.9	74.8
Eastern Terai	33.9	95.3	78.5	79.4	72.3
Central Mountains	28.8	97.6	69.6	87.2	73.8
Central Hills	50.2	97	77.5	90.9	84.2
Central Terai	14.9	95.9	63.2	64.7	45.7
Western Mountains	(24.8)	(93.2)	(51.1)	(93.2)	(62.7)
Western Hills	45.9	99.3	73.6	97.3	81.6
Western Terai	36.5	98.6	71.3	75.8	64.7
Mid-Western Mountains	11.7	93.6	40.8	88.7	42.9
Mid-Western Hills	13.9	98.2	52.6	92.3	55.4
Mid-Western Terai	26.5	95.4	57.2	90.8	56
Far Western Mountains	12.3	89.7	78.7	83.5	69.7
Far Western Hills	7.7	89.6	62.8	79.5	56.2
Far Western Terai	27	100	60.7	95.9	68.4
Area					
Urban	57.3	99.2	79	89.7	83.6
Kathmandu Valley	75.1	100	77.9	92	91.6
Other urban	51.3	98.9	79.4	89	80.8
Rural	24.5	95.9	67	80.3	61.5

Source: NMICS, 2014

The stark difference between children from different regions who are developmentally on track in literacy/numeracy illustrates some of the challenges in the provision of ECD. Only 7.7% of children in Far Western Hills were developmentally on track, whereas in Kathmandu Valley this was 75.1%.

The difference between the areas with the highest and lowest proportion of children who were developmentally on track was thus almost ten-fold.

This difference in the ECDI by region is also replicated when the data is disaggregated according to wealth. For literacy/numeracy, among the poorest quintile 12.3% were developmentally on track, whereas among the richest quintile this was 65.1%. The richest were thus more than five times more likely to be developmentally on track compared to the poorest.

Nepal has been able to make some progress in indicators of quality of input in terms of curriculum, facilitator training, and recruiting facilitators with higher academic qualifications (there are facilitators with high academic qualifications, ranging from Grade 6 to master's level). There has also been gradual improvement in increasing the share of children with ECD experience in Grade 1. However, Nepal is yet to make significant improvement in the ECDI, including on literacy and numeracy. In almost all these developmentally 'on-track' indicators, there is a disparity in performance among different geographical regions and wealth quintiles, and a significant proportion of children are still not performing well across different indicators. This suggests that ECD programming in Nepal needs to expand and improve further to ensure that each child receives the support and guidance needed to ensure they are developmentally on track.

Infrastructure of ECD centres

A study was carried out by Save the Children International (SCI) to explore the status of SCI partner NGO-supported ECD centres in 21 districts. The study found that most of the observed centres do not have satisfactory physical infrastructure. The ECD centres were classified, based on quality, into categories 'A', 'B' and 'C' in terms of the eight areas of ECD centres as mentioned in the National Minimum Standards (SCI, 2011). The National Minimum Standard for ECD centres (2010) was developed by the Ministry of Education, Department of Education for the uniformity of the services. The Minimum Standard is divided into eight major sectors and 14 subsectors. The major sectors are: 1) Physical infrastructure, 2) Health nutrition, safety 3) Minimum required materials, 4) Outdoor environment, 5) ECD management committee and governance, 6) Human resource quality, 7) parents, children and community, 8) drinking water and sanitation (toilet). The minimum standard has focused on the overall management and governance of the ECD centre. All these sectors have indicators for the standardisation.

An ECD centre that met 50% of the National Minimum Standard was rated as B; those above and below 50% were rated as category A or C respectively. The DoE has endorsed minimum standards for ECD centres that were developed via a collaboration between SCI, UNESCO, UNICEF, Seto Gurans, educationists, professionals, and teachers/facilitators. These actors working in the education sector often raise a key concern about the quality aspect of ECD. The minimum standards are intended to bring uniformity in quality by standardising the various components within ECD centres and mapping ECD service effectiveness. The objective of an ECD centre is to ensure the rights of children of 3–5 years of age by promoting their health, nutrition and sanitary situation, increasing learning abilities for overall development and preparing them for primary education (DoE, 2010 cited in SCI, 2011).

In the SCI study, only 12% of ECD centres were found to be in category A, 41% in B, and 47% in category C in regard to their physical infrastructure. This indicates that the physical infrastructure of ECD centres needs improvement in line with the defined minimum national standard set for ECD centres (*ibid.*). Without such improvements, even if children attend ECD centres, the quality of the services they receive might be compromised because of sub-par facilities.

Learning environment and ECD pedagogy

A child-friendly environment is essential for quality learning. This means that a non-threatening, loving, respectful and caring environment, with facilitators showing an understanding of the vulnerability and peaceful nature of children, contributes to the essence of peace and quality education in an ECD centre. Facilitators in school-based centres used to focus on education and teaching, whereby children were taught to write the alphabet and were provided with books and printed materials to recite and copy. Teachers preferred this kind of direct instruction in school-based centres and also in private schools (Seto Gurans, 2015). The ECD strategic paper stated that this type of direct instruction should be discouraged; however, our findings suggest that such practices are still being pursued, as will be discussed throughout the report.

ECD facilitators are found to have concentrated more on children's all-round development in community-based ECD centres. However, in PPCs at school-based centres, teachers also tend to be teaching higher grade students as well. This practice can result in reduced care for their own ECD classes, especially as teachers are often motivated to try to be promoted to teach at a higher grade in the same school. However, retaining facilitators with Grade 8 level qualifications or higher in community-based ECD centres is essential to ensuring quality ECD activities in these centres.

At the same time, in the absence of ECD facilitators in community-based ECD centres such centres are closed. On the other hand, a school-based centre has the benefit of continuing to run because other teachers at the school can take responsibility for the ECD classes.

The DoE has developed Early Learning and Development Standards (ELDS) for children aged 48–60 months. These ELDS focus on holistic development and learning competencies, behaviours, knowledge and skills in children as they grow. The ELDS package is based on five domains: physical development, social and emotional development; cognitive development, language development, and cultural development. These come with 66 standards and 157 indicators. Moreover, lists of activities are also provided for the reference of facilitators to use in the centre. However, this is not applied in ECD centres (NCE, 2015).

3.1.5 Equity in access to ECE services

The number of ECD centres as well as the GER in ECD has increased for all ecological belts and development regions. However, there is no uniformity in access to ECD for children under five. The number of ECD centres is highest in Hill and Terai regions, as these places have high populations. The number of ECD centres in Hill regions is 15,671 and the number of ECD centres in Terai regions is 14,929. On the other hand, the number of ECD centres in Mountain regions is just 3,412.

Table 12: GER* for children aged three and four, 2004–2015

Geographical area	2004			2010			2015		
	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total
Nepal	37.3	41.4	39.4	69.2	70.9	70	80.9	81.2	81
Ecological zone									
Mountain	9.8	11.6	10.7	62.4	62.8	62.6	69.4	69.7	69.6
Hill	34.3	35.3	34.8	64.1	62.8	63.4	79.3	81.3	80.3
Kathmandu Valley	160.6	165.7	163.3	117.7	126.1	122	109.1	102.2	105.3
Terai	32.3	38.3	35.4	68.5	72.2	70.4	80.2	79.9	80
Development region									
Eastern	36.4	41.5	39	61.6	61	61.3	91.6	90.3	90.9
Central	46.2	50.1	48.2	65.3	67.9	66.6	72.6	72.4	72.5
Western	37.3	39.5	38.4	80.6	81.1	80.9	98.9	102.1	100.6
Mid-Western	24	29.3	26.7	73.6	78.8	76.3	69.6	70.5	70
Far Western	28	32.7	30.4	70.1	70.6	70.4	77.5	76.3	76.9

*Gross enrolment computed with enrolment of age four

Source: Flash Report I (2004–2015)

The number of ECD centres has increased in all regions of Nepal in the last 11 years. The GER for ECD is highest for Kathmandu Valley (105.3) and lowest for Mountain regions (69.6).

Among development regions, Western Development Region has the highest GER and Mid-Western Development Region has the lowest (DoE, 2015). Finally, in terms of wealth index quintiles, the percentage of children attending ECE is highest for the richest quintile. The percentage of children attending ECE for the richest quintile is more than double of poorest three quintiles. The percentage of children attending ECE from the poorest households is 41.2% but it is 83.5% for the richest (NMICS, 2014). There is not much difference between the GER in ECD for males and females, indicating that Nepal has achieved gender parity in the GER at this level of education (DoE, 2015). The GERs in ECD for males and females are 80.9% and 81.2% respectively.

An evaluation report commissioned by UNICEF observed that access to ECD services in Nepal has increased for the most disadvantaged and marginalised groups (UNICEF, 2011). According to MoE data from 2006/07 and 2008/09, the proportion of Dalit and Janajati entrants to Grade 1 who have some ECD experience increased substantially in this short period.

Equity in quality of ECE services

The percentage of ECD facilitators who have academic qualifications higher than the SLC has increased for all ecological belt and development regions. The percentage of ECD facilitators who have academic qualifications higher than SLC level is 51% in Kathmandu Valley and 34.9% in Mountain Region. With regard to development regions, Central Development Region has the largest share of ECD facilitators whose academic qualifications are higher than SLC. Far Western has the lowest share of ECD facilitators who have academic qualifications higher than SLC. The

percentage of ECD facilitators who have academic qualifications higher than SLC is 39.9% for Central Development Region and is 28.8% for Far Western. Similarly, the percentage of ECD facilitators who are trained is highest for Kathmandu Valley and lowest for Hill Region. There is not much difference in the percentage of ECD facilitators who are trained; the figure is high for all regions.

Table 13: ECD facilitator qualifications

Indicator	Eastern	Central	Western	Mid-Western	Far Western
Qualifications greater than SLC	36.7	40.7	38.9	35.9	29.4
Trained facilitators	86.9	87.7	85.2	88.5	91.5

Source: DoE 2015

The percentage of children with ECD experience in Grade 1 has increased for all ecological belts and development regions. The percentage of children with ECD experience in Grade 1 is highest for Terai (66.4 %) and lowest for Mountain Region (57.0 %). Meanwhile, the percentage of children with ECD experience is highest for Eastern Development Region, although the difference is not significant.

There is a difference in the percentage of children attending the first grade of primary school who attended preschool in the previous year. While the national average is 74.2%, 90% of children from the richest quintile in primary school have attended preschool in the previous year, whereas this number is only 67.8% for the poorest quintile. As such, regional and income differences continue to persist in terms of school readiness as well.

The ECDI measures the developmental status of children within four domains: literacy/numeracy, physical, socio-emotional, and learning. In the fourth round of the NMICS, the ECDI was used for data collection. The MICS is the only global survey to measure children's outcomes in a holistic manner in the early childhood years. As MICS analyses disaggregated data, the process is important to reveal inequities faced by children such as those related to gender, area of residence, ethnicity, and household poverty. In Nepal, the ECDI is higher for females compared to males; for females it is 66.6 and for males it is 62.4 (NMICS, 2014). The children of highly educated mothers have higher ECDI scores compared to the children of less educated mothers. The difference in ECDI for the children of mothers who have completed higher education compared to the children of mothers who do not have any education is 23. There seems to be a strong correlation between the wealth of households and the ECDI. The richest quintile households have ECDI scores that are much higher than the poorest quintiles. The ECDI score of children from the poorest quintile is 60.2% and that of the richest quintile is 86.3 (NMICS, 2014). This reflects that poverty could hinder access to quality ECD services. Clearly, a higher level of education of mothers can lead to better ECD outcomes for children.

Table 14: ECD experience and the ECDI

Indicator	Male	Female	Mountain	Hill	Kathmandu Valley	Terai
Percentage of children with ECD experience in grade one	62.5	62.3	57.0	58.1	61.5	66.4

ECDI	62.4	66.6
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Source: DoE 2015, NMICS 2014

3.1.6 Parenting education

Parenting education is essential for providing care to children from birth, supporting proper management of the centres, and monitoring ECD activities in centres. Good parenting education can lead to parents regularly visiting the centre, providing support and care to the children, and focusing more on children's nutritional and sanitation habits (Seto Gurans NCDS, 2015; CERID, 2006). The parenting orientation classes are designed to improve parents' knowledge, attitudes, and practices related to child health and nutrition, early learning, prenatal and postnatal care, birth registration, gender discrimination, and the importance of ECE (UNICEF, 2011).

As expressed by parents, participation in parenting programmes helped them realise their role in supporting young children's growth and development, as well as in strengthening or modifying their attitudes, beliefs, and practices in relation to caring for a child. However, parents particularly from disadvantaged and underprivileged communities do not seem to have access to parenting education (Seto Gurans NCDS, 2015). Moreover, some parents opined that the contents of parenting education should also be included in non-formal education programmes such as adult literacy programmes. Parenting education should also cover hands-on knowledge on young children's requirements, including in regard to nutrition, health, sanitation, immunisation, parental love, respect and care, play, and other motor requirements (Ibid.).

Working with parents and Management Committee members has created a collaborative environment to support ECD centres. A study by CERID identified that, in most community-based ECD centres, the relationship between the community, parents, and CBECD centres was found to be satisfactory in terms of attendance of community people in the meetings/gatherings, donation of land, labour, and materials for physical infrastructure development, and collection and mobilisation of funds. It was further suggested that parents cooperated with community-based ECD centres by setting up children's savings funds and by paying tuition fees. This was explained in relation to the fact that all community-based ECD centres had management committees. However, as mentioned in the report, most of the school-based ECD centres did not have management committees, which should liaise with the community, parents, and school-based ECD centres. As a result, they could not establish close relationships with the community and parents (CERID, 2006).

3.1.7 Community involvement

Community participation has been instrumental in regard to the development of infrastructure, management of ECD centres, collection of instruction materials, and supporting facilitators for effective implementation of ECD centres in the community and monitoring of the centres. The study conducted by Malla, Bhomi, and Shrestha (2003) explored important aspects of community involvement for the operation of ECD centres. The authors find that communities possess knowledge, skills, and resources. Trained community people have a willingness to take ownership and contribute to the sustainability of the centre, and they emphasise the physical, financial, and human resource aspects for better management of ECD programmes. Moreover, centres need good relationships with parents and people from the community to ensure their involvement in ECD activities. They can also fulfil different roles such as assistant facilitators in times of need, when the facilitators may be absent, and can provide information on the socio-emotional behaviour of their children at home.

Management and operation of ECD centres has been the responsibility of local bodies, whereas PPCs are the responsibility of schools. Cost-sharing approaches have been adopted with extensive community support and participation to run both community-based and school-based ECD centres (Shrestha, 2008). Various forms of parental orientation programmes are being launched by various organisations and partnerships between schools and community-based organisations (CBOs)/NGOs have been encouraged. The importance of ECD services and the need for ECD centres have been found to be the main focus of such orientation programmes (*Ibid.*).

3.1.8 Coordination of ECD activities

ECD operation guideline 2061 BS has mentioned the ECD council at national level, District ECD board at district level, and ECD management committee at centre level to provide the overall management, coordination, and support for ECD services.

National level

The ECD council was formed under the leadership of the secretary of the MoE, and the secretariat was also based in the MoE. Other secretaries of line ministries were members of this body. As noted in the ECD Operation Guideline, a national level ECD council was formed with the MoE as a Secretariat and an ECD steering committee was formed under the coordination of the NPC, as per the suggestions made by a study by Shrestha et al. (2008), in order to coordinate ECD activities in the country. Suggestions were given to incorporate more members from NGOs, ECD experts, other professionals, District Development Committees, and VDCs. The secretary of MoE was recommended to be the member secretary. Council members include the secretaries of the MoH, MoFALD, and MoWCSW, and other stakeholders (Shrestha *et al.*, 2008).

However, at the implementation level, ministries other than the MoE do not have adequate communication and joint working in mainstreaming ECD programmes in the country. Although most of the policy documents emphasised the need to establish coordination and networking among the different ministries and NGOs involved in ECD, no concerted efforts were ever made to coordinate the activities of the relevant ministries and other organisations.

Government institutions, local and international NGOs, and private sector actors are all involved in the protection of children's rights and in facilitating the learning of young children in Nepal. However, private sector actors and NGOs do not always have well-defined roles. Thus, it is also important to define the role of each of these organisations to ensure proper coordination among them. This lack of awareness and conceptual clarity has often hindered their ability to give importance to all ECD programmes. As reported by a respondent working for an international NGO, since there are different organisations conducting different ECD programmes in their own way, coordination between the government and NGOs should also be strengthened (*Ibid.*).

District level

District ECD committees are formed at the district level for the purpose of monitoring, support, and coordination. According to a number of respondents at the local as well as district levels, the only work performed by ECD district coordination committees was to distribute the ECD quota (i.e. the number of facilitators and centres for ECD) in the districts. Distribution of ECD quota was not found to be made as per the needs and demands of the community. According to ECD experts interviewed over the course of this evaluation, representation in the coordination committee did not cover all concerned sectors, such as NGOs, CBOs, ECD professionals, and ECD trainers.

Interviewees further disclosed that more than one ECD quota was given to some centres or schools, which resulted in the mismanagement of ECD distribution activities in the districts.

Local level

Local-level support is crucial for the success of ECD programmes and the main responsibility for implementing ECD activities falls under the purview of local-level organisations and government bodies. In this regard, a study has recommended the allocation of a certain percentage of the local development budget to ECD activities (Shrestha *et al.*, 2008). Local-level institutions like VDCs and municipalities should be involved in the district-level committees to assist in the coordination of ECD activities (Ibid.).

Planning, programming, and implementing ECD activities in collaboration with local bodies, government, NGOs, and CBOs is also one of the objectives of ECD strategic paper. Coordination, networking, and partnership with communities are the main strategies mentioned in the paper for the effective implementation of ECD in the community. Coordination of the activities at the point of service delivery was observed to be weak, however, as noted by the fieldwork research for this evaluation. The government has not had an established menu of ECD services available (World Bank, 2011), and this was corroborated in our field visits as well. Coordination and collaboration was limited between education sector and non-government sector actors.

Local and international NGOs have collaborated with the government in providing physical facilities and materials such as toilet construction, drinking water, play materials, and even matching grants to top up facilitators' remuneration. However, many such stakeholders focused more on collaborating on the physical development of ECD centres than on children's overall requirements (CERID, 2006). This could partly be because the immediate need was to provide physical space for the children.

While physical and material support were very important for children's development, long-term intersectoral collaboration was also equally important to sustain and thereby mainstream child development initiatives. However, the focus on physical and material support continued to be the pattern of collaboration. A UNESCO (2008) sponsored early childhood policy review also sheds light to the same issue, clearly illustrating a lack of intersectoral coordination. It was revealed that 'mainstreaming is related to incorporating ECD in their own objectives and including it in the structure of education' (Ibid., p. 51). Indeed, in 2011, when UNICEF evaluated its own ECD programmes, the evaluation revealed the lack of intersectoral coordination among institutions like government and non-government actors, UN agencies, NGOs, and the private sector. Although efforts have been made toward the integration of ECD involving MoFALD, the MoE, and the NPC, cross-sectoral integration is yet to be achieved (UNICEF, 2011). UNICEF also raised concerns about resource utilisation and asserted that, 'Monitoring conducted by multiple stakeholders, without coordination and standardized monitoring and reporting tools, is not an efficient use of ECD resources' (Ibid., p. 25).

Intersectoral coordination is a process of establishing relationship with the persons working within and among institutions for a common goal. Different government actors, local and international NGOs, UN agencies, and private sector actors are involved in the development of young children in Nepal. However, as yet their respective roles have not been clearly defined. Thus, it remains important to define the roles and responsibilities of each of the organisations to facilitate proper coordination among them. These issues are discussed in further detail in Section 6.

3.1.9 M&E

Nepal does not have a comprehensive system in place to track the needs of individual children and intervene where needed (World Bank, 2013). Although quality standards for ECD services have been established, in Nepal the enforcement of regulatory mechanisms still needs strengthening (UNESCO, 2015). This makes ensuring quality standards a serious concern and challenge.

Thus, there is a need for M&E of ECD services to measure the quality of such services. Feedback from such M&E exercises would enable better implementation of ECD programmes. Currently, administrative and survey data are collected regarding ECD programmes, such as data on enrolment, usage, nutrition, and health (World Bank, 2013). However, accurate data are not collected for ECD centres and their activities. Systematic data are also not collected on other ECD activities being piloted on a smaller scale, such as data on facilitator training, awareness raising, stakeholder orientation, and ECD messages on nutrition (UNICEF, 2011). There is no formal mechanism to report monitoring findings to district-level education officers or any other body. Monitoring of ECD activities that are conducted by multiple stakeholders, without coordination or standardised monitoring and reporting tools, cannot inform the efficient use of ECD resources (UNICEF, 2011).

It is thus found that the monitoring system for ECD programmes is yet to be formed, although there are some on-the-ground practices in terms of ECD supervisors and joint monitoring visits to local and international NGO-supported programmes that are helpful. The District ECD Committee, along with the DEO, has not yet developed the M&E system for the ECD programme. In some cases, head teachers of the parent schools (under which the ECD centres sit) and resource persons were involved in monitoring. However, it was mostly found that these activities only focused on data collection.

Some respondents noted that some monitoring tools have been designed, and should be in place, so the challenge is in terms of implementation. However, during this evaluation we did not find any evidence to suggest that these tools were in use. Even ministry officials who were supposed to be responsible for the implementation of these monitoring tools were not aware of them, and did not mention them in the context of carrying out their monitoring activities.

3.1.10 Management and facilities in ECD centres

Various studies have found that government and international NGOs have different approaches to ECD expansion (see, for instance, CERID, 2004). Plan Nepal, UNICEF, Save the Children Nepal, and Save the Children US were implementing bottom-up approaches to ECD programming, whereas the DoE was adopting a top-down approach. Similarly, international NGOs adopted the demand-driven approach whereas the DoE adopted a supply-driven approach to the distribution of ECD centres. A study conducted by CERID (2004) draws attention to the problem of quota distribution for ECD centres. Quota distribution is related to the supply-based approach adopted by the DoE, an approach that may not address the actual needs of the community. This is further related to ownership of the centre and its sustainability. If it is supply driven, people think that the higher authorities will be responsible for its management (CERID, 2004). These challenges might be because of the lack of proper mapping of ECD centres and awareness of the community about the importance of the ECD programme to their children. In such a case, a supply-driven rather than demand-driven approach to the distribution of ECD centre quotas has come to dominate.

The physical environment and facilities are important for a better ECD environment. School-based ECD classes take place in a room within the school building, while many community-managed centres are in separate premises or hired rooms. School-based ECD centres usually use school

furniture whereas most community-based centres do not have furniture and they use a carpet or mat (Chatai or gundri) in the centre. A study conducted by Seto Gurans (2015) on two successful cases (the two centres of Bajura and Rautahat) stated that community-based ECD centres are located in a peaceful environment, with better-quality school buildings and furniture. Both of the case ECD centres have better managed classrooms with six learning corners, for maths, languages, creative arts, role play, science, and construction. These learning centres can be used to encourage a joyful learning environment for the children. Of course, two success cases may not be enough to generalise from, but these centres give some evidence on how to improve services to young children.

However, another study carried out for Seto Gurans NCDS detailed the reality in the following terms: 'Although most of the ECD classrooms have six learning areas, the proper use and effective management of these learning areas are found ineffective in most centres due to the unavailability of adequate materials required in each area, and also due to the lack of proper knowledge and skills on the part of facilitators to organise and use the learning areas effectively' (Seto Gurans, 2015). The National Minimum Standards (2010) specify that each ECD centre should have at least six learning areas inside the classroom: language, pre-maths, science, creativity, construction, and role play. Facilitators have to manage learning materials, puzzles, domino, story books, maths learning materials, seeds, colours, building blocks etc. as per the minimum standard. Facilitators are not trained sufficiently to organise and use learning area resources. Different learning areas need different materials, such that a maths area needs mathematical and geometric shapes, figures and materials, while a science area needs such things as different colour liquids, sound boxes, weighing tools, soil, and so on. Moreover, facilitators are provided materials support to the centre for effective use of six learning corners.

Conclusion

The ECD strategic paper sets out a vision of well-managed community- and school-based ECD centres that create an enabling environment for young children's holistic development. However, due to insufficient resources, inadequate training for facilitators, and regular turnover of the facilitators in both community- and school-based centres, these centres have not been able to adopt ECD based pedagogy for early age children. Proper coordination among ECD service providers is an urgent requirement for the effective implementation of ECD programmes. Studies show that at the local level ECD coordination committees have not been effective. Access to ECD programmes has increased, but there is still a gap in terms of the equity of services as regards disadvantaged and marginalised groups. Lower qualified (Grade 8 pass) facilitators do not have adequate knowledge and skills to make ECD classes more effective, while qualified teachers (with the right credentials) do not stay for a long time in ECD centres because of other opportunities. This has created problems for the regularity of ECD activities in the centres.

The proper management and facilitation of ECD centres differ between centre-based and school-based centres. The differences are obvious when comparing centres supported by international NGOs and other centres run by DoE. Some of the community-based centres have managed different learning centres whereas majority of ECD centres in school do not have the provision of learning centres. This may have resulted in differences in quality services.

3.2 Health

The Strategy Paper for ECD in Nepal envisions that the holistic nature of children's development will be addressed through the integration of health and nutrition services:

The ultimate aim of an ECD programme is to ensure the wellbeing of our children and facilitate the process of their holistic development. The programme should embody a developmentally appropriate practice, which caters to the health, nutrition, security and learning needs of the child (MoE, 2004)

The Strategy Paper recognises the importance of the integration of health and nutrition in ECD. Although there are several development partners engaged in the health sector, the MoH plays the central role in the implementation of health activities in the country. MoH expenditure represents 81.4% of total expenditure in health (MoH, 2016). The health programmes of the government include maternal health, child health, adolescent health, and HIV. However, the major focus is on child health and maternal health. This is evidenced by the fact that 18.5% of the health budget is allocated for these programmes (MoH, 2016). The major areas of focus within the budget are administration and equipment for hospitals. Programmes implemented in the health sector related to child health and maternal health include ANC, birth preparedness counselling, immunisation, sick newborn care management, pneumonia, micronutrient supplementation and fortification, infant and young child feeding (IYCF), immunisation, community-based integrated management of childhood illness (CB-IMCI), and safe motherhood. These programmes form the core of ECD-related health services, and the status of each of these components is discussed below.

Programmes that support nutrition, immunisation, and hygiene have demonstrated significant benefits for health and ECD (Jukes, 2006). It is important to recognise that the interventions, including those promoting opportunities for early stimulation and learning, have a direct impact on children's health and development. Programmes that strengthen young children's cognitive and socio-emotional abilities can lead to fewer health problems in later life, in part because they reduce the likelihood of mental health problems. Improving physical and mental health and reducing reliance on the health care system are key interventions in terms of ECD. However, the majority of health programmes are focused on children up to two years of age, excluding the age group from three to five years, although these slightly older children are also recognised as within the ECD years in the Strategy Paper.

3.2.1 Safe motherhood

The National Safe Motherhood Plan 2002–2017 was developed to facilitate an enabling environment where a woman's right to safe pregnancy, delivery, and post-partum care is achieved.

It is crucial to support mothers and children during the antenatal period by reaching pregnant women through a number of different interventions. Increased attention during pregnancy helps not only in terms of better support to foetal growth and development, but also supports the mother's health. It also helps ensure that pregnant women take support from skilled attendants or deliver with the assistance of a skilled health care provider (medical doctor, nurse, etc.). Compared to 2001, there has been an overall increase in the number of pregnant women seeking proper ANC and PNC. According to HMIS data, the percentage of women receiving four ANC sessions increased from 44.1% in 2004/05 to 51.4% in 2015/16. The target for percentage of women completing at least four ANC visits during pregnancy was 80% (NHSP2, MoH 2010), however, so this achievement still falls significantly below this target. The National Safe Motherhood Plan 2002–2017 also set targets for increasing the percentage of ANC and PNC check-ups and deliveries by skilled birth attendants (SBAs). The national target for the proportion of births attended by an SBA was attaining 60% by 2015 (NDHS, 2016). In 2001, only 13% of women were attended by a health worker during delivery, and it is important to note that not all of these health workers qualify as SBAs (NDHS, 2001; cited in National Policy on Skilled Birth Attendants, 2006, Supplementary to Safe Motherhood Policy 1998).

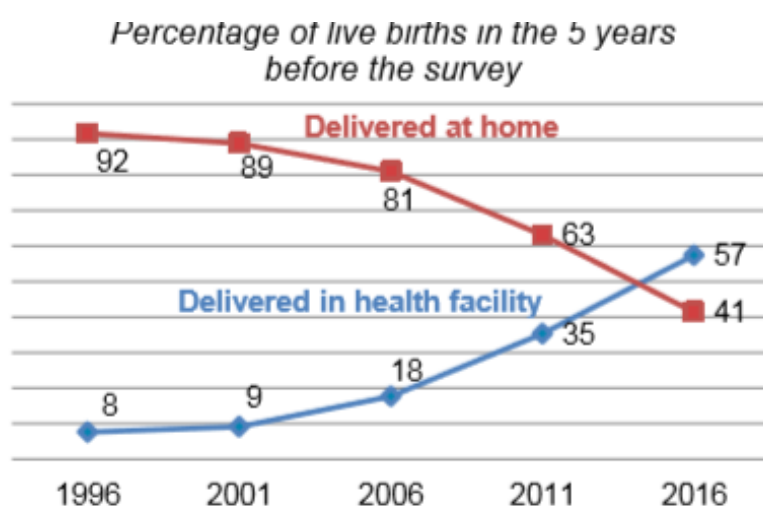
Table 15: Information on deliveries

Deliveries	2001	2016
By SBA	12.7%	40%
At institutions	9%	22%

According to NDHS (2016), the trend in ANC service utilisation from a skilled provider is increasing. There was a 25 percentage point increase in the proportion of women receiving ANC from 2011 to 2016, far higher than the increase from 2006 to 2011 (14 percentage points) and from 2001 to 2006 (16 percentage points) (NDHS, 2016). Overall, 84% of women received ANC from a skilled provider for their most recent birth. While segregating the number by age groups, women under the age of 20 were more likely (87%) to use ANC services from skilled providers than their older counterparts aged 35–49 (67%) (NDHS, 2016).

The percentage of institutional deliveries in Nepal increased to 55.1% in 2015 from 11.3% in 2004 (HMIS 2004; HMIS 2015). This is a robust improvement of 43.8 percentage points in 11 years, and has surpassed the target of 40% (HMIS 2004; HMIS 2015; NHSSP2, 2010). The provision of the government's conditional cash transfer could have helped Nepal to surpass the target by mandating institutional delivery/birth with an SBA as a criterion for receiving the cash grant.

There has thus been significant improvement in facilities providing safe delivery services such as institutional delivery (both in public and private health services) and delivery by SBAs, etc. In this vein, the government has initiated the 'Aama programme', which gives additional benefits to women delivering in health facilities and has improved the provision of safe delivery services and institutional delivery (DoHS, Annual Report 2069/70 (2012/2013)). Since then, almost nine in every 10 (89%) mothers have received the transportation grant due to them if they go for regular checks during pregnancy and deliver in a health facility.

Figure 2: Trends in place of birth

Source: NDHS, 2016

The NDHS (2016) shows that only 5.9% of women are not receiving ANC services from any service provider, while 83.6% are receiving ANC services from SBAs. The following table depicts the percentage distribution of women aged 15–49 who had a live birth in the five years preceding the survey by ANC provider.

Table 16: Distribution of caregivers for live births

Doctor	Nurse/ANM	HA/AHW	MCHW	Other	No ANC	From SBAs	Total
43	40.6	8.6	0.8	1.1	5.9	83.6	100

Note: (i) ANM = Auxiliary Nurse Midwife, (ii) AHW = Auxiliary Health Worker, (iii) MCH = Maternal and Child Health Worker, and (iv) SBA = Skilled Birth Attendant

The percentage of women having a first PNC visit has also increased, from 30.4% in 2004 to 54.5% in 2015 (HMIS, 2004; HMIS, 2015).

Regionally, the highest proportion of women seeing a skilled provider for ANC services was in the Central Hills (83%) and the lowest proportion was in the Mid-Western Mountains (42%). Urban women were more likely than rural women to see a skilled provider (93% compared to 65%). Younger and older women were less likely than women aged 20–34 to see a skilled provider. Women with higher education levels and/or living in households in richer quintiles were much more likely than other women to receive ANC from a skilled provider (NMICS, 2014).

Similarly, the expansion and strengthening of different safe motherhood services such as safe abortion services, basic and comprehensive emergency obstetric care services, the safe delivery incentive programme, the birth preparedness package and maternal and neonatal health activities at community level, emergency obstetric care and birthing centres, and newborn care are all being carried out in a planned manner (Ibid.). Education level and household wealth status were strongly associated with the likelihood of a woman making her first ANC visit during the first trimester (NMICS, 2014). About three-quarters of all maternal deaths occur due to direct obstetric causes (Ibid.). In some cases, complications during pregnancy or childbirth can lead to death. It is the direct obstetric deaths resulting from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

According to NMICS (2014), 57.6% of newborns received a health check-up immediately following birth in the facility, or at home. With regard to PNC visits in the following days, the vast majority of newborns did not receive any visits (83%). When they did ensue, they were either on the same day (1%), 3–6 days following birth (2%), or after the first week (9%). As a result, only 58% of all newborns received some form of postnatal health check. This percentage varied from 17% in the Mid-Western Mountains to 75% in the Central Hills. Urban newborns were much more likely than rural newborns to receive a postnatal health check (87% compared to 53%). It was likelier for newborns delivered in a health facility than those delivered at home to receive a postnatal health check (91% compared to 17%); only 15% of newborns delivered at home received a health check immediately following birth, and 90% did not receive any PNC visits in the following days. There was a positive correlation with both education and household wealth, with an increased likelihood of a postnatal health check for newborns as mother's education and household wealth increased (NMICS, 2014). This is because educated mothers are usually more aware of what is required for safe delivery.

The highest proportion of women receiving a postnatal health check for both mother and child was in the Central Hills (72%) and the lowest proportion was in the Mid-Western Mountains (15%). Urban women were much more likely than rural women to receive a postnatal health check for both mother and child (85% compared to 50%). Women delivering in a health facility were much more likely than those delivering at home to receive a postnatal health check for both (86% compared to 16%). Some 39% of women with no education received a postnatal health check for both mother and child, compared to 78% of women with higher education. Only 31% of women living in the poorest households received this compared to 87% of women living in the richest households.

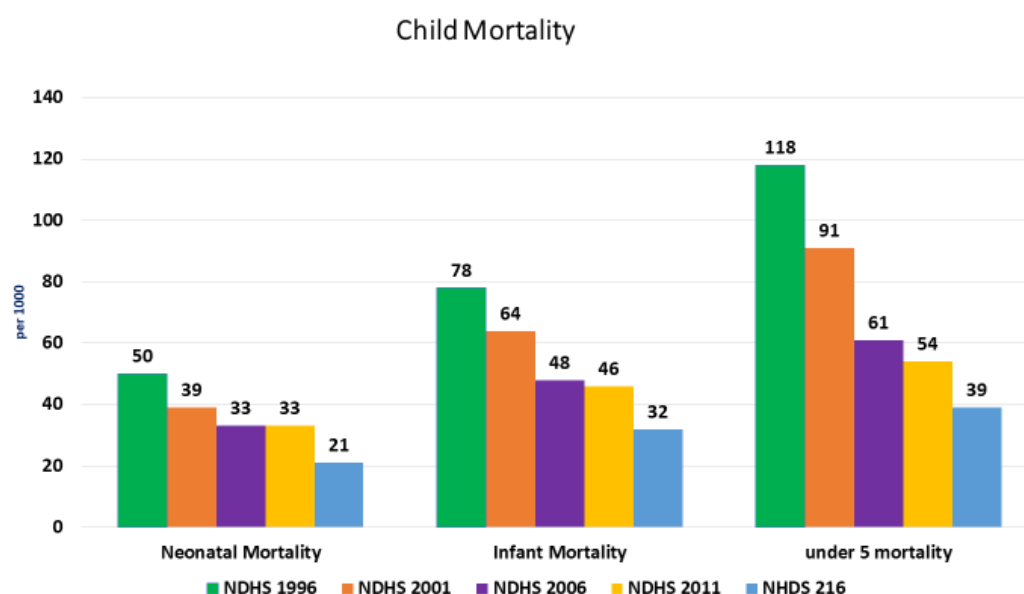
Despite the increase in the overall reach of safe motherhood practices across the nation, the distribution of women by geography, economic status, education level, and other characteristics is not uniform. Some women are still at more risk than others during and after birth.

3.2.2 Child mortality

Child mortality is a sensitive indicator of a nation's development, representing multiple inputs to child wellbeing including health, nutrition, immunisation, safe drinking water, sanitation, birth spacing, access to health services, and the general safety of the environment. In Nepal, child mortality has shown a declining trend at the national level over the last 15 years, with under-five mortality at 56 deaths per 1,000 live births during the years 2000–2015 preceding the survey and 38 deaths per 1,000 live births during the most recent five-year period, which is roughly the years 2009–2014 (NMICS, 2014). The 2014 NMICS findings on under-five mortality show progress and positive trends. The under-five mortality rate in Nepal is 38 deaths per 1,000 live births, the infant mortality rate is 33 deaths per 1,000 live births, and the neonatal mortality rate is 23 deaths per 1,000 live births (NMICS, 2014).

Nepal achieved its MDG of reducing the under-five mortality rate from 54 per 1,000 live births to 34. However, there are substantial disparities in terms of urban–rural location, mother's education, and household wealth status, as well as between regions. Infant and under-five mortality rates in rural areas are both over 50% higher than in urban areas. The under-five mortality rate is much higher in the Mid-Western and Far Western development regions, compared to the national average (NPC, 2015). Mortality rates tend to decrease with an increase in the education level of the mother. Children in the poorest households are twice as likely to die before reaching one and five years of age compared to children living in the richest households. According to the NMICS (2014) data, the mortality rate for children under the age of five is 22 per 1,000 live births for the richest quintile whereas this increased to 57 per 1,000 live births for the poorest quintile, which is a significant disparity. Child mortality by socioeconomic characteristics also shows variations; mortality rates are higher among rural children than urban children.

Nepal has successfully improved coverage of effective interventions to prevent or treat the most important causes of child mortality through a variety of community-based and national campaign approaches (Annual Report, 2070/71). These include high coverage of semi-annual vitamin A supplementation and deworming, CB-IMCI, high rates of full child immunisation, and moderate coverage of exclusive breastfeeding of children under six months, among others.

Figure 3: Child mortality (1996–2016)

Source: NDHS 2016; UNFPA 2017

The most promising intervention strategy for ensuring children's survival is the promotion of exclusive breastfeeding. The Government of Nepal launched the 'Golden Thousand Days' programme to improve the health of pregnant women and reduce the infant mortality rate in the country. The programme is expected to reduce infant mortality by initiating awareness campaigns among pregnant women on health and nutrition issues. It supports mothers' exclusive breastfeeding up to six months and supplementary food after six months, and increases the number of health facilities in rural areas in the country.

There has been definite progress through government interventions such as Golden Thousand Days and CB-IMCI, which are contributing to increased survival rates for infants and children. Now it is imperative to combat the disparities that exist in the realisation and implementation of the goals, and in these programmes across different geographical regions, economic statuses, and mother's education level.

3.2.3 Immunisation

The target of the immunisation programme was to make the country polio free and to reduce the occurrence of measles outbreaks by 2011. Although the incidence of polio is rare, the percentage of children that are vaccinated against polio3 was 83% in 2004 (HMIS 2004). According to HMIS 2015, the percentage of children vaccinated against polio3 has remained similar in the last 11 years (79.4%).

The national immunisation coverage of all antigens in the regular Expanded Program of Immunization (EPI) was intensive compared to the last 10 years according to fiscal reports (Annual Report 2071/072; 2013/2014). There are 10 antigens (BCG, DPT-HepB-HIB, OPV, measles-rubella and Japanese encephalitis) in the national immunisation schedule for children.

Table 17: Vaccine coverage

Name of the vaccines	Percentage reached	Source
BCG	92.4	MoH Annual Report 2061/062 (2004/05)
DPT-Hep B-Hib-3	80	
Polio3	83	
Measles	79.3	
BCG	87.1	HMIS, 2015
DPT-HepB-Hib	81.5	
Measles	79.4	

Coverage of the major vaccines – i.e. BCG (92.4), DPT-Hep (80) B-Hib-3, Polio3 (83) and measles (79.3) – has been high in the last 11 years and has been maintained. According to the HMIS, the percentage coverages of BCG, DPT-HepB-Hib and measles were 87.1, 81.5 and 79.4 respectively in 2015 (Annual Report FY 2061/62).

The target of reaching 90% DPT coverage by 2015 was not reached. Coverage of TT-2 for pregnant women has also increased from 44.9% in 2004 to 66% in 2015 (HMIS 2004; HMIS 2015). A school-based immunisation programme has also been ongoing. A measles campaign has been organised, which had a significant positive impact in terms of a reduction in measles outbreaks and measles cases compared to earlier periods. However, the coverage is not uniform throughout the country.

Table 18: Immunisation coverage by antigen doses

SN	Antigens	Target population	Targets	Achievement	% achieved
1	BCG	Under 1 year	660,629	575,383	87.1
2	DPT-Hep B-Hib 1	Under 1 year	660,629	567,787	85.95
3	DPT-Hep B-Hib 2	Under 1 year	660,629	549,793	83.22
4	DPT-Hep B-Hib 3	Under 1 year	660,629	538,466	81.51
5	Polio1	Under 1 year	660,629	557,217	84.35
6	Polio2	Under 1 year	660,629	532,346	80.58
7	Polio3	Under 1 year	660,629	524,522	79.4
8	IPV	Under 1 year	660,629	474,391	71.81
9	PCV1	Under 1 year	660,629	506,527	76.67
10	PCV2	Under 1 year	660,629	439,854	66.58
11	PCV3	Under 1 year	660,629	284,873	43.12
12	Measles/rubella 1st dose	Under 1 year	660,629	509,531	77.13
13	Measles/rubella 2nd dose	15 months	616,230	149,431	24.25
14	Japanese encephalitis	12 months	476,693*	301,466	63.24
15	Td2 & Td2+	Pregnant women	751,490	495,957	66

Source: DoHS, Annual Report 2072/73 (2015/2016)

According to NMICS (2014), 67% of children aged 12–23 months had received all recommended vaccinations by their first birthday. However, this level of coverage is still low as the target is 90% during the year. Some 88% of children had received a BCG vaccination by the age of 12 months. Similarly, 89% of children had received Polio 1 by the age of 12 months, although this dropped to 85% for the third dose. Coverage for the first dose of measles vaccine is 85%. Coverage figures for children aged 24–35 months are generally similar to those aged 12–23 months, suggesting that immunisation coverage has been stable between 2013 and 2014. In total, 66% of children aged 24–35 months had received all recommended vaccinations by their first birthday. However, coverage of all antigens varies among the districts.

Our fieldwork revealed a few reasons for the gap in coverage for immunisation. According to some health workers across the districts, children living in remote areas missed immunisation drives because the health posts were far away. Further, parents would often forget about the next dosage because of the gaps between the dosages of the vaccines. These and other reasons are explored further in a later chapter.

Two rounds of national immunisation programmes in a year and intensified national immunisation days have substantially contributed toward the goal of eliminating polio. The country has sustained polio-free status since FY 2069/70 (2012/13). Measles cases have been dramatically reduced after measles catch-up and follow-up campaigns as well as satisfactory routine coverage. The achievements gained need to be sustained in the coming fiscal year through the intensification of planned regular activities and implementation of recommendations made during the national reviews.

The National Newborn Care Package, currently under revision, combined local strategies with global evidence about the community-based management of newborn infections, promotion of newborn care practices, and the use of birth preparedness programmes. The overall coverage of immunisations, while seemingly on the rise, still requires a focused approach to achieve its targets.

3.2.4 CB-IMCI

Programmes in Nepal targeting child health have been intentionally community based. They include the CB-IMCI programme delivered by FCHVs supported by the health system. This programme has been credited with reducing the under-five mortality rate by improving effective management of pneumonia.

The incidence of Acute Respiratory Infection (ARI) for children under five years increased from 614 per 1,000 children in 2007 to 647 in 2015 (HMIS, 2004; HMIS, 2015, while the percentage of diarrhoea cases treated has decreased to 87.4% in 2015 from 88.3% in 2004. The decrease in incidence for diarrhoea is a result of the mobilisation of FCHVs in the community, who observed these cases and treated them.

Similarly, the national incidence of diarrhoea per 1,000 children under five has decreased considerably to 501 in FY 2071/72 (2014/15) from 528 in 2069/70 (2013/14).

In FY 2071/72, a total of 1,413,111 diarrhoeal cases were reported (DoHS, Annual Report 2071/72 (2014/15). The overall period-prevalence for diarrhoea in children under five is 12% and ranges from 5% in the Western Mountains to 21% in the Mid-Western Mountains. The highest prevalence is seen among children aged 12–23 months (19%), which approximately corresponds to the weaning period (NMICS, 2014).

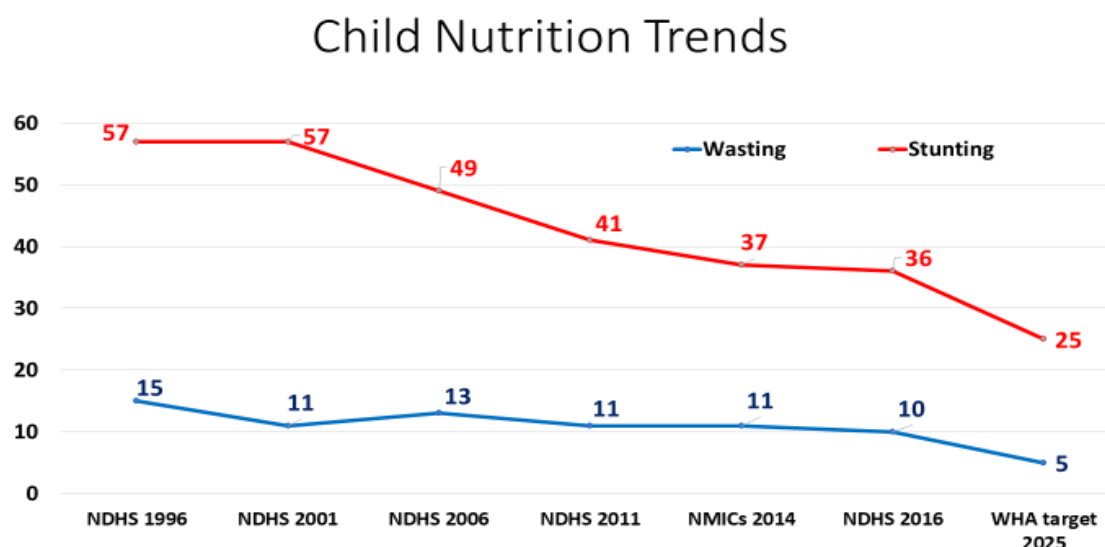
There has been a successful focus on increasing the use of health services for delivery care, ANC, family planning, and SBA attendance through a combination of financial incentive programmes and policies such as the National Policy for SBA. There has also been an important emphasis on community-based approaches to delivering maternal and child health promotion and services. Special provisions are made to reach the target communities and programmes are being implemented to improve community engagement and empowerment to reach poor, marginalised, socially excluded and underserved populations.

While reviewing the ECD vision, health is included as one of the development domains that contribute towards the holistic development of children. However, comprehensive support to children in the health domain is not adequately addressed in the strategy despite the strategy envisioning the sectoral integration of services in the process of planning and implementation. Our review of sectoral programme reports shows there are many activities conducted related to ECD but they are not developed or prepared with reference to the ECD strategy. There is no system of regular health check-up, records of immunisation of an individual child, or growth monitoring and record system in ECD centres. Some NGO-supported centres may have growth monitoring and record-keeping systems, but this was not found consistently in all the centres (NCE, 2015).

In this context, it is recommended that wider consultations with all the government line ministries/authorities need to take place to develop integrated multisectoral strategic outline which can guide sectoral programmes in the future.

3.3 Nutrition

Health and hygiene in early childhood are closely interrelated with nutrition. Poor diet (quantity and quality), inadequate caring practices, and childhood infections can contribute to malnutrition in children (National Nutrition Policy Strategy, 2004). Illness can suppress appetite as well as increase a child's nutritional requirements, while nutrient deficiencies can increase the risk of illness and the severity of disease (World Bank, 2006). Environmental risk factors such as malnutrition, poor health, unstimulating home environments, and child maltreatment have all been shown to have a negative impact on children's overall development (Irwin *et al.*, 2007). Moreover, inadequate nutrition, particularly before birth through age two, leads to stunting.

Figure 4: Child nutrition trends

The 2004 Nepal Health Sector Strategy and the Nepal Health Sector Implementation Plan have recognised the nutritional problems of mothers and children, and have recommended adopting a specific implementation strategy with regards to nutrition (National Nutrition Policy Strategy, 2004). Poor nutrition often begins in utero and leads to poor health outcomes later in life. Maternal undernutrition (including inadequate calories and deficiencies of iron and iodine) and untreated infections (for example, malaria and sexually transmitted infections) contribute to intrauterine growth restriction, low birthweight (LBW – classed as weight at birth of less than 2,500 g), and stunting (Child Health Division and WHO, 2012). Already facing disadvantage before birth, LBW children rarely fully recover the lost linear growth suffered in utero (Alderman *et al.*, 2006). Additional risks of LBW and small babies are associated with later adult health problems. Research shows that undernutrition also leads to impaired brain development, cognitive delays, and reduced productivity (Ibid.).

Nepal has pioneered the implementation of a multisectoral approach to undernutrition. In 2009, Nepal's Nutrition Analysis and Gap Assessment resulted in the formation of a multisectoral nutrition plan (MSNP) of action in 2011 to address malnutrition in pregnant women and children under five. This MSNP for improving maternal and child nutrition and reducing chronic malnutrition was prepared by five government sectors, under the lead of the NPC and in collaboration with development partners. It offers a package of interventions with priority strategic objectives through a sector-wise approach that, over a period of five years, should contribute to a reduction by one-third in the current prevalence rates of chronic malnutrition.

3.3.1 Reducing malnutrition

The percentage of children who had a growth monitoring visit increased to 78.2% in 2015 from 54.4% in 2004. Nepal has made significant improvement in reducing the prevalence of stunting, wastage, and emaciation in the 10 years from 2006 to 2016. The stunting rate has decreased to 36% from 57% in last 10 years. However, the MDG target (2015) was to reduce this to 28 by 2015. Similarly, the wastage rate has decreased to 10% from 13% in the last 10 years. Finally, the underweight rate has decreased from 39% to 27% (DHS 2006; DHS 2016).

Table 19: Indicators and targets for reducing the prevalence of PEM

Indicators	1990s	2000s	Target 10th Plan (2007)	Target 11th Plan (2012)	Target MDGs (2015)	Target Second Long Term Health Plan (2017)	Reference
Prevalence of underweight (<5yrs)	46.9b	48.3	39	32	27	24	NFHS1996 DHS2001
Prevalence of stunting	48.4 b	50.5	41	33	28	25	NFHS1996 DHS2001
Prevalence of wasting	11.2b	9.6	8	6	5	5	NFHS1996 DHS2001
Rate of exclusive breastfeeding	74.0	68.3	77	84	88	>90	NFHS1996 DHS 2001
Rate of optimal complementary feeding (6–9 months)		65	75	83	88	>90	DHS2001
Coverage of growth monitoring (<3yrs)		12-17	30	45	55	>60	DoHS AR 20002/03

Source: Adapted from National Nutrition Policy and Strategy, 2004

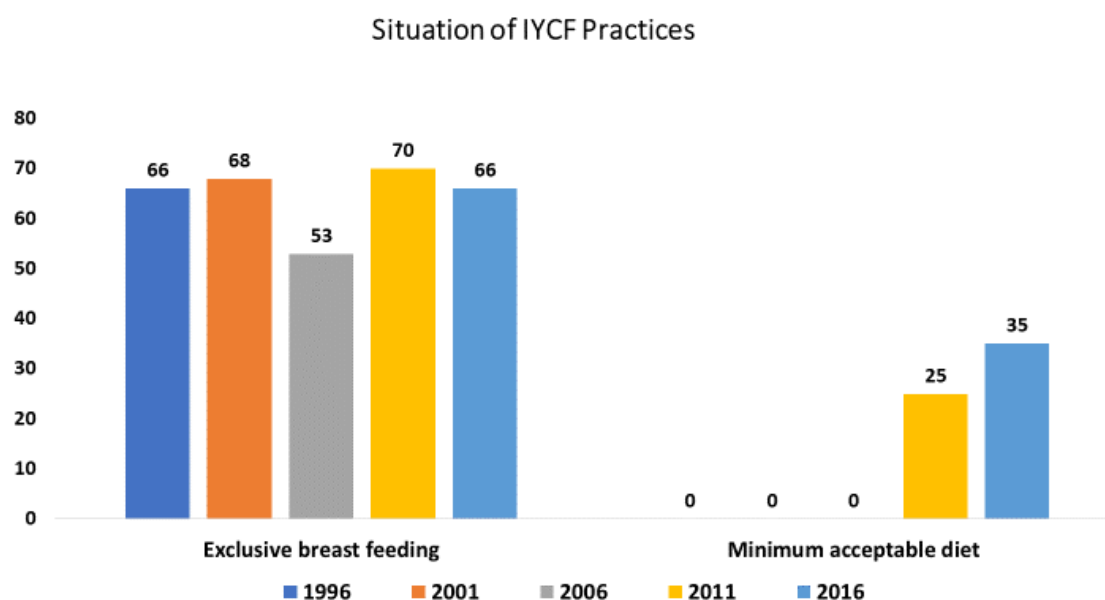
Early stimulation, adequate nutrition, hygiene, and optimal child health and development are the major interventions that are imperative to be applied nationwide. For those who survive, poor health and inadequate nutrition and stimulation in early childhood often lead to long-term health and development issues. It is costly for societies to ensure that children survive the first five years of life. However, survival alone is not sufficient for children to grow into healthy, competent, and productive members of society. Walker *et al.* (2007) estimate that at least 200 million children under the age of five worldwide will most likely survive early childhood but fail to reach their full potential in life because of poor health, undernutrition, and lack of stimulation in early childhood.

In Nepal, some 60% of all newborns were weighed at birth. For all births, 24% of infants were estimated to weigh less than 2,500 grams (i.e. were underweight) (NMICS, 2014). There was some regional variation, ranging from 20% in the Eastern Terai to 33% in the Mid-Western Mountains. One in three (30%) children under five in Nepal were moderately or severely underweight, with 9% classified as severely underweight. More than one-third (37%) were moderately or severely

stunted, with 16% severely stunted, and 11% were moderately or severely wasted, with 3% severely wasted. Only 2% of children were moderately or severely overweight. Children in rural areas were more likely than those in urban areas to be underweight, stunted, or wasted. Those children whose mother has secondary or higher education were the least likely to be underweight, stunted, or wasted compared to children of mothers with no education. Older children were more likely than younger children to be underweight and/or stunted but less likely to be wasted.

According to NMICS (2014), almost all (97%) newborns in Nepal were breastfed at some point after birth. However, only 49% started breastfeeding at the recommended time (i.e. within one hour of birth). Some 57% of infants under six months of age were exclusively breastfed and 75% received breast milk as the predominant source of nourishment during the day prior to the survey. Boys were more likely than girls to be exclusively breastfed. A cultural dimension partially explains this difference, as boys are usually introduced to semi-solid food at six months, as compared to girls at five months. Mother's education level was inversely associated with exclusive breastfeeding. One of the reasons behind this is that educated women are involved in work and may not get time to feed their babies during the work day.

Figure 5: IYCF situation



However, there are still severe problems related to malnutrition in Far Western regions as noted by a report published in the daily newspaper *Kantipur* (Singh, 2017), which suggests that in Bajhang 47% children are stunted and 29% have low weight according to the district health office. Almost 11,000 children suffer from malnutrition in Bajhang alone, and the situation is worse for girls. According to an auxiliary health worker, there was a marked difference in the parents' response in cases of their sons and daughters falling sick. In the case of sons, they would go as far to borrow loans for his treatment and take him to medical facilities in nearby cities like Dhangadi or even all the way to Kathmandu. In contrast, it was rare for the parents to bring their daughters even to the district headquarters in similar cases. This raises serious questions about the effectiveness of different parenting education programmes and the quality of service of ECD programmes in terms of ensuring gender equity and justice, as envisioned by the Strategy Paper.

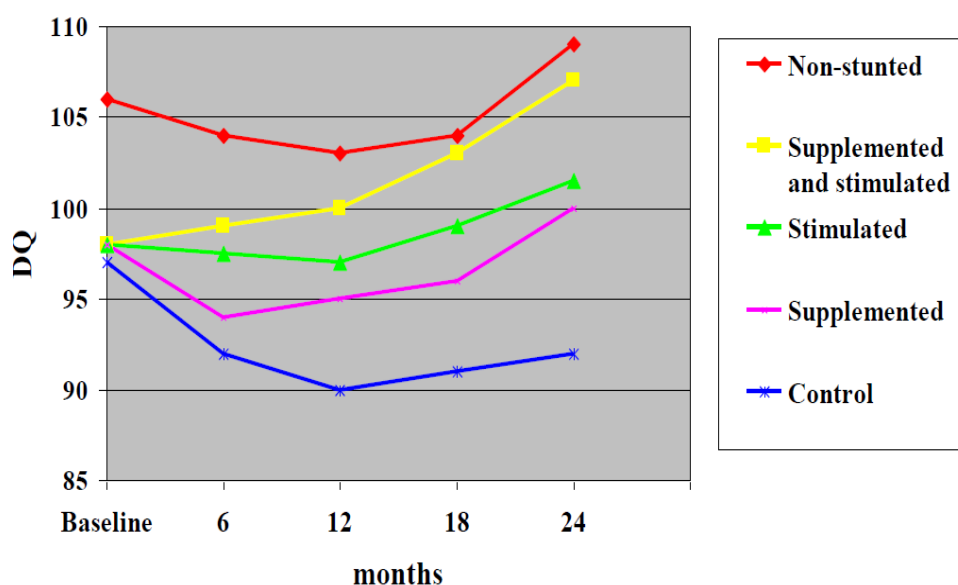
There are also significant variations based on families' wealth. According to NMICS (2014) data, the prevalence rate of stunting (moderate and severe) for children under the age of five is only 15.2% for children from the richest quintile of households but is 54.7% for children from the poorest quintile of households. This difference of almost 40 percentage points, or 3.6 times, is incredibly high, and demonstrates the work that still needs to be done to ensure equitable outcomes across income levels.

The Government of Nepal implemented the Integrated Management of Acute Malnutrition (IMAM) Programme to control acute malnutrition in children aged 0–59 months through inpatient and outpatient services at facility and community levels. This programme is being implemented in 11 districts (Achham, Kanchanpur, Bardiya, Jajarkot, Jumla, Mugu, Kapilbastu, Sarlahi, Dhanusha, Saptari, Okhaldhunga, Kalikot, Humla, Dolpa, Dadeldhura, Bajhang, Bajura, and Baitadi) (DoHS Annual Report 2072/73 (2015/16)). This programme aims to integrate nutrition support across the health, ECD, WASH, and social protection sectors for the continued rehabilitation of cases and to widen malnutrition prevention programme and services (Ibid).

There is strong evidence that ECD interventions focusing on health, nutrition, and early stimulation (rather than on health and nutrition alone) yield the greatest benefits in terms of children's health and overall development. Evidence from a study in Jamaica (Gertler *et al.*, 2014) demonstrates the cumulative effects of nutrition and child stimulation.

Figure 6: Importance of early stimulation: Evidence from Jamaica

Early stimulation is important. **Jamaica**: Effects of supplementation and stimulation on the mean development quotient of stunted groups compared with non-stunted groups



Among 9- to 24-month-old children who were stunted, those receiving both nutritional supplements and stimulation scored higher on developmental tests than children receiving only one or neither of the interventions (Grantham-McGregor *et al.* 1997)

Conclusion

There has been definite progress in the areas of health and nutrition, as evidenced by the statistics for different indicators. The mortality rates for children and mothers have gone down, and awareness on health has gone up, with increases in the percentage of pregnant women seeking

ANC and PNC. Programmes like the Golden Thousand Days have been linked with the future development of children and promote early development of children. The Government of Nepal has also pioneered policies like MSNP, which relate the needs of children across different sectors as they relate to tackling issues concerning early nutrition. Despite this, there is definite gap in addressing the holistic development of children. The programmes all show definite progress in their own sector but do not address early childhood as a whole.

Furthermore, ECD policies are linked only with children of ages three to five years (ECD centre children). ECD plans are developed more as a part of education policies for school readiness and are not linked with other aspects of early childhood. Early childhood is understood as beginning from conception to five or eight years, but the ECD strategy did not cover the entirety of this age group. It would be better for programmes to be age-based to cover all the age groups, so that each child receives all the services for the relevant age. There should also be a sector-based implementation plan that can integrate all existing programmes/policies for the holistic development of children. There are school health and nutrition programmes implemented in schools. However, in many cases, as ECD was not in school structure, the programme has not addressed the children in ECD centres. School health and nutrition programmes can support parents and families as well as integrating with the ECD framework and government nutrition programmes to reach nutrition-related goals. However, there was no evidence that the ECD strategy had been consulted while developing the school health nutrition programme, for example.

3.4 WASH

This section of the report discusses the WASH situation in relation to children under five years old and the ECD Strategy Paper of 2004. Any attempt to improve the WASH situation directly or indirectly benefits younger children. Therefore, WASH is a sector that can hardly be separated or analysed from the lens of beneficiary's age alone. However, we have attempted to highlight the specific areas within WASH with direct bearing on younger children's health and wellbeing.

The ECD Strategy Paper envisioned collaboration between sectors and the development of packages/materials and programmes integrating WASH to materialise the vision of the holistic development of children. The paper aspired to impart WASH-related knowledge and initiate hygiene- and sanitation-related behaviour changes in both children and caregivers. While the education sector reasonably envisioned intervention through education, other sectors and organisations continued addressing communities' and families' WASH-related needs and issues irrespective of what the ECD strategy envisioned.

At the implementation level, the paper proposed an integrated parental education package and ECD curriculum focusing on personal hygiene and sanitation. Objectives in the 'Early childhood development guideline (Curriculum) 2062' also included hygienic habit formation in children as a priority. This guideline also envisioned coordination between line ministries and agencies both at national and local levels to achieve holistic child development, which included hygiene and sanitation. Facilitators were expected to coordinate with health workers at the local level through a coordination framework to achieve the objectives. The paper presumed to help the MoH and MoWCSW and other concerned agencies to make their health- and hygiene-related programmes effective by incorporating such aspects in ECD parenting education programme.

WASH interventions are often general in nature (e.g. improved water sources, safe drinking water, toilet construction, handwashing facility, etc.) and thus address the needs of any age group. In other words, because the household as a unit utilises the WASH facilities, separating out a group of users, in this case children under five, is challenging.

3.4.1 Access and use of improved water sources

Access to improved water sources has increased. In 2016, 95% of households had access to improved water sources. This represents an increase of around 13% from 2006 when it was 81.8%. There has also been increase in use of appropriate water treatment. Around 23% of households now follow appropriate water treatment practices (Ministry of Health and Population, New Era and ICF International, 2016).

The percentage of households with improved water sources increased by three percentage points between 2001 and 2011. Nepal achieved its MDG target for percentage of households with improved water sources, which was 73% of households with access to improved drinking water (Ministry of Water Supply and Sanitation, 2016). However, quality of water has been a concern particularly when talking about young children because poor water quality can cause diarrheal diseases, which is one of the main causes of death among children in Nepal (CCWB [Central Child Welfare Board], 2007).

Table 20: Access to improved water sources: a comparative picture

Area	Households with improved water source (%)	
	2001 Census	2011 Census
Nepal	82.0	85.36
Eastern Development Region	84.3	89.83
Central Development Region	86.7	85.26
Western Development Region	83.3	88.62
Mid-Western Development Region	69.5	75.15
Far Western Development Region	70.4	81.76

Source: National Population and Housing Census, 2001 and 2011

The NMICS of 2010 (CBS and UNICEF, 2012) found that in Mid-Western and Far Western regions 83% of the population were using improved drinking water sources. Ninety-nine percent in Far Western Terai and 70% in Far Western Mountains were using improved sources of drinking water. The next NMICS in 2014 (CBS and UNICEF, 2015, which was wider in coverage, found 93.3% using improved drinking water sources. This figure showed further improvement from the Population Census of 2011. However, both the surveys revealed that the percentages of urban and richest households using improved sources of drinking water were higher.

These changes can be attributed to both 'soft' and 'hard' efforts, such as behaviour change and infrastructure development respectively, made by government and non-government actors in this sector. However, children still suffer from illnesses caused by drinking untreated water, and inadequate hygiene practices has also reportedly caused repeated outbreaks of water-borne diseases (HERD International, 2017).

The ECD strategy expects facilitators to work on 'soft' parts of WASH. The strategy was particularly expected to initiate behaviour change among ECD children through curriculum implementation and collaboration with local-level health workers. However, as the qualitative findings show, the availability of WASH facilities has been limited, and this behavioural change has not been observed extensively either (as discussed in a later chapter).

3.4.2 Use of improved sanitation

The proportion of the population using improved sanitation facilities increased to 81.95% in 2015, compared to 39% in 2005 (Ministry of Water Supply and Sanitation, 2016). Nepal has surpassed the MDG target for the proportion of population using improved sanitation facilities, which was 53%.

The data from two censuses show some changes in terms of the number of households using designated sanitation facilities with an increase of 15% over the 10-year period.

Table 21: Households by types of toilet

	Having toilet		Modern with flush	Improved toilet	Ordinary toilet	
	2001	2011	2001	2011	2001	2011
Nepal	46.8	61.83	23.0	41.72	23.8	19.47
Development region						
Eastern	46.1	60.26	15.7	30.10	30.4	29.60
Central	51.7	63.94	30.4	49.42	21.2	13.66
Western	55.1	72.99	27.0	53.14	28.1	19.36
Mid-Western	31.9	51.42	16.2	30.30	15.7	20.63
Far Western	28.6	47.29	12.6	30.99	16.0	15.71

Source: National Population and Housing Census, 2001 and 2011

Data presented in the table above indicates that there are still regional differences in terms of the use of sanitation facilities. Far Western Development Region, which is behind in many other development indicators, is behind in the provision of toilet facilities as well. However, Eastern Development Region, which is generally better in terms of the human development index than the Far Western Region, is at a similar level in terms of availability of improved toilets. The Nepal Human Development Report of 2014 (NPC and UNDP, 2014) has also pointed out that ‘high levels of human poverty in the Mid-Western and Far Western regions reflect deprivations in health, education and sanitation’ (p. 22). It is also important to note that the Eastern Region showed the highest Gender Empowerment Measure (GEM) at 0.575, whereas the Far Western Region the lowest with 0.523. The reason for the lowest GEM being in Far Western Region is women’s low representation in administrative and professional positions (Ibid.), which is linked with their education attainment rate. Mother’s education, then, has a positive effect on children under five’s health and hygiene (Ministry of Health, New Era, and ICF, 2017; Badji, 2016). Therefore, it is important that ECD programmes use a two-pronged implementation strategy to ensure children’s wellbeing as is aspired to in the ECD strategy and ECD curriculum documents. A functional linkage with non-formal education providers to cater to the learning needs of mothers is required, as well as cultivation of gender and social inclusion attitudes and behaviour in children from an early age.

Another important indicator that has a direct bearing on younger children’s health is the disposal of children’s faeces. The NDHSs of 2006, 2011, and 2016 surveyed the practices related to the disposal of under-five’s stools. In 2006 and 2011, the NDHS covered mothers of children below five years, whereas in 2016 it covered mothers of children below two. The findings of these recent NDHSs have shown positive changes in the practice of safely disposing of children’s stools, as demonstrated in Table 22. When viewed through a regional lens, significant changes can be observed, except in the case of Eastern Region. In Eastern Region the percentage of children

whose stools were safely disposed of decreased by five percent points in 2016. Also, there are variations based on the age of the children, as 55.8% of 18–23 month-olds stools are safely disposed of, while this is only 33.1% for children below the age of one month. However, this could have happened due to the smaller coverage of children, i.e. below two as opposed to below five, or due to increased interventions by government and non-government actors. Increased labour migration might also have contributed to changed behaviour, but research is required to test this assumption.

Table 22: Children under five living with mother by safe disposal of stool (percentage)

Background characteristic	Year			
	2016		2011	2006
Age in months				
0–1	33.1	<6	19.2	9.5
2–3	29.3	6–11	28.7	16.6
4–5	31.6	12–23	35.7	24.6
6–8	42.3	24–35	45.5	26
9–11	47.1	36–47	52.1	35.2
12–17	50.4	48–59	62.8	42.1
18–23	55.8			
6–23	50.3			
Development region				
Eastern	45.1		50.2	28.3
Central	37.1		34.7	29.8
Western	57		51.7	35.7
Mid-Western	55.1		34.7	16.7
Far Western	45.8		29.3	9.6

Source: NDHS 2006, 2011, and 2016

3.4.3 Handwashing

Organisations working in WASH, particularly those focusing on children below the age of five, implement behaviour change communication as one of the key interventions. As mentioned earlier in this section, the changes in practices can be attributed to such interventions, along with infrastructural development and behaviour change that both government and non-government actors have been investing in.

Table 23 gives a picture of the changes in key indicators of WASH and incidence of diarrhoea among children under five particularly in Western Development Region. The table reflects the highest and lowest ranking regions in terms of the indicators. Far Western was highest ranked, with 99% of its population using improved drinking water sources and 73% of households having a specific place for handwashing with soap and water. The same region is positively correlated with the low (3.8%) incidence of diarrhoea among children under five. However, regarding the availability of toilets this region was not of the highest rank. Far Western Region, which was neither at the highest range nor the lowest in terms of the indicators, had the highest incidence of diarrhoea among children under five.

Table 23: Comparative WASH situation

Highest and lowest levels of some WASH-related indicators and episode of diarrhoea (NMICS 2011)						
Regions in highest and lowest ranges in WASH indicators and diarrhoea cases	Population using improved drinking water sources	Perceived importance of handwashing before eating	Households with no toilet facility	Households with specific place for handwashing	Households with both soap and water at handwashing place	Episode of diarrhoea in 2 weeks preceding the survey among 0–59 months
Mid- and Far Western regions	83%	82%	56%	94 %	51.2%	11.2
Far Western Terai	99%			73%	73%	3.8
Far Western Mountain	70%		76%			
Mid-Western Mountains				27%	27%	
Mid-Western Terai			49%			
Far Western Hills						18.4
Highest and lowest levels in some WASH-related indicators and episode of diarrhoea (NMICS 2014)						
Regions in highest and lowest ranges in WASH indicators and diarrhoea cases	Population using improved sources of drinking water	Households with knowledge on necessity of washing before eating	Households with improved sanitation facilities	Households with specific place for handwashing	Households with both water and soap or another cleansing agent at handwashing place	Episode of diarrhoea in 2 weeks preceding the survey among 0–59 months
Total	93.3%	92.2%	60%	97.1%	72.5%	12%
Eastern Terai	99%				81%	
Central Terai			42%			
Western Terai				94.1%		

Mid-Western Mountains	73%	80.5%		41%	21%
Far Western Mountains		97.6%			
Western Mountains					5%
Eastern Hills			99.8%		
Western Hills			94%		

Sources: NMICS 2010; 2014

Based on the data presented above, it is difficult to reliably draw a link between the availability of improved drinking water sources, and access to a handwashing place with soap and water, with episodes of diarrhoea among children under five. In 2014, people using improved drinking water source and households having soap, water, and other cleansing agent at the handwashing place were highest (99% and 81% respectively) in Eastern Terai; however, episodes of diarrhoea among children under five were not lowest in this region. The lowest number of episodes of under-five diarrhoea was noted in Western Mountains with 5% and the highest in Mid-Western Mountains with 21%. Households with a specific place for handwashing were most prominent in Eastern Hills but the data indicated that all these households did not have water, soap or any other cleansing agent at the place of handwashing. NDHS also found that 47% of the households used water and soap for handwashing and around one-fifth of the households did not have any cleaning agents (MoH, New Era, and ICF, 2017). However, data from NMICS and NDHS cannot be compared due to methodological differences.

When viewed in light of the expectations set out in the ECD Strategy Paper, one can see success in terms of the WASH situation of ECD children in the available data. However, the contributions of ECD programmes to achieving positive change, and where and why ECD programmes failed to contribute, cannot be deciphered from the available literature. In our qualitative analysis, we found that young children found it difficult to access toilets at the ECD centre. It emerged that the toilets often lacked water and toiletries and sometimes were not physically accessible because they were either far away from the ECD centre or at a height that was difficult for young children to climb. We found that in some school-based ECD centres young children would have to share the toilets with the entire school, which could cause problems, since again the height of the toilets might be too difficult for small children.

3.4.4 Water quality

The increased availability of improved water sources over the years is a noteworthy development in WASH. However, the quality of water remains highly questionable (see

Table 24). According to NMICS 2014 (CBS and UNICEF, 2015), around 71% of households in Nepal are at risk of E. coli because of its high concentration in drinking water. The E.coli risk level in source water for these households is greater than 1cfu.per 100 ml.

Table 24: E. coli risk level in source water

Geographic/ thematic area	Percentage of household members by <i>E. coli</i> risk level in source water					Percentage of household members with <i>E. coli</i> risk level in source water ≥ 1 cfu/100 ml [1]	Number of household members
	Low risk	Moderate risk	High risk	Very high risk	Total		
Total	28.9	23.6	28.8	18.7	100	71.1	465
Area							
Urban	37.4	17.4	23.7	21.5	100	62.6	94
Kathmandu Valley	43.3	8.2	18.7	29.7	100	56.6	31
Other urban	34.5	22	26.1	17.5	100	65.6	63
Rural	26.8	25.1	30.2	17.9	100	73.2	371
Wealth index quintile							
Poorest	11.6	16.6	46.7	25	100	88.3	88
Second	21.7	30.8	28	19.4	100	78.2	101
Middle	27.5	33	24	15.4	100	72.4	87

Fourth	40.3	20	22.5	17.1	100	59.6	85
Richest	42.3	17.5	23.8	16.5	100	57.8	104
Sanitation facility							
Unimproved	31.4	28	23.6	17	100	68.6	210
Improved	26.9	20	33.2	20	100	73.2	255

Source: NMICS 2014 (CBS and UNICEF, 2015)

The data show that the poorer the household the higher the *E. coli* risk level in source water. NMICS 2014 also revealed that unimproved water sources had higher (47%) chances of detection of *E. coli*, but even with improved sources the risk of *E. coli* was still high at about 20%. It is interesting that the availability of a handwashing facility in the households is positively correlated with *E. coli* in drinking water. Where there was a handwashing facility with soap and water, the risk of having *E. coli* in the drinking water is lower.

Table 25: *E. coli* risk level in drinking water

Geographic/ thematic area	Percentage of household members by <i>E. coli</i> risk level in drinking water					Percentage of household members with <i>E.coli</i> risk level in household water \geq 1 cfu/100 ml [1]	Number of household members
	Low risk	Moderate risk	High risk	Very high risk	Total		
Total	17.8	23.6	37	21.6	100	82.2	6,507
Area							

Urban	27.8	22.1	34.4	15.8	100	72.3	1,116
Kathmandu Valley	32.1	22.2	24.4	21.2	100	67.8	323
Other urban	26	22	38.4	13.6	100	74	792
Rural	15.8	24	37.5	22.7	100	84.2	5,391
Education of household head							
None	12.6	23.3	40	24.1	100	87.4	2,867
Primary	14.2	22.4	39.9	23.5	100	85.8	1,398
Secondary	20.4	28.5	32.3	18.8	100	79.6	1,336
Higher	35.9	19.5	29.8	14.7	100	64	898
Wealth index quintile							
Poorest	8.6	21.8	32.1	37.5	100	91.4	1,233
Second	10.9	22.7	44.1	22.3	100	89.1	1,460
Middle	13.3	24.6	43	19.1	100	86.7	1,279
Fourth	21	21.8	36.4	20.8	100	79	1,235
Richest	35.9	27.2	28.2	8.7	100	64.1	1,300

Source of drinking water							
Unimproved	10.6	13.2	28.9	47.2	100	89.3	475
Improved	18.4	24.5	37.6	19.5	100	81.6	6,032
Hand washing facility with water and soap							
Not observed	7.9	23.8	35.2	33.2	100	92.2	1,744
Observed	21.7	23.6	37.8	16.9	100	78.3	4,731

Source: NMICS 2014 (CBS and UNICEF 2015)

As part of a household unit, children under five are also at risk of being affected by E. coli. Table 25 further indicates that children from poorer families are at higher risk than those from richer families. As mentioned earlier, the availability of improved water sources is higher among richer families than among poorer families, meaning the risk factor is higher among poorer children. This negatively affects the learning and development of ECD children from poorer families. Therefore, functional collaboration between ECD programmes and other service providers is crucial from an equity perspective as well.

In the 10-year period between 2005 and 2015, efforts in this vein yielded positive changes. However, the data reveal more progress in the sanitation subsector than in the water subsector, and there is still a long way to go.

Table 26: Progress in WASH

Indicators	2005(a)	2010(a)	2011(a)	2014(b)	2015(c)
% of population using an improved water source	81	80.4	85	83.59	86.45
% of population using an improved sanitation facility	39	43	62	72	81.95

Sources: (a) MDG Progress Report, NPC, 2013; (b) NMIP, 2014 (c) DWSS annual review, 2015, as cited by Ministry of Water Supply and Sanitation, 2016

The population using an improved water source increased from 81% to 86.5%, and there was a dramatic increase in the population using an improved sanitation facility, from 39% in 2005 to almost 82% in 2015. This indicates that more ECD children have higher chances of living and growing in a hygienic environment, which is more likely to inculcate positive behaviour in them regarding WASH. This could also facilitate supportive physical health for learning and overall development. These kind of changes contribute positively to ECD programmes in the long run.

Along with the government's efforts (Ministry of Water Supply and Sanitation, 2016), many NGOs have also been working in both 'soft' and 'hard' elements of WASH for a long time. Their contributions cannot be neglected when talking about the positive changes observed in this sector. Most of these organisations work with and for communities, as well as with schools. The Nepal Trust, Nepal Water for Health (NEWAH), Water Aid, Plan International Nepal, Save the Children Nepal, World Vision Nepal and Water, Sanitation and Hygiene – Resource Centre Network Nepal (WASH-RCNN), a network of organisations involved in WASH, are all examples of organisations working in this field.⁹

One of the major focuses of UNICEF Nepal has also been WASH, particularly in addressing the need of younger children. The MoE has been financing WASH-related facilities in school as well. As a result of government and non-government efforts, more than 80% of schools in Nepal have at least one toilet (DoE, 2013). The activities of education and WASH have been well integrated in Mid-Western and Far Western development regions. Local government in particular has created an enabling environment to promote hygiene and sanitation activities (UNICEF, 2013). Despite these efforts, a lack of WASH facilities in schools remains a challenge that leads to low attendance in

⁹ The Nepal Trust, www.nepaltrust.org/wash/; NEWAH, 2014; NEWAH, 2015; Water AID www.wateraid.org/np/; World Vision, 2016; Save the Children Nepal, <https://nepal.savethechildren.net/about-us/sabal>; Maskay, Rimal, Adhikari, Manandhar, 2009; and WASH-RCNN, www.wash-rcnn.net.np/.

schools (Government of Nepal, 2016). Since many ECD centres are school based, this problem certainly affects ECD programme participants.

3.4.5 Open defecation free (ODF) zone

To date, Nepal has declared one zone, 15 districts, 17 municipalities, and 1,615 VDCs as ODF (Ministry of Urban Development (MoUD), 2013). This is important to note because episodes of diarrhoea among children under five who had an unimproved toilet facility and practice of open defecation was highest (NDHS, 2016).

The availability of relevant documents that specifically speak about WASH in health facilities is extremely limited. Most of the available health sector literature primarily talks about households or people's access to and practices related to WASH, and how they should be educated to change their behaviour. As stated by the Ministry of Water Supply and Sanitation (2016), the availability and/or situation of WASH facilities in health care facilities is the least discussed topic. The same source indicates that, although relatively better than other public institutions, healthcare facilities are still not adequately equipped with WASH facilities. Regarding the WASH situation in health facilities in Nepal, it has been estimated that water coverage, sanitation coverage, and hygiene coverage were 84%, 71%, and 19% respectively (WHO and UNICEF, 2015).

When assessing the WASH situation in the ECD context, it was found that some organisations were more focused in integrating WASH in ECD programmes than others. For example, Kadel and Mahat (2011) found Plan Nepal, Save the Children Nepal, World Vision Nepal, CCS Italy and Child Welfare Scheme promoting the integration of WASH in ECD programmes in their working areas. The study, however, did not find any evidence of collaboration between ECD programmes and health facilities/personnel at the local level to monitor the child health situation such as is envisioned by the ECD Strategy Paper.

Evidence shows that the integration of a WASH component in ECD packages, particularly parenting education, can bring about behavioural change in the long run. For example, a knowledge, attitudes and practices study conducted in Achham, Mugu, and Mahottari (three among the five districts where UNICEF piloted a revised parenting education programme in 2016/17) showed changes in handwashing practices. The practices of washing before eating and after defecation among children, and before feeding among caregivers, showed significant change in the endline survey (IIDS, [Institute for Integrated Development Studies] 2017). Probably as a result of increased knowledge, incidence of diarrhoea and fever had also reduced (Ibid.). Such improvements would clearly facilitate better health and ultimately greater wellbeing of ECD children – and they also demonstrate the interlinkages between different sectors associated with ECD.

Conclusion

The processes involved in the holistic development of children as envisioned by the Strategy Paper could not necessarily be achieved in significant ways. This was true for WASH related gains, or lack thereof, as well, and this could be because of 'a far greater emphasis placed on the "teaching triad" of reading, writing, and maths, often at the expense of play-based, social, and behavioural approaches to learning' (Jackson Institute of Global Affairs, 2014, p. 21). This kind of practice is very likely to promote theoretical knowledge about WASH, as opposed to instigating attitude and behaviour changes regarding hygiene. Nepali children's learning outcomes are largely measured through paper-pencil tests, with such practice from an early age reinforcing learning behaviour and learning outcomes that are detached from real life. This turns out to be very challenging to reverse in the later years of students' lives.

3.5 Protection

This section of the report discusses the protection situation in relation to children under five in light of the ECD Strategy Paper of 2004. Any attempts to ensure children's right to protection directly or indirectly contribute to younger children's long-term social and psychological wellbeing and learning outcomes. However, the body of literature on the protection situation of children under five is extremely limited. Many of the discussions and information regarding protection issues relate to children over the age of five. Nevertheless, attempts are made below to present protection-related aspects as they pertain to children under five in Nepal.

The ECD Strategy Paper did not define 'protection' as it is understood now, and this was only defined in later years. Although the paper was an MoE initiative, other actors such as the MoH and MoWCSW were involved in the process. However, the strategy did not directly address protection issues such as violence and abandonment. Nevertheless, if viewed from broader perspective, the protection aspects can be traced in the vision and the subsequent strategies. Although what 'protection' means in the context of ECD and how it should be implemented are not clearly stated in the paper, the MoE has been adopting policies promoting a rights-based approach for the survival, development, and protection of children. Since a rights-based approach is a key point of reference, it is understandable that the 'protection' component was considered crucial in ECD strategy implementation, but in a different sphere: health and nutrition. The ECD strategy also envisions developing integrated packages focusing on a range of issues including personal hygiene, sanitation, safety measures, and protection from adulterated food as well as gender and social equity.

Attempts have been made through different mechanisms to ensure ECD children's right to holistic development. One of the mechanisms has been parenting education. Earlier parenting education packages were primarily concerned with children's physical, mental, cognitive and social development with a focus on learning achievements. For example, the Early Childhood Development Guideline (Curriculum) 2062 (DoE, 2006) and Early Learning and Development Standard (2069/2012) emphasise developmental aspects and learning achievement. Another mechanism has been the National Framework of Child-Friendly Schools for Quality Education (DoE, 2010). One of the key policy actions is to develop a code of conduct to maintain peace in schools. This framework automatically covers school-based ECD centres but neither the code of conduct nor any other initiative under the framework explicitly embrace ECD programmes. This indicates that although the ECD Strategy Paper advocates for holistic child development, MoE initiatives do not always account for this, including ensuring birth registration as part of its ECD initiatives. This is an example of the absence of intra-sectoral integration.

Gradually, a tendency toward a more holistic approach to child development, with protection rights as spelled out by UN Convention on the Rights of the Child (UNCRC), has been considered in the ECD interventions. For example, the ECD parenting education package, which has recently been developed and piloted, includes birth registration along with other protection aspects to safeguard children's identity and thereby open doors for future development opportunities (DoE, UNICEF and Seto Gurans, 2016).

Moreover, several instruments have been formulated and are available to ensure children's right to protection. Such instruments include the Vital Registration Act 1976, Children's Act 2074, Children's Act 2048, Children's Rules 2051, Begging Prohibition Act 2018, Bonded Labour Prohibition Act 2058, Caste-based Discrimination and Untouchability (Offence and Punishment) Act 2068, Child Labour (Prohibition and Regulation) Act 2056, Child Labour (Prohibition and Regulation) Rules 2062, Domestic Violence (Offence and Punishment) Act 2066, Child Right Protection and Promotion Program Implementation Directive 2065, National Policy on Children

2069, Domestic Violence (Offence and Punishment) Rules 2067, Human Trafficking and Transportation (Control) Act 2064, Elimination of All and Worst Forms of Child Labour: Master Plan 2073–2083, Child Friendly Local Governance: National Strategy 2068 (2011), and Juvenile Justice Procedural Rules 2063. Institutional arrangements such as village child protection committees (VCPCs) and municipality child protection committees (MCPCs) are also active local and community mechanisms designed to deliver child-friendly local governance, which primarily ensures protection of children's rights.

These policies and statutory provisions are relevant to ensure the protection rights of children. Most of these provisions were formulated to comply with the UNCRC, which Nepal is a signatory of, and also in the initiatives of international organisations such as UNICEF. Therefore, it is fair to say that the policies and provisions of development processes have revolved around central-level mechanisms and sectoral priorities, perhaps far away from Nepali cultural contexts. This has resulted in the absence of protection components, for example in ECD programmes, such as are envisioned by the policies and provisions.

Child Club is a grassroots-level (both school- and community-based) mechanism that is located within the VCPC or MCPC. These clubs were promoted as a viable mechanism to ensure children's right to participation. Through participation, children advocate for their right to protection. By nature of its function, Child Club members are older children, usually 8–18 years old (UNICEF, 2016). Through different processes, child clubs get engaged in child protection issues but not necessarily on issues relating to children under five.

As mentioned earlier, the available literature on protection mechanisms does not necessarily talk about the protection of children under the age of five. Where they are mentioned, the concern is limited to the opening and operating of ECD facilities and birth registration (MoFALD, 2011; MoFALD, 2013). Therefore, the question is: how much has the ECD Strategy Paper embraced these instruments and mechanisms to ensure early age (0–5 years old) children's right to protection, and how much does the implementation of the instruments or mechanisms pay attention to provisions made in the ECD Strategy Paper? The available literature indicates that ECD strategies have been implemented and the components of child rights that were the reference point of the strategy papers have also been implemented, albeit through separate channels. The two have thus been inadequately interfaced. This compartmentalised implementation situation has been observed in both government and non-government interventions. For example, in the government sector, VCPCs and vital registration have been implemented through MoFALD with no systemic linkage with the MoE, which implements the ECD programme. Moreover, the activities and interventions of VCPC focus more on children who are eight years or above. This kind of separation is also seen in the non-government sector, which is discussed further later in this section.

NMICS reports inform the core of this section. NMICS 2010 (CBS and UNICEF, 2012) included birth registration, child labour, child discipline, early marriage and polygyny, attitudes toward domestic violence, and child grant as subcomponents of the child protection component. NMICS 2014 (CBS and UNICEF, 2015) included all the 2010 components but replaced child grant with children's living arrangements. Since the ECD Strategy Paper has not identified subcomponents of protection, this section will review the situation in regard to NMICS-identified components except early marriage and polygyny and attitudes toward domestic violence. These two subcomponents were not included primarily due to the lack of information that directly addressed ECD children in such situations. Lack of age-wise disaggregated information is evident in the documents produced by CCWB (2006, 2007, 2011, 2013, and 2014) and MoWCSW documents. The annual progress reports and other reports of MoWCSW (2016, 2015, 2015, and 2014) provide data about children under different circumstances. For example, they include gender-disaggregated data related to

abandoned, ran away, rescued children, street children, and children living in other difficult circumstances. The programmes and efforts made to protect these children have also been reported on. However, this information has not been disaggregated by age, meaning it was not possible to link the situation and effort made to promote young children's right to protection. Similarly, the report on children prepared by the National Human Rights Commission talks about the situation of children's right to protection in totality, and there is no reference to the national ECD strategy or ECD centres operated by the MoE (National Human Rights Commission, 2009).

The protection sector in relation to ECD will be discussed in the following subsections in reference to key components associated with protection.

3.5.1 Birth registration

Birth registration is a vital event that helps protect children's rights by ensuring the identity and citizenship rights of children. It is important for child protection because it helps children enjoy subsequent rights such as identity, education, citizenship, and state-granted facilities and benefits. Although the ECD Strategy Paper recognised that ECD covers services from birth to five, it did not include birth registration as a strategy. Nepal has a legal and administrative structure stipulating standard procedures for birth registration. Although the birth registration system was introduced more than 36 years ago, it is not adhered to uniformly in the country. This is evidenced by the fact that only 56% of children aged below five years are registered with the authorities (NDHS 2017). The probability of children having their births registered is much higher in Mountain Region compared to the Terai. This could be a result of universal cash transfer for children in Karnali Region, which lies in the Mountain Region, as birth registration is required for people to be eligible for the cash transfer (Department of Civil Registration (DOCR), 2017). This motivates parents to register the births of their children. The percentage of female children having their births registered (55.2%) is slightly lower than their male (57.1%) counterparts. Nepal is far behind in meeting the SDG target of ensuring a legal identity for all, including birth registration, by 2030 (United Nations, 2015). Nepal does not seem to have set annual targets to reach 100% birth registration by 2030.

Birth registration practice has, however, gradually increased in recent years. Ministries such as the then Ministry of Local Development (now MoFALD) have played a crucial role in promoting child registration. Under its conditional cash transfer scheme, birth registration is required as an eligibility criterion for the child grant, which has significantly contributed to the increased trend in child registration in selected districts. For example, according to a survey conducted by UNICEF, after the implementation of the Child Grant Program birth registration of children under five crossed 90% in Karnali Region (CCWB, 2016).

Other development partners have also been rigorously working on birth registration, not necessarily through ECD programming but under other programme headings in their focus districts and areas. For example, Plan International Nepal, during 2006 and 2010, achieved 100% birth registration in 75 VDCs that it was working in. This was done in coordination and collaboration with local governments and local organisations under Child Protection and Participation Programme (Maskay *et al.*, 2009), under which ECD was implemented under the Child Development and Learning Programme. Likewise, during 2014/15, Plan achieved 100% birth registration in its 20 VDCs (Plan International Nepal, 2015), although whether and how many ECD children were registered is not mentioned. Save the Children Nepal has also been promoting birth registration in its programme areas through campaigns, capacity enhancement of local bodies, and public awareness (Smith and Watson, 2015). These examples reveal that efforts made by multiple partners have significantly contributed to increased birth registration. However, integration of birth registration with ECD has still been inadequately pursued. This is reflected in ECD-related materials and activities. For example, the Centre Facilitator/Teacher Facilitation Support Book

(Rajbhandari, 2015), jointly published by Save the Children Nepal and Seto Gurans, does not cover birth registration. The focus is still on learning and other developmental aspects.

Table 27: Birth registration trend

Year	Girls	Boys	Source
2006	48.4	51.6	CCWB, 2007
2007	48.71	51.29	CCWB, 2007
2009	46.8	53.2	CCWB, 2011
2011	44.0	40.4	NDHS (MoH, ICF, New Era 2011)
2012	45.6	52.2	Federal Affairs and Local Development Ministry, cited by CCWB 2014
2013	47.47	52.2	Vital registration department 2070 [2013], cited by CCCWB, 2070 [2013]
2014	57.0	59.2	Central Bureau of Statistics and UNICEF Nepal, 2015
2016	55.2	57.1	NDHS (MoH, ICF, New Era 2016)

The birth registration data of children born in the reported year was not available (CCWB, 2015; 2016). Therefore, with the exception of NMICS 2014, NDHS 2011, and NDHS 2016, the data presented in Table 27 is inclusive of 0–18-year-old children whose birth was registered in that reported year. It is also noteworthy that the results from the NMICS and NDHS are quite different for the percentage of birth registrations. This stems from the fact that both surveys follow their own methodology and had their own sampling approach. Likewise, NMICS 2010 has also reported on the birth registration situation of children under five from Mid-Western and Far Western regions (CBS and UNICEF Nepal, 2012). According to the report, 42.3% of male and 41.5% of female children below the age of five were registered in those regions.

The above table indicates that the practice of birth registration has gradually increased since the 2004 ECD Strategy Paper was prepared and implemented. Although statistically the disparity may not be significant, it was evident that more boys were registered than girls. The reason could be that the parents did not find it necessary to register girls by virtue of their gender, or the population of boys was higher than that of girls. There are other possibilities as well. The increased practice of female infanticide (Bhandari and Mishra, 2012; Ghimire, 2013; Bhattarai, 2011; CREHPA, 2007; Rajbhandari, 2009) and the greater concern for male children's health than females' found by Singh (2017) could also have contributed to the disparity in birth registration. Besides, slow progress in birth registration has been attributed to parents' lack of awareness about the importance of vital registrations. In addition, reasons such as the process being complex, a long distance to the office, and that there is no need for birth registration certificate to obtain a citizenship card and enrol in school could also have led to low levels of registration (CCWB, 2007; 2011). However, in order to address these issues, concerned organisations have already initiated

public awareness raising, facilitating the process and providing technical support to local bodies to strengthen their vital registration systems. That said, ECD centres' involvement in such processes has hardly been noted. Moreover, the issue of female feticide is barely raised in parenting education packages.

In terms of regional status, the percentage of births registered is highest in Mid-Western Development Region and lowest in Central Development Region, as shown below.

Table 28: The status of birth registration by region

Development region	Percentage of children registered
Eastern	57.2
Central	53.1
Western	56.6
Mid-Western	63.4
Far Western	54.4

Source: NDHS 2016

Regarding the linkage of changes in birth registration practice and the ECD Strategy Paper, hardly any evidence was found to connect increased birth registration with ECD interventions. As indicated above, both the birth registration and ECD have been priority programmes of government and non-government actors working to ensure children's rights but they usually implement ECD and birth registration interventions under separate frameworks. For example, for Plan International Nepal, child protection programmes for children under five include birth registration but other protection-related programmes are geared toward older children (Communication with Plan International Nepal staff, 2017).

Moreover, vital registration and ECD are the responsibilities of different organs of the government, where coordination has been the perennial issue. Several reports (e.g. Kandel and Mahat, 2011; Shrestha and Aryal, 2008; CERID, 2004) have also highlighted the necessity of integration of and collaboration among different services with ECD, but they do not explore why this did not happen and how it could be achieved. Even where collaboration was reported to have occurred it was limited to the level of ECD operation rather than delivery of different sectoral services to ECD children (CERID, 2004).

3.5.2 Child labour

According to CBS and the International Labour Organization (ILO) Nepal, child labour from age five to 14 has been decreasing, yet it is a complex problem (Ministry of Labour and Employment, 2073 [2016]) It was estimated that about 5% of children between the age of five and 17 are involved in child labour, and 20% of these children are engaged in the worst forms of labour (Ibid.).

Although the Nepal Labour Force Survey of 2008 (CBS, 2009) and subsequent reports based on the survey (e.g. ILO, 2011; ILO and CBS, 2011) reveal that Nepali children as young as five are engaged in labour, no documents focus on labourers of this age. The ECD Strategy Paper also

does not address protection issues relating to five year-olds engaged in labour. The Strategy Paper was more geared toward those children who have already become incorporated within the ECD programme through ECD centres. Therefore, the needs of children not within the ECD programme, who could be engaged in labour, were not explicitly recognised or addressed. Resultantly, data on the extent of five-year-old children's engagement in labour and ECD efforts or engagement in protecting their rights could not be explored substantively.

3.5.3 Child discipline

As mentioned earlier, several frameworks including statutory provisions have been developed to protect children from different types of violations, including measures applied to discipline them. Both government and non-government actors are engaged in alleviating and monitoring the physical and psychological wellbeing of children. In other words, these organisations are working to ensure that children do not get hurt physically or psychologically in the name of disciplining. However, a general notion that children should be physically or psychologically battered to make them obey as per the norms of the family, parents, or school still persists (IIDS, 2017; Kadel and Mahat, 2011).

The ECD Strategy Paper does not specifically talk about ECD children's security and protection from violent activities such as measures applied to discipline them. The National Framework of Child-Friendly Schools for Quality Education (DoE, 2010), which was conceptualised and formulated to protect children's rights, is also focused more toward the needs and issues of children in school. On the one hand, the general trend has been to promote school-based ECD centres. However, on the other, the framework does not give due consideration to explicit issues concerning children of ECD age.

In terms of the situation regarding child discipline practices, NMICS 2010 and 2014 (CBS and UNICEF, 2011; 2015) have recorded disciplining methods experienced by one to four year-olds.

Table 29: Disciplining methods

Age (years)	Only non-violent discipline	Psychological aggression	Physical punishment		Any violent discipline method
			Any	Severe	
1–2	14.2	59.7	50.9	10.2	66.9
3–4	14.2	76.4	61.9	18.7	81.9
Percentage of children aged 1–4 years from Mid-Western and Far Western regions who experienced different disciplining methods as reported by NMICS 2010					
2–4 years	13.9	72.0	61.5	16.3	79.2

Sources: CBS and UNICEF, 2012; 2015

This table shows the percentage of children aged 1–4 years who experienced different disciplining methods during the month preceding the survey in Nepal in 2014. The table shows that young children also experience violent disciplining methods in Nepal. Although the information does not

represent the entire country, the 2010 survey conducted in Mid-Western and Far Western regions also indicates that disciplining children through harmful method was in practice.

Orientation about child-disciplining practices through parenting education programmes has been gradually introduced. Parenting education programmes have often been major components of ECD programmes implemented by most organisations, including the DoE, since the early 2000s. Using rights-based approaches, in line with the 2004 ECD Strategy Paper, these programmes do include topics like harmful behaviour toward younger children. Nonetheless, young children are still getting exposed to harmful disciplining methods, which raises serious concern about ECD strategies and their implementation status. Only a handful of studies are available, but they confirm that attitudes and behaviours regarding child-disciplining methods have not significantly changed despite orientation and awareness raising aimed at parents and other caretakers. For example, 33% of household members believed that 2–4-year-old children need to be physically punished (CBS and UNICEF, 2012). NMICS 2014 similarly reported that 35% of household members believed that children should be physically punished (CBS and UNICEF, 2015).

Although the NMICS 2014 report is not explicit on whether parents were referring to older children or ECD children, it does reveal that physical punishment was still a preferred measure to try to make children obedient. These findings are supported by UNICEF's Knowledge, Attitude and Practice baseline and endline studies conducted in Achham, Mugu, and Mahottari districts, where UNICEF introduced a new parenting education package that included a child protection component for parents of ECD children (IIDS, 2017). The study revealed that many caretakers still used harsh measures to discipline children and from their perspective they stated that children would not obey if softer measures were applied. Such practices were more evident among low-income caregivers and caregivers who were not literate (Ibid.). In fact, statistically, incidence of child battering in the name of disciplining showed an increase from the baseline to endline. From our qualitative analysis, it emerged that ECD facilitators and parents both received training from the DEO and from NGOs such as UNICEF and World Vision regarding using corporal punishment against young children. However, some parents across the seven districts continued to state that children would be better disciplined if they received punishment.

The ECD Strategy Paper was not specific about child discipline. Therefore, child-disciplining practices could not be viewed against the backdrop of the paper. However, the parenting education programme is a key component of the ECD strategy, which is gradually initiating discussion about child discipline in a conducive forum to continue orienting caregivers toward positive child-disciplining methods.

3.5.4 Child grant scheme

Social protection has become a significant policy initiative in Nepal. The child grant scheme under the social protection initiative was introduced in 2009/10. It has been a milestone in ensuring the right to protection of Nepali children. The objective of the scheme was to protect children under five from Karnali Region, where the HDI was low, as well as all Dalit children under the age of five (Bhandary, 2014). The grant incorporates socioeconomic support to enhance nutritional outcomes for children (VaRG, 2016).

Table 30: Child grant budget and status

Fiscal year	Budget allocated (in NPR '000)	Budget expenditure (in NPR '000)	Target children	Actual recipient children	Per child amount	Duration	Eligibility
2009/10	720,000	706,249.8	400,000	392,361	200	9 Months	Under 5, and up to 2 (per mother) all Dalit families and all families from Karnali Region
2010/11	960,000	981,852	400,000	409,105	200	1 year	
2011/12	1,200,000	1,099,524	500,000	458,135	200	12 year	
2012/13	1,200,000	1,324,598.4	500,000	551,916	200	12 year	
2013/14	1,200,000	1,289,083.2	500,000	537,118	200	12 year	
2014/15	1,200,000	1,216,123.2	500,000	506,718	200	12 year	
2015/16	1,210,231.2	1,127,812.8	504,263	469,922	200	12 year	
2016/17	2,280,120		475,025		400	12 year	

Sources: Annual Development Programme, NPC Secretariat, Singha Durbar, Kathmandu (www.npc.gov.np); Economic Survey, Ministry of Finance, Singha Durbar, Kathmandu (www.mof.gov.np); Budget Speech, Ministry of Finance, Singha Durbar, Kathmandu (www.mof.gov.np); Red Book, Ministry of Finance, Singha Durbar, Kathmandu (www.mof.gov.np)

The child grant is provided by MoFALD through local bodies. It was initiated six years after the launch of the ECD Strategy Paper and was not envisioned at the time of the development of the Strategy Paper; it was more geared toward children who were already enrolled in ECD centres. The 2004 paper focused on grants to establish, develop, and improve ECD centres rather than provide cash support to individual children. The child grant, on the other hand, was initiated to support children irrespective of their enrolment in ECD programmes. As a result, the scheme did not consider the ECD programme as a viable mechanism through which to reach children. The child grant scheme was introduced to address child poverty and thereby protect children from being malnourished.

The link between education sector interventions and health sector interventions was not explicitly established in thinking about ECD, so perhaps relevant stakeholders did not always feel a need to establish sectoral collaboration when implementing schemes. This is seen in NGO interventions too. As indicated above, the ECD programme and child protection, particularly child health and child grant programmes, are implemented under separate schemes, the timing of which may not coincide. This usually happens because NGOs have to implement projects as per their donor's interests and as per the grants they receive. For example, Save the Children Nepal, with funding from Save the Children Finland, initiated Child Sensitive Social Protection (CSSP) to support the Government of Nepal's child grant scheme in 2011. The project started in Sindhupalchok district and later expanded to Kavrepalanchok, Dolakha, Mahottari, and Jajarkot, with plans to reach Kalikot (communication with Save the Children Nepal staff working in CSSP).

CSSP has also initiated the Child Endowment Fund, particularly focusing on orphan children. The endowment fund is a community-managed social protection mechanism for orphan children led by the Village Child Protection Committee with financial support from the VDC and a matching grant

from Save the Children. Currently, hardly any under-fives are covered by this fund, although they are eligible, because there are older orphan children needing support. The CSSP through local NGOs has been facilitating the implementation of the child grant scheme through awareness raising about eligibility criteria and application processes, as well as technical support to local bodies to strengthen their vital registration system (Roelen and Chettri, 2016). However, we did find mothers who were not aware of the availability of the grant and/or eligibility criteria (Ibid.). This shows that the two sectoral programmes, although working for the same age group, were not communicating. This is where ECD programmes could have been mobilised. ECD parenting education programmes could cover processes to apply for the child grant and also have facilitators mobilise the caregiver. This would help implement the ECD Strategy Paper, which expected facilitators to collaborate with other sectors for the holistic development of ECD-enrolled children.

Nevertheless, despite these issues awareness on birth registration has significantly increased due to the child grant scheme. For example, more than 96% of beneficiaries in Karnali knew about the child grant (VaRG, 2016). Roelen and Chettri reported: 'Key informants in Karnali shared the view that the child grant had increased overall birth registration, particularly in conjunction with awareness campaigns and assistance in getting the appropriate documentation provided by NGOs' (p. 19).

Studies of the child grant scheme show mixed results. According to Akubo (2014), the scheme showed positive change in underweight (42.5% among non-recipients and 18.8% among recipients) and severe wasting (3.9% among non-recipients and 1.9% among recipients) in Karnali Region, with the study thus asserting that an additional increase in the grant amount would contribute to increased positive impact. In another study conducted by Adhikari *et al.* (2014), however, the results were more mixed. The study reported that 'out of the 75% of respondents who perceived their food habits had changed, 45% said the grant had enabled them to eat more desirable food' (p. 28). There has been an improvement in nutritional outcomes of children (UNICEF, 2016). However, it is difficult to attribute this change to the grant alone, given its small value. Moreover, the study found that the grant was spent on various items needed for both children and adults, and also on school-going children's midday meal and snacks.

Besides the regular child grant scheme, an immediate cash transfer to respond to the emergency situation after the 2015 earthquake was also executed. To respond to the emergency, UNICEF provided cash support in two phases to the beneficiaries of social protection from earthquake-affected districts (OPM, 2017). The strength of the project was that its coverage was wide and included the most vulnerable populations, and it also showed that the regular social protection mechanism could be utilised to respond to emergencies (Ibid.).

Hagen-Zanker *et al.* (2015) found that households were using the grant effectively in getting food and medicine but there were some issues: the amount was too low to show visible impact; although the target population was catered for there was some targeting error; the capacity of local bodies was inadequate for better management of the grant; the processes put an additional burden on the beneficiaries; and awareness raising that focused only on mothers was not adequate.

From an equity perspective, in Mid-Western Mountain region, the percentage of female children receiving the grant was higher (77.2%) than their male counterparts (75.4%). In terms of wealth quintiles, the percentage of children from the poorest quintile receiving the cash grant was higher (79.5%) than the richest 60% (69.2%), as shown below.

Table 31: Children receiving the child grant

	% of children receiving child grant
Gender	
Male	75.4
Female	77.2
Wealth index	
Poorest	79.5
Second	76.4
Richest 60%	69.2
Nepal	76.3

Source: CBS 2010 and UNICEF, 2012 (NMICS)

The child grant status reveals that ECD children are getting state support for protection from ill health and thereby for holistic development, as was the aim of the ECD Strategy Paper. In this sense, although collaboration between the child grant scheme and the ECD programme hardly occurred, one is still positively contributing to the other.

3.5.5 Children's living arrangements

The numbers of abandoned and orphaned children in Nepal are growing for several reasons, meaning alternative living arrangements for children are growing too. Since this issue has become a significant part of child protection schemes, statutory provisions to regulate alternative living arrangements are also in place. Examples of the available provisions that govern institutional homes for children include: Conditions and processes related to adopting children by foreign nationals 2065; Residential home operation and management standard 2069; Child helpline operation guideline 2064; and Children as zone of peace national framework and implementation guideline 2068.

Reports show that significant numbers of children are living in institutional homes. In 2014, 16,617 children (8,423 boys and 8,194 girls) were residing in 594 alternative care homes (i.e. correction homes, orphanages, institutional homes, and intellectual disability centres operated in 46 districts) (CCWB, 2014). Updated information suggests that 16,529 children (8,313 boys and 8,216 girls) are residing in 566 children's homes spread across the seven provinces (CCWB, 2017). These data show that girls and boys residing in alternative residential arrangements are almost equal in number. However, the data on children living in institutional homes mentioned above are not disaggregated by age. Therefore, data about children under five living in institutional homes are not available. Information about children under the age of six was recorded in 2005 in a study conducted by New Era. New Era studied 335 children's homes, out of which 72% were in Kathmandu Valley and the rest outside the valley (New Era, 2005). There were 135 homes with

children aged between six and 59 months. Twenty percent of these homes coordinated with health personnel to come to the homes to give children vitamin A capsules. Seventy-three percent of these homes took children to health facilities on specified dates, but the rest had no such arrangements. Likewise, out of 183 homes with children below the age of six, 75% had ECD facilities, most with a separate room. However, the study did not mention the ECD strategy, so there was no indication whether the strategy was followed or whether collaboration with the MoE was undertaken to operate ECD facilities.

The research team could not trace any other studies related to children's institutional homes that covered children below the age of five or that addressed their ECD needs. A study conducted by ACR INT, CPCS INT, and CCWB (2009) covered 196 children's homes based in 24 districts, with 57% located in Kathmandu. Most of these homes had children below the age of 14, while 84% had children below the age of eight. However, the study was more focused on institutional aspects. There was no information about how ECD services were provided to younger children or on whether the homes collaborated with other sectors to provide services.

CCWB (2015) reported that from 2006 to early 2015, CCWB/District Child Welfare Board (DCWBs) rescued 328 children (200 boys and 128 girls) who were living in vulnerable situations in different children's homes. The report does not provide age-disaggregated information on children residing in such homes, nor does it talk about the facilities. However, this information tells us about a critical concern regarding the safety of children in such homes. In 2014, MoWCSW jointly with SOS assessed 131 residential child care homes (MoWCSW, 2014). There were 4,365 children (2,162 girls and 2,203 boys) living in those homes in total, and about 11% of these children were aged below six years. Most residential care homes had healthcare arrangements, while protection mechanisms and educational opportunities were provided for children either in their own schools or in schools outside of the homes. However, information about the ECD opportunities available in the homes is not reported. One of the reasons for not reporting the arrangements relating to ECD could be attributed to the Standards for Operation and Management of Residential Child Care Homes of 2012. The Standards (MoWCSW, 2012) provide comprehensive guidelines to protect the rights of children living in such arrangements. However, they are general to all children. In other words, the document does not speak about protection needs and requirements related in particular to children below the age of five.

The ECD Strategy Paper also does not explicitly address the arrangement of ECD opportunities for children living under non-conventional circumstances. It does not speak about orphanages and prisons or those not having access to mainstream ECD programme activities for other reasons. Nevertheless, some NGOs have been providing early development and learning opportunities to young children living in prison with parent/s to some extent. ECD Centre and Butterfly Nursery Kits (<http://ecdcnepal.org/project/the-butterfly-home/>), the day care centre in prison established by Prisoner Assistance Nepal (<http://panepal.org/>), and the infant care facility improvement project of the International Child Resource Institute (www.icrichild.org/nepal/) are three examples. The Network on Children, Prisoners and Dependents, a group of NGOs supporting ECCD of the dependent children of prisoners (www.icrichild.org/network-for-children-prisoners-dependants), is also active. However, no record was available about collaboration between these initiatives and MoE/DoE ECD programmes.

Interaction and collaboration between these programmes and the national ECD strategy is crucial. In general, such homes represent a cross-section of society that is particularly marginalised, and many children there are least likely to access the facilities and benefits they are meant to be receiving through ECD programmes. Like schools, these facilities – which have to be registered with various official authorities – can serve as sites for the provision of integrated and holistic ECD packages. However, the current ECD strategy has clearly not been adopted as a marker and guide

to facilitate the provision of ECD services to many poor and vulnerable communities, thereby raising concerns regarding the equity of their delivery.

Conclusion

Since Nepal signed the UNCRC, it has been an obligation of the state to incorporate the rights-based approach in all ECD interventions. However, there are sectoral interventions without coordination and linkages between all aspects of the development rights of the children. For example, there is a connection between birth registration and the child grant, but this link is missing with ECD centre interventions. The ECD parenting education package included birth registration along with other protection aspects, but it is not linked with gender equity and children in alternative forms of care (such as in orphanages and prisons). The ECD strategy has, then, failed to clearly envision the cross-sectional societal requirements needed to coordinate and collaborate for the holistic development of all children.

4 Efficiency of ECD sectoral resource allocation

This chapter presents our analysis of the efficiency of sectoral resource allocation in ECD. The research question addressed is: *How efficient were the sectoral resources allocated to ECD in meeting national and subnational needs?* Although this analysis has been possible in some sectors, and especially in ECE, the lack of data has meant this analysis has not been possible for a number of sectors, particularly in WASH.

At the international level, it is extremely difficult to obtain relevant data, and nearly impossible to estimate total spending on ECD. The international reference point can vary tremendously depending on the country perspective, but there have been recommendations in terms of international standards. In light of the recent Sustainable Development Goal 4 (SDG4) Education 2030 debates, governments agreed to recommend that at least 4% to 6% of gross domestic product (GDP) or at least 15% to 20% of all public expenditure be spent on education. UNESCO has recommended at various points that at least 10% of total public education expenditure should be dedicated to pre-primary education, leading to the proposal that 2% (or 10% of the 20%) of total government expenditure be spent on pre-primary education (or 0.6% of GDP, which is the OECD spending average) (UNESCO, 2013) (United Nations, 2015).

4.1 Education

Financial investment is vital for ensuring that resources are available to implement policies and achieve goals. Studies show that investment in higher quality pre-primary education and child services increases primary school efficiency and yields a high return on investment. The Ministry of Finance allocates its education budget to the Ministry of Education to disburse funds to schools and its various institutions (UNESCO, 2015). The financing of ECD in Nepal is achieved through both public and private contributions (World Bank, 2013). The current level of ECD financing in Nepal is insufficient to meet the needs of the population (World Bank, 2013).

According to the EFA National Review Report, the budget of pre-primary education constitutes between 1% and 3% of the total public expenditure on education. The education budget is between 3% and 4% of GDP. The ECD budget represents less than 0.1% of GDP. The OECD suggests that public investment represents a minimum of 1% of GDP to ensure quality ECCE services (World Bank, 2013). Studies suggest that, in developing countries, investments in pre-primary education are startlingly low—on average, 0.07% of gross national product is spent on pre-primary education, compared to 0.5% in developed countries (Bernard van Leer Foundation, 2016). Tracing the flow of funds for ECD is challenging because of uncoordinated institutional arrangements and opaque budget development processes in developing countries (Financing Early Childhood Development, 2015).

4.1.1 ECD budget

The education sector budget for ECD is in increasing trend in nominal terms. The total amount allocated for ECD increased from NPR 25 crore (NPR 251 million) in FY 2006/07 to NPR 128 crore (NPR 1,286 million) in FY 2015/16 (DoE, 2015). This represents around a five-fold increase in the budget. The share of the ECD budget as a percentage of the total education budget has also increased in these years. The share of ECD budget as a percentage of total education budget increased to 1.47% in 2015 from 0.5% in FY 2004/05 (DoE, 2004; 2006; 2015). The share of ECD budget as a percentage of GDP was around 0.2% of GDP. This is not enough to ensure quality ECCE services. The expenditure of the budget allocated for ECD has been more than 95% in the last decade. The financing services for pre-primary level of education include finances from

the MoE, finances from DDCs and VDCs, contribution from households, and finances from NGOs and development partners. It is not possible to estimate the exact proportion of financing from each of these sources, as we do not have comprehensive and reliable data covering all the financing and expenditure from all the sources for ECD services. However, an attempt has been made to provide information on such contribution by analysing data from the National Education Account (NEA) (NEA, 2015).

The budget for ECD is allocated toward the salaries and perks of ECD teachers, non-teaching staff, the procurement of goods and services (such as teaching materials), capital expenditure, meals, boarding and transportation, and general administration costs (NEA, 2015). The analysis of expenditure data, both in terms of absolute value and percentage, provides a scenario for ECE financing in Nepal for 2015. The analysis is very similar for other years.

The contribution of households is highest in terms of ECD expenditure. The total expenditure for pre-primary education (inclusive of government, households, international and local NGOs, development partners, and internally generated funds) was NPR 7,113.8 million in FY 2014/15 (NEA, 2015). Household contributions amounted to about 60% of this amount, with households spending on uniforms, textbooks, transport, snacks, and private tuition. This high household expenditure arose as a result of sending their wards to private ECD centres. The share of expenditure by the MoE was 19%. The share of expenditure made by MoFALD was 2.6%. The contribution of national and international NGOs was around 3.1%. The share of expenditure from internal sources as a percentage of total expenditure was also 3.1%. The remaining expenditure came from local NGOs (NEA, 2015).

However, the share of household expenditure on pre-primary education as a percentage of total expenditure on ECD goes down if we only analyse data for pre-primary education in community schools and community-based ECD centres. The share of household expenditure for pre-primary education becomes 9.9%. It is not surprising, then, that the share of the MoE's expenditure on pre-primary education is 42.8% (NEA, 2015). The share of the MoE's expenditure is much higher if we take into account pre-primary education in community schools, because parents do not have to spend much money to send their children to these ECD centres.

4.1.2 ECE expenditure

Households account for a significant amount of ECE expenditure. Households' total expenditure at the pre-primary level was NPR 2,732.7 million. Most of this was spent on sending children to private centres. The total amount spent on private institutions was NPR 1,963.7 million. However, parents also spend some amount of money in sending their children to community schools at this level. The amount is mostly spent on uniforms, textbooks, transportation, and private tuition.¹⁰ This amount comes to NPR 572.5 million for parents that send their children to community schools (NEA, 2015). The household burden will increase if there is a need to send children to private ECD centres.

The expenditure for pre-primary education can broadly be divided into teaching activities, services, and general administration. The salary of teachers is a major component of pre-primary education budget, accounting for 56.1% of total expenditure. Another 42% is for the salary of non-teaching staff, expenditure on infrastructure, and general administration. This leaves around 2% of total expenditure for teaching and learning materials, including textbooks, to enhance the quality of pre-

¹⁰ The practice of sending pre-primary school children to attend tuition is already extremely problematic, and antithetical to the principles of play-based, age-appropriate learning as part of ECD.

primary education. The share of teacher's salary is around 66% for the pre-primary level in community schools. Community schools use around 3% of total expenditure on learning materials (NEA, 2015).

The total *per capita* financing for sending a child to ECD is around NPR 7,000 per year. However, the *per capita* financing (including household expenditure) at pre-primary level in institutional (private) schools (centres) is three times more than the average for all schools. The *per capita* financing at this level in institutional schools is NPR 21,500 per year (NEA, 2015). The government spends NPR 1,620 per child per year at the pre-primary level.

Nepal has also developed an implementation plan along with the ECD strategy. The estimated allocation needed to achieve the set targets was around US \$12.6 million per year (World Bank, 2013). Lack of adequate financing is the most important constraint on the development of ECE in Nepal (CERID, 2008).

There is a need to allocate more resources toward the areas of enhancing teaching and learning processes to improve better learning, ECDI, and physical and social development.

In the new federal structure, the funds for ECD are expected to be channelled to local government, which will allocate the resources thus received to ECE centres. The provincial government will also allocate the budget for ECE services.

Community-based centres receive both financial and non-financial support from the community (CERID, 2006). Community-based centres also create a conducive environment for raising awareness around early childhood services. According to the Financing Early Childhood Development Report, community-based centres provide better quality and more holistic services (Financing Early Childhood Development, 2015). Communities also hire additional ECD facilitators if required. They manage the source funds by themselves through earnings from sale of forest products and contributions from women's networks. Observed communities have also made contributions in providing daymeals to students (Seto Gurans, capacity report, 2010).

The overall ECD education budget execution rate is very high in Nepal. The education budget execution rate has been more than 95% in last decade (DoE, 2015). The budget is allocated mostly for recurrent activities, but the current level of financing falls far short of providing access to high-quality services for all children (Financing Early Childhood Development, 2015).

4.2 Health

The Government Health Expenditure provides budgets for health facilities, the procurement of drugs and consumables, and health programmes, including the Disease Control Programme, the Family Health and Child Health Programme, CBIMNCI, the Nutrition Programme, the Maternal Health Programme (Aama Programme), national level campaigns, immunisation programmes, the Primary Health Revitalization Programme, Laboratory Services Immunisation, and abortion services.

The financing aspects play a crucial role in optimising the health and nutrition status of the population. The Government of Nepal has been implementing health programmes through the decentralised health system. The Finance Section of the Department of Health (DoHS) is the focal point for the financial management for all programmes under the DoHS, and all health institutions at central, regional, and district levels have their own Finance Section. The Nepal Health Sector

Programme (NHSP–2, 2010/15) called for the share of health spending in the total government budget to rise from around 7% in 2010/11 to 9.6% in 2014/15 (Dulal *et al.*, 2014).¹¹

A review of the overall trend in budget allocation in the area of health and nutrition finds that it is increasing. In the health sector alone, the budget allocation in FY 2004/05 was NPR 949,104,000. In FY 2015/16 the amount increased four-fold, and the allocated amount was NPR 42,15,920,000. This is a significant increase, even accounting for the expected increase in the total population. Similarly, in nutrition, the allocated budget in FY 2004/05 was NPR 15,863,000; in FY 2015/16, the allocated budget was NPR 10,06,136,000 (Budget Allocation and Expenditure Red Book 2015).

Budget allocation and expenditure need to be aligned. In Nepal, the budget absorption capacity seems suboptimal. The expenditure is not as efficient compared with the allocation of the budget; as a result, a huge amount of money is underspent. In FY 2004/05, only 53.62% of the allocated budget was utilised in the health sector. This increased to 86.96% in FY 2015/16. Similarly, in nutrition, 32.07% of the funds were used in FY 2004/05; this increased to 48.19% (NPR 484865) of the total allocated budget in FY 2015/16 (Budget Allocation and Expenditure Red Book 2015). This shows there is still a significant gap between allocated budget and the fiscal expenditure, despite the improvements.

A sector-wide approach (SWAp) has been adopted since 2004 to finance healthcare and improve aid effectiveness, as a result of which there has also been substantial financial investment from the donor community. This has increased the contribution of external development partners (EDPs) in the health sector, as per government priorities and plans. In 2011, EDP contributions made up 39% of Nepal's MOH services budget (WHO, 2015).

It was found that the country's financial investment in health is also related to the political priorities of the country. Moreover, issues like maternal and child health, maternal mortality, and child mortality are being prioritised, increasing financial investment and the focus toward coordinated and aligned efforts on the part of government, national, and international NGOs, as well as UN agencies and bilateral organisations (WHO, 2015).

Apart from the investments and initiatives within the health sector, investment in other sectors also provides health-related outcomes. Investment in women's educational status has been directly linked with maternal and neonatal mortality in Nepal. In recent years, the enrolment of girls in schools has increased, driven partly by targeted free education policies. Access to healthcare has increased through a rapid expansion of the road network, vehicle movement, communication through mobile phones, growing access to clean drinking water, and sanitation, especially toilets in rural areas and the construction of health facilities.

4.3 Nutrition

Health sector programmes recognised the interdependencies between nutrition, healthcare, and education from the 'first 1,000 days' onwards. Interdependencies between young children's survival, healthcare, and learning are best promoted through coordinated and integrated policies and services. Experimental studies have calculated the cost of intervention against the returns to children and society through, for example, reduced costs of special education, reduced social protection costs, higher earnings, etc. Economic analyses add to the weight of evidence that ECD is not only critical, but also cost-effective (van der Gaag and Tan, 1998; Barnett, 2009).

¹¹ 'Analysis of the Health Sector Budget of Nepal' [online], available from https://www.researchgate.net/publication/308116933_Analysis_of_Health_Sector_Budget_of_Nepal [accessed 08 January 2018].

Recognising its importance as a contributing factor to child mortality, Nepal has made addressing undernutrition a national priority and has adopted a multisectoral approach to the challenge.

Less than 50% of the budget has been utilised for nutrition, resulting in poor performance and affecting the achievement of the target beneficiaries. In spite of gaps in budget allocation and utilisation, Nepal has made significant improvements in reducing the prevalence of stunting, wastage, and emaciation in last 10 years (from 2006 to 2016).

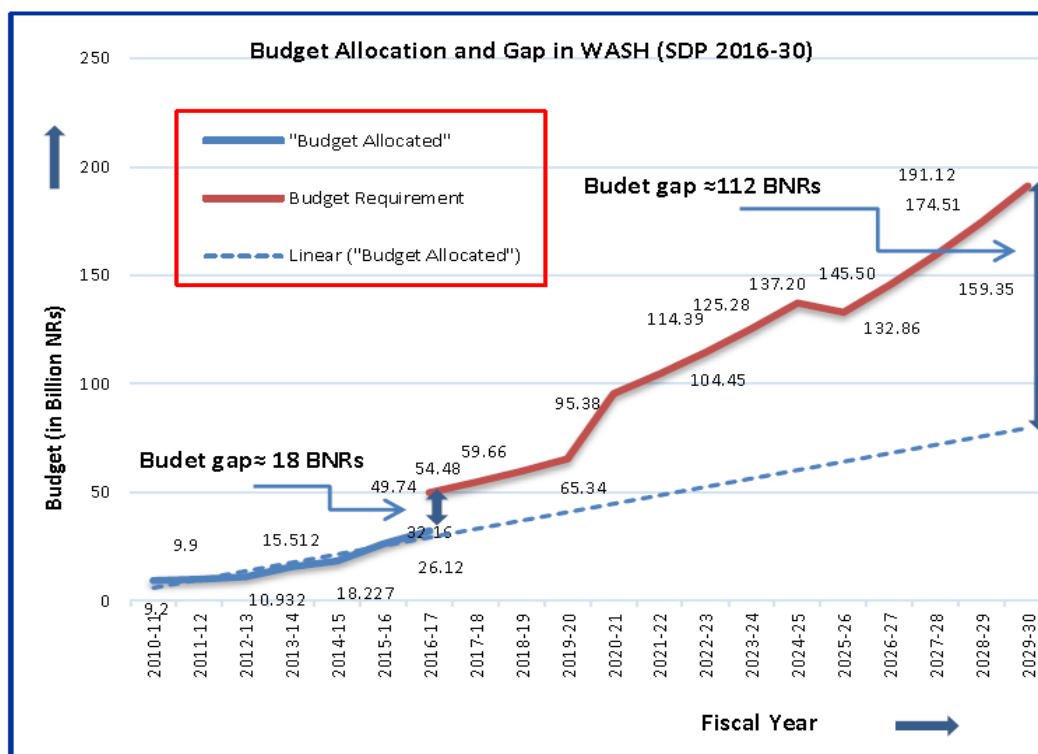
Conclusion

Although the total budget allocation for health is limited, the sectoral disbursement of the budget has been found inadequate to meet the targets related to the provision of health services. However, the rate of expenditure was also found to be below 50%—an underutilisation of the budget.

4.4 WASH

As mentioned in a previous chapter, many organisations besides the government have been investing in WASH-related activities. These activities include both soft skills and infrastructure development geared toward addressing the WASH-related needs and issues affecting communities and households. Some funding is reflected in the Red Book,¹² but some may not; it is therefore difficult to calculate the total WASH budget in Nepal. It is not, for example, possible to derive how much of the total expenditure was spent on children under five, because most of the activities related to WASH address the needs of all household or community members. These programmes are also not explicitly targeted toward children under the age of five, so it is not possible to assess the funding and efficiency of WASH activities catering specifically toward ECD. Nevertheless, the government records show there is certainly a funding gap in WASH (Ministry of Water and Sanitation, 2017). The gap is likely to widen in the coming years, as shown in Figure 7.

¹²The Red Book is an official document that reflects the entire budget the government allocates to different sectors in a given year.

Figure 7: Predicted budget allocation and gap in WASH

Source: Ministry of Water and Sanitation, 2017

4.5 Protection

No information was available for protection in relation to ECD children, despite repeated efforts to gather relevant information for this analysis.

5 ECD programmes and achievements: stakeholder perceptions

This chapter discusses the third question as outlined in the ToR:

How were the implementation of ECD programmes and achievements perceived by key stakeholders?

The primary qualitative data collected through FGDs and KIIs with key stakeholders informs this section. Since this evaluation is expected to contribute toward the next ECD strategy, qualitative research was carried out with the aim of forming an in-depth understanding on the performance and outcome of the ECD strategy as perceived by key stakeholders, and to answer questions on attitudinal changes, perceived improvements in the provisions of ECD services, community preferences, quality and access to ECD services, and the perception and satisfaction of intended beneficiaries.

Section 2 provides a brief description and profile of the regions and communities where qualitative data collection was carried out. Section 3 discusses ECE services, followed by the health and nutrition services in sections 4 and 5 respectively. Section 6 discusses WASH practices, and Section 7 explores the protection sector. The relationship between the local government, the ECD centre, and services is discussed in Section 9. Section 10 looks at integration across the different sectors, followed by the conclusion.

5.1 Community profile

The fieldwork teams visited seven sites in seven districts across the three ecological zones, as prescribed in the ToR. This section provides a brief introduction to the sites visited for this evaluation.

Site A

This site lies to the west of Kathmandu. The population is composed of mostly Brahmin and Chhetri groups. There are other minority social groups present in the area, such as Magar, Kami, Sarki, Damai, Newar, Gurung, and Thakali. People living in this area practice these religions: Hindu, Sikh, Buddhism, Kirat, and Christianity. The population mostly speaks Nepali, Magar, Tamang, and Newari.

Site B

This district also lies to the west of Kathmandu. It took us three days to reach this site, as travelling across and through it was a challenge because of the narrow and rough roads. A majority of the community was Brahmin, with Dalits in a minority. People from the Thakuri and Chhetri groups also live here. Most of the population speaks Nepali mixed with a local dialect. Most of the people living here work in agriculture or animal rearing, or as daily wage workers. A few have migrated to other regions or abroad to look for work. Due to election preparations at this site, it was difficult to schedule some interviews.

Site C

This site in western Nepal borders India. Although Hinduism is the dominant religion in the region, there is a sizeable Muslim population. Most of the people in this region speak either Nepali or Awadhi. We faced linguistic constraints in a few parts of this site. We also observed that mothers

were not allowed to travel alone here. Even when we were conducting interviews with them, they were accompanied by their mothers-in-law. Due to elections at this site, it was also difficult to set up a few interviews here. People belonging to the following communities lived in the region: Nau, Dhobi, Chamar, Pasi, Jaiswal, Moriya, Chauhan, Yadav, and Chaudhary. Most of the men have migrated to India or to the Gulf for work because of insufficient farm production. Agriculture and fishing are key sources of earning for a few families here.

Site D

This district lies in central Nepal and is among the most remote places in the country. We found there was no electricity in the region, and most of the villagers used solar power. Most of the region is under forest cover and, because of its remoteness, we faced a few technological challenges. Due to elections, we also faced some obstacles in setting up interviews here. The Magar community is in the majority, but there are other communities present, such as Brahmin, Chhetri, Newar, and Dalits. Nepali is spoken widely, although the Magar community speak their own language. Most of the people in the community are dependent on agriculture and livestock; some people have migrated to the Gulf for employment.

Site E

This site lies to the east of Kathmandu and is close to India. The majority community here is Madhesi, along with Yadav, Muslim, and Querri. Most of the people are involved in agriculture. There is a high degree of migration to Saudi Arabia, Qatar, Malaysia, and Dubai. The region also comprises of different communities such as Musahar, Shah, Mahara, and Kewot. Most of the people speak Maithili.

Site F

This lies to the east of Kathmandu and has some roads in rough condition. The local communities here are Sherpa, Tamang, and Rai, but because of migration there are also Brahmins, Chhetri, Newar, and Dalits. Most people here work in the civil service, in trade, or as teachers in boarding schools. Most people migrated here to give their children a good education, or for work.

Site G

This lies in western Nepal, and the inhabitants of the region include Chhetri, Magar, Kaami, Brahmin, and Thakuri. Nepali, Magar, Tharu, and Maithali are the languages spoken here. Most of the population is involved in agriculture. There is religious diversity, with people following Hinduism, Buddhism, Christianity, and Islam.

5.2 ECE

Understanding ECD

As discussed in the literature review, UNICEF refers to ECD as a comprehensive approach to policies and programmes for children from birth to eight years of age, their parents and caregivers (UNICEF, 2014).¹³ ECD policies seek to protect a child's right to develop their cognitive, emotional, social, and physical potential. The goal of the services is to meet the vital needs—such as health, nutrition, education, water, and sanitation—of infants and young children (UNICEF, 2014).

¹³ For the purposes of this evaluation, we have focused on children up to the age of five, for reasons discussed in Chapter 1.

Most of the district officers articulated ECD as a process of mental, physical, and social development through different learning activities. Very few district level respondents saw ECD only as a way of preparing children for school. Some officials also consider ECD as a foundation for life and as a first step to educational achievement. As one district official said:

ECD is a foundation for life. It is the primary stage and first step to educational achievement. It provides a real environment in which to adjust to senior class education. It intends to develop a child's physical, social, emotional, and psychological aspect.

Most school principals, like the district officials, also believed that ECD was a process for supporting the development of a child. Some principals articulated that, by going to the ECD centre, children would inculcate a habit of going to school. As a school principal said:

The ECD centre is a preparation for children to develop different qualities for school. ... They learn about motor activities like playing, walking, and eating; they learn about sanitation, studying, and nutritious food.

Health workers usually thought of ECD centres as places where children go to learn and inculcate a habit of studying. However, this is not consistent across all health workers. Only a few of them associated ECD with health, nutrition, physical wellbeing, and the growth of young children, as seen in this quote from a health worker:

It is related to nutrition and food, but the most important thing is timely immunisation. They have to measure their weight to find out whether they are growing and developing.

It appeared that mothers usually associated ECD with education rather than with health or nutrition. Some mothers believed that ECD centres were safe spaces for their children. According to them, by sending their children to ECD centres, their children would not only be safe, but would also learn good habits and behaviour. As a mother said:

Yes, at home he will play and may come under a vehicle. There (at the ECD centre), he will be engaged with friends and it'll be easy, at least for 2–3 hours.

Other mothers viewed the ECD centres as a pathway for better opportunities and for their children to learn and improve their skills. They believed that by sending their children to ECD centres they were inculcating a habit of going to school, which would develop social skills. As a mother stated:

I am sending my child just to form a habit for leaving home (to prepare for Class 1) and to learn the alphabet.

Few mothers consider ECD centres as a foundation for good education and preparation for higher classes. As a mother noted:

The ECD centre is a place where they get an education. Although we did not get an education, if our children get a primary education, then their future will be bright. We send them to get an education and a good job.

Although there was some variation among different respondents about the nature and purpose of ECD, it appeared that most respondents were conscious of the range of ECD possibilities. All respondents tied ECD to attendance at ECD centres, but many respondents were also able to link it to the holistic development of children. Issues related to health and nutrition were regularly identified as part of ECD, although WASH and protection issues were rarely identified as ECD concerns.

5.2.1 School-based ECD centres

Barriers to attendance

The age of children attending ECD centres across the districts is between three and five. The size of the ECD classrooms in our sample range from 17 to 33 children. According to a school principal, most of the ECD students had elder siblings attending higher classes at the same school.

According to school principals from a few districts, parents send their children to ECD centres because they consider it as a stepping stone toward attending boarding schools or higher education, where the children can learn English. As one principal articulated:

The school-based ECD centre is considered training by many parents. In their starting year, the school does a lot of hard work to make changes in the children, but after the formation of the school habit, lots of parents are taking their children to boarding school. It is for the same reason: the English language. Speaking and learning English has become so important.

Although the quote shows some tensions regarding public–private transitions, it is clear that parents and teachers alike see ECD attendance as a starting point for the education pathway of their children. This belief that the ECD centre is an essential foundation for their children's development and education is shared by quite a few mothers. One mother noted:

The ECD centre is a really good platform to start the studies of children. The centre helps children in motor development and brain development. They will learn many things in the centre if they join as early as possible.

Nonetheless, several ECD-age children were not in ECD centres. Geographical distance emerged as the most common reason for children not attending ECD centres. Children living in distant communities or in remote areas had limited access to ECD centres. As a health worker stated:

Lots of children have been enrolled in every ECD centre. I think no child has been left out of these centres, except Sherpa children from the upper belt, who ... might have been deprived of this ECD (education) service because of the distance.

A similar observation is made by an education worker:

It is a problem in the villages, where school is far from home and parents are uneducated, so they do not focus on education. But I don't know the numbers. It is mostly found in Tamang community. My house is next to this hill. In the Tamang community, women get married at a young age and have children. They do not even pass the SLC and they lack parental education.

This quote illustrates how geographical and remote areas make ECD centres difficult to access for young children, but it also highlights the role of parental education in a child's access to ECD centres. Some facilitators noted that uneducated parents often did not realise the importance of ECD centres for their young children.

A few district officials also said the lack of resources in distant ECD centres affected operations, which in turn had an impact on children's attendance (as the centres didn't have services). They also said that, often due to limited funding, ECD centres were not built in remote areas, as a result of which children were left out. As a district official said:

Mostly, in rural areas, some ECD centres are not running, even if they are established, due to limited funds; to run the centre, there is a need for physical instruments and a proper salary

for the teacher. In such cases, children may not attend the ECD centre. In many rural parts, there are no ECD centres, and the children there also haven't attended ECD centres.

Another reason why young children were unable to go to ECD centres was that a few young children supported their parents with housework, according to a few health workers:

Some of the children from the Dalit community do not attend. They might have been enrolled, but they attend irregularly at those centres. Some of them have been completely left out. They are bound to help in household chores.

These quotes are useful for understanding perceptions of ECD attendance, including perceptions of how attendance might be affected by caste and ethnicity. It also emerged that children in a few districts did not have access to meals at the ECD centres on the basis of their caste. A number of respondents also noted that Dalit children were less likely to attend ECD centres in a number of districts. We were not always able to verify whether these caste and ethnic groups really were less likely to attend ECD, or whether there was simply a perception that this was the case, but we wanted to report these perceptions nonetheless. Although these issues were also presented in caste terms by our respondents, we observed that the communities referred to often lived far away from ECD centres and were usually made up of poorer families, so their lack of attendance could be attributed to poverty and the cost of ECD attendance.

Lack of birth certificates and identification papers was another reason for children being out of school. According to a community worker, birth certificates and identification papers are required by some ECD centres for enrolment. As the community worker observed:

Lots of children do not go to an ECD centre. Let me say, few of them go to those centres. The centre requires identification for enrolment but lots of children out here are without identification (a birth certificate).

A few mothers confirmed that they were asked for birth certificates for their children to be admitted to the ECD centres.

According to a few education workers, there has been a decline in the number of children attending school-based ECD centres because parents who are economically well off prefer to send their children to private ECD centres and Montessori schools.

It appears, then, that most children are attending ECD centres in most districts, although the long distance from ECD centres, the cost of ECD attendance, and the lack of birth registration documents could be limiting factors preventing some children from attending.

Cost and funding

In most districts, parents do not have to pay any admission fee in a government-run ECD centre, but they have to pay various fees in private centres. In two of the districts, parents were expected to pay an admission fee/enrolment fee as well as a lunch fee in school-based ECD centres. The admission fee usually ranges between NPR 400 and NPR 600 as a one-off fee, and the lunch fee is between NPR 100 and NPR 150 per month. In community-based ECD centres, the parents are only asked to pay for the lunch fee.

The DEO is a key source of funding for ECD centres. According to a school principal, schools usually received monetary support from the DEO, which meets 60% of their demand; the rest was to be met by the community. Principals from two other districts confirmed that the DEO provided funds to pay the salaries of the principals and the facilitators and contributed to the Per Child Fund

(PCF),¹⁴ which meant that the centres' funds were based on the number of children enrolled. Some schools receive financial support from local governments, such as municipalities. This is discussed later in the chapter.

However, in a few districts, ECD centres received more support from international and local NGOs than from the local government or the DEO. Although most of the mothers across districts are unaware of the sources of funding for the ECD centre, a few mothers noted that organisations such as *Janahit* provided monetary support to the ECD centres. According to ECD facilitators, organisations such as the Community Forest Committee, REED Nepal, SWAN Nepal, and the Himalayan Trust also provide monetary support to ECD centres. Many of these local and international NGOs also support ECD centres materially. Organisations such as World Vision and Seeds offer support by distributing bags, shoes, and clothes, and by offering training for making play materials. According to a few other school facilitators, REED Nepal and the Himalayan Trust provide stationery and game materials to the children. ECD facilitators received a salary of NPR 3,000 from the DEO until 2015; this amount was increased to NPR 6,000 after 2015. Most of the ECD facilitators said their salaries had increased in the last few months, but they were not satisfied with the new amount. According to them, this was because they often had to work for long hours, and the amount was not enough to run their households.

M&E

Monitoring of the ECD centres in districts were usually carried out by DEO staff. In some districts, they would visit every 2–3 months; in others, it was once every year. The Resource Person (RP) carried out monitoring visits in three of the districts. The RP was sometimes accompanied by a school observer, and visits in districts ranged from once a month to once every quarter. M&E comprised of checking the regularity of students, attendance sheet, and teaching methods; provision of food to children; the learning capabilities of children; the school environment, including the sitting arrangement; and the use of playing material.

School Management Committees (SMCs) are also required to conduct M&E of the functioning of ECD centres. As a member of an SMC noted:

We monitor the school regarding the number of children who attend, and visit homes to know about why they are not coming. We go door to door to provide counselling to send their children to school. We also inform them about the provision of meals at school so that they will send their children to school.

It was not always possible to corroborate from other respondents whether (and to what extent) SMCs fulfilled this function across all sites. While SMCs from a few districts claimed to monitor the schools about the number of children attended, and visit their homes to find the reasons for their absence, a few SMCs in other districts are unable to monitor these activities as they are busy with their own (house) work. As such, although DEO staff, RPs, or the SMCs have been involved in monitoring activities, these do not appear to be structured or regularly implemented across districts.

Strengths and challenges

The ECD programme has several strengths, according to both the service providers and the mothers. One strength of public ECD centres was that they are free of cost. Mothers were happy to

¹⁴ The Government of Nepal started the PCF in 2007. This fund allocates NPR 1,626 for each student to cover the cost of uniforms, stationery, and other essentials (Bishwakarma, 2013)

send their children to these ECD centres because they did not have to pay for these services. According to a mother:

It (ECD) is free of cost and if my daughter gets a good education, then I will continue her education in this school.

The provision of free ECD services allowed mothers the time and space to do their housework or agricultural work easily. Another mother framed it thus:

ECD is a place where students should learn, and there is less chance of getting lost. I cannot look after the child the whole day, (as) I have to go the field and do other work.

The expansion of ECD services has made it easier for children to attend ECD centres. With more ECD centres closer to home, parents feel more comfortable sending their children to them. Mothers further noted that ECD facilitators were friendly and cared about their children, which helped gain their trust.

A few mothers appreciated that ECD centre facilitators introduced games as a way to teach their children. ECD facilitators from these districts felt that, with the provision of resources, they were able to carry out fun and creative activities, which led to an engaging classroom. As an ECD facilitator said:

Nowadays, there are more teaching materials, charts, maps and playing materials in comparison to the past. New school buildings are being built.

Greater investment into ECD thus allowed facilitators more opportunity to engage children more effectively in these ECD centres.

Nonetheless, managing parental expectations was a challenge for a number of school principals. According to a school principal, parents did not understand the concept of ECD; they expected that, once their child joined ECD centre, they would be able to read the alphabet immediately. A number of ECD facilitators corroborated this perception among parents.

A number of mothers noted the lack of WASH facilities in ECD centres as a major challenge in ECD provision. In a number of districts, the toilet facilities were not good, as they were not clean, and water facilities were limited, if available at all. We also observed in a school that the toilet was shared between both teenage students and ECD children. We observed children defecating in the open because the toilet was far away from the ECD centre. Further, a member of an SMC noted that there were no nannies or extra staff to take the young children to toilet.¹⁵

Some ECD centres lacked clean drinking water for the children. According to mothers, in some schools, children had to carry water bottles from their homes to ensure they had drinking water while they were in these centres. This was not always easy for young children.

SMC members and mothers reported that the quality of education was a challenge at some ECD centres. They noted their children were not able to read and write, even after attending ECD centres. In a few schools, they found that the facilitator found it difficult to manage because there were many children at the centre. Few mothers also found that the facilitators were not punctual, and as a result their children would run away and not attend school.

¹⁵ These issues will be discussed in more detail in the WASH section later in this chapter.

According to a few district officials, despite an increase in the salary from NPR 3,000 to NPR 6,000, the availability of trained teachers and teacher retention remain key challenges. District officials say they often receive complaints that facilitators do not teach properly and are sometimes violent toward children. Some district officials also find that often facilitators are not qualified to teach and manage young children. According to them, a few teachers are not selected on the basis of their qualification but by preference due to familial connections. A district official noted:

There are no qualified teachers for the children, (or teachers) who know child psychology and can take responsibility of children. ... There should be a specified education level for the teacher and they should be elected through competition. But the method of choosing teachers is bizarre. Teachers are elected through relative connection(s). Although we are providing training to those teachers, we don't remove the teacher who has been already selected. Instead, we try to make them more eligible as an ECD teacher through training.

This quote highlights the need for monitoring of recruitment of facilitators. It also shows the role that training of facilitators plays for facilitators to be eligible for teaching and looking after young children. There are guidelines already in place in terms of the requirements to be an ECD facilitator, but perhaps these are not being followed as expected

Teacher retention is a challenge as facilitators keep changing because of better opportunities or because they leave their jobs after their marriage. According to a district official:

School-based centre facilitators are paid little, which results in (their) dropout and resignation. Those facilitators who are unmarried also leave their job after marriage. When these facilitators are replaced, the new ones are often inexperienced. The school committee should appoint new ECD facilitators according to the (required) educational qualifications.

The quote above demonstrates that the issue of retention is affected by a number of factors. To compound matters, the replacement facilitators are often inexperienced and do not have the right qualifications, further affecting the quality of ECD provision. This continuous flux of teachers also made it challenging to provide training to the new teachers, as attested by a district official. As a consequence, children are unable to learn effectively because of untrained new teachers.

Violence by teachers was a concern among district officials and parents. As a district official noted:

Some teachers are violent toward the children. The lack of trained teachers contributes toward this. After training, we found change in these things.

A mother of a pupil confirmed this sentiment regarding violence against children:

My daughter once said she got hit (by the teacher), so she does not want to go school. I think children misbehaved in the class and did not follow instructions; that is why teacher got angry.

As the quote demonstrates, violence by teachers not only disrupts the class and discourages children from attending schools, but it also affects their development.

A few ECD centres also face linguistic challenges. According to a district official, the language of instruction was a major concern, but they have hired facilitators who are capable of speaking multiple languages and have a command over the mother tongue.

Sending children unaccompanied to attend ECD was another challenge faced by beneficiaries. According to a mother, the distance and travel from their home became a challenge, especially

during the rainy season. She believed it would be helpful if ECD facilitators could accompany the children, collecting them from home as well as bringing them home after school.

5.2.2 Community-based ECD centres

This section discusses the community-based ECD centres that we visited. We found that three of the seven districts we visited did not have community-based ECD centres. It appears there has been a continual streamlining of ECD centres to bring them within the purview of local schools. Although the intention had been for schools to provide some support and coordination function to all ECD centres, including community-based centres, it appears that this has been interpreted at the local level to mean that even community-based centres have to be attached to and become a part of schools. As a result, the number of community-based centres appears to be declining rapidly across the country.

The profile of children attending and not attending

The number of students enrolled in community-based centres ranged from 15 to 25 students. The age group in the districts varied from 17 months to four years. The children who attend these sampled ECD centres come from diverse ethnic backgrounds. The families of children enrolled in the ECD centres are mostly agricultural workers. Although parents regularly enrol their children in community ECD centres, they often withdraw the child after some months when they have got into the habit of going to school, rather than completing the entire duration of ECD. This was because, at the age of three, parents usually prefer to enrol them in a pre-primary school instead. As an ECD facilitator noted:

Many have not attended an ECD centre properly. There are many cases where parents send their children to ECD just to get into the habit of going to school. When the children become able to study, at that time they take the children to school. The children should remain in an ECD centre (until they are) four years old. But the parents take a 17 month old child to ECD centre, and when they reach the age of three, they take (the child) to school. This is the situation of this area, and they blame us for not teaching them at an early age. If anyone attends ECD centre fully, then we provide the certificate to them of (having attended) the ECD centre.

This quote demonstrates not only that children are not regular in their attendance at ECD, but also that parents place a high value on teaching and formal schooling. Instead of allowing the children to learn in a comfortable, friendly, informal environment, it appears that parents prefer their children to begin to prepare for school. As such, the focus of ECE appears to have become a downwards extension of the school system, rather than a focus on holistic or play-based ECD for the development and wellbeing of the child.

In some districts, we also found that ECD children with older siblings in another school would accompany them to those schools. The ECD-aged children without siblings studying in schools usually attend community-based centres, as these are usually situated close to their homes.

Cost and funding

There are various sources of funding for community-based ECD centres. One source is the parents. In most of the districts, parents did not have to pay an admission fee but had to pay for the lunch services offered by the ECD centre. The lunch services costed NPR 150 per month to the parents. In other districts, according to a few ECD facilitators, the parents had to pay NPR 600 per month. As a ECD facilitator said:

We take an admission fee of NPR 600. We pay a salary from this amount to the ECD assistant by deducting the meal expenses.

The above quote shows the amount of admission fee that parents have to pay to the community ECD centre. It also shows how the money is utilised by the ECD centre to pay for the ECD staff and the lunch services offered by the centre. According to a few mothers, the ECD centre would also ask the community to collect money and give it to the ECD centre for funding. This would range from NPR 1,000 to NPR 1,500.

Another source of funding for the community ECD centre is the PCF from the government according to district officials. A health worker commented that the community-based centre in her area received NPR 500 per child. This is supplemented by municipalities and VDCs, which also serve as a source of funding. According to a district official, municipalities and VDCs provide funds to the ECD centres and support ECD centres through building construction, toys, and playing tools. Funding from municipalities to the community ECD centres contributed to building maintenance, buying furniture, recruiting teachers and learning materials.

Community ECD centres would also receive funding and monetary support from the DEO and other local and international NGOs. According to a few district officials, funds received from the DEO are often used to pay the salaries of the facilitators and to buy learning materials. In some districts, organisations such as SWAN Nepal support facilitator salaries and lunch services. DEO and UNICEF together provide refresher training for facilitators. In a few districts, ECD facilitators say that organisations such as Swabalambi cooperatives provide not only funds but also ration, clothes, and mattresses for children. Organisations such as PEACEWIN and Seto Gurans in collaboration with each other provide material support to the ECD centre such as carpets and cushions in some districts.

In districts that did not charge an admission fee, parents supported centres in other ways. According to a mother,

... We also make toys ourselves and give to the centre so that children have something to play with there. When there are issues with damages, we help fix them too.

The above quote demonstrated that parents not only provide monetary support but also provide human resources in the form of labour to help build and maintain the ECD centre. Community-based schools thus rely on multiple sources of funding and support for their operations.

M&E

According to ECD facilitators, monitoring of community-based centres is usually carried out by district officials or organisations such as UNICEF and World Vision Staff. M&E has been reduced in some districts, according to an ECD facilitator, because of changes in the local administrative units. According to an ECD facilitator, monitoring was earlier carried out by DEO and then by the ECD committee. As a facilitator says,

DEO and ECD trained teacher monitor the ECD centre. They visit often and suggest us about ways to improvise our way of caring and teaching children. They also observe the situation of the children (attending the centre).

The above quote by an ECD facilitator shows that monitoring is usually carried out by senior district officials such as the DEO, RP, and ECD trained teacher monitor. They observe the school environment and offer suggestions to improve the ECD centre and its management. As a result of this, according to another ECD facilitator, the facilitators receive different training opportunities.

Some district officials confirmed that they visit ECD centres twice a month, whereas an ECD facilitator note that the DEO visits only once a month. A district official claimed that they monitor not only the centre but also listen to the concerns of the parents and facilitators of the centre.

Local NGOs and international NGOs such as UNICEF also carry out monitoring, as noted by an ECD facilitator,

DEO, UNICEF members, Peacebin, and Seto Gurans monitor the ECD centre. They don't have exact interval of time. Sometimes they monitor 4-5 times a year. If there are many programmes then they may visit 20–25 time in a year too.

The above quote shows that various organisations visit few times a year, but their monitoring depends on whether they have programmes in the centre/area.

The M&E of community-based centres then follows a similar pattern to school-based ECD centres, where some monitoring does take place, but this is not always regular or structured.

Strengths and challenges

Both the service providers and the beneficiaries discussed and highlighted the strengths and challenges facing the community-based ECD centres.

A number of respondents perceived that children learn well in these centres. As an ECD facilitator noted:

There are some cases where the kids from our centre have become first and second in the nursery class. It is a proud moment when they respect us whenever they see us (because of their achievement).

The quote suggests that some children attending community-based centres are performing well when they continue with their schooling. The link between ECD and school preparedness is also relevant, as the purpose of ECD is seen as to get children to perform well in school.

Road access to community-based centres appears to have improved in at least three districts. Respondents also highlighted the availability of safe spaces for children as a key strength concerning the expansion of ECD centres.

Community-based centres receive support from their communities but challenges remain. The lack of toilet facilities emerged as a concern in a number of community-based centres. We observed a lack of child-friendly toilets in the sampled community-based ECD centres in the districts. They found the toilet unclean and water facility poor. We also observed a shortage of drinking water in some centres. These problems appear to have been compounded in community-based centres as compared to school-based centres, as the latter were more likely to have better provisions because they were part of a school system.

Some centres also lack educational and learning materials, which, coupled with lack of proper instruction, affects the performance of these centres. According to a mother:

The current situation [in regard to the community-based centre] is not as good as expected, as no progress has been made recently. Students are leaving ECD centre for a higher secondary school from the village, because they are showing greater improvement in shorter period of time.

Although the mother was not able to elaborate on why this might be the case, she vocalised the perception that school-based centres were considered to be preparing children better.

Most facilitators find it challenging that parents withdraw their children from the community ECD centre before the stipulated time, and then complain that their child has not progressed enough.

Community ECD centres also face difficulties with teacher retention. The lack of qualified teachers poses a challenge similar to the circumstances faced by school-based centres. According to a district official, teacher retention is difficult because ECD facilitators perceive their salaries to be low and often leave their jobs for better opportunities. This is because they have to work for long hours and they find their salaries to be insufficient to cover their living costs.

A district official noted the need for qualified facilitators in these centres. According to a facilitator:

The school committee appoints new ECD facilitators according to educational qualifications. No training is initially held for those newly appointed ECD facilitator, and later they are included for training provided by the DEO.

The above quote shows the need for training for facilitators so that they are qualified to manage and run the operations of an ECD centre.

Some children were not able to access these centres because they did not have birth certificates, while others did not attend because of the distance from their homes to the centres. Although children attend, they do not always stay in these centres till the appropriate and recommended age. Instead, parents often remove their children after a few months to enrol them into schools, including private schools.

According to our findings, parents send their children to ECD centres for a number of reasons. They believe that sending children to attend ECD is useful to learn good behaviour, hygiene, and cleanliness. Some parents still see ECD as a downward extension of the school system, so they want their children to learn based on a curriculum. ECD centres still face a number of challenges, including teacher training and retention and the lack of WASH, drinking facilities, and learning, educational, and play materials. Although some monitoring takes place, this is not always structured or uniform, so it is not always easy to assess the performance of ECD centres.

5.3 Health

This section discusses perceptions and accessibility of health services for stakeholders. This is a crucial component of ECD, and the health and wellbeing of children as well as mothers are important for the development of children. This section explores the key services available, quality of services, cost and funding of the programmes, and the M&E of key programmes.

5.3.1 Key services

According to qualitative data, beneficiaries should receive ECD services for birth preparedness, immunisation, and managing illnesses. These ECD services comprise of:

- Birth preparedness: Expectant mothers should receive counselling, antenatal check-ups, misoprostal/chlohexadine (for pregnant women); there should be the administration of antenatal corticosteroids for premature deliveries, and skilled/institutional delivery.
- Immunisation (for children): BCG, diphtheria, tetanus, the oral polio vaccine, pertussis, and measles.

- Illness management: ARI, malaria, neonatal sepsis management, diarrhoea (zinc and ORS).

Across all seven districts, most beneficiaries had received iron tablets, vitamins, warm clothes, deworming medicine, and vaccines such as BCG, TT, measles, and polio. As a mother noted:

I got a TT injection twice during pregnancy, an iron tablet (from pregnancy until 45 days after delivery), and vitamins. ... The hospital provided NPR 1,500 after delivery. My child has got all the immunisation vaccines (BCG, DPT, measles, polio, PCV) according to the card. Recently my child also got vitamins.

The services mentioned in the above quote were provided at district hospitals, outreach clinics, and health posts. A few mothers reported receiving deworming medicine as well from the health posts. Very few mothers claimed to have received warm clothes as part of the child safety kit for children. Mothers who did not receive the warm clothes might have missed out because they did not go for postnatal check-ups.

In one district, it was found that children from both school-based and community-based ECD centres received health services as a common programme at the school-based ECD centre, while in most of the other districts mothers and children received health services from the health post but not from the ECD centres.

According to most district officers, expectant mothers were supposed to receive counselling. Most health workers were aware that they had to counsel mothers and that mothers should receive vaccines, iron tablets, and cash and child safety kits for institutional delivery. A few mothers said they received these child safety kits. In all the seven districts, most mothers said they received cash from the hospital for institutional delivery. Most mothers across districts said that pregnant women were encouraged and counselled by the health workers to have their deliveries in a birthing centre or a hospital. Mothers said they received a remuneration of NPR 1,500 to reduce the mortality rate and an additional NPR 400 if the ANC check-ups were conducted during the pregnancy.

5.3.2 Cost and funding

Across all seven districts, services such as counselling, check-ups, institutional birthing options, or vaccinations under the national programmes are free of cost to the beneficiaries at government health centres. It appeared that mothers who attended private centres paid a lot of money to access these services for immunisations, vaccinations, and vitamins. At the district health office, mothers were only charged a nominal registration fee (ranging from NPR 5 to NPR 30) in various districts; this money was used to make the cards for the children. These were not considered to be substantial costs, and none of the respondents mentioned this as a constraint on accessing health services.

Other costs for mothers, according to mothers and health workers, were transportation costs, cost of ambulances, and the costs of accidents and general treatment, such as lab tests and X-rays.

According to district officials and health workers, funding for the National Programme (consisting of vaccinations, tablets, and counselling) is provided by the Government of Nepal.

5.3.3 Access to health services

Most of the health workers across all districts say that most of the mothers received services such as counselling, tablets, and vaccinations. According to the Nepal Demographic Health Survey, the

percentage of fully immunised children increased from 43% in 1996 to 78% in 2016. One reason for lack of universal immunisation, according to the qualitative data collected, was the lack of awareness about the benefits of vaccinations among beneficiaries. Some beneficiaries did not get their children vaccinated as they believed their children fell ill when they were previously vaccinated. According to a mother:

I did not go to get the third dose of DPT because my child got a fever while taking the first and second doses and cried all night. The FCHV came to ask me not to miss the vaccine, but I did not go.

This parental misconception about the vaccines affects the children in receiving these vaccines and health services. A few beneficiaries and children were left out of immunisation because they worked in agricultural fields, and were unable to go to clinics and health posts because of work. As a beneficiary mother from a district noted:

Many women from the community are not serious about taking vaccines from the HP. They are busy with their agricultural work and do not care about these health services.

Some beneficiaries were unable to make the most use of immunisation programmes, as they were unable to remember the number of vaccines and the dosage gaps between them. Although most mothers received immunisation cards, they often misplaced or forgot to bring them, so records are not always kept properly. Another reason why beneficiaries miss receiving vaccines and other services, such as antenatal health check-ups, counselling, and iron pills, is because of migration. According to health workers, because of lack of fluidity of information between health posts across districts, health information about beneficiaries is lost during migration.

Social and gendered norms also limit access to health services, although these instances are limited. Very few beneficiaries were unable to access health services because their husbands did not allow them. According to both health workers and beneficiaries, a few women did not go to the hospital for an institutional delivery because they felt it was not socially appropriate to give birth in such a place. As a health worker said, *'It is still a matter of shame for (some) women to visit hospital and give birth at health centre in front of others.'*

Geographical conditions and lack of transportation also emerged as reasons for limited access to institutional delivery for a few beneficiaries. Although rare, some women said they did not go for health check-ups as they had to walk for miles to reach the clinic. They said that, because of unavailability of vehicles and the distance of the clinic, they have to rely on home births. As a beneficiary said:

(We) All knew that we should give birth at hospital or birthing centre. But after the labour pains started, we could not reach it, because of the long distance. There is no transportation available either.

Given the difficulties our field researchers experienced in reaching some of the evaluation sites, we can attest to these reasons being constraints, especially for pregnant women or sick women and children.

The lack of medical supplies, human resources, and trained staff at health centres shows the quality of services at the health centres, and makes accessing healthcare a challenge for women, according to some healthcare workers. As a health worker noted:

In our community, we are not able to provide sufficient facilities needed by pregnant women for safe motherhood. Though women come for check-ups here; there are no proper trained

staff to handle the emergency cases. Neither do we have the human resources to manage these cases properly for pregnant women. Ideally, pregnant women should visit four times, but all of them do not visit often. We are in the state where we can't even encourage them to get all the facilities, as everything is not available here.

This quote highlights that facilities are not equipped for emergency medical care, and, because of these challenges, health workers find it difficult to encourage beneficiaries to visit regularly. Expired and poor quality of tablets available at the health posts also reflects the poor quality of services at some health centres.

These findings then support the analysis presented in previous chapters. The provision of health services have improved in recent years, but coverage remains patchy and is yet to reach all women and children.

5.3.4 M&E

The quality of services remains a concern for a few health service providers and health workers. Monitoring the number of children and pregnant women within the community, their age, provision of counselling and then reporting the information to the health post are some of the responsibilities of district health workers.

Health workers carry out some monitoring functions in their areas of operation. For instance, they monitor the quality of iron and vitamin tablets by checking their expiration date. According to a district official:

We can't check for the quality of medicine but can check medicines for expiration date. We cannot raise question about the quality of medicine. We check its expiry date and its colour while keeping in cold store. Changing colour means it is damaged and we throw it out.

The above quote illustrates that the health workers seek to ensure the quality of the medicine they are providing by checking the expiration date.

Health workers also check with the mothers that they are getting all the health services, and follow up with those who have not received or have not accessed the health services. Many health workers visit homes of those who have not received these health services and counsel and advise them. From our interviews, we found that only some district officials monitor health activities, and that only once a year.

5.4 Nutrition

This section looks at key issues concerning nutrition, which forms another key component of ECD. It gathers the community and stakeholder perception about cost and funding, access, and the M&E of these services.

5.4.1 Key services

During data collection, we found that the key nutrition services that mothers and children should receive were iron tablets, deworming tablets, vitamins and Baal Vita (a multiple micronutrient powder given to children between the ages of six months and two years to tackle malnutrition). We also found there were nutrition centres or rooms in the hospitals to treat children suffering from (severe) malnutrition. Malnutrition programmes and school lunch programmes were implemented in some districts. Some of the health workers noted that there are malnutrition programmes (such

as IMAM) in their districts. This programme provides special services to children with malnutrition, including Ready to Use Therapeutic (RTUF) food. According to health workers, nutrient-rich weaning foods such as sarwottam pitho (fortified flour), Baal Vita, and Jaulo (a mixture of rice and dal) are given to malnourished children. Some mothers also reported receiving training to prepare food such as Jaulo or sarwottam pitho from organisations such as World Vision.

Creating awareness and counselling about nutrition is important to reducing malnutrition. A district official observed that the main reasons for malnutrition are poverty and lack of knowledge about a nutritious diet. Health workers carried out counselling and awareness campaigns such as *SUAAHARA* (Good Nutrition), which seeks to highlight the difference between nutritious food and junk food; these were common in all seven districts.¹⁶ In some districts, health officers collaborate with organisations such as UNICEF to create awareness about nutrition and to distribute vitamins, deworming tablets, and foods such as Baal Vita. They use various media to achieve this, including posters, pamphlets, talk shows, and radio programmes. A few health workers also spread awareness about the importance and benefits of consuming nutritious food through counselling. As a district official stated:

UNICEF is playing a vital role in improving the situation of nutrition in this district. They sometimes help us to distribute vitamin and deworm tablets by providing funds when we are in low budget. In addition, UNICEF is also raising awareness among people through posters, pamphlets, talk shows, and radio programmes.

The above quote shows that local and international NGOs (such as UNICEF and World Vision) play an important role in raising awareness of malnutrition.

5.4.2 Cost and funding

In all seven districts, our respondents noted that key nutrition services should be available free of cost at the health posts. Most of the mothers corroborated that they did not pay for iron tablets, vitamins, deworming tablets, Baal Vita, or Pitho.

According to a mother:

I did not pay money for Pitho. After showing card to sisters (nurses) at hospital, they provided it easily. But we have to pay 10 rupees each for transportation cost to receive Pitho.

The above quote highlights that, although mothers do not have to pay for nutrition services, they have to pay for transportation costs to reach the health post or the hospital. However, mothers did not consider these costs to be substantial.

However, in some cases, a few schools that provided school lunches charged parents a lunch fee. The Nepalese government (and sometimes UNICEF and other organisations) provides funds for Baal Vita, Vitamins, and deworming tablets. UNICEF and USAID also fund ready-to-use therapeutic food (RUTF).

Some of our respondents commented that, although some nutrition services are available in their district, these were not extensive. It appeared that programming targeting nutrition was limited in our field sites; as a result, many respondents did not know or could not report the source of the funding of nutrition activities.

¹⁶ This programme is an awareness programme targeting pregnant women to inform them about nutritious food.

5.4.3 Access to nutrition services

Most mothers in our research sites noted that they received vitamin and deworming tablets, and that their children felt good after consuming them. They said the health workers provide these services through outreach clinics and ECD centres. They found the health workers helpful because they are regular and visit their homes if their children miss receiving these services. In a few districts, mothers visited the district hospital to buy these tablets because they wanted quality services and the health posts did not have these iron, vitamin, and deworming tablets in sufficient quantities. This is because health posts often do not receive supplies from the centre on time. In a few districts, mothers bought iron and vitamin tablets from the regional hospital, as it was closer than the health post. The taste of the tablets affects the uptake of iron and vitamin tablets by children because, according to a few mothers, children do not like the taste.

Most of the children receive Baal Vita. The taste of Baal Vita also affects its consumption, as a few children do not like how it tastes. In some districts, there are also a few misconceptions about Baal Vita. A few mothers believe children will die from it, although they were not able to explain clearly why they felt this. Nonetheless, most of the mothers said they noticed their child had gained weight as a result of consuming Baal Vita. Few mothers were aware that RUTF is also provided for those children who are severely malnourished. They know that RUTF is provided for free until the children are cured. Baal Vita and RUTF are supplied by DEO and UNICEF across the districts. In extreme cases of malnutrition, a few health workers direct mothers and children to nutrition centres in district hospitals. At these centres, both mothers and children can learn about nutrition, while children receive nutritious food to improve their health.

In most of the districts, mothers said they received training on preparing nutritious food using local production in the best possible way. In a few districts, mothers received pulses, beans, and seeds to grow at home and consume regularly. Mothers appreciated receiving this training because they could then cook nutritious food for them and for their children.

Access to nutrition services is dependent on the availability of mothers and children within the village. According to health workers, children often do not have access to services such as tablets and nutritious food such as Jaulo and Pitho because they were not present in the village from the beginning of the programme. As a result, they miss the services provided at the health post. According to a health worker:

Those children who are out of village during those programmes are assumed to be left out of services. Those left out have to wait until next programme to arrive at community. But Baal Vita can be reached any time through the Health Volunteer. Those left out are informed by facilitator herself and the Health Volunteer.

According to a few health workers, children may also miss out on nutrition services if they live in remote areas, and the health posts are far from their homes.

5.4.4 M&E

Assessing the quality of nutrition services is important for M&E of nutrition services because the quality of any service has an impact on its uptake. Across the seven districts, many mothers and workers found the quality of the flour (*pitho*) to be beneficial in the growth and development of their child. As a mother said:

I am happy that SUA AHARA provided those services. It is very helpful for those who are economically weak.

As stated earlier, SUAHHARA is a large-scale integrated nutrition programme aimed at reducing undernutrition and malnutrition among mothers and children in the first 1,000-day period. However, there were some concerns regarding the quality of iron and vitamin tablets provided in a few districts. Some mothers claimed to have received and consumed poor quality or expired iron and vitamin tablets. Misconceptions about the consumption of food supplements also arose as a result of the consumption of poor quality iron and vitamin supplements. This misconception was observed in a few mothers after a few children from a district fell ill after consuming Baal Vita. According to a mother:

In (a place), people have preconception that if someone takes Baal Vita then he/she will die. It is because children vomit after taking it, because they do not like the taste.

In the few districts that had nutrition programmes, some health workers monitored the weight of malnourished children. They then submitted the report to the district officials. As a health worker noted:

FCHV weigh children every month to find out about malnourished children. Even Public Health asks for such report; so the FCHV work accordingly. Otherwise, there is no other or separate evaluation programme.

Nutrition programmes under ECD showed that most mothers and children were able to access various nutrition services, mostly free of cost. A few mothers and children may not be able to access these services if they are not present in the village when these programmes are implemented, or if they live in remote areas. Mothers and children were slightly concerned about the expiration date and quality of the medicine, along with the taste of the tablets and micronutrient foods such as Baal Vita, which affects the uptake of nutrition programmes.

5.5 WASH

This section discusses the key WASH services that are accessible to young children in the ECD centre. This section explores accessibility to these services and the challenges faced by those who are unable to use them. It looks at the sources of funding of these WASH services, as well as their M&E.

5.5.1 Key services

In most districts visited, drinking water and hand washing training were the key WASH services provided by health workers and by the DEO and local and international NGOs. In very few districts, a kit consisting of a brush, toothpaste, soap, a towel, and a sanitary pad were provided at times of emergency. A key WASH service that was observed across all seven districts concerned spreading awareness about cleanliness and hygiene. Education facilitators would teach children about washing hands, washing hands after using the toilet, bathing, brushing, and consuming clean drinking water. Training about hygiene and spreading awareness of cleanliness by organisations such as World Vision was conducted in few of the districts. According to ECD facilitators:

We have taught children about cutting their nails and washing their hands before eating any food. ... We also teach them to wear clean clothes. Most of the time, children don't even comb hair when they come to the centre. So, we teach them to comb their hair and brush their teeth.

The above quote demonstrates the way in which ECD facilitators play a role in teaching children about cleanliness and personal hygiene. In a few districts, some ECD facilitators also taught parents about cleanliness and hygiene. As an ECD facilitator noted:

Although we advise them about sanitation and hygiene, in reality, parents don't have time to be concerned for the sanitation of their children. So, according to the context of this community, on behalf of parents we provide the sanitation service as much as we can.

This quote shows that some parents are not aware of the importance of sanitation, and consequently do not educate children about its importance. As a result, ECD facilitators provide awareness of sanitation among children at the ECD centre.

5.5.2 Cost and funding

According to a number of workers and district officials, there is no cost to WASH activities since they only involve counselling children about hygiene and cleanliness. In some districts, however, a few NGOs supported WASH activities. For instance, according to a respondent:

Root shake Nepal NGO is here. It coordinates with the municipality. It provides sanitary pads to the teenage girls, constructs child-friendly toilets and taps.

The above quote shows there are NGOs that support ECD centres as they collaborate with the local government to provide WASH services. Other NGOs, such as the Himalayan Trust Nepal, the Sunshine Developmental Hospital, UNICEF, and NEWA also provide support in building toilets and constructing drinking taps in the districts.

Although parents do not have to pay for WASH services at the ECD centre, according to a district official, some schools charge a fee to the parents for the helper who looks after the sanitation of the toilet.

There are thus limited WASH-related activities in ECD centres. It appears there are even fewer programmes concerning WASH at the community level, so children not attending ECD centres are likely to have even less access to ECD services.

5.5.3 Access to WASH services

Most of the children received WASH-related counselling from workers at the ECD centres. If children missed school on a given day when they were being told about WASH, they would not learn about these WASH-related issues. Migration is another factor that can influence access to WASH services. As a worker said:

There is one household with no WASH facilities. They have migrated from a different place.

In a few districts, according to mothers, communities that are economically vulnerable do not have access to WASH facilities, such as toilets. ECD centres in most districts had toilets built after the earthquakes (in 2015), but often they did not have water facilities inside the toilets, making it a challenge for children to use them. These toilets would also not have provisions of toiletries, such as soap. In some ECD centres, the toilets were far from the centre, making it difficult for children to access them. According to ECD facilitators, most ECD centres are unable to provide toiletries because of lack of monetary support from the government. In a few districts, young children had to go to nearby water bodies to use water, which would then become contaminated. In some districts, a few school-based ECD centres shared the same toilet with the entire school and the young children from the ECD centre. We observed that in some ECD centres, children found it difficult to

access the toilets because they could not climb the steps to them. ECD centres rarely had clean toilets with water and toiletries, which would make toilets easily accessible for children.

Accessing drinking water is also a challenge for young children at the ECD centre. In some centres, the taps are too high for young children to use. In most districts, the quality of water was not checked or monitored. Due to this lack of access and good quality water, young children often carried water bottles to the ECD centres in some districts.

Although young children receive training and counselling to wash their hands regularly, they do not always follow it, usually because they tend to forget. Some ECD centres ran environmental cleanliness campaigns to increase cleanliness and sanitation awareness among people, although this was rare.

5.5.4 M&E

For continuous uptake of services and hygiene, the M&E of WASH services is essential. A few workers claimed to continuously counsel mothers about maintaining hygiene. However, in most of the sampled districts, there were very few WASH programmes, so there were no M&E programmes either.

To the extent that schools had WASH components, these were claimed to be monitored in line with the M&E of ECD centres. However, our fieldwork did not find any evidence to support this claim that WASH facilities and services were being monitored systematically.

5.6 Protection

This section discusses the key protection services available to young children and new mothers across the seven districts.

5.6.1 Key services

The key services that should be available to mothers and children are birth certificates, allowances provided to Dalit children, and training facilitators to prevent corporal punishment in centres.

In most districts, parents are able to get birth certificates from the ward office or from the VDC. As discussed in an earlier section, parents require birth certificates as some ECD centres need them as part of the enrolment process. We found that, although there is no charge for getting a birth certificate, parents have to pay NPR 50 if they get the birth certificate more than 35 days after the birth of the child. In a few districts, to encourage parents to build toilets in their homes, VDCs do not process birth registration certificates if parents do not have a toilet in their house.

Teaching ECD facilitators about a child-friendly approach can be considered an important intervention related to protection. According to an ECD facilitator:

REED Nepal provided training to us. The major focus of training was ECD and teaching methods. (REED Nepal taught us) how we should love children, (and) not teach them directly, (but by) using another medium, we should be close to the children.

The above quote shows that ECD facilitators received training about how to teach children and how to treat them with care. It also shows that NGOs such as REED Nepal and World Vision play a role in training facilitators. These training go further, including discussing about the role of violence, as articulated by a mother,

During the training given by World Vision, they informed us not to punish children, because they cannot learn and open up if they have fear in their mind. It is their right to play, and (we were told) family should provide nutritious food for them.

The above quote shows that NGOs such as REED Nepal and World Vision not only provide training to facilitators, but also counsel parents about how to take care of children without resorting to violence. Facilitators are taught that they should not physically hurt children. However, a few parents still believe that physically reprimanding children is essential for discipline.

Monetary support to vulnerable children is another important protection service. Children from the Dalit community across all seven districts receive an allowance of NPR 400 per month, according to mothers and ECD facilitators. Most children from Dalit communities receive a regular cash transfer as part of their social protection from the Ministry of Federal Affairs and Local Development, which is provided to the parents. Both male and female Dalit child receive this allowance as long as they are between the ages of zero and five. Some ECD facilitators note that mothers need to open bank accounts to access the Dalit allowance, and that they believe the bank will charge money for this service. In one district, mothers with children between the ages of zero and two received NPR 500 from Kishan Micro Finance. A few districts also had a disability allowance, according to a few district officials.¹⁷

According to a few district officials, there has been an improvement in the reduction of corporal punishment given out by teachers. There is an increased awareness about corporal punishment among both mothers and ECD facilitators. It also shows that most of the children from the Dalit community receive the Dalit allowance. The data also shows that the government is supported by NGOs to train teachers and raise awareness in this regard.

5.6.2 Cost and funding

Parents did not have to pay any direct additional costs to receive social protection services (such as training and awareness) from ECD facilitators regarding corporal punishment or Dalit or disability allowances. Parents only have to pay NPR 50 as a fee for the registration of a birth if the birth certificate is drawn up after 35 days. Across all districts, funding for social protection services are provided by the local government, such as the municipality or the VDC.

5.6.3 Access to protection services

Most of the mothers were able to get birth certificates for their children and said that they received counselling regarding corporal punishment. A few district officials said it was challenging for communities living in remote areas to access these services. It was not always possible to corroborate with other stakeholders about access to social protection services.

5.6.4 M&E

It was found that the DEO was responsible for monitoring of the implementation of social protection services. Since counselling and training of ECD facilitators and parents regarding corporal punishment accompanied other training, it was not always possible to corroborate the M&E of these particular services with other stakeholders.

¹⁷ Children with disabilities are categorised based on the severity of those disabilities.

5.7 Gender and equity

The enrolment numbers gathered from interviews with district officials and workers for sampled schools show that the number of children enrolled in ECD centres does not deviate significantly based on gender. This can be seen in the table below.

Table 32: Enrolment in ECD centres

Site	Total number of Students	Number of male students	Number of female students	Type of school
Site 1	11	6	5	School-based ECD centre
Site 1	15	7	8	Community-based ECD centre
Site 2	25	12	13	School-based ECD centre
Site 2	18	8	10	Community-based ECD centre
Site 3	17	8	9	School-based ECD centre
Site 3	25	9	16	Community-based ECD centre
Site 4 ¹⁸	15	8	7	School-based ECD centre
Site 5	26	16	10	School-based ECD centre
Site 6	8	0	8	School-based ECD centre
Site 7	33	23	10	School-based ECD centre

¹⁸ We do not have the enrolment data for a community-based ECD centre in Site 4.

Site 7	25	19	6	Community-based ECD centre
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This is consistent across all seven districts. Most ECD facilitators and district officials believe that all male and female children are treated equally, and that there is no discrimination between them in school.

Interviewer: Are there any children in this community who do not receive some or any of these services in education, health, nutrition, protection, or WASH?

Respondent: No, there is no one. Every child has access to education, health, nutrition, and protection in this community.

Most mothers also say they do not discriminate between their children on the basis of gender when deciding to enrol them at the ECD centre. A number of facilitators and health workers expressed that they have been trained to treat all children equally, and that they do not observe any disparity between children across gender, class, and caste. Some mothers also say that they have observed a change in the community regarding the school attendance of young girls. As a mother said:

Now people send their daughter as well to school. People won't laugh if anyone sends their daughter to school.

This quote reflects the fact that it is now socially acceptable for young girls to go to school, and that parents who would like their young daughters to study do not have to worry about social consequences in the community.

In terms of inclusiveness for children with disabilities, a district official highlights that there is no specific programme for differently abled children, except that in a few districts the differently abled children receive an allowance from the government. This disability allowance depends on the degree of severity of their disability.

Socioeconomic factors play a role in getting equitable access to ECD for young children. Children from poor or vulnerable social backgrounds are often unable to access ECD centres. This is because some of them live in remote areas, which means the ECD centres are geographically far. Some children are expected to help their families with housework. Some young children also migrate seasonally with their families to make a living, which reduces their attendance at the centre. A school principal noted that usually people migrate to the locality for seasonal employment, so the absence rate can fluctuate tremendously.

There is also a perception that ethnic background also affects ECD participation. According to a school principal, children belonging to vulnerable communities emphasise more on their culture and work rather than attending school. A principal went so far as to state:

Some (ethnic) communities are busy, and they enjoy their (negative) cultural practices over giving priority to education. They do not send their children in on a regular basis. For example, children do not attend school if there is any wedding ceremony or birthday party. They attend school only if they are free and available; otherwise they are busy with other work.

This quote shows a perception that parents from certain communities apparently do not perceive attending an ECD centre to be important, although it is difficult to confirm whether this is actually the case, or whether ethnicity plays a role in this determination.

5.8 Local governance

This section explores the relationship between the local government and ECD centres. This is of particular importance given the expectation in the ECD Strategy Paper that local government would be instrumental in supporting and delivering ECD services to children at the local level.

5.8.1 Funding of ECD services

According to most principals, district officials, and workers, VDCs, and municipalities provide funds to ECD centres for their development. These funds are used to provide various services for children, such as lunch, learning materials, toys, and building construction. A few school principals save the money they receive from the local government in a fixed deposit for emergency expenses, but district officials stress purchasing teaching materials for children before using the money received from the local government for anything else. This is reflected in a district official's quote:

We instruct them to buy necessary teaching and learning material. If they can save some amount, they can use them in other ways, like lunch for the children. But specifically, they should be used for teaching materials.

Very few districts claimed that they received minimal or no funding from the local government. Some principals also rely on internal sources or revenues of the school to run ECD centres, independent of the government. According to district officials, a few local governments provided services to ECD centres such as supplying toys and learning materials, and supporting the construction of buildings, besides providing monetary support.

According to a district officer, the local government should assess and identify the areas where there is a need for ECD classes and run them for the betterment of the children. A few workers believe that there is a need to budget for ECD maintenance so there are opportunities to increase the quality of teacher instruction, a quota for more facilitators, and training for these new facilitators.

At the community level, very few beneficiaries were aware of the sources of funding for ECD services. A few mothers did note that local government provides budget for their ECD centres, and that these funds were used for construction of centres as well as to train teachers.

It appears, then, that local government is involved with the provision of funds to centres, although these might not always be enough to cover all the material and human costs and support required by all ECD centres.

5.8.2 Monitoring of ECD services

According to various district officials and workers, ECD services and the expenditure of the ECD budget are monitored by the government. According to a principal, the municipality monitors all information regarding the budgets of the ECD centres, from the source of the funds to the way they are used. District officials noted that during their ECD meetings, they discuss issues such as whether the ECD centres are operating actively or not, what can be done if there are problems, need for establishing ECD centres in a particular region, moving an ECD centre according to

demand of area, and demand of support provision in ECD centres. The members of the ECD committees monitor the distribution of the ECD quotas to the ECD centres to see if the centres are using the funds and resources efficiently. Most of the district officials say that the meetings are held once every 3–4 months.

District officials claim that they not only monitor the budget, but also how well the government services are being provided. They focus on how regular the ECD facilitators are, their capabilities, and the availability of learning materials within the centre. As a facilitator said:

In most of the districts, the frequency of monitoring by district official ranges from once per year to five or six times per year. These are not carried out on a fixed, structured basis in most cases.

However, even in their claims, very few district officials mentioned any form of joint monitoring of ECD that included a cross-sectoral approach which included monitoring health, nutrition, WASH, and protection with education.

Monitoring of ECD services is also carried out by various other organisations besides the government. NGOs such as REED Nepal come and monitor the performance of children in school and their use of learning materials.

Few beneficiaries across the seven districts are aware of the monitoring processes carried out by the local governments for the ECD centres. Some beneficiaries stated that ECD centres are monitored once per month by SMCs or the local government. They know that those who come to monitor also visit the schools with plans for improvement and talk with the parents of the children. As a beneficiary said:

Yes, they call us and talk about securing future of our children, developing a habit of saving (funds), and not speaking loudly with the children.

To the extent that some beneficiaries know about these M&E activities, they are not actually involved in any form of direct monitoring at the community level. Their engagement in directly informing the design and delivery of ECD services for their children thus appears limited, as their engagement only extends to sending their children to attend these centres.

5.9 Integration

This section discusses the integration of education, health, nutrition, WASH, and social protection sectors in ECD services.

The findings from the qualitative data suggests that there is some integration across sectors over services. We found that education services such as training of facilitators, provision of learning materials, and PCF are provided at the ECD centre by the DEO. These ECD centres also serve as platforms for spreading awareness about sanitation and cleanliness by ECD facilitators, and for nutrition by providing lunch meals for children. Health posts served as a place of dissemination for iron and vitamin tablets, immunisation and vaccinations. Health workers also provided awareness about sanitation and cleanliness to mothers.

All mothers perceived ECD centres as places of education and foundations of learning. They believe their children will learn about good behaviour, sanitation, and cleanliness at the ECD centre from the ECD facilitators and teachers; yet it appears that very few mothers saw ECD centres as a place providing health or nutrition services.

A number of workers and district officials claimed that ECD services are being provided in an integrated way. However, some quotes from the same officials showed that each sector, and even the local government, is responsible for its own area. For instance, a district official noted:

Well, they give their best from their own sector altogether. We do not look at each of the sectors individually; they play their role on their own.

A few respondents raised concerns about integration in a few districts, given their reservations about integration with the ECD services. They believe that to reduce repeated programmes, different sectors should collaborate at the district level because representatives of different sectors bring with them different insights in ECD. A district officer suggested:

When DOHS wishes to launch health, educational (health) and other programmes, they should collaborate with the education sector, because we have our own bodies and policies.

This quote reflects the belief that collaboration could bring intersectoral insights and reduce implementation of overlapping policies. A few district officials believe there is a need for greater coordination and collaboration for intersectoral programmes. As a district official noted:

We are putting our effort into this (integration), but (it) is not going according to our plan. There are many programmes running to make ECD better. Now different organisations and district children welfare office have initiated their programme(s) to make school(s) a peace zone. They make people aware about child rights. They are operating behind the scenes. They are not seen yet. We have these programmes hither and thither because everyone is having their own programme.

As the above quote suggests, greater coordination and integration is required between the sectors because there are a number of programmes being implemented by different sectors, which are not being implemented efficiently due to a lack of coordination.

The review of each of the sectors shows some level of integration among different sectors. For instance, ECD centres can serve as sites for a number of other interventions including health, nutrition, WASH, and protection. There is a greater degree of integration between health and nutrition. Protection services appear to be fairly 'standalone', as they are not directly integrated into the other ECD services. It is not clear from this research whether the same child is receiving all of these services in an integrated, holistic way. Even if this were happening, it would *not* be through a concerted, coherent integrated plan that intentionally targeted all children. Instead, integration of services appears to be accidental at best and non-existent at worst. The opportunities for integration are obvious, as each sector is trying to reach all children, but further efforts are required to ensure that these sectoral approaches can come together in a more holistic, effective way to ensure the provision of ECD to all children.

5.10 Conclusion

The findings from this section provide a complex understanding of ECD provision in Nepal. ECD centres are considered, by both beneficiaries of school and community ECD centres, as a place where their children can develop and grow physically and mentally. Mothers from both types of ECD centre see it as a stepping stone toward higher education and for learning the English language. A few also see ECD centres as places where their children learn about good behaviour, WASH and cleanliness. Few mothers are concerned about the WASH facilities and physical safety when they send their children to both types of ECD centre. For both types of centre, there are access challenges, most notably a lack of documentation and the distance from centre.

Although some district officials and a few workers are aware, most of the beneficiaries do not know the source of funding for ECD centres and other ECD-related services such as health, nutrition, WASH, and protection. A few centres charge a monthly fee and/or an admission fee (and even fewer charge a lunch fee), but public ECD centres also receive monetary support from the Government of Nepal, local government units such as municipalities and VDCs, and other organisations such as World Vision and UNICEF. These organisations not only provided monetary support, but also carried out M&E activities for some ECD services.

For health and nutrition services, it appears that basic services are provided free of cost to most beneficiaries. However, it is essential to provide good quality services not only in the form of tablets and vaccinations but also in the availability of staff and resources at the health centre. This is because lack in quality of health and nutrition services affects perceptions, raises misapprehension about the services, and reduces uptake of the services. For instance, in interviews with mothers, the poor quality of vaccines and vitamins often led mothers to believe that vaccines and vitamins were not beneficial for the growth and development of their children.

Mothers believed that it was good that their children received counselling and advice about WASH and protection from the facilitators at the ECD centres. This also illustrates integration across sectors, although much remains to be done. While some services are being provided in an integrated way, this has not developed into a comprehensive, holistic framework that ensures that each child receives all the key services they are expected to receive as part of the ECD package.

The provision of various services as part of ECD has increased. However, it is clear that each child has not received all of the services they have a right to receive. The gains so far give (potential) beneficiaries hope that ECD provision will continue to be more comprehensive, of better quality, and inclusive of everyone in an integrated, holistic way.

6 Lessons learned and recommendations

This evaluation and analysis of the ECD strategy provides a wide overview of the key issues arising from the development and implementation of the strategy as well as various sectoral programmes and activities associated with it. The ECD strategy was particularly bold and relevant in articulating a comprehensive, holistic vision for the wellbeing of all children of ECD age. As the previous chapter has highlighted, there have been significant improvements in terms of the provision of ECE and health and nutrition services in particular, although disparities do remain, particularly in terms of geography and wealth.

The findings from the evaluation allow us to provide some formative recommendations, particularly to inform the new ECD strategy. Although the lessons are varied and extensive, we have focused on providing five prioritised learnings to guide our recommendations for the next ECD strategy. These learnings and recommendations are intentionally presented here in an integrated way rather than dividing them up according to various sectors. Such an approach, we hope, will facilitate a more comprehensive, integrated approach to thinking about and implementing ECD programmes in the future. In addition to these holistic learnings, sector-specific learnings and recommendations are presented in 0.

6.1 Ownership and integration

A sense of ownership of the entire ECD strategy by each of the relevant ministries is a pre-condition for the successful development and implementation of an ECD strategy. However, there was a lack of ownership of the current ECD strategy by relevant ministries such as the MoH, MoFALD, MoWCSW, and Ministry of Water and Sanitation (previously known as the Ministry of Physical Planning and Transportation). Only an integrated approach to the development and implementation of the strategy can lead to the necessary joint sense of ownership, to ensure that the provision of services is both comprehensive and holistic.

When we refer to integration, we mean that the different line ministries as well as local authorities work together to deliver all the services that each child of ECD age is supposed to receive. This does not mean that each relevant institution provides all the services; instead, each of the relevant institutions provides the service they are supposed to provide, to ensure that ultimately each child receives all services. Ideally, the delivery of each of these services will also be linked to each other. For instance, when a child is born, any health official involved with the process should inform the parents about registering the child with the local authorities as well as providing vaccines to the child. During the process of registration, the parents should again receive the same messaging around vaccination and follow-up doses. When a child approaches pre-primary education age, the health caregivers involved with providing support to such children should inform the parents about options for ECE. For children who are enrolled in pre-primary centres, these centres should be used as sites to provide further health, nutrition, WASH, and protection services.

This explanation of integration is not meant to be exhaustive; it is intended to be illustrative and to demonstrate the way in which ECD provision can be integrated. The design and service delivery can be integrated at each stage, to ensure that comprehensive messaging concerning ECD and all its associated services are being provided to parents and children from conception to five years of age. Under this model, each relevant sector would provide its own services effectively, but also inform the expected beneficiaries about further services (both in this sector as well as other relevant sectors) and ideally provide these services in partnership and collaboration. Such integration would also consider service provision in a consolidated way, so that public institutions such as health posts and ECE centres can serve as sites for the provision of services related to

other sectors as well. The expansion of the roles and responsibilities of local government provides an opportunity to facilitate this integration, as will be discussed later in this chapter.

To be sure, there was a recognition that both ownership and integration were important even during the strategy development process in 2004. Although the MoE took the lead in drafting the policy, officials from the relevant ministries were invited to key meetings and workshops during the drafting phase. The ministries in turn sent a representative to attend these events, but usually it was a different person representing these key ministries at different meetings. Officials who had attended a previous event did not always inform the next person about the key discussions and decisions made in each meeting, something confirmed by multiple ministry officials during our research. This meant that, although each key ministry was represented in theory, the lack of continuity and real ownership resulted in other ministries not being as engaged in this process as the MoE.

Consequently, since other relevant ministries did not have active ownership in the preparation of the ECD strategy, they did not follow the strategy as prepared by the MoE. According to an MoE official familiar with the process:

We [i.e. the MoE] made a mistake because we drafted the policy, and no matter how good the policy, the other ministries felt that they did not have any reason to follow that policy. So it did not matter how good the policy was in the end.

The lack of ownership over the process meant that the ultimate implementation of activities outlined in the strategy fell under the purview of the MoE. However, if engagement from different line ministries, as well as local authorities (see next section), could be ensured, this would enable stakeholders to define a clear division of roles among them.

Such clear understanding of roles and responsibilities along with ownership of the strategy will lead to integration of ECD activities in the formulation of policy, legislation, and budgets, as well as in service delivery. ECD services are currently being provided by different ministries. As a result, organisations working for the holistic development of children mostly delivered their programmes under different banners, and separately. Those separate programmes are often funded through separate channels and operate on separate timelines. It is, however, of the utmost importance to implement an integrated framework for ECD that can be delivered through an integrative approach. Such a process will minimise duplication, enhance accountability, increase community participation, leverage local financing, and provide value for money to achieve greater results.

The new strategy should be developed with the active participation of relevant ministries, with key personnel from each ministry assigned the specific responsibility to develop the strategy. We suggest that a convening body, such as the NPC, should oversee the coordination and development of the policy, to ensure that all the relevant line ministries are actively involved and taking ownership over the key processes related to their ministries. This ownership over the process of drafting the new ECD strategy will then translate into implementation, as activities mentioned in the strategy will be included in the annual work plans and budgets of respective ministries. The ECD strategy should be used as a guiding document to ensure that the annual and strategic plans of each ministry are consistent with and build on the aspirations and expectations highlighted in the strategy.

6.2 Engagement with local government

As Nepal is undergoing an extensive decentralisation process under the new federal set-up, engagement with local government presents a unique opportunity to ensure the holistic

development and delivery of ECD. As numerous respondents noted, while various central line ministries have been responsible for various sectors such as health and education, in the new situation it is expected that local units will be responsible for all these dimensions. Their involvement in the development process is thus even more critical in this changing context.

There is a need to involve local governments in the ECD strategy development process to ensure there is local ownership on the ground as well. Local governments' involvement will be useful in at least two ways. First, representatives from local-level government will bring local knowledge in the drafting process, and they can provide advice on how effectively the activities outlined in the strategy can be implemented. The involvement of stakeholders who have hands-on experience in the strategy development process will thus provide legitimacy to the entire exercise. Second, local government will be able to comprehend and internalise the activities of the ECD strategy, so the involvement of central government can be cursory thereafter.

The Local Governance Act stipulates that rural municipalities and municipalities are responsible for the

Formulation, implementation, monitoring, evaluation and regulation of policies, laws, standards and plans for early childhood development and education, basic education, parental education, informal education, open and alternative continuous learning, and community learning

The exact nature of the implementation of this new policy remains to be seen, but it is clear that local governments are expected to play a central role in the design and delivery of ECD services. From a budgeting and financing perspective, local governments will receive four kinds of grant (fiscal equalisation grants, which are unconditional; conditional grants for federally mandated programmes; special grants; and matching grants) and local governments are expected to prioritise and invest in various sectors. If there is clear engagement with and support to local governments to prioritise investments in ECD, they might be more likely to invest further to expand ECD provision in their constituencies. It is therefore important to consider providing extensive training and support to local authorities to sensitise them on good practices concerning ECD and facilitate their systems and processes to ensure holistic provision of ECD services for all children throughout the country.

This emerging context of decentralisation also raises questions about the need and nature of central-level engagement and coordination in relation to ECD provision at the local level. While being mindful that the devolution process is in its early stages of implementation, we believe there is a need to have a guiding framework and a coordinating body at the national level to provide an overarching outline for the provision of basic ECD-related services. Such a guideline could be useful for local authorities as they prepare their own plans and programmes, including concerning ECD. In the absence of such guidelines, there is a risk that there will be extreme variation in the provision of ECD services based on the different local government units, which could contribute toward exacerbating rather than addressing the various disparities in ECD provision. There is thus the opportunity for a coordinating body like the NPC to develop the next strategy that can guide smooth transition where authority is devolved to the local level but standards are maintained and quality ECD services are delivered in a holistic and equitable way.

6.3 Key services and integrated checklist

The ECD strategy should clearly spell out the minimum ECD services that all children from conception to the age of five years should receive. The developed integrated ECD strategy should clearly state the key services that each child is expected to receive to ensure effective ECD.

Such a service mapping should account for both chronology (that is, the services that a child should receive based on their age) *and* theme (that is, the services a child should receive in each of the key sectors relevant for ECD, including nutrition, health, protection, WASH, and education).

In defining and implementing such a package, we suggest a holistic child-centric, as opposed to an ECD centre-centric, approach to programme delivery. Such an approach would ensure that *all* children, regardless of their circumstances, will be targeted through the ECD strategy, as opposed to only those children who are already part of the ECD centre system. This is particularly important because those students who are not attending ECD centres might precisely be the ones who are most vulnerable and in need of all the other ECD services as well. The learnings from the implementation of the integrated ECD plan in 25 districts can help in devising integrated ECD services. Such an approach will enable Nepal to achieve the SDGs related to reducing neonatal deaths, providing children with a legal identity, and getting them ready for primary education.

In developing such a strategy, we recommend that each ministry responsible for a component of ECD develop a checklist listing the minimum services each child is supposed to receive, and that they maintain oversight over this list to follow up when some children are missed out. Some service providers already maintain such lists (for instance, the vaccination card can serve as a list for some ECD services delivered by the MoH) but these are not comprehensive at this stage. Once all the services that each child is supposed to receive are identified, they should be arranged according to a timeline (beginning at conception and progressing to the age of five, when entry into the school system is expected), and all information related to the provision of all these services can be recorded chronologically for each child in the country. The Philippines can provide one example of how this can be done, as they use a comprehensive ECCD checklist that charts all the services each child receives.¹⁹ As children progress each year, their key ECD indicators are noted and the checklist can be used to easily keep track of the status of each child.

In developing such a checklist of key services, we also recommend ministries develop follow-up and accountability mechanisms to reach those children who might not be receiving those services. Knowing what services children are supposed to receive, and what services they actually receive, is important; however, this should then be the basis upon which action is required to ensure that all children receive all these services, which is the goal of complete ECD service provision. Clearly defining which ministry, and even which division or subdivision within that ministry, is responsible for delivering each service can then facilitate easy follow-up and accountability mechanisms to ensure holistic ECD provision throughout the country.

The development and use of a checklist should not be used as a way to disqualify any child from receiving any of these services. For instance, if a child does not have a birth registration, if the child then comes to a vaccination centre, they should be provided with the vaccine without question – then, follow-up measures should be pursued to ensure the child also receives their birth registration. The checklist should be seen as a way to integrate and improve service delivery, not as a tool to exclude any child from receiving any of these services.

6.4 Integrated M&E system

From an M&E perspective, once the key services have been identified, some key indicators should be agreed to provide guidance on the success (or failure) of the programme from the beginning of the strategy period. Each ministry as well as relevant local authorities should then regularly collect disaggregated data on those indicators through the relevant MIS, to ensure this information can be

¹⁹ In the Philippines, the term early childhood care and development (ECCD) is used more commonly than ECD.

analysed to assess and evaluate the performance of the programmes as well as to inform the design and delivery of future programmes.

If the design, development, and implementation of the M&E framework is prepared as part of the new ECD strategy, then data collection and analysis will be much more effective. Carrying out an evaluation after the completion of a strategy that lasted for 11 years, which was carried out two years after the stated end of the time period of the strategy, made it extremely difficult to collect and analyse relevant data across different sectors. In addition to the ease of carrying out an effective evaluation, the concurrent development and use of an M&E framework alongside an ECD strategy from the very beginning would also allow for regular checks and feedback to provide course correction to help improve programme implementation on a real-time basis. The M&E framework should also include process evaluations to assess the design and implementation of ongoing activities across the different sectoral and cross-sectoral ECD activities, and to provide course corrections as necessary. The framework should also include more relevant quality indicators so that the focus is not only on access and participation.

6.5 Credible resource plan

The minimum ECD services spelled out in the ECD strategy should be backed by a credible resource plan as well. There should be a strong political commitment to allocate the required resources to deliver this ECD strategy. The current level of ECD financing in Nepal is insufficient to meet the needs of the population (World Bank, 2013). As already discussed, the budget for pre-primary education constitutes between 1% and 3% of the total public expenditure on education, representing less than 0.1% of GDP. The OECD suggests that public investments represent a minimum of 1% of GDP to ensure quality ECCE services (World Bank, 2013). Similarly, the budget under Health and Nutrition is around NPR 52,22,056,000. The total expenditure in ECD services related to education, health, and nutrition is around 0.34% of GDP. The annual expenditure on ECD should be increased many times to achieve the desired results.

This significant deficit suggests a need for innovative financing. Communities should be mobilised so that community members can make both financial and non-financial (labour) contributions, although these are still likely to not be enough. Local-level government can also levy taxes on goods and services to provide ECD services in their area. The ECD strategy could envision resource allocation on a certain formula using indicators such as the geography, population, and HDI of that place.

There is limited evidence to suggest that the ECD strategy, and the subsequent ECD programmes designed to contribute toward this strategy, were appropriately and comprehensively costed. Once each of the services is mapped out per child, ministries should assign the corresponding budget required annually to ensure that the funds are available to deliver to the strategy throughout its life cycle. In making this assessment, it is not only financial but also human and material resources that should be discussed, as they are instrumental for service delivery.

Such a development of a resourcing plan could also provide guidance to local authorities as they assume greater responsibilities concerning ECD provision at the local level.

6.6 Specific focus on deprived children

The ECD strategy should clearly outline both supply- and demand-side initiatives to enhance access for deprived children. The strategies should be formulated after analysing the determinants of children who are currently deprived of ECD services. These determinants could include age, gender, caste, poverty, disability, and geography. For example, the percentage of

children attending ECE for poorest households is 41.2%, while for the richest it is 83.5% (NMICS 2014). Supply-side initiatives such as establishing ECD centres within 15 minutes distance from households from the current ECD strategy should be retained (though it might be necessary to provide guidance on how this can actually be achieved logistically and financially). Based on the ongoing ECD mapping process, the number of ECD centres required in the community could be finalised. There might be a need to separate ECD centres from schools, as the tendency of schools is to focus on upper grades for excelling in high-stakes examination such as the end-of-year exams after Grade 10 or Grade 12. According to a DoE official, *'From the perspective of psychology and development, ECD (children) and Grade 12 children should not be housed in the same place.'* On the demand side, a comprehensive communication strategy could be developed and social networks such as women's and Dalit networks could be utilised to create awareness as well as increase household demand for ECD services. One of our respondents noted that no one is focusing on increasing access for children with disabilities, which causes further concerns about equity in ECD access and experience.

It appears in some ways that the ECD strategy was prepared based on the conventional notion of an ideal family, with both parents available for child caring and rearing. It did not foresee the development, protection, and learning of children living in institutional homes, in prison with convicted parent/s, in foster care, or in single parent households. As a result, the MoE's ECD programmes hardly collaborated with ECD providers catering to children living in unconventional situations. Future strategies should be more inclusive and accommodating, to ensure that the most vulnerable children are not missed out.

One of the ways to contribute to improving quality for all children could be to strengthen existing M&E systems so as to better understand the state of ECD in the country. The MoE has initiated the collection of child-level data, which contains an array of information on children. According to MoE officials, however, this information is collected only for reporting purposes and its use has not been ensured for planning purposes. Going forward, the next strategy could outline mechanisms to use the collected information for planning purposes as well. Our findings suggest that there is a severe dearth of data, especially as concerns ECD. For instance, most of the data on WASH and protection is not disaggregated by age, and even in health, nutrition and education it is extremely difficult to determine the exact information for children under the age of five. Similarly, gender-disaggregated data is difficult to trace in these sectors. Such data deficiencies make it difficult to first determine and then address quality concerns regarding ECD provision, especially to ensure equitable and meaningful service delivery for all. If data were to be made available at the level of each child, through cooperation between different ministries, then it would be possible to track the individual needs of children and intervene where necessary. The ECD checklist mentioned above could help in this regard, ultimately helping assess and then provide quality ECD services to all children. Through close monitoring and timely interventions, the next ECD strategy should explicitly endorse initiatives to close the gap in terms of access to and quality of ECD services for *all* children. Throughout this report, we have been able to document the lack of uniformity in accessing quality ECD services, with gender, proximity to cities, education of parents, and wealth all playing mediating roles in determining ECD outcomes.

6.7 Emphasis on quality

The next ECD strategy should explicitly address the quality of ECD services available to children. The quality of children's outcomes as measured by the ECDI is low for Nepal. Only 64.4% of children in Nepal are developmentally on track according to this indicator (NMICS 2014). The next ECD strategy should focus on improving the quality of outcomes for ECD children. In the words of one of our respondents:

Service delivery is weak and there are several issues in providing quality services. The question then arises – how to improve the quality of services?

The next ECD strategy should clearly outline quality standards and control mechanisms as well as define clear roles for the agencies involved in quality assurance. There is an issue here about what constitutes quality in the first place. For instance, many parents and even teachers consider ECD to mean school preparation, and treat ECD centres as downward extensions of the school system. They consequently focus on paper and pencil-based tests and exams. However, young children are supposed to be playing and learning through alternative methods rather than focusing on tests and exams. Such good practices were often identified as problems by many parents during our research, which demonstrates that quality is contested. More will need to be done to explain and demonstrate what constitutes quality ECD so that this can then be delivered effectively.

7 Conclusion

The report has presented our key findings in relation to the four research questions. This chapter provides a conclusion by summarising the main findings, presenting them in relation to the adapted DAC criteria. The chapter therefore provides further guidance on relevance, effectiveness, efficiency, interim outcomes, sustainability, and gender and equity. Each of these themes is discussed in turn in the following subsections.

7.1 Relevance

It is clear from our evaluation that the ECD strategy is extremely relevant to the present context of the development of children in Nepal. The development and wellbeing of children is critical to ensuring an environment in which they can grow and thrive effectively, and we have already discussed the importance of ECD services in facilitating this process. The strategy was developed with extensive cross-sectoral inputs and discussions, with the key sectors relevant to ECD provision all accounted for as part of the strategy.

The relevance of the focus on ECD extends further to each of the key sectors associated with ECD. For instance, the MoE's focus on improving and expanding services through ECD centres was timely in terms of improving access to pre-primary education, which is considered critical not only in terms of school readiness but also for the holistic development of children. Similarly, in a country that has not yet achieved universal coverage for safe deliveries and vaccinations, efforts to reach all pregnant women, mothers, and children were critical to ECD provision. Incentives such as provision of cash for institutional deliveries and regular health check-ups for newborns have supported better health provision within ECD. The availability of feeding programmes in pre-primary schools helps not only with malnourishment but also pre-primary enrolment and attendance. Other malnourishment programmes, run in partnership with health sector actors, help with the overall development of children. Similarly, the provision of WASH services, particularly through ECD services, is crucial in supporting behaviour change that promotes better sanitation and hygienic practices. Finally, protection services are also critical in a context where children suffer from extreme poverty, face adverse conditions (including in schools, where corporal punishment is still common), and are at risk of hunger.

Within this wider context of deprivation, the focus on the provision of ECD services remains as relevant today as it did during the launch of the ECD strategy in 2004. The need to provide these services in an integrated way is particularly relevant, and although this was envisioned and articulated by the strategy, this was not implemented effectively in practice.²⁰ It is clear that not all children of ECD age are receiving all the services they are supposed to receive as part of the ECD package. There are also clear concerns particularly regarding equity, given the variations in access and outcomes based on a number of factors (such as gender, geography, proximity to urban areas, and so on). As such, there is an urgent need to ensure that the provision of ECD services extends further so that the rights of all children are guaranteed, and they receive the early support they need to grow and prosper. The relevance of the previous ECD strategy is thus not in question. If anything, the challenges faced in the implementation of the strategy, as discussed throughout this report, highlight the critical need to develop and implement an even more targeted and effective ECD strategy to meet the need of all children to receive quality ECD services.

²⁰ The implications of this lack of integration will be discussed further in the next subsection on effectiveness.

7.2 Effectiveness

The findings from this evaluation paint a mixed picture in terms of the effectiveness of ECD programmes and the ECD strategy in the period 2004–2015. The messaging on ECD appears to have been effective, as respondents at all levels – community, school, district, and national – demonstrated appreciation for the fact that ECD encompasses a holistic approach to ensuring the all-round development of children. Education, health, and nutrition in particular were regularly associated with necessary interventions that comprise ECD. Nonetheless, some beneficiaries, particularly parents, still consider ECD in narrow terms, believing it to be primarily concerned with education and school preparedness. Although education is of course a crucial component of ECD, the purpose of ECD is not only to prepare children for school; a more comprehensive formulation of the purpose and importance of ECD thus remains to be communicated effectively to all key stakeholders.

The effectiveness of Nepal's ECD policies is hindered most by the lack of integration of ECD services as envisioned by the ECD strategy. Although the policy captures the necessity of integrating key services, in practice all stakeholders agree that the ECD agenda has been driven by the MoE. The drafting of the ECD policy included stakeholders from other key ministries as well, but their participation was not continuous and substantive and thus these ministries did not take the same ownership over the ECD agenda. There was unanimous agreement that the MoE led and owned the ECD agenda, and even MoE officials commented that this was a key oversight in the design and drafting of the ECD strategy. Although the strategy outlined key responsibilities for various ministries, including MoFALD, the MoH, and other line ministries, in reality their roles and functions in delivering the ECD strategy were extremely limited.

This lack of coordination and shared ownership over the ECD agenda has undoubtedly limited the effectiveness of the ECD programme. The key sectoral strategies and policies, programmes, and activities rarely reference the ECD strategy explicitly. Again, all the key sectors deliver programmes related to ECD and targeting the right age group, but these are not cross-referenced against the design and delivery of the strategy itself. As a result, it has not been possible to ensure that each child receives all the key interventions they are expected to receive to facilitate their development. For instance, although each of the line ministries has continued to carry out various programmes for children up to the age of five, the lack of coordination and integration has meant that each child has not necessarily benefitted from each of these services. The ECD strategy also envisioned that local governments would be at the forefront of assessing and delivering the expansion of ECD services at the grassroots level. Our findings suggest, however, that although local governments played some role in disbursing funds, they were not effective in actively assessing ECD needs and priorities to ensure the successful delivery of the ECD programme.

Despite this situation, Nepal's ECD programme has still been effective in a number of ways. For instance, most children over the age of four now attend ECD centres, whose reach and presence have increased in the last decade. Similarly, health services such as birth preparedness, immunisation, and illness management are also readily available to pregnant women, mothers, and newborn and infant children. Public health posts usually offer iron tablets, deworming tablets, vitamins, and multiple micronutrient powder for children, while nutrition rooms and centres in hospitals treat children suffering from malnutrition. Most ECD centres have WASH facilities, although their quality and the availability of pure drinking water appear to be continuing constraints. Protection services have also become more expansive, and there is a growing understanding about the services necessary to ensure the safety and wellbeing of children, both at centres and at home.

7.3 Efficiency

The lack of availability of relevant data has made it difficult for us to assess fully the efficiency of the ECD strategy. This has been discussed at length with NPC and UNICEF over the course of the evaluation, and all stakeholders have acknowledged the limitations particularly regarding the extent of this analysis on efficiency.

The allocation of funds for ECD in education has increased about five-fold in the last decade, demonstrating the increased emphasis ECD has been receiving in recent years. The share of ECD as a percentage of the total education budget also increased from 0.5% in 2005 to 1.47% in 2015. In education, the expenditure of budget allocated for ECD is more than 95% in the last decade, demonstrating a high level of use of the allocated funds.

Households contribute the highest in terms of ECD expenditure, accounting for about 60% of all spend on ECD. They are followed by the MoE (19%) and complemented by NGOs (3.1%), internal sources (3.1%), and MoFALD (2.6%). When this data is disaggregated to account only for school- and community-based ECD centres, households contribute only 9.9 and the MoE accounts for over 42% of total expenditure. The expenditure for pre-primary education can be broadly divided into teaching activities, services, and general administration, with 56% of total expenditure for salary of teachers, 42% for salary of non-teaching staff, infrastructure, and general administration. About 2% of expenditure is for other expenses, including teaching and learning materials such as textbooks.

The total *per capita* financing needed to send a child to ECD is around NPR 7,000 per year. This is more than three times more expensive in private/institutional centres, where it totals about NPR 21,500 per year. Unfortunately, comparable data for school- vs. community-based centres was not available for analysis, but we found that parents and community members are usually expected to contribute more in community-based centres. We were only able to visit four community-based centres in the seven sites, and the funding they received was neither streamlined nor consistent. Some of the community-based centres were also supported by NGOs while others were not. As such, it was not possible to determine the cost-effectiveness of community-based vs. school-based intervention approaches at this stage.

The proportions of the budget for health and nutrition have also increased steadily, although the breakdown of this distribution for ECD-specific activities is not available, as discussed in sections 4.2 and 4.3.

The lack of disaggregated data makes it difficult for us to analyse the efficiency of spend on WASH and protection activities. There is a significant gap between the budget allocated and the budget required in WASH, and although this is not differentiated based on age of beneficiaries it is reasonable to expect that this gap will affect service delivery for ECD-aged children as well. The findings from the evaluation, which demonstrate the lack of WASH facilities and availability of pure drinking water, even in school-based ECD centres, corroborate this finding.

7.4 Interim outcomes

There has been some significant improvement in terms of ECD provision during the period of the ECD strategy.

The GER for ECD has doubled from about 40% in 2004 to 81% in 2015, passing the target of 80% set out in the Strategy Paper. The number of children enrolled in ECD has also almost doubled, from 512,151 in 2004 to 977,365 in 2015. The percentage of ECD centres within 30 minutes of households increased to 88.8% by 2011, and the average time taken to reach ECD centres has

decreased to 19 minutes. The number of ECD centres increased from 4,032 in 2004 to 35,991 in 2015. Although still below the target of 74,000 centres, this is nevertheless a significant increase in terms of sheer number of ECD centres.

Some improvements have been noted in health and nutrition as well, although these have been more modest compared to ECD attendance rates. There has been an overall increase in the number of pregnant women seeking proper ANC, with women receiving four ANC sessions rising to 54.1% in 2015/16 from 44.1% in 2004/05 – although this falls short of the target of 80%. The percentage of institutional deliveries in Nepal increased from 11.3% in 2004 to 55.1% in 2015, surpassing the target of 40%. The government has initiated a programme providing additional benefits to women delivering in health facilities, which has improved the provision of safe delivery services and institutional delivery. There has also been an increase in the number of women completing PNC, from 30.4% in 2004 to 54.5% in 2015. A significant number of newborns did not receive any PNC visits, however. There was significant regional variation as well, ranging from 17% in the Mid-Western Mountains to 75% in the Central Hills.

Nepal achieved its MDG of reducing the under-five mortality rate from 54 per 1,000 live births to 34, but substantial disparities remain in terms of urban/rural location, mother's education, household wealth status, and between regions. Although immunisation programmes have been effective, the percentage of children vaccinated against polio3 has remained similar in the last 11 years, at around 80%. The coverage of the major vaccines (BCG, DPT-Hep, B-Hib-e, Polio3, and measles) has been quite high for the last decade, and this has been maintained through 2015 as well. Although 67% of children aged 12–23 months had received all recommended vaccinations by their first birthday, this coverage is low compared to the target of 90%.

Nepal has pioneered the implementation of a multisectoral approach to undernutrition. The 2009 Nutrition Analysis and Gap Assessment resulted in the formation of an MSNP in 2011 to address malnutrition in pregnant women and children under five. This MSNP for improving maternal and child nutrition and reducing chronic malnutrition was prepared by five government sectors, under the leadership of the NPC and in collaboration with development partners. It offers a package of interventions with priority strategic objectives through a sector-wise approach that, over a period of five years, should contribute to a reduction by one-third in the current prevalence rates of chronic malnutrition.

The percentage of children who had a growth monitoring visit increased to 78.2% in 2015 from 54.4% in 2004. Nepal has made significant improvements in reducing the prevalence of stunting, wastage, and emaciation in the 10 years from 2006 to 2016, with the stunting rate decreasing to 36% from 57%. However, the MDG target was to be down to 28% by 2015. Similarly, the wastage rate decreased to 10% from 13% in that 10 years. Finally, the underweight rate decreased from 39% to 27%. Some 60% of all newborns were weighed at birth. Of all births, 24% of infants were estimated to weigh less than 2,500 grams (i.e. classed as underweight).

According to NMICS (2014), almost all (97%) newborns in Nepal were breastfed at some point after birth. However, only 49% started breastfeeding at the recommended time (i.e. within one hour of birth). Some 57% of infants under six months of age were exclusively breastfed and 75% received breastmilk as the predominant source of nourishment during the day prior to the survey. Boys were more likely than girls to be exclusively breastfed.

There has been some progress in WASH as well. Access to improved water sources increased from 81.8% in 2006 to 95% in 2016. The proportion of the population using improved sanitation facilities increased from 39% in 2005 to 82% in 2015, surpassing the MDG target of 53%. There are still significant regional differences in terms of sanitation facilities, as exemplified by the findings on households by types of toilets, with Mid-Western and Far Western regions showing

deprivations in sanitation (as well as health and education). Although the quality of water sources appears to have improved, around 71% of households are still at risk of *E. coli* in Nepal.

The integration of protection services into the ECD strategy has taken place in a circuitous way, so it has been difficult to assess the interim outcomes in this sector. A lot of different acts and policies have been put in place to address the protection of young children, and this is a welcome development. The approach for ECD provision in general has shifted toward creating a safe, caring environment for children, which can be considered a move toward ensuring the protection of children.

Although ECD services are provided according to age, the Strategy Paper does not stipulate a standard or system to ensure birth registration of children. As a result, only 56% of children aged below five years are registered in the government system. Although there has been a steady increase in the number of birth registrations, there was no evidence to suggest that this was a result of the ECD strategy. The child grant scheme, which was introduced in 2009/10, has been a milestone in ensuring the right to protection of Nepali children. Although the ECD Strategy Paper does not focus on providing cash support to individual children, the expansion of this policy has played a key role in supporting the wellbeing of children and could ultimately facilitate their ability to attend ECD centres, which is the focus of the ECD paper.

The interim outcomes as a result of the ECD strategy are different based on the sector in question. Some significant progress has been made in education, health, and nutrition, but these gains are not uniform across different ecological zones. The situation concerning WASH and protection is even more difficult to ascertain, because of the lack of disaggregated data as well as the fact that these sectors have not been integrated as effectively through the ECD strategy. It has also not been possible to ascertain confidently the relationship between the ECD Strategy Paper and the outcomes in each of these sectors, as the link has not always been explicit between the strategy and the sectors. Nonetheless, there is general progress in each of the sectors, and this could be consolidated further if the next strategy is more coordinated, integrated, and explicit about the areas to address in the future.

7.5 Sustainability

The sustainability of most ECD services appears to be secure, given the strong will and commitment to expand and improve ECD services for all children among all key stakeholders. In particular, the provision of services related to education, health, and, increasingly, nutrition has improved significantly in recent years, and this trend appears set to continue.

The government accounts for a significant proportion of spend on the public provision of ECD services. Public ECD centres, and particularly school-based centres, receive substantial funding and some support from local as well as central government, and the commitment to ensure that all children attend ECD centres before starting primary school appears to be taking hold even among parents and communities throughout the country. The Constitution also mandates that basic education is free and compulsory, and pre-primary education is considered to be a part of basic education. However, households do not currently face any immediate or obvious repercussions if their children do not attend basic education, so the implementation of this declaration might not be as effective as desired.

Although the support of NGOs is often critical, including in reaching people and communities who are marginalised, their financial contribution at the local level appears to be limited, so the immediate viability of the ECD centres does not appear to be dependent on external funding. Nonetheless, it is clear from our findings that the level of funding available to ECD centres has to

increase significantly to ensure the sustainability and quality of these centres. This additional funding is urgently required for two reasons. First, there is still a small but substantial minority of children who are not reached by current ECD centres, and the distance from their nearest centre appears to be the key reason for their non-attendance. Second, the quality of ECD provision could be improved, as numerous centres currently operate on a very small stipend for facilitators (which is not always enough to attract the right facilitators), few materials and play resources, and limited training and support for key personnel. A systematic, extensive combination of pre-service and regular in-service training for all ECD facilitators would improve the quality of ECD provision, which could in turn improve the quality and experience of ECD for all children.

The sustainability of community-based ECD centres could be more challenging, given the way these centres have been understood at the local level. Respondents mentioned that their understanding is that all community-based centres have to be associated with a primary school, which should have some oversight over these centres. Although this was meant to ensure that all centres, including community-based centres, received support from the school system, it has been interpreted to mean that all community-based centres have to be a part of a primary school. As a result, it appears that community-based centres are now becoming incorporated within the school system. This could have significant implications in terms of the expansion of ECD services, as ECD provision around schools would be reinforced while community provision in areas where schools have limited reach might be threatened.

The commitment for the expansion of health and nutrition services is also firmly in place. Most services are available to most mothers and children free of cost, but it is likely that universal access will always be challenging given the topography of the country. Nonetheless, alternative modalities of healthcare delivery, including increasing use of health volunteers and mobile health camps, could ease the burden in these areas.

For education, health, and nutrition, the key challenge for the next strategy is to identify mitigating plans to ensure that the minority of people who are missing out on receiving these services are somehow identified, targeted, and ultimately served. Although the rate of penetration of these services is relatively high, the commitment to reach every child from the perspective of a human rights approach requires a concentrated effort to ensure a strategy that is geared toward reaching those who are currently not receiving these services. This higher demand requires not just the sustainability of the current approach but also an additional push to capture those currently missed by the current provision system.

The sustainability of the WASH and protection components appears to be under greater duress. The current provision of these services appears to be inadequate, as their reach is still limited in real terms. A concerted funding effort is now required to provide resources as well as training and support to facilitate behavioural change to ensure that communities adopt better hygiene and sanitation practices. To ensure the sustainability of these programmes, they should not be imposed from above but rather developed in a consultative manner, building on existing social and cultural norms and practices. Such an approach is likely to be more effective, and it would also be more understandable for the targeted beneficiaries. In terms of protection services, the government appears committed to expanding the universal child grant, as announced in the budget speech in 2017. The programme is currently being piloted in some districts with the intention of reaching all districts very soon. This expansion would not only provide necessary resources to households with children but also reinforce the belief that Nepal places a high value on their care and wellbeing. The provision of social protection funds targeted at children is also expected to contribute toward better ECD opportunities for them, so the provision of a universal child grant under the government's social protection system could significantly bolster the sustainability of ECD in the country.

Although we have discussed here the sustainability of each of the sectors comprising ECD, the sustainability of a holistic approach to ECD remains to be established. This evaluation has followed the path forged by the national ECD programme, which has remained sectoral and fragmented. As a result, the provision of ECD has not been holistic or comprehensive enough to ensure that each child receives all these services from conception to five years of age. The sustainability of holistic ECD thus remains an open question, and the next strategy will have to address this concern substantively.

Recent political developments in Nepal present a unique opportunity to further entrench the sustainability of ECD, as well as the realisation of the SDGs. For the first time, these goals incorporate specific ECD indicators as measures of success at the international level, demonstrating the high value the global discourse now places on ECD. As a federal republic, Nepal is now undergoing a decentralisation process, where service delivery is expected to be streamlined at the local level, with local government taking ownership over the entire process. As such, although line ministries can have sectoral approaches to delivering services, there is an opportunity for local government authorities to coordinate and drive the integrated, comprehensive ECD agenda. This does require a lot of capacity building, as, while local governments might be more sensitive to local needs, they are also perhaps more entrenched in standard methods of service delivery. Should they be successful, they could provide holistic support to all children, which would lay the groundwork for the success of all children to develop fully and contribute directly toward meeting other related SDGs.

7.6 Gender and equity

This evaluation has sought to account for gender and equity throughout the analysis. We present some of the key findings here.

A total of 51.9% of all boys between the ages of 36 and 59 months are currently attending ECD centres. This ratio is slightly lower, at 49.4%, for girls. In terms of the GER, boys and girls were attending ECD centres at the rate of 41.4% and 37.3% respectively, but these rates increased to 81.2% for boys and 80.9% for girls by 2015. Respondents across all types noted consistently that they felt that both boys and girls should attend ECD centres. The percentage of children with ECD experience in Grade 1 was also almost identical, with 62.5% of boys and 62.3% of girls with ECD experience.

In terms of their performance in ECD-related indicators, the performance of girls appears to be consistently better than boys, as demonstrated by the table below:

Table 33: ECDI performance by gender

	Percentage of children aged 36–59 months who are developmentally on track for indicated domains				ECDI score
	Literacy/numeracy	Physical	Socio-emotional	Learning	
Total	28.8	96.4	68.6	81.6	64.4
Sex					
Male	27.5	96.1	65.8	81	62.4
Female	30.2	96.6	71.4	82.2	66.6

It appears, then, that there is very little difference between girls and boys in terms of attendance ratios, and that girls perform better than boys in literacy/numeracy as well as physical, social-emotional, and learning indicators. This is reflected in the disaggregated ECDI score, with girls receiving 66.6 and boys receiving 62.4.

There are also significant variations in terms of the achievement of pre-primary children based on geographical regions. For instance, the GER for Mid-Western region is only 70, whereas for the Western region it is 100.6. Similarly, the percentage of children aged 36–59 months who are developmentally on track for literacy ranges from 14.9% (in Central Terai) to 50.2% (in Central Hills). The ECDI score is also lowest in Central Terai (45.7) and highest in Central Hills (84.2). This significant variation is demonstrative of the fact that equity of outcomes remains a serious challenge. This also reflects the need to collect more disaggregated data to allow us to make meaningful comparisons based on caste, wealth quintile, proximity to urban centres, and so on.

There is little difference in receiving health and nutrition services in terms of gender and equity. There are some variations in male and female child mortality according to NMICS (2014). Among the total 23 deaths per 1,000 live births, there are 21 female and 24 male child deaths per 1,000 live births (NMICS, 2014). The data also varied with mother's education level and the wealth index quintile. Neonatal mortality ranges from 12 to higher educated mothers to 26 among non-educated mothers. Similarly, there are 14 deaths in the richest families but 32 deaths in the poorest.

Immunisation status also varied by the sex of children, with 86.3% male and 82.4% female children receiving the full range of vaccinations by the age of 12 months. Vaccination is also affected by the education of mothers, as 89% of children having mothers with higher education and 80.6% of mothers having no education received their full vaccinations. Similarly, 92.7% of children were fully vaccinated in urban areas but only 83.4% of children in rural areas.

There were some variations in nutrition status according to the sex of the child, geographic region, and the education level of the mother. Underweight children ranged from 20% in Eastern Terai to 33% in Mid-Western Mountains. Among them, 28.8% of boys and 31.1% of girls are underweight. Children with educated mothers were the least likely to be underweight, stunted, or wasted, compared to children of mothers with no education, demonstrating the importance of parental education in relation to the health and wellbeing of parents and their children.

Clear linkages could not be established between WASH and protection outcomes in terms of gender and equity, as most of the available information regarding the protection situation was neither disaggregated by age nor by gender. For instance, birth registration data were reported in totality, and information regarding registration of children born in the reported year was not disaggregated. This made it difficult to understand to what extent the right to identity and citizenship of female and male infants as well as ECD children has been ensured. The ECD Strategy Paper itself did not have specific measures to address issues related to gender and social equity in connection with the protection rights of ECD children. Even research and evaluation studies related to the effects of the child grant hardly address gender differences in terms of uptake and implications.

Data related to WASH facilities were also not disaggregated by gender or age because generally most such facilities are used or consumed by all the members of a household or community, and there cannot be separate facilities for ECD children. Although this could have been possible in relation to ECD centres, data were hardly available related to WASH facilities specifically at ECD centres.

As such, although we have sought to understand gender and equity concerns in ECD services, it is clear that more could be done in the future to have a clear policy, matched with a set of agreed, disaggregated indicators, to ensure greater focus and understanding of these issues.

7.7 Summary

This evaluation has provided a comprehensive review of the ECD strategy, as well as the sectoral plans and programmes of relevant line ministries and sectors associated with ECD. Significant progress has been made in all sectors. In particular, the expansion of ECD services in education is noteworthy, and there have been consolidated gains in health and nutrition as well. Although progress has been made in the protection and WASH sectors too, gains there appear to be modest and more effort and resources are needed to extend them further. In all sectors, a small but sizeable proportion of children remain deprived of these services, which presents a challenge in terms of designing and implementing programmes that will ensure such children are reached immediately. This is particularly important from a human rights perspective, to ensure that gender and equity considerations are also addressed.

Despite these gains, the fact remains that ECD provision in Nepal remains sectoral. In effective terms, the understanding of ECD has been reduced to ECE, and to the extent that service delivery is integrated, it is often accidental rather than intentional. Despite multiple ministries providing services to children that could be considered integral to holistic ECD, the strategy and conception of ECD has rarely been explicitly acknowledged in the various annual and strategic plans and policies of these ministries. There is currently no mechanism to ensure that each child receives all the services they should be receiving under ECD.

The findings from this evaluation can provide timely feedback for the development of the next ECD strategy. The successes that have been achieved during the previous strategy can provide the impetus to propel further action and achievements in this sector. The political will and commitment to ensure a comprehensive, integrated, and holistic ECD programme for all children is clearly in place, and a concerted, coordinated effort is now required to ensure that this vision can become a reality under the new ECD strategy.

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Annex A Evaluation ToR

(See attachment)

Annex B Literature review

(See attachment)

Annex C Data analysis

(See attachment)

Annex D Sectoral learning and recommendations

(See attachment)