**PROJECT INFORMATION DOCUMENT (PID)**

**APPRAISAL STAGE**

Report No.: AB5068

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| Project Name | Second HNP and HIV/AIDS Project |
| **Region** | SOUTH ASIA |
| **Sector** | Health (100%) |
| **Project ID** | P117417 |
| **Borrower(s)** | GOVERNMENT OF NEPAL |
|  | Ministry of FinanceSingh DurbarNepalTel: 977-1-425-9820 Fax: 977-1-425-7854 |
| **Implementing Agency** |  |
|  | Ministry of Health and PopulationSingha Durbar, Kathmandu Nepal |
| **Environment Category** | [ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined) |
| **Date PID Prepared** | February 1, 2010 |
| **Date of Appraisal Authorization** | January 27, 2010 |
| **Date of Board Approval** | April 20, 2010 |

1. **Country and Sector Background**

Nepal is a landlocked country with an average per capita GDP of US$470. Its population of 28 million is culturally, ethnically and religiously diverse, comes from more than 100 caste/ethnic groups, and speaks more than 90 languages and dialects. There are three distinct eco-zones- the mountains, the hills and the *terai* plains - running north to south and five east-to-west development regions. Poverty is widespread with 31 percent of the population living below the poverty line, but increases to 35 percent in rural areas where about 85 percent of the population lives. Various forms of social exclusion based on caste, religion, gender, language and ethnicity have exacerbated poverty with higher poverty rates among minorities, lower caste and tribal groups.

The country emerged from prolonged conflict with the signing of the Comprehensive Peace Accord in November 2006, laying out a roadmap to a lasting peace and the construction of a new governance structure. Constituent Assembly (CA) elections were peacefully held on April 10, 2008, creating the structure to draft a new constitution. The political system remains unsteady and the security environment remains delicate.

Despite the decade-long conflict, Nepal has made significant strides in reducing poverty in the past decade. The head count poverty rate decreased dramatically from 42 percent in 1995/96 to 31 percent in 2003/04. The incidence of poverty in urban areas declined from 22 percent to 10 percent, while poverty in rural areas also declined notably from 43 percent to 35 percent, but remains high.

In 2004, donors began supporting a sector-wide approach (SWAp) in Nepal to reduce transaction costs to the government by aligning external support with the Government of Nepal’s (GON) health sector planand strengthening harmonization among the development partners in the health sector. Under the GON’s leadership, the donors support a common sector program – the Nepal Health Sector Program. The performance of the program is jointly reviewed by all stakeholders on a yearly basis. All the main health donors[[1]](#footnote-1) are participating in the SWAp. IDA, the Department for International Development, UK (DfID) and the Australian Agency for International Development (AusAID) are currently pooling funds. Nepal is also one of the seven first-wave countries to benefit from the International Health Partnership (IHP). This partnership strives to further consolidate harmonization and further strengthen the SWAp. Reviews of the current sector program concluded that it is performing well and has achieved good progress.

The health sector has made impressive progress in the past few years**.** Infant mortality declined by 39 percent over the last fifteen years from 79 deaths per 1,000 live births in 1991-94 to 48 deaths per 1,000 live births in 2001-2005 (DHS 2006). An even more impressive decline was observed in under-five mortality, which declined by 48 percent from 118 to 61 deaths per 1,000 live births over the same period while neonatal and postnatal mortality also decreased by 34 percent and 48 percent, respectively. Further declines in mortality rates were confirmed by a recent survey showing infant and under-five mortality declining to 41 and 50 per 1,000 live births respectively in 2004-2008 (NFHP 2009). Similarly, maternal mortality declined significantly from 530 per 100,000 live births in 1996 to 281 in 2006 (DHS 2006), a trend consistent with the data from the “mini” DHS in 2009 which showed a MMR of 229 (NHFS 2009). Coverage of maternal and child health services increased significantly in the five years preceding 2005. Skilled antenatal care increased from 34.9 percent in 2001 to 43.7 percent in 2006 (DHS 2001, 2006) and the rate of skilled birth attendance increased by 72 percent, from 10.9 to 18.7 during the same period. Similarly, coverage of DPT3 increased from 72 percent in 2001 to 89 percent in 2005 and full immunization increased from 66 percent to 83 percent. Several of Nepal’s nutrition programs are also performing very well. For example, more than 90 percent of children 6-59 months receive Vitamin A supplementation and de-worming twice yearly, and iron and folic acid (IFA) supplementation coverage during pregnancy increased from 23 percent in 2001 to 60 percent in 2006, with a related decrease in maternal anemia. Virtually all the salt consumed in the country contains some iodine to protect newborns from mental impairment.

Despite the progress, enormous challenges remain. Inequality is a major issue that needs to be addressed. There is wide disparity in health conditions as reflected in all health outcome indicators. Infant mortality in rural areas, for instance, is 73 percent higher than urban areas and those of mountain zones is more than twice of the hill zones. Similarly, infant, child and under five mortality rates among the poor are significantly higher than the non-poor (DHS 2006). Nutritional outcomes are far from ideal and some of the successful nutrition programs have yet to be scaled up. Chronic energy deficiency in women (as measured in BMI) remains unacceptably high at 24.4 percent in 2006, only slightly down from 28.3 percent in 1996. The prevalence of low birth weight babies is reported as between 20-32 percent in hospital based studies and 14-19 percent in community-based studies. Child underweight has shown a slight improvement between 1996 and 2006 but more than a third of children weigh less than they should for their age. It is alarming that wasting, which reflects more short-term under-nutrition or increase in infections, became worse during the 1996-2006 period and currently stands at 13 percent. Sustained effort is also required to maintain the gains made in reducing maternal mortality, Vitamin A supplementation and immunization coverage.

Nepal has the highest HIV prevalence in South Asia with 0.49 percent of the population aged 15-49 infected with HIV[[2]](#footnote-2). Like other South Asian countries, Nepal’s HIV epidemic is concentrated mainly in high risk populations such as injecting drug users (IDU), male and female sex workers (SW) and their clients, men-having-sex-with-men (MSM), and migrants to high risk districts in India (especially Mumbai) and their partners. Although Nepal has some effective prevention, diagnosis, treatment and care programs already reaching some of the key risk groups identified above, there are large areas of the country with an unknown prevalence and where no programs are being implemented. Moreover, current coverage needs to be sustained, and intervention effectiveness improved as HIV prevalence has increased slightly amongst FSW and MSM.

GON has established universal free[[3]](#footnote-3)essential health services at the health post and sub-health post levels and has introduced targeted free health care in primary health centers and district hospitals, and plans to expand these programs up to higher levels. The universal publicly financed free care policy may have contributed to increased utilization of health care services by the poor and marginalized but the availability of resources to adequately supply health facilities may have limited the benefit of the policy. For instance, with universal publicly financed free care, drug stock-outs occur at 66.8 percent of the facilities while under the targeted publicly financed free care program, where free care is targeted to the poor and vulnerable (and utilization has also increased) drug stock-outs are less at 25 percent of the health facilities. This shows the potential gain from further refining and targeting the free care policy.

The main challenges facing the sector include*:* i) *enhancing access, social inclusion and equality in health service utilization*: though Nepal has made significant progress, not everyone benefits equally from the progress. The poor have the largest unmet demand for family planning, make the lowest use of maternal care, have the lowest vaccination coverage, and are least likely to seek care when ill. The poor also have the lowest physical access to health care. In geographical terms, the mid and far west regions have the worst access to health services. Surveys have shown that Dalits and ethnic and religious minorities have lower utilization of health services. *ii)* *MDG targets for nutrition and HIV/AIDS are not on track;* and additional efforts will be required to make progress in improving the nutrition and HIV/AIDS indicators; *iii)* *Governance and accountability*: governance issues are pervasive in Nepal and are exacerbated by the fluid political situation and resulting uncertainty surrounding law and order. There are significant fiduciary risks, especially with regard to financial management and procurement where procurement processes have been interfered with through collusion, intimidation and corruption. *iv) working multi-sectorally across ministries which poses significant coordination challenges is key for additional gains in health outcomes:* the most significant gains in health status are likely to be dependent on more complex multi-sectoral activities and community participation, particularly in the area of water, sanitation and hygiene, in the area of nutrition and in the area of road safety. *v)* *maintaining the gains made so far*: Nepal has made impressive progress in reducing maternal mortality and in increasing the coverage of Vitamin A supplementation and immunization. The challenge is maintaining the focus so that these services do not slip.

1. **Objectives**

The development objective for the proposed project is to assist the Government of Nepal in improving the equitable delivery of health care services, specifically by increasing access to essential health care services and their utilization by the underserved and the poor. Progress towards achieving this objective will be tracked using an agreed up on set of indicators disaggregated by income, geographic and social characteristics. These indicators include both health service delivery and health system indicators.

1. **Rationale for Bank Involvement**

The proposed project is a continuation of on-going and evolving support to Nepal’s health sector. The Bank has been working closely with the government and development partners in supporting the government’s sector program since 2004. The Bank has significant experience in SWAp, and is well-placed to assist the Ministry of Health and Population (MOHP) in coordinating partners under the SWAp framework. The Bank’s financial inputs will supplement those from government and other partners, while its technical expertise in nutrition, health care financing, governance, pro-poor health strategies, multi-sectoral action for AIDS, and monitoring and evaluation will complement that of other partners. The preliminary and early assessment of the outcomes of the Bank’s support to the health sector has been rated as satisfactory[[4]](#footnote-4) and the Bank is well placed to continue its engagement in the sector and build on its knowledge and on past achievements. The project would broaden the scope of the existing operation to include non-governmental entities and involvement of other sectors to provide, among other services, HIV and AIDS prevention, mitigation, and treatment services.

**While the Bank has not significantly financed HIV and AIDS services, its current engagement in HIV related activities in Nepal will allow it to rapidly fill in financing gaps. Bank financing would build on** long-term technical assistance provided both to establish institutional options to address non-health based interventions, funding innovative pilot projects to address stigma, a mapping and size estimation study of most-at-risk groups to better target the program, and the development of quality assurance instruments. To date, most financing for HIV has come through earmarked project financing (USAID, DfID and GFATM) and financing from these sources is declining. **DfID expects to complete its bilateral parallel financing for HIV activities in March 2011, and funding through Round 9 of GFATM, the main remaining funder, has not been approved. Thus, several of the ongoing programs are at risk of being under-funded. The Bank has been a lead donor for nutritional activities and played a key role in a Nutrition Assessment and Gap Analysis (NAGA). The NAGA** has catalyzed commitment within the MOHP and other Ministries to intensify national efforts to address nutrition.  The financial resources and technical assistance for nutrition provided through the proposed project would enable to government to further scale-up successful interventions as well as pilot innovations to address some of the gaps identified in the NAGA process.

1. **Description**

The project, which supports the government’s five year (2010/11-2014/15) sector program (NHSP 2), comprises two components: (i) Service Delivery and (ii) Health Systems Strengthening. The total program cost is estimated at US$1527 million over five years, equivalent of which DfID, AusAid and IDA will provide US$225 million through pooled funds. IDA’s total financing of US$115 million includes approximately US$30 million made available through the Crisis Response Window. The total IDA financing will comprise a grant of US$51.75 million and a credit of US$63.25 million. IDA’s financing will disburse against the entire program expenditure, which follows an agreed annual work plan and budget (AWPB). Although IDA resources will be disbursed against the reviewed and approved total annual work plan and budget, there are a number of areas of special attention within the two components as described below. Results, rather than financing, in these areas will be “ring-fenced” and treated as high priority. The results framework for the project reflects the results framework of the sector program.

Component 1: Health Service Delivery:

*Increasing access to, and utilization of, an affordable package of essential health services by the underserved and poor in line with MOHP’s Gender and Social Inclusion strategy*: The project will support the expansion and strengthening of “essential health services” with a focus on better reaching poor and excluded populations (i.e. women, disadvantaged indigenous peoples, the formerly “untouchable” occupational castes, religious minorities (including Muslims), people from the southern plains belt of Nepal and those from the remote Far West region). This will be achieved through a combination of interventions related to improved human resource availability in underserved areas, exemption and incentive schemes for the poor and underserved to utilize specified health services, improving and expanding physical infrastructure and the introduction of feedback mechanisms for communities to raise issues of quality of care, any form of discrimination, and governance of health facilities.

*Improving the nutritional status of children and pregnant women****:***The project will support GON’s strategy to reduce malnutrition with a particular focus on the “critical window” of opportunity of -9 to +24 months. The project will support the consolidation of existing government programs that are currently operating at scale (e.g. Vitamin A supplementation and de-worming for children 6-24 months, IFA supplementation and de-worming for women during pregnancy, iodized salt promotion) but which require additional inputs to enhance sustainability and improve equity. It will also support increases in coverage of well-proven nutrition interventions that are within the responsibility of the MOHP to deliver (e.g. zinc supplementation along with ORS for the treatment of diarrhea, interventions to promote and support early and exclusive breastfeeding). Special focus will also be given to strengthening the capacity to work multi-sectorally to address more comprehensively the underlying factors that are hindering progress in reducing basic under-nutrition. The project will promote the establishment of a high-level multi-sectoral coordination mechanism for nutrition and food security to enable better planning for nutrition within relevant ministries. Much of the remaining effort to eliminate under-nutrition involves behavior change and this, in turn, requires working with non-government entities at various levels. The project will pilot innovative approaches to engage communities, including the private sector, more pro-actively in addressing nutrition challenges.

*Expanding coverage, and improving the effectiveness in the response to HIV and AIDS****:***The project will support the expansion of coverage of interventions (prevention, diagnosis and treatment) for underserved high risk groups and the quality of services provided by: i) contracting out service delivery targeting these groups to non-state entities; ii) improving the targeting of existing services; iii) developing quality assurance mechanisms; and iv) strengthened monitoring. It will also expand the coverage and quality of public health facility based services including diagnosis and treatment of HIV and AIDS, sexually transmitted infections and opportunistic infections. Services to be delivered by NGOs will include prevention services for most at risk groups (including comprehensive harm reduction activities, behavior change communication, condom promotion and distribution), community based services and referrals for diagnosis, treatment and care of STIs and HIV.

*Further reducing the mortality and morbidity associated with pregnancy and child birth:* The project will continue efforts to further reduce maternal mortality by increasing the percentage of births attended by trained health workers, especially among the poor and under-served. Ante-natal attendance will be improved by providing incentives for pregnant mothers to attend at least four ante-natal consultations and a behavior change communication campaign will target reducing teen-age pregnancies.

Component 2 –Health Systems Strengthening:

*Improving the availability of human resources for health, especially in under-served areas:* The MOHP will initiate an organization and management survey to assess the human resource requirement of the ministry. The results of the survey, together with staffing norms, will be used to obtain approval for new positions. The MOHP’s human resource strategy will be revised to ensure staffing. The ministry will implement deployment and retention strategies to staff facilities in remote areas. The outcome of these strategies will be assessed regularly to improve performance. A human resources study focusing on recruitment, deployment and retention of health workers in remote areas will be conducted during the first year of project implementation.

*Improving the sustainability of financing the sector and designing mechanisms to provide protection against impoverishment due to ill-health:* The project will assist with analytical work to explore options of health care financing in Nepal that respond to emerging interest in publicly financed and provided free health care and financial protection against health shocks. This work would also assist the government and its partners to develop options to increase the long-term sustainability of health care financing in Nepal. It is envisaged that the analytical work and consultations will help MOHP develop a sound health care financing strategy.

*Strengthening and expanding the scope of monitoring and evaluation:* This activity will support the MOHP’s effort to continue monitoring progress towards the objectives of the health sector program including quality of care and inclusion. The project will support GON’s effort to collect disaggregated data using the HMIS and so that key indicators are disaggregated by gender and social characteristics. To complement data generated by the existing systems, including HMIS, the project will support annual facility surveys, one household survey and a social auditing system including the use of community score cards. The current practice of conducting studies on the governance aspect of quality and availability of drugs, the functioning and specification of equipment, and civil works will continue as part of the Governance and Accountability Action Plan (GAAP). At least one equipment study, one civil works study and two drug studies will be conducted during the life of the project. To assess the impact of community based interventions in HIV/AIDS related services, biannual Integrated Bio-Behavioral Surveillance Surveys (IBBS) will be carried out.

*Improving governance and accountability in the health sector:* A comprehensive description of the related results and activities is reflected in the GAAP. It refers to actions that will mitigate the risks related to procurement, financial management, exclusion, and monitoring and evaluation. While the governance environment remains precarious, a procurement arrangement will be put in place that will shield the MOHP against inefficiency and other risks of fraud and corruption. Progress in the implementation of the GAAP will be reviewed regularly during the Joint Annual Review.

The project will support the expansion of the results focus and results-based mechanisms in the ministry’s program. The project will support MOHP during the first year of implementation of results-oriented programs in three areas: a) the project will introduce an in-kind transfer of fortified food for pregnant women once they present themselves for antenatal care and for children 6-24 months when they are brought for growth monitoring and promotion, in a limited number of food insecure districts; b) the project will make additional resources available for the training and deployment of an additional 2,000 of skilled birth attendants (SBAs) in year 1 of the program and, upon deployment of these SBAs, finance the associated additional recurrent costs; and c) the project will support the expansion and quality improvement of the ongoing incentive program for health facilities who offer delivery services free of charge to the client.

1. **Financing**

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| **Project Financing Data** |
| Total Bank financing (US$m.): 115.00 |
| **Financing Plan (US$m)** |
| **Source** | **Local** | **Foreign** | **Total** |
| BORROWER/RECIPIENT |  489.8 |  0.00 |  489.80 |
| International Development Association (IDA) Credit | 38.12 | 11.39 | 49.50 |
| IDA Grant | 31.19 | 9.32 | 40.50 |
| IDA (Crises Response Window) Credit | 10.59 | 3.16 | 13.75 |
| IDA (Crises Response Window) Grant | 8.66 | 2.59 | 11.25 |
| AUSTRALIA: Australian Agency for International Development | 23.1 | 6.9 | 30.00 |
| UK: British Department for International Development (DFID) | 61.6 | 18.4 | 80.00 |
| Bilateral Agencies/Other sources (unidentified) | 812.53 | 0.00 | 812.53 |
| Total: | 1,476.73 |  51.76 | 1,527.33 |
|  |

1. **Implementation**

Three development partners, IDA, DfID and AusAID, have agreed to pool financing which will be disbursed against the MOHP annual work plan and budget. Development partners who are involved in the SWAp arrangement but who do not pool their funding provide technical and/or financial assistance to the implementation of the annual work plan and budget. Detailed arrangements for disbursing, managing and reporting upon the use of the pooled funds are described in a Joint Financing Arrangement (JFA) which has been agreed between the GoN and the three pooled funding partners.

The project supports the sector program developed by the government and implemented by the MOHP with its existing structures. The government is responsible for the implementation of the program and will take the lead in areas that require the collaboration of other ministries for successful implementation. The MOHP takes the overall responsibility for implementation. Internationally recruited technical assistance (TA) will advise the Ministry in the implementation of the sector program.  On behalf of the pooled funding partners, DfID will procure the TA following a consultation process with MOHP.

Under the leadership of the Ministry, the Department of Health Services (DOHS) will be responsible for implementing the service delivery component. Specific divisions under this department will be responsible for the respective EHCS interventions. Similarly, the nutrition unit under the Child Health Division will be responsible for implementing the subcomponent of improvement in the nutritional status of children and pregnant women. The National Center for AIDS & STD Control (NCASC) will be responsible for the implementation of both the state and non-state response. It will oversee the delivery of services through the MOHP’s network of health facilities and health workers and will be responsible for contracting out NGO-delivered prevention, diagnosis and treatment services to reach the most at risk populations in their communities and ensure the quality of services. The HIV/AIDS and STI Control Board (HSCB) will coordinate the overall national, multi-sectoral response through strategic planning exercises and overall national policy formulation.

Pooled funding support from IDA, DfID and AusAid will finance a share of the government’s budget expenditures. The proportion of MOHP expenditures under its budget to be financed by IDA will be determined annually based on performance. The annual work plan and budget to be agreed with pooled funding partners will form the basis for program implementation and disbursement.

1. **Sustainability**

The next phase of the health sector program is being prepared with broad participation and consultation. Stakeholder consultation will continue during implementation to sustain the broad support for the program. The community score card generation process will ensure regular participation of the community. The project will be implemented through the regular government system and does not entail establishment of new units or institutions.

The space for increasing public spending is limited. Projections indicate that maintaining the current level of government spending on domestic resources base is unsustainable. Assuming an optimistic scenario of a real GDP growth of 4 to 5 percent and revenue increasing to 16 percent of GDP, maintaining the government spending at its current nominal level would require increasing the fiscal deficit to 5.3 percent throughout the years 2010-2015. The potential to generate space through effective prioritization with the MTFE exercise and enhancing absorptive capacity is limited. The share of health in total public expenditure has increased from 5.2 percent in 2003/04 to 6.0 percent in 2005/06 and to 7.3 percent in 2006/07 and GON is committed to maintaining the share of public health expenditure in the coming years. At the projected level of GDP and revenue growth, maintaining public spending in health at its current level of 7 percent would require significant mobilization of external resources, an increase in grants to 3.6 percent from the 2008 level of 2.5 percent and increase in net external borrowing to 0.5 percent from the 2008 level of 0.1 percent. The project will support the GON in developing a health financing strategy to enhance its strategic thinking on the long-term sustainability of the sector financing and on the efficiency of spending.

1. **Lessons Learned from Past Operations in the Country/Sector**

*An environment of unstable law and order and a fluid political situation can undermine improvements in governance and particularly in procurement capacity*. While procurement capacity has improved, procurement processes are interfered with through collusion, intimidation and corruption. Risks related to procurement need to be mitigated, including through the contracting of an independent procurement assistance consultancy and greater use of surveys on the quality of drugs and equipment procured. The project design, therefore, includes the use of an independent procurement assistance consultancy, local communities for health facility management, stakeholders and the use of independent sources of data for monitoring.

*The expansion of essential services to the populations in need has not always translated to improved health*. Quality of services will be regularly monitored under the project, particularly in view of the fact that the free care policy eliminated sources of income facilities previously relied on. This will be done through the scaling up of social auditing mechanisms, periodic surveys and reviews of goods and works procured and periodic facility surveys.

*Performance-based incentives have the potential to achieve results*. Emphasis will be given to feasible results or reform areas where performance has been lagging. Performance incentives will be disbursed against achievement of the stated and verified results or reforms.

*Adherence to an agreed work plan and budget and the budget allocation process is critical in order to expedite annual commitments by pooled funding partners*. To ensure the budget allocation reflects consultations and agreement with external development partners (EDPs), the consultative process will be continuous.

*An independent performance assessment will enhance the Joint Annual Review (JAR) process*. Currently, HMIS generated data and process targets are used to prepare the Annual Progress Report. Given the unknown quality of the HMIS data, future JARs will use an independent party to carry out the assessment to provide an independent view of program progress. Similarly, an independent assessment of EDP performance is planned to add value to the joint reviews.

*The management of the SWAp arrangement needs more clarity on the roles of all players*. An understanding of clear rules of engagement for coordination and management of the SWAp will be defined, to ensure decisions are taken swiftly, that time is not consumed by numerous meetings to reach consensus, and to maintain the focus of the program.

1. **Safeguard Policies (including public consultation)**

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| **Safeguard Policies Triggered by the Project** | Yes | No |
| [Environmental Assessment](http://www.worldbank.org/environmentalassessment) ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064724~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064614~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.01) | [X] | [ ] |
| Natural Habitats ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064757~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064560~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.04) | [ ] | [X] |
| Pest Management ([OP 4.09](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064720~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)) | [ ] | [X] |
| Physical Cultural Resources ([OP/BP 4.11](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20970738~pagePK%3A60001219~piPK%3A280527~theSitePK%3A210385%2C00.html)) | [ ] | [X] |
| Involuntary Resettlement ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064610~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064675~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.12) | [X] | [ ] |
| Indigenous Peoples ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20567505~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20567522~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.10) | [X] | [ ] |
| Forests ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064668~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20141282~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.36) | [ ] | [X] |
| Safety of Dams ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064653~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064589~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 4.37) | [ ] | [X] |
| Projects in Disputed Areas ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064615~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064640~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 7.60)[[5]](#footnote-5)\* | [ ] | [X] |
| Projects on International Waterways ([OP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064667~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html)/[BP](http://intranet.worldbank.org/WBSITE/INTRANET/OPSMANUAL/0%2C%2CcontentMDK%3A20064701~pagePK%3A60001255~piPK%3A60000911~theSitePK%3A210385%2C00.html) 7.50) | [ ] | [X] |

1. **List of Factual Technical Documents**
* Environmental Health Impact Assessment Plan, NHSP II
* Environmental Management Framework for Physical Infrastructure Works, NHSP II
* Indigenous People’s Development Framework, NHSP II
* Framework for Land Acquisition and Resettlement, NHSP II
* Health Sector Gender Equality and Social Inclusion (GESI) Strategy
* Vulnerable Community Development Plan for Nepal Health Sector Programme Implementation Plan (2004/5 – 2008/9)
* Health Care Waste Management Strategy and Action Plan, NHSP I
* Health Care Waste Management Strategy and Action Plan, NHSP II
* Environmental Impact Assessment (EIA) of Nepal Health Sector Program-Implementation Plan, (NHSP-IP-2004-2009)
* Governance and Accountability Action Plan (GAAP)
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1. The list includes AusAID: Australian Agency for International Development, DFID: Department for International Development (UK), GTZ: Gesellschaft für Technische Zusammenarbeit, KfW: Kreditanstalt für Wiederaufbau, SDC: Swiss Development Corporation, UNAIDS – UN Joint program on HIV and AIDS, UNFPA: United Nations Population Fund, UNICEF: United Nations Children’s Fund, USAID: United States Agency for International Development, WHO: World Health Organization, Global Alliance for Vaccine Immunization (GAVI). [↑](#footnote-ref-1)
2. Estimates for 2008 (HIV, AIDS and STI Control Board, Government of Nepal, 2009). [↑](#footnote-ref-2)
3. Free health care in refers to the publicly financed free-to-user services. [↑](#footnote-ref-3)
4. IEG, Nepal CAE, 2009. [↑](#footnote-ref-4)
5. \* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas* [↑](#footnote-ref-5)