I. Project Context

Country Context

Nepal emerged from a prolonged internal 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. Political parties are currently engaged to reach consensus on the country’s future political and administrative form. With an average annual per capita income of US$490 (WB, 2011) Nepal's population of 26.6 million is culturally, ethnically and religiously diverse. 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 has significantly declined from 31 per cent in 2003/2004 to 25 per cent in 2010/2011 and Nepal has reached its MDG 1 target related to the eradication of extreme poverty – reducing poverty by half - ahead of time (WB, 2012). Poverty rates are higher among minorities, lower caste and certain tribal groups but inequality in consumption expenditure has declined over the last 5 years (Nepal Living Standard Survey III – NLSS III).
Sectoral and institutional Context
Nepal’s health indicators have shown rapid and impressive improvements over the last 10 years. The country is on track to reach the MDG targets related to Infant Mortality Rate, Maternal Mortality Ratio and HIV/AIDS. However, anticipated diminishing returns from investments in ongoing programs will slow down the progress unless additional interventions are put in place. The Ministry of Health and Population, together with development partners and other stakeholders are working closely together through a Sector-wide Approach to keep Nepal on track to reach these health related MDG targets by scaling up selected programs and putting in place new initiatives. The proportion of deliveries attended by the skilled birth providers over the last five years has nearly doubled, from 19% in 2006 to 36% in 2011 (DHS). The Maternal Mortality Ratio (MMR) declined significantly from 530 per 100,000 live births in 1996 to 281 in 2006 (DHS 2006), a trend consistent with the data from 2009 which showed an MMR of 229 per 100,000 live births (Maternal Mortality and Morbidity Survey, 2009). The Total Fertility Rate has declined from 3.1 (2006) to 2.6 (2011) and the percentage of children fully immunized against major preventable illness increased from 83.5% (DHS 2006) to 87% (DHS 2011). From 2006 to 2011, the under five mortality has declined from 61 (DHS 2006) to 54 (DHS 2011) per 1,000 live births but the neonatal mortality has remained the same and the pace of improvement in post neonatal and infant mortality has slowed down. The prevalence of HIV in Nepal is below 0.5%, the treatment success rate for tuberculosis treatment has increased to over 84% and only a single death due to malaria has been reported during the first and second trimesters of FY 2010/11. Significant progress has been seen in reducing micronutrient deficiencies over the past decade and consistent semi-annual Vitamin A supplementation to children 6-59 months covers >90% of children. Similarly, the household consumption of adequately iodized salt has risen to almost 80% and the Iron and Folic Acid supplementation and de-worming during pregnancy has made progress (NDHS 2011).

In contrast to these improvements in health indicators, Nepal is not on track to reach the MDG 1c target – to reduce the rate of malnutrition by half - and has a very high rate of child malnutrition with 46.7 per cent of children under five being stunted, 15.1 per cent being wasted and 36.3 per cent being underweight (NLSS III, 2010/11). Although there is a declining trend compared to the rates 5 years ago, these rates are still alarmingly high. The economic costs of malnutrition are very high – an estimated 2-3 per cent of GPD (US$250 to 375 million) is lost every year in Nepal due to vitamin and mineral deficiencies alone. Improving nutrition contributes to productivity, economic development, and poverty reduction by improving physical work capacity, cognitive development, school performance, and by reducing disease and mortality. The window of opportunity for improving nutrition is small – the 1000 days from the first day of pregnancy through the first two years of life. The damage to physical growth, brain development, and human capital formation that occurs during this period due to inadequate nutrition is extensive and largely irreversible. The main focus in Nepal in improving nutrition therefore is to accelerate the reduction of child malnutrition. Interventions must therefore focus on the risk factors that influence nutritional outcomes during this critical period.

For an individual woman or child, the basic causes of maternal and child malnutrition are: insufficient intake and absorption of nutrients, and excessive energy expenditure. The risk factors for insufficient intake of nutrients include: poor economic and social access to food, lack of knowledge about the nutritious value of foods and which foods are required at specific times (e.g. pregnancy, young children), poor feeding practices for children, gender dynamics that dictate that women should eat last and least, cultural beliefs about eating down during pregnancy and the need
to limit weight gain to avoid having large babies and thus increase the risk of complicated delivery, smoking during pregnancy and indoor air pollution during pregnancy which reduce the capacity of blood to carry oxygen to body tissues. Similarly, insufficient weight gain before and during pregnancy and adolescent pregnancies limit the availability of nutrients to the foetus, because the mother and foetus are competing for nutrients. The risk factors for insufficient absorption of nutrients include: poor hygiene and environmental sanitation that cause diarrhea and other infections that limit the gut’s ability to absorb nutrients, the presence in the diet of certain “anti-nutrients” such as phytates which bind with iron and limit its absorption in the body and infections with parasites (e.g. helminths) that compete with the host’s body for nutrients. The risk factors for excessive energy expenditure relate to the metabolic rate increases caused by infections, and excessive physical workloads of women before and during pregnancy.

In Nepal, these risk factors for young child malnutrition emerge at an early stage in the life-cycle. Almost one in five (18.2%) women of reproductive age in Nepal has chronic energy deficiency (Body Mass Index <18.5), compromising the additional energy requirements during pregnancy. Low maternal age is strongly associated with low birth weight, preterm birth, babies who are small for gestational age as well as with neonatal mortality. There is significant cultural and family pressure to marry and give birth at an early age in Nepal. The median age at first birth has remained constant around 20 years of age over the 2001, 2006 and 2011 Nepal Demographic and Health Surveys, evidence that social and cultural attitudes regarding early childbearing continue to be prevalent. It is estimated that some 12 to 16 per cent of children in Nepal are born with a low birth weight. Other risk factors include anemia among pregnant women, excessive physical workloads, smoking during pregnancy and indoor air pollution, poor hygienic practices and, related, frequent episodes of illnesses such as diarrhea.

Current infant and young child care practices, from immediately after birth and up to the age of 24 months, point to the next set of risk factors for child stunting. Particular problems in Nepal are low levels of early initiation of breastfeeding and early and late complementary feeding with a low quality complementary feeding diet. Exclusive breastfeeding rates declined between 2001 and 2006 but improved significantly between 2006 and 2011. The Lancet Nutrition Series (LNS) calculated that quality implementation of breastfeeding and complementary feeding interventions (possibly including supplementary food) could reduce infant mortality and stunting at 12 months by 11.6% and 19.8% respectively. Delays in health care seeking behavior often results in more serious and prolonged conditions among children, taking an unnecessarily heavy toll on their nutritional status. Young children in Nepal suffer from frequent infections such as diarrhea and too often care takers do not know how to properly treat diarrhea, as witnessed by the very low rates (less than 10 per cent) of utilization of zinc with oral rehydration solution (ORS) to treat diarrhea.

Community – wide factors constitute risks for malnutrition that are independent from the life-cycle. The availability of an appropriate variety of food products is problematic in a number of districts, as is the accessibility in terms of the costs of food items. Poor access to safe drinking water and poor hygiene and sanitation practices contribute to the disease burden of communities with a negative impact on nutritional status, especially among children. Cultural beliefs and practices add important elements to the wide array of factors that perpetuate the intergenerational problem of malnutrition in Nepal. Also, despite improvements in female education in Nepal, the level of educational attainment is still a significant factor for malnutrition in Nepal (NLSS III, 2010/2011). There is a strong positive correlation between mothers’ educational attainment and the nutritional status of her children.
To address the range and variety of risk factors described above requires coordinated action and resources from various sectors, agencies and actors, including communities. The Nepal Multi-Sectoral Nutrition Plan (MSNP) represents Nepal’s intention to address this requisite. The MSNP has recently been finalized, detailing the roles of the Ministry of Health and Population, the Ministry of Education, the Ministry of Physical Planning and Works, the Ministry of Agriculture and Cooperatives, and the Ministry of Local Development, under the leadership of the National Planning Commission, in this effort. This planning framework is the result of collaboration among a wide range of stakeholders and sectors. At the same time external development partners, through the Nepal Nutrition Group (NNG) and the Food Security Group have improved the coordination of their interventions and analytical work. A number of nutrition and nutrition related projects are under preparation in parallel, the main ones being the USAID funded Suaahara Project and Feed the Future Project, the Global Agriculture and Food Security Program (GAFSP) financed Nepal Agriculture and Food Security Project and a large project by Heifer International working with small scale farmers. A list of on-going and planned projects in the area of Food and Nutrition Security in project districts is provided in the PAD.

II. Proposed Development Objectives
The Development Objective for the Project is to improve attitudes and practices known to improve nutritional outcomes of women of reproductive age and children under the age of 2. Changes in attitudes and practices would address the key risk factors for child malnutrition and create demand for nutrition related services and products. The supply of these services and products will be provided through existing public sector and donor-funded programs, the private sector and, to a limited extent, financed through the Project.

III. Project Description

Component Name
Results for Nutrition Initiatives at the ward level
Comments (optional)

Component Name
Project Management, Capacity Building, Monitoring and Evaluation
Comments (optional)

IV. Financing (in USD Million)

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V. Implementation
The National Planning Commission (NPC) will be the project oversight agency in accordance with its mandate to coordinate Nepal’s efforts in Food and Nutrition Security and the Ministry of Local Development (MOLD) will be the main implementing agency. Project implementation at MOLD will be headed by a Project Director. Under his leadership, a Project Management Team will include a Financial Management Officer who will be primarily responsible for ensuring efficient flow of funds for the project and for financial reporting to the Government and the Bank, a Monitoring & Evaluation Officer, a Social Mobilization Officer and a Procurement Officer or Consultant who will assist in supporting all procurement related functions.

The Rapid Results for Nutrition Initiatives will use separate grants to the 15 project districts for the purpose of the project to finance demand based sub-projects, relying on the established social mobilization mechanism within MOLD’s Local Governance and Community Development Program (LGCDP). The implementation mechanism will focus on nutrition issues, through the involvement of NFSSCs at the district and village levels. MOLD will prepare the work program for this project under a separate budget heading that will appear in the government’s budget (Red Book). The Project would have its own flow of funds mechanism under a separate budget line item. The NFSSCs would be charged to review Work Plans submitted by wards and to ensure that the necessary inputs are secured. In case inputs can be supplied through public sector programs this will entail NFSSCs coordinating their work closely with the district level representatives of the relevant Ministries, including Health and Population, Education, Physical Planning and Works, and Agriculture and Cooperatives. It would also entail NFSSCs facilitating a sub-project grant allocation for the RRNI to finance additional supplies through the public sector, if needed, or to procure supplies from the private sector. Each NFSSC at the VDC level would also coordinate closely with the coaches responsible for their VDCs to ensure that project implementation is as efficient as possible. Similarly, each coach will work closely with the Ward Citizen Forums to ensure that the RRNI Work Plans meet the selection criteria, including the composition of the RRNI team and the inclusion of eligible expenditures only, and that the implementation of RRNIs is carried out in accordance with the Work Plan. An Operations Manual (OM) for the RR Process to be developed will provide all the necessary guidance and information to staff involved in implementation at all levels, from ward to the central level. As a supplement to the OM, a simplified version of Guidelines for the Communities will also be prepared, which will be produced in Nepali language. The OM will also outline the responsibilities of staff at each level and the monitoring and reporting requirements.

The Project will operate in 15 districts and the choice of districts selected on the basis of a) stunting levels; b) population size; c) poverty levels; and d) the absence of interventions by other partners that focus on social mobilization. Although rates of stunting are highest in the mountain and hill districts, the Terai is most affected in terms of the overall numbers of women and children.

VI. Safeguard Policies (including public consultation)

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Involuntary Resettlement OP/BP 4.12 | X
Safety of Dams OP/BP 4.37 | X
Projects on International Waterways OP/BP 7.50 | X
Projects in Disputed Areas OP/BP 7.60 | X

Comments (optional)

VII. Contact point

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