

# PROJECT PERFORMANCE ASSESSMENT REPORT

NEPAL

## Sunaula Hazar Din – Community Action for Nutrition Project

**Report No. 159888**

JUNE 16, 2021



**IEG**  
INDEPENDENT  
EVALUATION GROUP

**WORLD BANK GROUP**

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**WHAT WORKS**

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**NEPAL**

**SUNAULA HAZAR DIN—COMMUNITY ACTION FOR NUTRITION PROJECT**

**(CREDIT IDA-51370-NP AND GRANT IDA-H7860-NP)**

June 16, 2021

Human Development and Economic Management

*Independent Evaluation Group*

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## Abbreviations

CDD	community-driven development
DHS	Demographic Health Survey
IEG	Independent Evaluation Group
ODF	open defecation free
RRNI	Rapid Results for Nutrition Initiative
SHD	Sunaula Hazar Din
UNICEF	United Nations Children’s Fund
VDC	village development committee
WASH	water, sanitation, and hygiene

*All dollar amounts are US dollars unless otherwise indicated.*

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# Contents

Project Data .....	v
Summary .....	vi
1. Project Background, Context, and Design.....	1
Project Background and Context.....	1
Project Objective, Design, and Financing .....	2
2. What Worked, What Didn't Work, and Why? .....	7
Results.....	7
Design and Preparation.....	19
What Worked and Why.....	19
What Didn't Work and Why.....	21
Implementation and Supervision.....	22
What Worked and Why.....	22
What Didn't Work and Why.....	23
3. Lessons.....	25
Bibliography.....	28

## Boxes

Box 1.1. Menu of 15 Goals.....	3
Box 1.2. United Nations Children's Fund Activities in Districts Affected by the Earthquake ....	4

## Figures

Figure 1.1. Independent Evaluation Group's Theory of Change of the Project .....	6
Figure 2.1. Trends in Nutritional Status of Children under the Age of Two Years in Project Areas.....	17

## Tables

Table 1.1. World Bank Financing by Component.....	5
Table 2.1. Number and Percentage of Wards Selecting Each Goal.....	7
Table 2.2. Progress toward Project Targets .....	9
Table 2.3. Outcome Harvesting Analysis: Results from the RRNs in Selected Communities in Saptari, Udayapur, and Janakpur Districts.....	9

## **Appendixes**

Appendix A. Project Ratings.....	30
Appendix B. Fiduciary, Environmental, and Social Aspects.....	41
Appendix C. Methodology.....	43
Appendix D. Additional Data.....	46
Appendix E. List of Persons Met.....	54

## Project Data

This is a Project Performance Assessment Report (PPAR) by the Independent Evaluation Group (IEG) of the World Bank Group on the Sunaula Hazar Din (SHD)—Nepal Community Action for Nutrition Project (P125359). This instrument and the methodology for this evaluation are discussed in appendix C. Following standard IEG procedure, copies of the draft PPAR were shared with relevant government officials for their review and comment, and no comments were received.

### Basic Data

Country: Nepal	World Bank financing commitment: \$40 million
Global Practice: Health, Nutrition and Population	Actual project cost: \$31.6 million
Project name: Community Action for Nutrition (Sunaula Hazar Din, known as SHD Project)	Expected project total cost: \$35.9 million
Project ID: P125359	Actual amount disbursed: \$31.6 million
Financing instrument: Specific Investment Loan	Environmental assessment category: Partial Assessment (B)
Financing source: International Development Association (IDA credit of \$22 million and IDA grant of \$18 million)	

### Dates

Event	Original Date	Actual Date
Approval		26 June 2012
Effectiveness		24 August 2012
Restructuring		30 June 2015
Mid-Term Review		15 February 2015
Closing	30 June 2017	30 June 2017

### Key Staff Responsible

Management	Appraisal	Completion
Project Team Leader	Albertus Voetburg	Manav Bhattarai
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# Summary

## Project Background and Description

Improvements in child nutrition in Nepal have lagged behind the country's economic, social, and human development progress over the past decades. At the time of project design in 2011, Nepal ranked among the top countries with the highest national prevalence of stunted growth (40 percent) in children under the age of five, and the country was not on track to reach the Millennium Development Goal's target of reducing the rate of malnutrition by half.

Improving child nutrition is essential for enhancing human capital accumulation, boosting economic growth, and reducing poverty, since the consequences of undernutrition for young children last through adulthood and reduce their potential to learn and to contribute to society. The annual economic cost of undernutrition was estimated at 2 to 3 percent of gross domestic product (World Bank 2018c). The challenge of reducing child undernutrition is multisectoral, and thus requires interventions in health; agriculture; water, sanitation, and hygiene; social protection; education; and governance, depending on the country context.

The project was the World Bank's first stand-alone lending operation in support of Nepal's nutrition agenda. The project name, "Sunaula Hazar Din," which means "golden 1,000 days," reflects the importance of the period from conception to 24 months of age as a window of opportunity to prevent undernutrition before it surfaces. The project's objective was to improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two. At entry, the project covered 15 districts (out of 75 districts in the country), selected based on levels of stunted growth and poverty. A second objective was added in 2015, after the devastating earthquake that struck the country in April, to provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas. The project was then operational in 23 districts.

The project was approved in 2012 at an estimated cost of \$40 million (combining an International Development Association credit of \$22 million and an International Development Association grant of \$18 million). The first project objective envisaged community-driven Rapid Results for Nutrition Initiatives (RRNIs) by offering communities a menu of 15 goals having a direct or indirect effect on nutrition; communities would choose goals and formulate subproject proposals to be implemented over 100 days with project funds. At the end of each 100-day cycle, another 100-day RRNI could be proposed to target a new goal or reinforce the same goal, building on lessons learned. The menu of goals was multisectoral and consistent with the life cycle

approach of the mother and child, covering adequate feeding practices for pregnant women and young children, consumption of animal-sourced protein, exclusive breastfeeding, use of clean and safe water, elimination of open defecation, and delaying early marriage, among others. The second project objective, to provide emergency nutrition and sanitation response after the earthquake, was pursued by engaging the United Nations Children's Fund (UNICEF), since the agency had a comparative advantage in maternal and child undernutrition relief.

## Results

Overall, project results reflected a favorable pattern of raising awareness on the importance of nutrition and improving nutrition practices in communities. All goals offered were relevant for affecting overall nutritional status, but communities favored more tangible water and sanitation investments, and the selection of other goals, such as immunizations and family planning, was rather limited.

Outcomes related to sanitation, hygiene, and safe drinking water practices were noteworthy and were sustained after the project closed. Practices included the use of improved toilet facilities (flush toilet, covered pit within household, community latrine), which contributed to the government efforts in declaring open defecation-free districts, thus promoting the prevention of waterborne diarrheal diseases that limit the absorption of food nutrients. Similar favorable outcomes were observed in practices exhibited by mothers of children under two years in washing hands at critical times (after defecation, before eating, and before feeding the child). Communities improved their management of safe drinking water by using water filters, buckets, and storage tanks provided by the project. Increased awareness of the importance of filtered water to prevent the incidence of diarrhea and cholera reinforced the handwashing goal. However, the results for reducing exposure to indoor smoke for pregnant women and young children were rather modest, despite a majority of surveyed households having responded that they know how to avoid smoke in the house.

Consumption of animal-sourced protein increased, and other feeding and dietary goals, such as breastfeeding, minimum acceptable diet, and consumption of iron supplements showed modest progress. The percentage of pregnant women consuming animal-sourced protein exceeded project targets, despite subprojects involving chicken coops or rearing buffaloes or goats for their milk production (instead of distribution of eggs bought from the market) were difficult to implement and sustain after the project. Breastfeeding, minimum acceptable diet in children under two, and consumption of iron supplements by young women, however, did not achieved project targets because these goals were seldom selected by communities. Since chosen goals were unknown at entry, the impact evaluation did not factor in the proportion of wards that selected each goal,

resulting in a high correlation between the selection of goals and the project indicators' achievement. Therefore, it would be misleading to conclude that the project failed to achieve these targets when their goals were not widely selected by communities.

The achievement of goals addressing social norms were moderately successful. Results on extending education and delaying marriage and pregnancy for young girls showed some progress, despite the fact that only 22 percent of wards selected the former, and only 8 percent selected the latter. The goal for reducing the workload of pregnant women was attained through the use of village mills to grind rice, which allowed time and cost savings for women. The project also generated favorable elements of social cohesion, notably in trust and collective action, that may contribute to building social capital.

Importantly, the impact evaluation revealed improved nutritional status of children under two years of age as a result of the RRNIs. The impact evaluation shows that between 2014 and 2017, stunted growth decreased from 38 percent to 33 percent, wasting from 21 percent to 16 percent, and underweight from 32 percent to 15 percent. The project's high achievements in water, sanitation, and hygiene, and to a lesser extent in adequate dietary practices, plausibly contributed to reducing the prevalence of enteric infections, as shown by the impact evaluation. Child infections and diseases are known to be associated with reduction in food intake, intestinal malabsorption, and endogenous nutrient loss.

In areas affected by the earthquake, several nutrition-related results were achieved through the partnership with UNICEF. Approximately 53,300 households benefited from water supply system repairs and household drinking water treatment, and emergency hygiene and sanitation kits reached 80,013 vulnerable households. The treatment of severe acute undernutrition benefited 4,299 children under five years; approximately 360,000 children received multiple micronutrient powders; and 169,701 mothers of children under two received infant and young child feeding counseling, including on exclusive breastfeeding and complementary feeding, feeding practices, and hygiene behaviors. In addition, UNICEF undertook widespread promotion of breastfeeding and complementary feeding.

Sustainability of outcomes and financing of project activities were not fully achieved. The federal government transferred the project plan to local government and rural municipalities, where there was no evidence of budget commitments to sustain the scheme. RRNIs were discontinued at project closing. Some project benefits, such as those related to water, sanitation, and hygiene, and women's workload through community mills, were sustained after the project ended. However, it was difficult to sustain the progress made with chicken coops due to lack of financing for chicken vaccination,

chicken food, or maintaining the coops, also because RRNI offered a relatively brief community immersion resulting in transitory benefits.

## **Design and Preparation**

The project rightly focused on improving practices that are known to improve nutritional status during the window of opportunity of the “golden 1,000 days” of the life cycle when children are most vulnerable to undernutrition. “Sunaula Hazar Din” or “golden 1,000 days” became a “brand name” in Nepal, synonymous with the first 1,000 days of early childhood nutrition and health. The multisectoral design and comprehensiveness of the menu of goals was impressive in addressing nutrition determinants, particularly in integrating a focus on social norms related to early marriage, early pregnancy, and women’s empowerment. The RRNI were promising, both in terms of purpose and design, since they could quickly produce tangible results in community practices to reduce undernutrition. Sunaula Hazar Din justifiably used a community-driven development (CDD) approach to induce behavioral changes while increasing community ownership and empowerment in a context of federalism reforms, concerns regarding community empowerment, voice, and trust due to the political situation, and a strong track record of CDD programs in the country. The addition in 2015 of an objective to provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas was also pertinent as an immediate response to critical needs and for enhancing disaster risk management.

However, the combination of a multisectoral design and a CDD implementation approach is not necessarily a guarantee for convergence of interventions to respond to all households needs. Offering communities a menu of goals gave them alternatives to choose from but created the risk of not having a synergistic approach to combat malnutrition. Community choices showed clear preferences for tangible investments and less interest in other equally important priorities such as immunizations and family planning. Furthermore, short RRNI cycles without more emphasis on capacity building in local governments for supporting subprojects’ implementation may have biased the selection of goals by communities. Communities may have needed more local services and technical support in combination with the demand-driven empowerment support to implement some goals, notably the one related to increasing animal-sourced protein consumption, and build on efforts of the RRNI for sustainability.

## **Implementation and Supervision**

The project undertook multisectoral interventions, and notable joint work among sectors was observed at the district level, particularly in water and sanitation, and health. Multisector work was promoted by the government of Nepal. Equally important, and

through robust targeting, the project benefited most disadvantaged areas to maximize its development impact.

At the same time, the project was implemented in a difficult period during which the country was struck by a devastating earthquake in 2015, followed by a trade blockade at the Indian border and by protracted political unrest in the Terai districts. Communities and project beneficiaries were displaced, a part of project investments was damaged, and the emergency understandably shifted priorities and attention to earthquake relief and construction activities in critically affected areas. The trade blockade at the Indian border resulted in a fuel crisis that hampered transportation and increased the cost of goods needed for community subprojects.

The project was also implemented in an environment of weak institutional, human resource, and financial management capacity. Related risks were identified at entry, but their extent was underestimated. An assessment of financial management capacity at the district level was undertaken only after two years of implementation. District staff were already overstretched by other sectoral work. During the initial project years, coaching skills were weak and limited the extent to which coaches were adequately supporting RRNI teams. These challenges were addressed at midcourse in 2015 through additional technical support and additional human resources in each district.

The first two to three years of the project suffered from budgeting delays, extended implementation delays, and slow procurement, all affecting the rollout of RRNIs. The project was unable to use digital reporting in spite of the investment made. Between 2012 and 2015, total disbursement reached only 14 percent; this accelerated during the final two years of implementation, in 2016 and 2017, with final disbursements aggregating at 88 percent of project proceeds.

Throughout the project, the World Bank task team was proactive in seeking to address implementation challenges with due attention to development impact, including by restructuring the project and by facilitating the government's response to the earthquake needs. The team maintained strong implementation support, monitoring, and quality reporting. The project also demonstrated the borrower's adaptive management and proactiveness, especially after the Mid-Term Review, when the government accelerated implementation by allowing communities that had successfully completed their initial subprojects to submit more than one proposal in the subsequent rounds of proposals. The government also increased technical support and provided additional human resources to the districts. It responded effectively to meet nutrition and sanitation needs resulting from the earthquake by promptly entering into a contract with UNICEF to provide the required services, as agreed with the World Bank.

## Lessons

A community-driven implementation approach may not enforce the multisectoral design approach of the project to address the multiple determinants of nutrition. Although both approaches were intrinsically adequate to be undertaken given the country context and the multiple determinants of nutrition, their combination imposed risks for the convergence of interventions to respond to all households needs because some goals were not fully appreciated and hence not chosen by communities. Project experience indicated that communities may not have appreciated the value of certain outcomes and opted for more tangible investments. Hence, a more supply-driven approach combined with a thorough, systematic, documented, and unbiased gauging of community demand through an ex ante needs assessment before designing the menu of goals might be needed to ensure that all community needs are addressed synergistically.

Equal RRNI-cycle time frames across the menu of goals can slant the selection of goals toward those for which technical know-how is already available, and hence overshadow the spirit of flexibility of the CDD approach. The short RRNI-cycle implementation, aggravated by slow fund flows and without more emphasis on capacity building in local governments, imposed “task trade-offs” in the selection of goals by communities. Since not all the goals of the menu could equally be easily achieved in 100 days, some wards rejected the implementation of particular goals. This was true of the goal of increasing animal-sourced protein consumption, whether through subprojects of operating chicken coops or rearing buffaloes or goats for their milk production. Communities may have needed more time to show visible outcomes and more local services and technical support accompanying the demand-driven empowerment support to implement this type of subproject and build on efforts of the RRNIs for sustainability.

In settings with limited human resources, the implementation of innovative operations such as RRNIs requires a robust operational planning that takes into account a steep learning curve, strong preparatory arrangements that address weak capacities at entry, and adequate project readiness at entry. At midcourse, the project identified capacity gaps and provided additional human resources in each district to facilitate RRNIs, and capacity support for monitoring and evaluation and financial management. Initial readiness can be promoted through the early completion of basic procurement measures and the early preparation of an operations manual, which are already known to be standard good practices.

Good collaboration with specialized development partners in emergency relief facilitated the effective responses that maintained the focus on nutrition and on the original intent of the project. The World Bank’s task team worked jointly with UNICEF and the Ministry of Federal Affairs and Local Development to launch nutrition activities

that addressed an urgent humanitarian crisis, as UNICEF had a comparative advantage in nutrition and sanitation relief operations.

In CDD projects that support the achievement of goals yet to be chosen by communities, and which are thus unknown at the outset, additional efforts to collect more granular baseline data at the ward level can facilitate the assessment of the project achievements at completion. The project was one of the first initiatives in Nepal and in the world to implement RRNIs on a large scale, so it was important to conduct a rigorous evaluation. However, the impact evaluation measured projects gains at the village development committee level, regardless of the goals chosen by wards, thus limiting learning and biasing the assessment. As a result, the impact evaluation reported less successful outcomes in goals that were less often selected. The selection of goals by beneficiary communities was unknown at entry; therefore, it was tricky to set outcome indicators and targets at the outset. For instance, only 6 percent of communities selected “practicing proper and consistent breastfeeding” and as a result, the project was deemed unable to achieve the target.

Independent Evaluation Group project ratings are described in appendix A. The evaluation methodology and evidence sources are described in appendix C.

Oscar Calvo-Gonzalez  
Director, Human Development and Economic Management  
Independent Evaluation Group

# 1. Project Background, Context, and Design

## Project Background and Context

1.1 The project's name, "Sunaula Hazar Din" (SHD), means "golden 1,000 days" in Nepali. It refers to the period from conception up to the age of 24 months, when children are most vulnerable to undernutrition and which is considered as the window of opportunity for addressing nutrition. Child undernutrition develops from the insufficient intake or absorption of nutrients and is affected by inadequate feeding; care practices; health services; and water, sanitation, and hygiene (WASH) needed for the optimal health, physical growth, and cognitive development of a child. Undernutrition is a cumulative condition in that it begins with the nutrition and health status of the future mother, affecting the growth and development of the fetus, affecting birth outcomes, and having irreversible effects through early childhood and beyond.

1.2 Improving child nutrition is essential for enhancing human capital accumulation, boosting economic growth, and reducing poverty. The consequences of undernutrition for young children last through adulthood and reduce their potential to learn and contribute to society. These consequences are also often intergenerational, extending to future children. Galasso and Wagstaff (2018) estimate that the average per person income penalty from stunted growth of children is about 7 percent.

1.3 The challenge of reducing child undernutrition is multisectoral and requires interventions in health, agriculture, WASH, social protection, and education within the life cycle of mother and child. Malnourished pregnant women and mothers with low body weights and micronutrient deficiencies may deliver a low-birthweight newborn and struggle to sustain exclusive breastfeeding or to feed and care for their babies. Children with low and inadequate nutritional status are more prone to childhood infections (which further aggravate the child's capacity to absorb nutrients) and have slower growth and impaired cognitive capacity (Maternal and Child Nutrition Study Group 2013; figure D.1).

1.4 Improvements in child nutrition have lagged behind the country's economic, social, and human development progress over the past decades. At the time of project design in 2011, Nepal ranked in the top 20 countries with the highest national prevalence of stunted growth of children under five (40 percent) with persisting inequalities by rural-urban divide, income level, and geographical region. Stunted growth rates were higher in rural areas (42 percent, compared with 27 percent in urban areas); for the lowest wealth quintile of the population's income distribution (56 percent, compared with 34 percent in the middle quintile); and in the Mountain ecozone (52 percent), followed by the Hills (42 percent) and the Terai or plains area (37 percent).

Moreover, half of the population was seasonally food insecure, and key nutritional indicators remained low: 47 percent of children under five had a vitamin A deficiency; 48 percent of pregnant women had anemia; and 72 percent of children ages 6–23 months lacked a diversified diet encompassing the four food groups (Nepal 2011). Nepal’s transition to peace and stability had been accompanied by a notable decline in poverty from 46 percent in 1996 to 15 percent in 2011 (based on \$1.90 per day), with an average growth rate of 3.8 percent between 2001 and 2011 in the decade preceding the project and 4.4 percent between 2007 and 2017.<sup>1</sup>

1.5 The devastating earthquake and subsequent aftershocks that struck the country in April 2015 affected about one-third of the population, mostly located in the four severely affected districts. The delivery of essential health and nutrition services was disrupted, exacerbated by damaged roads and water sources, overwhelmed hospitals, and shortage of health personnel. Massive damage of livelihood and infrastructure and emotional stress caused by the earthquake were expected to further exacerbate nutritional vulnerability of young children and pregnant and lactating women. Total financial losses from the earthquake were estimated at \$7 billion, equivalent to 36 percent of the country’s gross domestic product in 2014 (UNICEF 2016).

## **Project Objective, Design, and Financing**

1.6 The SHD project was the World Bank’s first stand-alone lending operation supporting Nepal’s nutrition agenda. The project development objectives were to “(i) improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two and (ii) provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas” (see appendix C for details on the revision of objectives).

1.7 The first objective, improving practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two, was to be achieved through 100-day Rapid Results for Nutrition Initiatives (RRNIs) in targeted districts and communities. Communities were offered a menu of 15 goals with direct or indirect effects on nutrition. After the selection, communities formulated subproject proposals to achieve the selected goals and were granted funds to implement these subprojects on approval. Local government coordinated the RRNI teams, composed of community members, and managed the grants (up to \$3,000 each) to implement the 100-day subproject by the community. The RRNI teams could receive coaching and technical support and would mobilize local leaders and families in communities to influence the adoption of adequate nutrition practices related to the goal chosen. The project envisaged contracting with three nongovernmental organizations, which would be in charge of hiring and training coaches in nutrition-related issues and in the preparation

of subproject proposals. Sectoral technical extension workers from village development committees (VDCs; for example, in WASH) were expected to assist coaches and RRNI in the technical aspects of the work plan (for example, in building latrines). At the end of each 100-day cycle, the results would be assessed, and another 100-day RRNI could be conducted to target a new goal or reinforce the same goal, building on lessons learned. There were 8,950 RRNI subprojects across 15 districts. The RRNI were to target disadvantaged communities to help address inequities in nutritional outcomes and to geographically coordinate donor investments to improve national outcomes under the Multisectoral Nutrition Plan.

1.8 The menu of 15 goals for RRNI was designed to improve practices related to underlying causes of undernutrition, including social and cultural norms, within the life cycle of the mother and child. The menu of goals was expected to benefit women and children in the first 1,000 days from conception up to the age of two and other members of the community in such areas as sanitation and environmental health. As good practice, the World Bank's team piloted an early introduction of the RRNI in two VDCs to test the approach and incorporated lessons learned. The Implementation Completion and Results Report stated that the feedback from communities was very encouraging and the pilot helped articulate all areas of project implementation in the operational manual. Furthermore, some specific goals, such as eliminating open defecation and reducing indoor smoke, were closely aligned with ongoing national efforts (box 1.1).

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**Box 1.1. Menu of 15 Goals**

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1. Maintain adequate weight and regular eating among pregnant women and young children
  2. Increase consumption of animal-sourced protein among pregnant women and young children
  3. Practice proper and consistent breastfeeding
  4. Use clean and safe water
  5. Delay marriage and pregnancy for young girls
  6. Regular de-worming and utilization of iron supplements by young women
  7. Extend education of young girls
  8. Utilize family planning methods to avoid unwanted pregnancies
  9. Practice proper and consistent handwashing
  10. Ensure immunization of all children
  11. End open defecation
  12. Ensure prompt medical treatment of chest infection, fever, and diarrhea in young children
  13. Reduce workload of pregnant women
-

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14. Improve school sanitation

15. Reduce exposure to indoor smoke for pregnant women and young children

Source: Independent Evaluation Group.

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1.9 The second objective of providing emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas was to be achieved by providing nutrition care and treatment to malnourished children in districts critically affected by the earthquake. The objective added a focus on acute undernutrition outside the original theory of change. The World Bank partnered with the United Nations Children’s Fund (UNICEF; World Bank 2015), which was implementing nutrition response and recovery activities through the Ministry of Health and Population and other partners in 14 priority districts. UNICEF’s evidence-based nutrition recovery support addressed the nutrition issues of children under five and pregnant and lactating women in selected priority districts affected by the earthquake (box 1.2).

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**Box 1.2. United Nations Children’s Fund Activities in Districts Affected by the Earthquake**

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- Capacity enhancement of health workers, female community health volunteers, civil society organizations, and key stakeholders on management of acute undernutrition with medical complications
- Promotion, protection, and support for early initiation and exclusive breastfeeding (children ages 0–6 months)
- Promotion of timely and appropriate complementary feeding (6–23 months)
- Management of moderate acute undernutrition through supplementary feeding program (children ages 6–59 months)
- Prevention and management of acute undernutrition of pregnant and lactating women
- Management of moderate acute undernutrition through supplementary feeding program (children ages 6–59 months)
- Management of severe acute undernutrition program through therapeutic feeding program (children ages 6–59 months)
- Micronutrients for children and women such as micronutrient powder and vitamin A for children ages 6–59 months, iron–folic acid supplementation for pregnant and lactating women
- Distribution of cookery and hygiene kits to “golden 1,000 days” families from the most vulnerable segments of the community

Source: Independent Evaluation Group.

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1.10 To implement the nutrition emergency recovery program, UNICEF brought together other sectors such as health, WASH, child-friendly local governance, and social

protection to improve the nutrition status of children and pregnant and lactating women through multisectoral coordination and collaboration at the local level (UNICEF 2016). UNICEF signed the partnership cooperation agreement with civil society organizations and professional organization partners. To implement WASH in the emergency recovery program in coordination with nutrition interventions, UNICEF partnered with international and national nongovernmental organizations and civil society organizations to achieve results in WASH in communities and health centers.

1.11 The project’s implicit theory of change was based on the premise that the causes of undernutrition are multisectoral, as recognized by UNICEF’s conceptual framework of child undernutrition.<sup>2</sup> The full scope of the results chain could not be articulated at the design stage, since project activities were planned to be selected and subsequently defined and developed during implementation. Nevertheless, the menu of goals reflected the behavior changes known to improve the nutritional status of mother and children. The Independent Evaluation Group’s (IEG) imputed representation of the project’s theory of change in figure 1.1 shows that projects’ activities were logically linked to expected outputs and outcomes and are consistent with the problem analysis underlying the determinants of nutrition for children and pregnant women.

1.12 The \$40 million International Development Association financing commitment supported Nepal’s Multisectoral Nutrition Plan by mobilizing communities and local governments to promote nutritional practices in 15 districts in the western and central Terai region and by providing a nutrition emergency response in 14 districts affected by the 2015 earthquake (see table 1.1).<sup>3</sup>

**Table 1.1. World Bank Financing by Component**

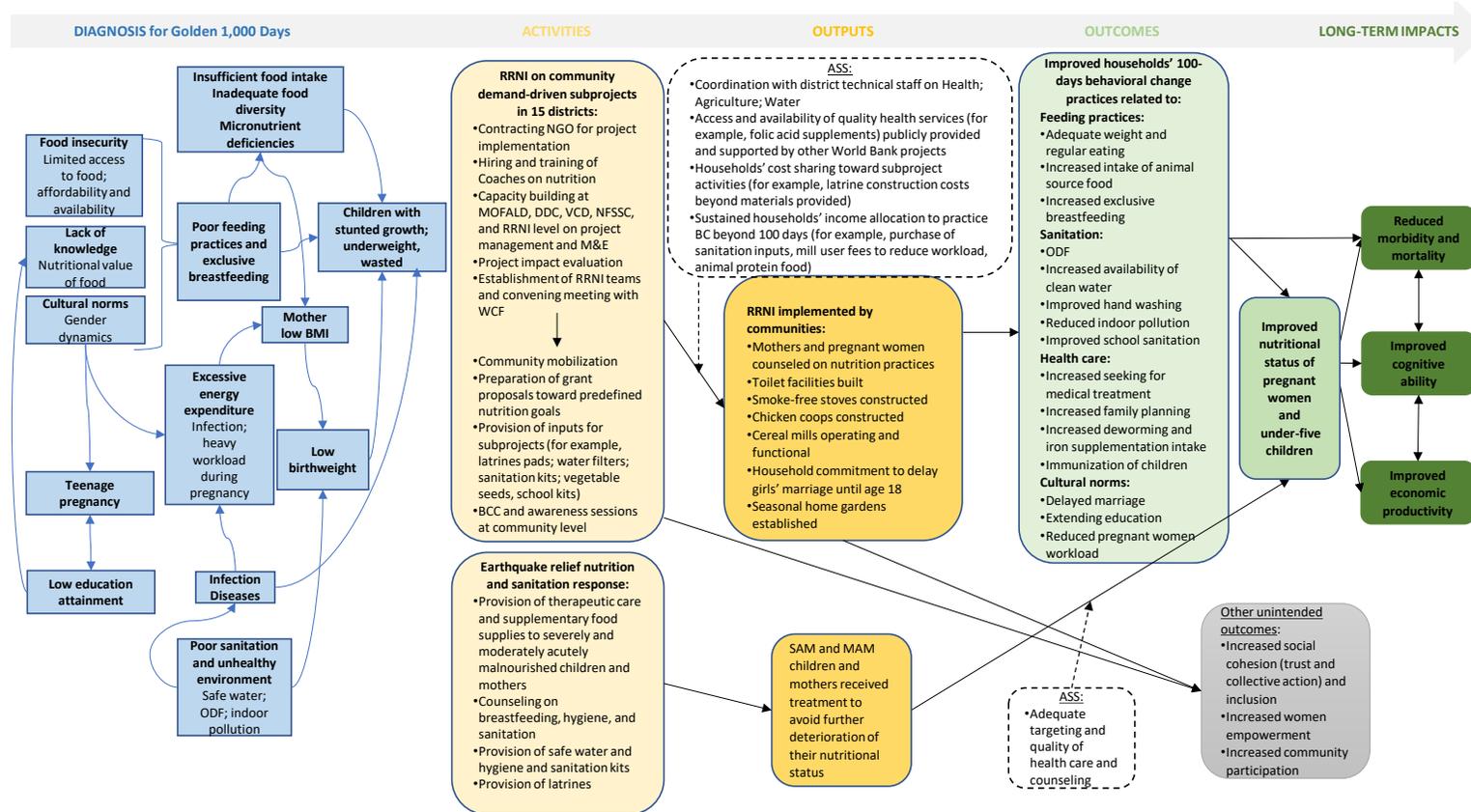
(US\$, millions)

Component	Appraisal Estimate	Restructuring	Actual Cost	Percentage of Appraisal
1. RRNI	34.86	22.86	17.2	49
2. Project management, capacity building, and monitoring and evaluation	5.14	5.14	2.6	51
3. Earthquake relief	n.a.	12.00	11.8	n.a.
Total project cost	40.00	40.00	31.6	79

Source: Independent Evaluation Group, Operations Portal.

Note: n.a. = not applicable; RRNI = Rapid Results for Nutrition Initiative.

Figure 1.1. Independent Evaluation Group's Theory of Change of the Project



Source: Independent Evaluation Group.

Note: ASS = assumption; BCC = behavior change communication; DDC = district development committee; MAM = moderately acutely malnourished; MOFALD = Ministry of Federal Affairs and Local Development; M&E = monitoring and evaluation; NFSSC = Nutrition and Food Security Steering Committee; ODF = open defecation free; RRNI = Rapid Results for Nutrition Initiative; SAM = severely acutely malnourished; VDC = village development committee; WCF = ward citizen forum.

## 2. What Worked, What Didn't Work, and Why?

### Results

2.1 All goals that were offered in the menu of interventions were important in influencing overall nutrition, but communities favored the more tangible water and sanitation investments; the selection of other areas, such as immunizations and family planning, was negligible. The highest selection rates within 2,321 wards consisted of the following: use of clean and safe water at 70 percent, consumption of animal-sourced protein at 43 percent, ending open defecation at 38 percent, and practicing consistent handwashing at 37 percent. By contrast, immunization of children and family planning were selected least often, at a mere 2 percent; iron supplementation at only 4 percent; and only 6 percent of the wards selected interventions for practicing proper and consistent breastfeeding (table 2.1). The significant differences in choices can raise concerns about demand-driven preferences versus a more multisectoral approach to reduce undernutrition.

**Table 2.1. Number and Percentage of Wards Selecting Each Goal**

Goal or Focus Area	Before Midline		After Midline				Total	
	Early Starter		Early Starter		Late Starter			
	(no.)	(percent)	(no.)	(percent)	(no.)	(percent)	(no.)	(percent)
Use clean and safe water	569	46	548	52	697	64	1,616	70
Increase consumption of animal-sourced protein among pregnant women and young children	330	27	327	31	393	36	1,005	43
Maintain adequate weight and regular eating among pregnant women and young children	196	16	346	33	462	42	965	42
End open defecation	654	53	78	7	202	18	878	38
Practice proper and consistent handwashing	323	26	317	30	266	24	857	37
Reduce exposure to indoor smoke for pregnant women and young children	190	16	257	24	247	23	660	28
Extend education of young girls	92	8	265	25	171	16	502	22
Improve school sanitation	69	6	126	12	67	6	241	10
Ensure prompt medical treatment of chest infection, fever, and diarrhea in young children	17	1	106	10	96	9	214	9

Delay marriage and pregnancy for young girls	19	2	88	8	85	8	190	8
Reduce workload of pregnant women	39	3	50	5	61	6	144	6
Practice proper and consistent breastfeeding	26	2	58	5	48	4	130	6
Regular deworming and use of iron supplements by young women	65	5	25	2	4	0	93	4
Use family planning methods to avoid unwanted pregnancies	8	1	28	3	12	1	48	2
Ensure immunization of all children	4	0	34	3	7	1	45	2
Number of wards	1,224		1,062		1,097		2,321	

*Source:* Ministry of Federal Affairs and Local Development 2018.

*Note:* Percentages add up to more than 100 percent because the wards had multiple rounds of Rapid Results for Nutrition Initiatives, ranging from 4 to 7 rounds (known as cycles). For example, 1,616 wards out of 2,321 wards (70 percent) selected the goal of using clean and safe water at least once in various rounds, and, within the same total pool of wards, 1,005 wards (43 percent) also selected the goal to increase the consumption of animal-sourced protein at least once in various rounds. Hence, the table has a concurrent data structure, like a scorecard, illustrating parallel results of the different choices made within the same group of wards during project implementation.

2.2 Overall, project results reflected a favorable pattern of raising awareness on the importance of nutrition and improving nutrition practices in communities. Findings were based on qualitative data collected during mission field visits (such as interviews and focus groups with beneficiaries and project stakeholders), IEG’s outcome harvesting analysis, secondary data sources (such as Demographic Health Survey [DHS] and Health Management Information System), and the project’s evaluations such as the impact evaluation and the qualitative study (see appendix C for more details on Project Performance Assessment Report methodology).

2.3 The project contributed in an important way to improving sanitation and hygiene practices in the communities implementing RRNIs. According to the endline survey, the percentage of households reporting using improved toilet facilities (flush toilet, covered pit within household, community latrine) increased from a baseline of 25 percent in 2014 to 80 percent in 2017, exceeding the target of 35 percent (table 2.2). IEG’s outcome harvesting analysis also confirmed positive results in WASH (table 2.3). IEG’s field trips to Saptari, Udayapur, and Dhanusha districts confirmed that toilet facilities constructed by the project were in place. RRNI teams constructed over 900 toilets in low-income households with children under two in Mahadeva, Tricol, Malhaniya, Bhutahi Paterwa, Mukhiyapatti, and Batteswor communities. There was a clear demand for the construction of toilets, as shown by the number of wards that selected the open defecation-free (ODF) goal and by cost contributions that were borne by communities to pay the builders and community masons. The demand for toilet

facilities was so high that the IEG mission was informed about some households protesting about not being eligible to receive toilet benefits. ODF subprojects were closely aligned with the national effort to end open defecation. The project contributed to government efforts in declaring ODF areas. In Nepal, declaration of districts as ODF encourages national efforts to prevent waterborne diarrheal diseases. Beneficiary groups in Mahadeva and Tricol confirmed the ODF status at ward level and recognized the role of the project in achieving such declaration. Some wards in Mahaniya even achieved a “full sanitation” declaration.

**Table 2.2. Progress toward Project Targets**

(percent)

Project Development Indicators	Baseline	Midline	Endline	Target
Pregnant women taking IFA supplements for 180 days	21	24	27	30
Children ages 0–6 months who are exclusively breastfed	69	69	58	80
Children ages 6–24 months who consume a minimum acceptable diet	9	13	15	25
Households reporting no smoke in the room while cooking	35	43	39	45
Pregnant women reporting consuming animal-sourced protein in the previous day	60	72	76	75
Households reporting using improved toilet facilities (flush toilet, covered pit within household, community latrine)	25	52	80	35
Mothers (of children ages 0–2) reporting always washing hands at critical times				
After defecation	71	77	85	80
Before eating	17	24	38	25
Before feeding children	10	14	22	20
After cleaning a child’s bottom	53	56	62	70

Source: Ministry of Federal Affairs and Local Development 2018.

Note: IFA = iron–folic acid.

**Table 2.3. Outcome Harvesting Analysis: Results from the RRNI in Selected Communities in Saptari, Udayapur, and Janakpur Districts**

New Action Undertaken in Communities	Significance	Contribution of the Project	Challenges (Optional)
General community education on nutrition			
In all the villages visited, RRNI teams mobilized mass communication about the full menu of messages on nutrition.	RRNI teams broadened the communication in villages to integrate all nutrition messages (complementary feeding, breastfeeding, sanitation, and so on).	The project trained the coaches in the full menu of themes and used the same BCC materials as other partner programs.	

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	<p>“Golden 1,000 days” is now commonly understood, and it became a slogan for nutrition even among other development partners.</p>	<p>The RRNI team and WDC gathered entire communities for the RRNI.</p>	
<p>In Mukhiyapatti, 35 community leaders (teachers, vulnerable groups, women groups, elders, and so on) cascaded nutrition messages to the community. They continue to do so in the present.</p>	<p>This allowed the RRNI team to mobilize the entire community about the nutrition messages.</p>	<p>The RRNI team conducted a household survey to understand needs and identify leaders.</p> <p>The district provided training.</p> <p>The RRNI team accompanied leaders to households, schools, and so on.</p>	
<p>11. Open defecation free</p>			
<p>In Mahadeva, Tricol, Malhaniya, Bhutahi Paterwa, Mukhiyapatti and Batteswor, RRNI teams constructed over 900 toilets in low-income households with children under two.</p>	<p>There was a clear demand for the construction of toilets, as shown by the number of wards that have chosen such objective and by cost contributions borne by communities to pay builders. This subproject was closely aligned with a national effort to eradicate open defecation, and thus the toilets helped the villages declare ODF.</p>	<p>RRNI teams identified target households.</p> <p>Community masons built the toilets.</p> <p>Communities received technical support from the district’s WASH personnel who inspected the toilets.</p> <p>WASH committees promoted toilets.</p>	<p>In some communities, the untargeted population was not eligible to receive toilet benefits, which created some tensions.</p> <p>Some elders do not use the toilets, even if they are available.</p> <p>There is anecdotal evidence of a few cases where toilets were not constructed after villages received the materials or were destroyed by the earthquake.</p>
<p>8. Handwashing</p>			
<p>In Mahadeva, Tricol, Katunje Babala, Herdeni, and Mukhiyapatti, households installed and use handwashing stations with soap.</p>	<p>Handwashing practices were inadequate. It was often done with ash or mud, not soap, and was not practiced when preparing food, contributing to diarrhea and other illness.</p> <p>Communities improved their handwashing practices, and households visited continued to buy soap.</p>	<p>District or health posts staff contributed with coaches in providing training.</p> <p>RRNI teams procured and distributed handwashing kits (for example, buckets, taps, soap, and towels).</p>	
<p>4. Clean water</p>			

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<p>In Mahadeva, Tricol, Katunje Babala, Herdeni, Bhutahi Paterwa and Batteswor, households installed water filters, tanks, pipes, pumps, or wells to access clean water.</p>	<p>Water sources needed to be filtered to prevent disease; in other areas, pipes, wells, and pumps now bring water to households, reducing the workload of women to collect water.</p>	<p>District gave training on water filtration. RRNI teams distributed materials to households (pumps, pipes, and so on) or constructed community wells.</p>	<p>Limiting materials to target groups created tension in communities.</p>
<p>10. Immunization of children</p>			
<p>In Tricol, through households visits in one community the RRNI team identified children that were not fully immunized and encouraged parents to send them to the nearest health post for immunization.</p>	<p>Household visits raised awareness on the importance of immunization convincing parents to immunize children by addressing misconceptions. This contributed to immunization coverage in the village.</p>	<p>The RRNI team worked with the health post and FCHWs to conduct door-to-door visits to households with children to promote immunization.</p>	
<p>5. Delayed marriage and 7. Extending education</p>			
<p>In Katunje Babala, 125 head of households committed to the WCF to delay early marriage of their children until age 18.</p>	<p>Child marriage is common in the community and often supported by the head of household and local leaders.</p>	<p>RRNI team mobilized 25 community leaders to follow the commitments. World Vision supported a delayed marriage program in the past and was contacted by the coach to support counseling in the community. Local health post staff and medical students also participated in counseling sessions.</p>	<p>Dissolution of WCF limits monitoring of a family's commitment on delay marriage. Some adolescents leave from home.</p>
<p>In Mukhiyapatti, in one community, women scheduled shifts for their work to be able to send their daughters to school; others started working in the field as a second source of income to the household; or adjusted timing of housework and improved productivity.</p>	<p>The adjustment of duties showed a new understanding of the importance of investing in education of girls.</p>	<p>RRNI team held education sessions for women with girls not in school and provided school supplies.</p>	<p>The workload of the mother increased.</p>
<p>In Herdeni, in one community, adolescent girls in school received</p>	<p>Girls' concerns about menstruation were identified as a main reason</p>	<p>The health post trained the girls. The RRNI team made sanitary kits.</p>	<p>One hundred days was not enough time to follow girls' progress.</p>

sanitary kits and health education.	for school absence or dropping out.		
In Tricol and Bhutahi Paterwa, RRNI teams in two communities registered out of schoolgirls and boys in school.	Girls (and boys) often do not attend school due to housework, awareness, cost, and so on. Heads of household were involved to influence family decisions. Before the project, girls school attendance was only 10 percent, now it is 50 percent. Approximately 60 percent of boys attend school. In both communities, school attendance is equal for boys and girls.	RRNI teams held education sessions for households with out-of-school children and provided school supplies. Schools organized registration days.	
<b>13. Reduction of workload of women</b>			
In Katunje Babala and Herdeni, women use village mills (about 20 women use each mill per week) to grind rice, reducing their daily workload.	Women previously walked over two hours to grind rice or ground rice by hand. The mill saves time and costs less to use than the mill in the town. Currently the mills manager charges user fees toward maintenance and fuel costs.	RRNI teams constructed three mills, with cost sharing from the community and identified villagers to manage the mills. RRNI organized counseling sessions to the community to explain the negative consequences of heavy duties during pregnancy, where husbands were included to eliminate misconceptions about heavy work helping baby delivery.	
<b>1 and 2. Diet diversity</b>			
In Katunje Babala, women produce, prepare and store leafy green vegetables for their consumption.	Women did not eat leafy greens in adequate quantity year round due to lack of knowledge about types of vegetables to grow seasonally; in-laws were involved to help influence household food decisions.	RRNI teams and coach liaised and sought collaboration with agriculture technicians to train women and in-laws on diet diversity and food preparation, distribution of seeds, and household visits with FCHW.	
<b>3. Breastfeeding</b>			
In Katunje Babala, women scheduled feeding times	Frequency of breastfeeding is a challenge with work in	Collaborated with health post to educate pregnant	Few communities chose this goal, arguing a

for breastfeeding four to six times per day between their agriculture work.	the field. There were misconceptions about the importance of giving colostrum to newborns.	women, women with young children, and in-laws on child feeding. FCHW helped monitor breastfeeding practices through household visits.	small number of pregnant women in their wards.
15. Smoke reduction (air pollution)			
In Katunje Babala and Herdeni, over 400 households replaced traditional cooking stoves with smokeless stoves.	Smokeless stoves reduce air pollution and are more efficient: they conserve firewood, reducing the burden on women's time, their health, and deforestation. Like ODF, smoke-free stoves were part of a national initiative, and all households in the ward benefited. Households continue to use the stoves.	RRNI teams distributed frames for stoves, and districts provided training for using the stoves. Local masons built the stoves.	

Source: Independent Evaluation Group.

Note: Villages had nine wards or settlement communities. Interventions were implemented in selected communities. BCC = behavior change communication; FCHW = female community health worker; ODF = open defecation free; RRNI = Rapid Results for Nutrition Initiative; WASH = water, sanitation, and hygiene; WCF = ward citizen forum; WDC = ward development committee.

2.4 The project's support for improving handwashing practices was also effective. The percentage of mothers of children ages 0–2 years reporting always washing hands at critical times (that is after defecation, before eating, and before feeding the children) increased during the project cycle and exceeded the targets, with the exception of washing hands after cleaning the child's bottom, which improved but fell short of the target (table 2.2). In Mahadeva, Tricol, Katunje Babala, Herdeni, and Mukhiyapatti, IEG confirmed handwashing stations with soap were installed and used. RRNI teams procured and distributed handwashing kits (for example, buckets, taps, soap, and towels). District or health post staff contributed with coaches in providing training. Beneficiaries reported knowing how and when to wash their hands. The project helped change handwashing practices from a traditional culture of using ashes and mud to using clean water and soap.

2.5 The project improved practices related to safe drinking water. Since the majority of households already had access to an improved water source, according to the project's impact evaluation, most communities selecting this goal did not actually build water sources but rather received filters, buckets, and storage tanks to improve management of safe drinking water. Provision of inputs was combined with training on how to install water filters to ensure long-term duration and maintenance, with the

support of coaches and technical extensions workers from the village WASH committee. IEG's outcome harvesting analysis confirmed that water filters were still functional in households. Communities were aware of the importance of filtered water to prevent diarrhea and cholera, and thus reinforced the handwashing goal (table 2.3).

2.6 Households' environmental results in reducing exposure to indoor smoke for pregnant women and young children were rather modest. The percentage of households reporting no smoke in the room during cooking increased from 35 percent in 2014 to 39 percent in 2017, short of the target of 45 percent. Yet, 77 percent of surveyed households at endline responded that they knew how to avoid smoke in the house, compared with 39 percent at baseline, which indicates that improved knowledge does not necessarily translate into improved practice. Like ODF, smoke-free stoves were part of a national initiative benefiting all households in the ward. Outcome harvesting analysis showed that in Katunje Babala and Herdeni, over 400 households replaced traditional cooking stoves with smokeless stoves. Smokeless stoves reduce air pollution and are more efficient because they conserve firewood, reducing the burden on women's time and health and reducing deforestation.

2.7 The projects' WASH benefits were sustained, as confirmed by the IEG mission. Continued monitoring and maintenance support by other sector staff, such as in water and sanitation, contributed to sustainability in this area. Improvements included the use and maintenance of latrines, community water pumps, water filters, cookstoves, and handwashing stations, along with related good practices such as handwashing with soap. Interviews with beneficiary community groups confirmed that improvements persisted within communities that had chosen sanitation goals from the menu. According to interviews with officials of the Ministry of Water, most wards selecting this goal remained ODF.

2.8 The project's contributions to improving adequate feeding practices for pregnant women and young children showed mixed results. Most household heads in the endline sample (93 percent) were aware of an adequate diet for pregnant women, compared with 75 percent at baseline; however, progress in adequate feeding practices remained low. The consumption of animal-sourced proteins was difficult to sustain after the project and in some cases was difficult to implement. Animal-sourced protein subprojects often chose either to raise chickens and distribute eggs or distribute eggs and milk bought from the market. The former activity was labor-, skill-, and cost-intensive: it required a lot of effort to build hen coops, and to buy and rear chickens. Younger hens were not ready to lay eggs from the first day of the project, and those hens that were old enough to lay eggs as soon as the project started would die soon. Therefore, because of the cost and effort of pursuing this goal, the desired results could not be obtained in 100 days (Oshima et al. 2017). Nevertheless, the percentage of

pregnant women reporting consuming animal-sourced protein in the previous day increased from a baseline of 60 percent in 2014 to 76 percent in 2017, above the target of 75 percent.

2.9 Breastfeeding, minimum acceptable diet in children under two, and consumption of iron supplements by young women showed modest progress because these goals were chosen by few wards. First, the percentage of children ages 0-6 months who were exclusively breastfed showed no progress from the baseline of 69 percent because only 6 percent of the total wards selected this goal at least once during the subproject cycles. During IEG's field visits, some communities justified not having chosen the breastfeeding goal because the number of pregnant women was low. Yet breastfeeding was stalled at the national level. In DHS 2011, breastfeeding was 70 percent, and the countrywide rate decreased to 66 percent in DHS 2016. Although there was no clear explanation for this national trend, it is possible that the massive earthquake in 2015 put greater pressure on women's chores and household damage repairs, thus limiting women's time and commitment to breastfeeding (World Bank 2018a, 17). Second, the percentage of children ages 6-24 months who consumed a minimum acceptable diet increased from a baseline of 9 percent in 2014 to 15 percent in 2017, but fell short of the target of 25 percent. Third, the percentage of pregnant women taking iron and folic acid supplements for 180 days increased from 21 percent in 2014 to 27 percent in 2017, short of the target of 30 percent since only 4 percent of wards selected this goal.

2.10 The impact evaluation reported less successful outcomes in goals that were less often chosen by communities. The project was one of the first initiatives in Nepal and in the world to implement the RRNI on a large scale, so it was important to conduct a rigorous evaluation. However, because of the community-driven nature of the project, the impact evaluation estimated project impacts using VDC population subgroups regardless of the goals chosen because they were unknown at entry. For instance, only 6 percent of communities selected "practicing proper and consistent breastfeeding" and as a result, the project was deemed unable to achieve the target. It would be misleading to conclude that the project failed to achieve the target when the associated goal was not widely selected by communities.<sup>4</sup>

2.11 Results on extending education and delaying marriage and pregnancy for young girls showed some progress, although only 22 percent of communities selected the former, and only 8 percent selected the latter. The IEG mission was informed that child marriage was a common practice. Also, girls (and boys) often did not attend school for several reasons, including household chores, lack of awareness, the cost involved, and girls' concerns about menstruation. It is also known that adolescent girls from displaced populations are more likely to drop out of school. Therefore, RRNI held education sessions for households with out-of-school children and mobilized community leaders.

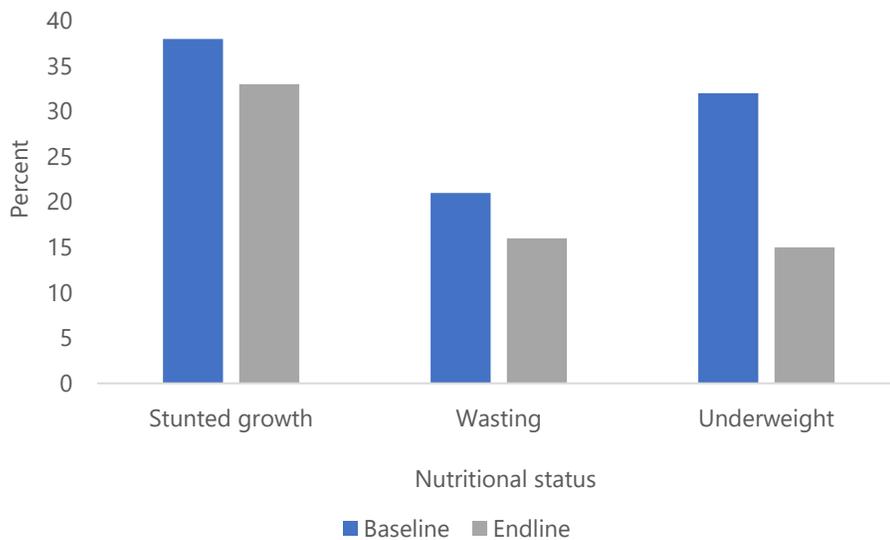
Peer learning among girls to motivate school attendance was common. Subprojects provided uniforms and books, and sanitary kits for girls who needed them. However, the endline survey found that only one-third of household heads believed girls should be sent to school until at least 20 years of age. Communities interviewed by the IEG mission stated that in Tricol 50 percent of girls regularly attended school, compared with a rate of only 10 percent before the RRNI, and about 60 percent of boys attended. In Mukhiyapatti, the mission noted that women made scheduled shifts in their work to send their daughters to school. Other women started working in the field to provide a second source of income to the household or adjusted housework timing for improved productivity. In Tricol and Bhutahi Paterwa, schools organized registration days to encourage parents. In Herdeni, adolescent schoolgirls received sanitary kits from RRNI teams and health education at health posts. But stakeholders reported that 100 days (the duration of an RRNI round) did not provide sufficient time to follow up on girls' practices and well-being. In Katunje Babala, 125 heads of households made commitments to the ward citizens forum to delay early marriage of their daughters until the age of 18, although it is understood that early marriage cannot be totally prevented in certain settings.

2.12 The goal of reducing the workload of pregnant women was attained in the areas visited by the IEG mission. The goal was selected at least once by a small group of wards (6 percent). Village mills saved time and cost less than using the town mill. In Katunje Babala and Herdeni, the IEG mission found that women use village mills (about 20 women use each mill per week) to grind rice, thus reducing their daily workload. Women reported that previously they had to walk more than two hours to grind rice or do it by hand. Progress made was the result of RRNI teams building three mills with community cost sharing and community management. RRNI also organized counseling sessions for the community to explain the negative consequences of heavy duties during pregnancy, and husbands were included to eliminate misconceptions about heavy work facilitating the delivery of babies.

2.13 Importantly, the impact evaluation revealed improved nutritional status, such as lower rates of stunted growth, wasting, and underweight of children under two years of age as a result of the RRNI. The baseline rates compared with endline rates showed the following improvements between 2014 and 2017: stunted growth decreased from 38 percent to 33 percent, wasting from 21 percent to 16 percent, and underweight from 32 percent to 15 percent (figure 2.1). Although these trends are not strictly comparable to the national rates, because DHS measures the nutritional status of children under five, Nepal has made good progress in reducing stunted growth and improving other nutrition outcomes (table D.1). The project's high achievements in WASH, and to a lesser extent in adequate dietary practices, plausibly contributed to reducing the

prevalence of enteric infections, as shown by the impact evaluation. Reducing child diseases and infections is key to improving nutritional status because they are associated with reduction in food intake, intestinal malabsorption, and endogenous nutrient loss. At endline, fewer children suffered from coughing, diarrhea, and vomiting compared with the baseline and midline: 20 percent of children under age two had had a cough in the 15 days before the interview, compared with 36 percent at baseline; 5 percent of children suffered from diarrhea for more than three days, compared with 10 percent at baseline; and 3 percent of children suffered from vomiting, compared with 6 percent at baseline.

**Figure 2.1. Trends in Nutritional Status of Children under the Age of Two Years in Project Areas**



Source: Ministry of Federal Affairs and Local Development 2018 and World Bank 2018a.

2.14 In areas affected by the earthquake, promotion of breastfeeding and complementary feeding was effectively undertaken by UNICEF. The agency trained 15,000 people (including district trainers, district public health office staff, health workers, and female community volunteers) in the management of acute undernutrition, medical complications, and promotion of breastfeeding and timely initiation of complementary feeding with diversified, appropriate, and nutritious food across the 14 affected districts (UNICEF 2016).

2.15 Treatment of severe acute undernutrition in children under five years and prevention of undernutrition in earthquake affected areas was achieved. Under the project, and through UNICEF-led efforts, 4,299 children ages 6–59 months with severe acute undernutrition received therapeutic care, exceeding the target of 4,000 children. UNICEF procured and delivered 44,000 and 2,500 cartons of ready-to-use

supplementary food and ready-to-use therapeutic food in all 14 districts for the management of moderate and severe acute undernutrition and provided 1.1 million boxes of multiple micronutrient powder. About 0.36 million children ages 6–59 months in earthquake affected 14 districts received multiple micronutrient powders during the two Child Nutrition Week campaigns held to improve the nutrient density of their diets and prevent micronutrient deficiencies. Also, 169,701 mothers of children ages 0–23 months in the earthquake affected 14 districts received infant and young child feeding counseling, including on exclusive breastfeeding and complementary feeding, feeding practices, and hygiene behaviors.

2.16 The provision of emergency sanitation support to vulnerable populations in earthquake affected areas was significant. Through UNICEF, the project financed the provision of 80,013 hygiene kits, including buckets and mugs, and cookery kits, to reach golden 1,000 days families, exceeding the target of 45,000 households. UNICEF hygiene kits consisted of 14 items for personal and family hygiene practices such as soap, toothpaste, toothbrushes, sanitary cloths for mothers, diapers for babies, nail cutters, and other items. In addition, 347,954 families were provided with WASH counseling, and 53,254 households benefited from water supply system repair and rehabilitation, system chlorination, and household water treatment for safe drinking water.

2.17 As unintended outcomes not included in the project development objectives, the project generated positive social cohesion elements that may contribute to building social capital. In terms of **trust**, the impact evaluation showed that respondents who stated that “most people in the village can be trusted” increased from a baseline of 89 percent to 94 percent in 2017, and that “most people in the village try to be helpful” increased from 87 percent to 90 percent. Respondents who stated that “people from the same ethnic origin” can be trusted increased from 80 percent to 95 percent, and that “people from other ethnic groups can be trusted” increased from 78 percent to 88 percent. At the same time, interviews suggested that social cohesion had a mixed pattern, with geography being one determinant, since it was observed that trust was elevated in hilly areas in contrast with modest or moderate trust in the plains. In terms of **collective action**, the impact evaluation showed a higher percentage of households reporting that they have worked with others in the village for the benefit of the community, at a rate that increased from a baseline of 11 percent before the project to 18 percent in 2017. Also, members of RRNI communities were more likely to attend village council meetings, public hearings, or public discussion groups, or to vote when compared with members of control group communities. As for community **empowerment**, the results were not favorable, since only 17 percent of respondents felt they had control over decisions affecting everyday activities, a decline from a baseline of 38 percent, and there was no improvement in the share of respondents who felt they had

an impact in making the village a better place. However, according to impact evaluation analysis, these trends could have been due to shocks unrelated to the RRNI program, such as the massive earthquake and political elections. At the same time, a government official noted during a IEG interview that the most meaningful benefit of the community-driven program was the elevation of people’s voices because communities had the opportunity to select and implement the interventions that they wanted.

2.18 Sustainability of outcomes and financing of project activities were not fully achieved. Notwithstanding positive elements in WASH investments and some aspects of technical sustainability discussed above, broader financial and institutional sustainability raise concerns. The federal government transferred SHD program to local government and rural municipalities, where there was no evidence of budget commitments to sustain the program, and the RRNIs were discontinued at project closing. Although certain initiatives were not maintained— for example, it was difficult to sustain the progress made with chicken coops due to lack of financing for chicken vaccination, chicken food, or for maintaining the coops— other areas of project support, such as community mills, were successfully maintained and managed by the communities.

## **Design and Preparation**

### **What Worked and Why**

2.19 The main design and preparation factors of the SHD project that worked well involve an adequate focus on the period of life that is most vulnerable to undernutrition, a multisectoral interventions approach, and flexibility in community choices that promoted ownership.

2.20 The project’s name “Sunaula Hazar Din” or “golden 1,000 days” became a “brand name” in Nepal, synonymous with the first 1,000 days of early childhood nutrition and health. Community members identified with the project’s name and understood SHD’s meaning. Households with pregnant women and children under two years old recognized themselves as SHD households targeted by the community for an action project. The following quote from a coach in Mahadeva village development reflects stakeholder appreciation:

The Golden thousand days as expressed by the word golden, are the new days that come in our life. I am fascinated by the way that golden thousand days are described by combining the days of pregnancy and the two years after delivery. I feel very happy to share the importance of golden thousand days in the community. This program has been very effective in our society in bringing change in sanitation of

surroundings to change in behavior of family members and golden thousand days mothers. The changes in their habits and behavior are: regular health-checkup of pregnant mother in health facilities, regular immunization of babies, providing nutritious food to delivered mothers, maintaining cleanliness etc. Though it is difficult in reaching the targeted group with proposed budget for golden thousand days, these program goals with less investment have been very effective in community. I along with community people have understood about nutrition and have been practicing in our daily life. These programs have brought many changes in behavior of people. There are a lot of good things about Golden thousand days that any writings about it, will be not sufficient.

2.21 The project concept was multisectoral by design and focused on addressing root factors contributing to undernutrition. The breadth of the menu of goals was impressive in addressing determinants and the life cycle of mother and child. Excluding earthquake relief, the design intended to focus on risk factors for chronic undernutrition from conception up to the age of 24 months, thus adopting a life cycle approach at its initial phases, rather than focusing on downstream care when morbidity would have had already surfaced. For example, daughters of malnourished and anemic women often grow up to become malnourished mothers themselves, thereby perpetuating the cycle of chronic undernutrition. The project focused on behaviors and practices that are known to improve nutritional outcomes. As such, the focus was to support communities in selecting, designing, and implementing small projects based on a menu of interventions that address risk factors and that are facilitated by community mobilization. Furthermore, some specific goals, such as eliminating open defecation and reducing indoor smoke, were closely aligned with ongoing national efforts.

2.22 Notably, the project design was innovative in integrating a focus on social norms related to early marriage, early pregnancy, and women's empowerment. Social norms were found to be strongly correlated with nutrition outcomes in a recent IEG evaluation on the World Bank support for child undernutrition (World Bank 2021). There is consensus that social norms can provide an understanding of gender roles, such as those related to decision-making regarding the care of children, and social and cultural practices that may influence the nutrition status of children and pregnant and lactating women, women's empowerment, early marriage, and childbearing. The RRNI was a successful approach to help address social norms such as related to delayed marriage and work time for the communities selecting such goal.

2.23 SHD justifiably used a community-driven development (CDD) approach to induce behavioral changes in communities; these changes addressed diverse cultural beliefs and practices that perpetuate the cyclical intergenerational challenge of undernutrition in families. Nepal has a strong track record in CDD, and other World

Bank projects in Nepal adopted the concept and had community-based subprojects, including in irrigation and water resource management, poverty alleviation, and HIV/AIDS (see table D.3). The CDD nature of RRNI, with flexibility in the selection of subprojects, was largely owned by communities. When the project was developed there were concerns regarding community empowerment, voice, and trust due to the political situation of the country. The country was undergoing institutional reforms toward a devolved governance system (although federalism and local political leadership were not established until 2017), and with this was a need to reinforce the participation of communities in developing their human capital.

## **What Didn't Work and Why**

2.24 However, a multisectoral design through a solely demand-driven approach was not enough to guarantee a convergence of interventions to respond to all households' needs. Although the project design had promising and innovative aspects with potential to influence undernutrition through selected goals, it was not necessarily conducive to addressing all prevalent community problems if associated goals were not selected by communities. The design was completely flexible for community choices, and selections showed clear community preferences for tangible investments such as in latrines, stoves, and clean water. There was much less interest from the communities in other goals such as immunization and family planning.

2.25 In that sense, the design of a menu approach gave communities alternatives to choose from, bringing the risk of not having a coherent set of activities to produce meaningful results. For example, promoting the use of latrines without adequate handwashing is not likely to reduce enteric infections. In practice, however, some goals were de facto bundled during the implementation of subprojects. For example, although the menu of goals offered proper and consistent breastfeeding, reduce workload of pregnant women, and adequate feeding practices, IEG's interviews revealed that counseling and awareness meetings introduced breastfeeding promotion or pregnant women's workload reduction under subprojects focusing on adequate eating.

2.26 The short RRNI implementation time frame without sufficient capacity building for local governments may have biased the selection of goals by communities toward goals that were easier to achieve. Some goals could not realistically be implemented and achieved in 100 days by communities without adequate technical support. The qualitative study by Oshima et al. (2017) found that some wards rejected the goal of increasing animal-sourced protein consumption because of the need to show visible outcomes in 100 days. Some could have considered rearing buffaloes or goats for their milk production but raising a calf (which was cheaper than buying a full-grown animal) would take more than 100 days to show results. Communities may have needed more

local services and technical support in combination with the demand-driven empowerment support to implement this type of subproject and build on efforts of the RRNI for sustainability. The design of the RRNI approach relied heavily on the quality of coaches to guide the RRNI teams and communities in goal selection based on lessons from implementing rapid results approaches in other countries, but with the challenge of carrying it out on a much larger scale. The heterogenous technical quality of the coaches' network to engage communities may partially explain the selection of more accessible goals, such as water filters.

## **Implementation and Supervision**

### **What Worked and Why**

2.27 Cross-sectoral collaboration in specific areas was adequately undertaken in project interventions. It should be pointed out that collaboration was facilitated by the government of Nepal's promotion of a multisectoral agenda. Overall, the country has good policies and plans, with adequate stakeholder appreciation of the need to promote nutrition and joint efforts (Webb et al. 2016), though weaknesses in implementation and monitoring persist. Joint work among sectors was facilitated by the common targeting criterion of the golden 1,000 days, which contributed to maximizing synergies among sectors. The golden 1,000 days criterion, which prioritizes households with pregnant and lactating women and children under two years of age for various interventions, is transparent and widely accepted (Banerjee et al. 2018).

2.28 Human resource skills developed by the project through UNICEF in the context of earthquake response were also maintained. Involvement of WASH programs in addressing children's undernutrition and stunted growth continues through collaboration between nutrition and WASH programs from recovery to the development phase. The WASH program continues to work in supporting WASH facilities in health posts and to assist communities in the improvement of water supplies and sanitation within nutrition programs. Under UNICEF-led project activities, all health workers and female community health volunteers in earthquake affected priority districts have already been trained on the management of nutrition among children. A smooth transition is foreseen, since existing government structures and processes are in place to take over related responsibilities.

2.29 The World Bank and the borrower demonstrated that through adaptive management the project could continue pursuing project objectives and respond to the earthquake crisis. In reacting to the earthquake, and rather than following a common pattern of diverting funds to understandable new needs unrelated to the original development objectives, the project maintained its nutrition focus and was restructured

to provide emergency nutrition and sanitation relief to vulnerable populations while harnessing UNICEF expertise. The project broadened its scope from 15 to 23 districts by including new districts critically affected by the earthquake. The government proactiveness became visible only at midcourse. After the delayed rollout of activities, the government sought to make up for the initial implementation delays and allowed communities that had successfully completed their subprojects to submit more than one proposal in the subsequent cycle of proposals. The project concurrently considered absorptive and implementation capacity, resulting in a decision to allow only those communities that had achieved 80 percent of their targets to undertake multiple initiatives at the same time. Finally, since capacity building takes time, the government adapted by providing enhanced technical support and additional human resources to support the districts. The project provided this additional support to each district to facilitate RRNIs, resulting in an increase in subprojects during the final year of implementation.

2.30 The project benefited most disadvantaged areas to maximize its development impact. The project covered 15 out of 75 districts in the country, based on stunted growth levels, poverty levels, population density, and the absence of overlapping interventions by other development partners. Within the selected districts, the project targeted 25 percent of the most disadvantaged VDCs (with nine wards in each). The results of the baseline survey confirmed that the VDCs where the project was being implemented were the most disadvantaged areas, since most baseline indicators in those areas were below the national averages for the country. This underlines the fact that the project had a strong targeting mechanism and that its developmental impact reached the most vulnerable and the lowest-income people of the targeted areas.

### **What Didn't Work and Why**

2.31 The project was hampered by administrative delays, inadequate financial management, and weak capacities and competencies. Actual implementation started only in 2014, two years after project effectiveness. The project could not secure funds for one year because of a countrywide delay in approval of a full budget for fiscal year 2013. The placement of the three nongovernmental organizations (known as national service providers) responsible for the recruitment and training of coaches was delayed because of slow procurement. The project operations manual was also delayed by two years.

2.32 Slow fund flows persisted throughout the project because of weak capacities in financial management. Unlike in the rapid results design, there were delays in project approval and grant disbursement, which created frustration among project implementers and beneficiaries (Oshima et al. 2017). The Ministry of Federal Affairs and Local Development suffered from weak capacity, and its staff was not fully dedicated to

project implementation. The project management team suffered from high turnover and vacancies. Staff who carried out project management activities at the local level did not have adequate technical skills and experience, and they were already overstretched by other tasks within the sector. The Nutrition and Food Security Steering Committee could not review and process proposals and work plans in a timely manner. Approval of community proposals was a lengthy process because of difficulties in convening meetings with committee members belonging to different line agencies. Substantial technical support was needed to help communities in developing proposals and in rewriting them because of their low quality.

2.33 During the initial project years, coaching skills were too weak to adequately support RRNI teams. Finding and organizing the nine RRNI members required for each subproject was challenging, and sometimes, members were selected without being informed, resulting in confusion and inefficiency (Oshima et al. 2017). According to findings of the Rapid Results Institute in its review of SHD in 2015 (RRI 2015), it was difficult for the RRNI teams to state their 100-day goal. Instead, most teams repeated their focus area, listed activities of their work plans, or both. This was of concern, since the 100-day goal of a given subproject was a key mechanism for driving iterative problem solving and for ensuring that activities translated into actual behavior change results. After the Mid-Term Review in 2015, related issues were alleviated, largely through training and additional human resources and technical support (World Bank 2018a, 25), which were provided to each district to facilitate RRNIs, resulting in an increase in subprojects during the last year of project implementation.

2.34 Challenges in the organization of RRNI teams diluted the community-driven nature of some subprojects. The composition of the RRNI team implementing the subprojects was intended to reflect the ethnic, gender, caste, class, and occupational diversity of the ward. Despite the difficulties in engaging women in RRNIs because of social norms and engagement in household work, 64 percent of hired coaches were local women. Furthermore, within the evaluation sample of 18 wards, all wards had women in their RRNI teams, and 12 out of the 18 RRNI teams had women as RRNI team leaders. Challenges in the formation of RRNI teams, however, hampered the community-driven approach in a handful of subprojects. In such instances, a small group of individuals dominated the decision-making process (Oshima et al. 2017). A 2015 report by the Rapid Results Institute also noted that in some cases officials of VDCs exerted pressure on coaches or subproject teams to select certain goals (RRI 2015), which was inconsistent with the RRNI model of generating buy-in and ownership by allowing communities to choose their own goal. Elements of elite capture are not uncommon in CDD projects, as documented by a previous IEG Social Funds evaluation, which noted how the existence of “prime movers” could also bias the kinds of projects that are

demanded by the community because of their ability to better mobilize communities around particular types of projects (Carvalho and White 2004). For the community's decision-making process to be effective, the SHD project should have to assess the feasibility of the RRNI team model in target areas to have a clear set of rules and requirements and to widely and clearly communicate them up-front. A mapping exercise of existing local platforms and community groups and consultations with target populations would have helped confirm the design efficiency and, even when implementing the same activity, to identify stronger synergies and partnerships to be built around the RRNI team (Oshima et al. 2017).

### **3. Lessons**

3.1 A community-driven implementation approach may not enforce the multisectoral design approach of the project to address the multiple determinants of nutrition. Although both approaches were intrinsically adequate given the country context and the multiple determinants of nutrition, their combination imposed risks for the convergence of interventions to respond to all households needs, since some goals were not fully appreciated and hence not chosen by communities. Project experience indicated that communities may not have appreciated the value of certain outcomes and opted for more tangible investments. Hence, a more supply-driven approach combined with a thorough, systematic, documented, and unbiased gauging of community demand through an ex ante needs assessment before designing the menu of goals might be needed to ensure that all community needs are addressed synergistically.

3.2 Equal RRNI-cycle time frames across the menu of goals can slant the selection of goals toward those for which technical know-how is already available and hence overshadow the spirit of flexibility of the CDD approach. The short RRNI-cycle implementation, aggravated by slow fund flows, and without more emphasis on capacity building of local governments, imposed "task trade-offs" in the selection of goals by communities. Since not all the goals of the menu could equally be easily achieved in 100 days, some wards rejected the implementation of particular goals. This was true of the goal of increasing animal-sourced protein consumption, whether through subprojects of operating chicken coops or rearing buffaloes or goats for their milk production. Communities may have needed more time to show visible outcomes and more local services and technical support accompanying the demand-driven empowerment support to implement this type of subproject and build on efforts of the RRNI for sustainability.

3.3 In settings with limited human resources, the implementation of an innovative operation such as an RRNI requires a robust operational planning that takes into

account a steep learning curve and strong preparatory arrangements that address weak capacities at entry and adequate project readiness at entry. At midcourse, the project identified capacity gaps and provided additional human resources in each district to facilitate RRNIs and capacity support for monitoring and evaluation and financial management. Initial readiness can be promoted through the early completion of basic procurement measures and the early preparation of an operations manual, which are already known to be standard good practices.

3.4 Good collaboration with specialized development partners in emergency relief facilitated the effective responses that maintained the focus on nutrition and on the original intent of the project. The World Bank’s task team worked jointly with UNICEF and the Ministry of Federal Affairs and Local Development to launch nutrition activities that addressed an urgent humanitarian crisis, since UNICEF had a comparative advantage in nutrition and sanitation relief operations.

3.5 In CDD projects that support the achievement of goals yet to be chosen by communities, and which are thus unknown at the outset, additional efforts to collect more granular baseline data at the ward level can facilitate the assessment of the project achievements at completion. The project was one of the first initiatives in Nepal and in the world to implement the RRNIs on a large scale, so it was important to conduct a rigorous evaluation. However, the impact evaluation measured projects gains at the VDC level regardless of the goals chosen by wards, thus limiting learning and biasing the assessment. As a result, the impact evaluation reported less successful outcomes in goals that were less often selected. The selection of goals by beneficiary communities was unknown at entry; therefore, it was tricky to set outcome indicators and targets from the onset. For instance, only 6 percent of communities selected “practicing proper and consistent breastfeeding” and as a result, the project was deemed unable to achieve the target

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<sup>1</sup> World Bank national accounts data, and OECD National Accounts data files. DataBank Microdata Data Catalog. World Bank, Washington, DC.

<sup>2</sup> See figure D.2 in appendix D (Maternal and Child Nutrition Study Group 2013; UNCNC21 2000; UNICEF 1990, 2015).

<sup>3</sup> The original cost of \$40 million (25.9 million special drawing rights) combined an International Development Association credit of \$22 million and an International Development Association grant of \$18 million. The original expected spending on Rapid Results for Nutrition Initiatives was overestimated because the extent of community demand was not well known, and this resulted in making funds available for the added third component on earthquake relief. The original cost was revised to \$35.9 million due to fluctuations in SDR exchange rates. The actual

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cost at closing was \$31.6 million (88 percent of planned costs). Appraisal was finalized on May 29, 2012, and the project was approved on June 26, 2012 and became effective on August 24, 2012. A Mid-Term Review was undertaken on February 15, 2015. The project was restructured on June 30, 2015 to revise the development objectives, results framework, and procurement, disbursement, and institutional arrangements, and to reallocate funds to earthquake relief. The project closed as planned on June 30, 2017.

<sup>4</sup>This shortcoming was not in the methodology of the impact evaluation that was supported by the European Commission, UK Aid, and the South Asia Food and Nutrition Security Initiative administered by the World Bank. Its rigorous design used a random selection of 282 village development committees and its surveys were adequate. The evaluation included rapid house listing; main household questionnaire; women and children questionnaire; and baseline, midline, and endline surveys. But the gap was in its final results presentation, using total denominators, thus diluting granular findings within subgroups.

## Bibliography

- Banerjee, C., T. Swinnen, J. Shoham, and C. Dolan. 2018. *Multi-Sector Programming at the Sub-National Level: A Case Study in Kapilvastu and Jumla Districts in Nepal*. Kidlington, UK: Emergency Nutrition Network and UK Aid Direct.
- Carvalho, Soniya, and Howard White. 2004. "Theory-Based Evaluation: The Case of Social Funds." *American Journal of Evaluation* 25 (2): 141–160.
- Galasso, E., and A. Wagstaff. 2018. "The Aggregate Income Losses from Childhood Stunting and the Returns to a Nutrition Intervention Aimed at Reducing Stunting." Policy Research Working Paper 8536, World Bank, Washington, DC.
- Maternal and Child Nutrition Study Group. 2013. "Maternal and Child Nutrition Series." *Lancet* 382 (9890). <https://www.thelancet.com/series/maternal-and-child-nutrition>.
- Nepal, Ministry of Federal Affairs and Local Development. 2018. *Nepal Sunaula Hazar Din Community Action for Nutrition Project*. Endline Report.
- Nepal, Ministry of Health and Population. 2011. *Nepal Demographic and Health Survey 2011*. Kathmandu: MOHP/MOHP/Nepal, New ERA/Nepal, and ICF International.
- Nepal, Ministry of Health and Population. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu: MOH/Nepal, New ERA/Nepal, and ICF International.
- Oshima, K., M. Biradavolu, C. Bashyal, and M. Bhattarai. 2017. *Qualitative Study of 'Sunaula Hazar Din' Community Action for Nutrition Project Nepal*. Washington, DC: World Bank.
- RRI (Rapid Results Institute). 2015. *Summary Report to Sunaula Hazar Din*. Stamford, CT: RRI.
- UNICEF (United Nations Children's Fund). 1990. Strategy for Improved Nutrition of Children and Women in Developing Countries, UNICEF, New York. [http://ceecis.org/iodine/01\\_global/01\\_pl/01\\_01\\_other\\_1992\\_unicef.pdf](http://ceecis.org/iodine/01_global/01_pl/01_01_other_1992_unicef.pdf).
- UNICEF (United Nations Children's Fund). 2015. "UNICEF's Approach to Scaling Up Nutrition for Mothers and Their Children." Discussion Paper, Programme Division, UNICEF, New York, June 2015.
- UNICEF (United Nations Children's Fund). 2016. "Provision of Technical Assistance Earthquake Relief and Emergency Component." Emergency Nutrition and WASH Response Final Report, Grant Reference SM150507, UNICEF, New York.
- Webb, Patrick, Shibani Ghosh, Robin Shrestha, Grace Namirembe, Sabi Gurung, Diplav Sapkota, Winnie Fay Bell, Dale Davis, Eileen Kennedy, Shailes Neupane, Swetha Manohar, and Kedar Baral. 2016. "Measuring Nutrition Governance: An Analysis of Commitment, Capability, and Collaboration in Nepal." *Food and Nutrition Bulletin* 37(4S): S170–S182.

- World Bank. 2002. "Social Funds: Assessing Effectiveness." Operations Evaluation Department, World Bank, Washington, DC.
- World Bank. 2009. "Nepal—Interim Strategy Note, FY10–11." Interim Strategy Note 48297-NP, World Bank, Washington, DC.
- World Bank. 2012. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Project Appraisal Document 65693-NP, World Bank, Washington, DC.
- World Bank. 2014. *Nepal—Country Partnership Strategy, FY14–18*. Washington, DC: World Bank.
- World Bank. 2015. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Restructuring Paper RES18529, World Bank, Washington, DC.
- World Bank. 2018a. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Implementation Completion and Results Report ICR00004261, Independent Evaluation Group, World Bank, Washington, DC.
- World Bank. 2018b. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Implementation Completion and Results Report Review ICRR0021238, Independent Evaluation Group, World Bank, Washington, DC.
- World Bank. 2018c. *Nepal—Country Partnership Framework, FY19–23*. Washington, DC: World Bank.
- World Bank. 2021b. *The World Bank's Support to Reducing Child Undernutrition*. Independent Evaluation Group. Washington, DC: World Bank.

# Appendix A. Project Ratings

## Nepal: Community Action for Nutrition Project

Indicator	ICR	ICR Review	PPAR
Outcome	Satisfactory	Moderately satisfactory	Moderately satisfactory
Overall efficacy	Substantial	Substantial	Substantial
Bank performance	Satisfactory	Moderately satisfactory	Moderately satisfactory
Quality of monitoring and evaluation	Substantial	Substantial	Substantial

*Note:* The Implementation Completion and Results Report (ICR) is a self-evaluation by the responsible Global Practice. The ICR Review is an intermediate Independent Evaluation Group product that seeks to independently validate the findings of the ICR. PPAR = Project Performance Assessment Report.

### 1. Relevance of Objectives and Design

#### Relevance of Objectives: High

Project objectives were fully relevant and responsive to the country context. In the decade preceding the project, notable improvements in health indicators were observed, in contrast with undernutrition rates that remained alarmingly high, and Nepal was not on track to reach the Millennium Development Goal target of reducing the rate of malnutrition by half. In 2010/2011, 46.7 percent of children under five had stunted growth. Anemia in women ages 15–49 was high at 35 percent (Nepal 2011). Past and existing programs, although worthy, had an insufficient focus on the wider range and variety of risk factors that contributed to slow progress in undernutrition. Hence, supporting a program targeting a wide range of underlying risks was clearly relevant.

Project objectives were consistent with the priorities of the World Bank Interim Strategy Note 2010–11 where it was highlighted that the high burden of undernutrition was a major persisting challenge that undermined human potential needed to achieve sustained and resilient growth (World Bank 2009). The government’s development strategy, outlined in the “Three-Year Plan Approach Paper (2010/11–2012/13)”, included a chapter on health and nutrition in multiple sectors (National Planning Commission 2010).

At project closing, the objectives remained relevant to the Country Partnership Strategy for fiscal years 2014–18 under its second pillar, outcome 2.3 on improved health and nutrition services, particularly for low-income and disadvantaged people. Objectives were relevant in their contribution to the Sustainable Development Goal 3, to ensure healthy lives and promote well-being for all, at all ages. The objectives were also

relevant to the *Multi-Sectoral Nutrition Plan 2018–2022* (National Planning Commission 2017), which aimed at improving maternal, adolescent, and child nutrition by expanding essential nutrition-specific and sensitive interventions and creating an enabling environment for nutrition.

The objective on earthquake relief remained relevant for enhancing disaster risk management.

The 2015 project restructuring sharpened the design and the results chain to focus on practices instead of attitudes. The latter reflect beliefs toward the importance of certain nutrition-related behaviors and not necessarily their actual practice. Hence, the revised project development objective (PDO) did not make a material difference from the original one and was rather a rectification of an unclear term—*attitudes*—which is also less relevant than actual practice in terms of changing nutrition behaviors. At the same time, the project restructuring expanded the objectives' scope to include emergency nutrition support to the populations affected by the earthquake. Therefore, this Project Performance Assessment Report used the restructured PDO as the benchmark for assessment, and a split-rating methodology was not applied based on the following: (i) the revised PDO did not make a material difference from the original PDO and, at the same time, it expanded the objectives' scope to include emergency nutrition support to the populations affected by the earthquake; and (ii) the downward revision of targets in two PDO indicators would not affect assessment results since the final value exceeded neither the original nor the revised target.

### **Relevance of Design: Substantial**

Relevance of design was consistent with the stated objective on improved practices, and the project's implicit theory of change was clear in its links. The latter was based on the premise that the causes of undernutrition are multisectoral, combining both direct causes (such as inadequate food intake and caring, and diseases) and underlying factors (such as access to nutritious food, maternal and childcare resources, and health and water, sanitation, and hygiene [WASH] services). Relevance of design was consistent with the objective of providing emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas.

The full scope of the results chain for improved practices could not be articulated at the design stage, since project activities were planned to be selected and subsequently defined and developed during implementation. Nevertheless, the menu of goals governing the various subprojects was reflective of changes in specific practices that would plausibly influence undernutrition and that are known to improve nutritional outcomes when such practices improve. However, as explained in the main report, the flexibility of the community-driven approach may not necessarily enforce the

multisector design of the project. The project design envisaged contracting with three nongovernmental organizations, which would be in charge of hiring coaches and training them (technical capacity building) in nutrition-related issues and in the preparation of proposals. Moreover, in some areas, technical extension workers from village development committee for WASH, for example, were expected to assist coaches and Rapid Results for Nutrition Initiatives (RRNIs) in the technical aspects of building latrines.

## 2. Efficacy: Substantial

### **Objective 1: Improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two.**

Efficacy for this objective is rated **substantial**. This rating is supported by (i) highly improved practices in water and sanitation, handwashing, and declaration of open defecation-free districts; (ii) satisfactory consumption of animal-sourced proteins by pregnant women; (iii) moderate progress in minimum acceptable diet in children and maternal anemia, with no progress in exclusive breastfeeding; and (iv) the project's contribution to advancing the country's Multi-Sectoral Nutrition Plan 2013–2017 through its implementation of related initiatives at the community level.

Results assessment took into consideration the important role of the World Bank-supported project during the implementation period in collaboration with other stakeholders.

Practices related to water and sanitation practices were noteworthy and exceeded targets. Practices included the use of improved toilet facilities (flush toilet, covered pit within household, community latrine), rising from a baseline of 25 percent in 2014 to 80 percent in 2017. The project contributed to the government efforts in declaring open defecation-free districts, since ending open defecation contributes to preventing waterborne diarrheal diseases. Similar favorable outcomes were observed in good practices exhibited by mothers of children ages 0–2 years in washing hands at critical times (after defecation, before eating, after cleaning the child, and before feeding the child).

The consumption of animal-sourced proteins was reflected in the percentage of pregnant women consuming animal-sourced protein, which increased from a baseline of 60 percent in 2014 to 76 percent in 2017, above the target of 75 percent. In environmental health, the percentage of households reporting no smoke in the room while cooking increased from 35 percent in 2014 to 39 percent in 2017, short of the target of 45 percent.

Both minimum acceptable diet in children under two and consumption of iron supplements by young women showed moderate progress, below the targets, and exclusive breastfeeding showed no progress. Breastfeeding was stalled at the national level and declined between DHS 2011, when the national breastfeeding rate was 70 percent, and DHS 2016, when it decreased to 66 percent. Although there was no clear explanation for this national trend, it is possible that the massive earthquake of 2015 with its pressure on women's chores was a contributing factor.

It is worth noting that the impact evaluation reported less successful outcomes in goals that were less often selected. Results on extending education and delaying marriage and pregnancy for young girls showed some progress, although only 22 percent of communities selected the former and only 8 percent selected the latter. The goal of reducing the workload of pregnant women was attained in the areas visited by the Independent Evaluation Group mission (see more details on project results in the main report).

**Objective 2: Provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas.**

Efficacy for this objective is rated **high**. This rating is supported by the effectiveness of the response demonstrated by two benchmarks set by the project, and which were exceeded: (i) treatment of children under five who were suffering from severe acute undernutrition; and (ii) households that benefited from hygiene and sanitation kits.

The project benefited from the engagement of the United Nations Children's Fund (UNICEF), its field presence, and its technical know-how to undertake an effective response. The delivery of essential emergency nutrition interventions was expected to contribute to protecting the lives of children, pregnant women, and breastfeeding mothers in 14 critically affected districts. Interventions included promoting breastfeeding and complementary feeding; providing therapeutic feeding, care, and supplementary feeding; supplementing children and women with micronutrients; and providing hygiene and sanitation kits and enhancing sanitation facilities.

Treatment of severe acute undernutrition in children under five years in earthquake affected areas benefited 4,299 children, exceeding the target of 4,000 children. Emergency sanitation support to vulnerable populations in earthquake affected areas reached 80,013 households, which benefited from hygiene and sanitation kits, exceeding the target of 45,000 households.

In addition, about 0.36 million children under five received multiple micronutrient powders. Water supply system repairs and household drinking water treatment benefited 53,254 households. In the earthquake affected districts 169,701 mothers of

children ages 0–23 months received infant and young child feeding counseling, including on exclusive breastfeeding and complementary feeding, feeding practices, and hygiene behaviors. About 0.35 million families benefited from WASH counseling.

**Nutrition outcomes.** Importantly, and in addition to improved practices and effective earthquake support in nutrition and sanitation, nutritional outcomes improved in project areas. The impact evaluation included anthropometric measurements for children under two years of age to assess changes in stunted growth (low height for age), wasting (low weight for height), and underweight (low weight for age). The baseline rates compared with endline rates showed the following improvements between 2014 and 2017 in children under the age of two: stunted growth decreased from 38 percent to 33 percent, wasting from 21 percent to 16 percent, and underweight from 32 percent to 15 percent (these trends could not be fully compared with national rates, as DHS 2011 and 2016 measured nutritional status of children under the age of five years [Nepal 2011, 2017]).

### 3. Efficiency: Modest

The World Bank team did not conduct a traditional economic analysis but referred to existing literature to discuss cost-effectiveness. The Project Appraisal Document referred to *Accelerating Progress in Reducing Maternal and Child Undernutrition in Nepal: A Review of Global Evidence of Essential Nutrition Interventions for the Nepal Health Sector Plan II and Multisectoral Nutrition Plan* (World Bank 2012a), and to the Copenhagen Consensus 2008 (Horton et al. 2008) to suggest that the cost-effectiveness of nutrition interventions was favorable.

Similar references were made at project closing, including *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action* and *Scaling Up Nutrition: What Will It Cost?* (World Bank 2006; Horton et al. 2010). The estimated cost-effectiveness interventions in several goals under RRNI indicated the following: iron–folic acid supplements: \$66–115 per disability-adjusted life year averted; hygiene promotion: \$3.35 per disability-adjusted life year averted; latrine construction: \$270 per disability-adjusted life year averted.

However, drawing inferences about cost-effectiveness from the literature would also need to consider that, under the project, the adoption of interventions known to be cost-effective from a menu of 15 different goals was variable and negligible in multiple instances, as discussed in the Results section in chapter 2 of the main report.

Significant shortcomings in efficiency were found during the implementation cycle, as also recorded in the Implementation Status Reports, notably around midcourse between 2014 and 2015. After project effectiveness in 2012, the project could not secure funds for

almost a year because of a countrywide delay in approval of a full budget for fiscal year 2013. The project operations manual and the baseline study were delayed by 18 months. Extended overall delays, specifically procurement delays, were impactful, notably for the engagement of consulting agencies that were responsible for the recruitment of coaches who were central to the realization of RRNI in the field. Actual implementation started only in 2014.

The Nutrition and Food Security Steering Committee did not have sufficient capacity to review and process RRNI subprojects. It faced difficulties in convening meetings with committee members belonging to different line agencies. Additional technical support was needed to help communities in developing proposals or in rewriting them because of their low quality. After the Mid-Term Review, some of these issues were alleviated, including through additional human resources and technical support in each district to facilitate RRNI (World Bank 2018, 25), resulting in an increase in subprojects in the last year of implementation.

The Ministry of Federal Affairs and Local Development capacities were weak and lacked competent human resources. Its staff were not sufficiently dedicated to project implementation since they were preoccupied with other tasks and projects. Staffing of the project management team was an issue because of frequent turnover of key project officials such as project coordinator, monitoring and evaluation (M&E) officer, and accountant position. Staff who carried out project management activities at the local level did not have adequate technical skills and experience, and they were already overstretched by other sectoral work.

The project planned for the installment of digital reporting, but the hiring of a software firm was delayed for more than two years for administrative reasons, and when the software was finally installed, it was not used because additional recruitment would have been required to bring in staff with the necessary skills. Data from the field continued to be administered manually throughout the life of the project.

Low capacity and shortcomings in financial management at the level of the district development committees and village development committees resulted in slow fund flows. Financial management issues persisted throughout the course of the project (World Bank 2018, 28), and financial management was rated as **moderately unsatisfactory** in the last Implementation Status and Results Report before closing. An assessment of financial management capacity at the district level was undertaken only after two years of implementation, and the assessment highlighted significant deficits in financial management capacity.

In addition, there were inefficiencies generated by the 2015 earthquake, beyond the control of the project. The earthquake damaged some of the project investments such as latrines. The trade blockade at the Indian border increased the cost of goods, including food and construction materials that were needed by communities to undertake their subprojects. At closing, the project had disbursed 88 percent of its original allocation.

#### 4. Outcome: Moderately Satisfactory

Relevance of objectives to country conditions, national plans, and the World Bank's Country Partnership Strategy for Nepal is rated **high**. Relevance of design is rated **substantial** because the flexibility of the community-driven approach was not fully consistent with the multisector design of the project. Efficacy is rated **substantial** since the objectives were almost fully achieved. Efficiency is rated **modest** because of significant shortcomings in the efficiency of implementation. This assessment corresponds to an overall outcome rating of **moderately satisfactory**, indicative of moderate shortcomings in the project's preparation, implementation, and achievement.

#### 5. Risk to Development Outcome: Significant

There are risks that development outcomes may not be maintained. The newly formed federal government transferred the program to local governments and municipalities, and there was no information on local governments having increased their resources to sustain the program that was discontinued on project closing. Financial and capacity constraints persist. Capacities that were strengthened at the level of involved stakeholders are likely to diminish with personnel turnover.

Although WASH and community mill benefits were successfully maintained and managed by the communities, others were not; for example, it was difficult to sustain the progress made with chicken coops because of lack of financing for chicken vaccination, chicken food, or for maintaining the coops.

The project contributed to strengthening organizational capacity through its cycles of RRNIs. The project helped in bolstering technical skills that would benefit the nutrition agenda. Mainstream institutional support from various government entities remains mixed; however, the project generated an added nutrition focus within the work of other sectors, such as with WASH, for example.

## 6. Bank Performance

### Quality at Entry: Moderately Satisfactory

Preparatory work and previous experience informed project design. The thrust to address practices that contribute to undernutrition was pertinent. Preparation benefited from the experience of other countries that undertook rapid results operations, such as Kenya, Madagascar, Nicaragua, and Rwanda, and where the important lesson of hiring community coaches was incorporated in the design. Adequate consultations with stakeholders were undertaken. A Quality Enhancement Review was carried out on March 27, 2012 and helped in sharpening the objectives and M&E design. Environmental and social safeguards were well prepared. The planning of implementation arrangements was adequate overall.

There were some shortcomings at entry. Community preferences and demand were not thoroughly explored. Sustainability aspects were not adequately addressed, and the project built on a funding stream with unknown prospects. Although there was a general recognition of capacity constraints and relevant training was planned, capacity constraints were underestimated along with the time required for capacity building. Subprojects were envisaged in settings with notable weaknesses in human resource capacities and skills at peripheral levels and with an overall limited institutional and organizational capacity at the decentralized level. Preparation underestimated the time required for hiring coaches to roll out interventions. The Project Appraisal Document (World Bank 2012b) stated that sustaining and expanding the achievements made during the 100 days initiatives will be a major topic for discussion with the ward citizen forum during the end-of-initiative evaluations; however, preparation could have also set the stage to explore options for more concrete long-term funding scenarios.

### Quality of Supervision: Satisfactory

The World Bank maintained adequate support and monitoring throughout project implementation. Reporting was regular and candid on arising challenges. The presence of the task team leader in the country further facilitated a sustained engagement with project authorities. World Bank supervision missions were carried out jointly with the government's project management team, with timely and adequate reporting.

The task team was proactive and attentive to adequately assess the development impact of the project by restructuring the project, sharpening its results framework, and dropping attitudinal changes from the PDO statement. Monitoring of safeguards was adequate. Although implementation shortcomings, such as financial management, were beyond the control of the task team, the team was instrumental in planning for additional human resources and technical support that alleviated capacity constraints in

the districts. The team was highly responsive to emergency needs for nutrition arising from the 2015 earthquake and was proactive in working with the Ministry of Federal Affairs and Local Development and UNICEF to develop an adequate and prompt response.

## **7. Borrower Performance: Moderately Satisfactory**

As the government and implementing agency were indistinguishable, only an overall rating is provided. The Ministry of Federal Affairs and Local Development, in collaboration with the National Planning Commission and other involved ministries, both at the federal and decentralized level, were an integral part of the same governance.

The overall nutrition agenda benefited from the commitment of political leadership, but commitment varied within mainstream government sections and personnel. After project effectiveness, the project could not secure funds for almost a year because of a countrywide delay in approval of a full budget for fiscal year 2013. In turn, this delayed the initiation of project activities and rolling out of subprojects. During implementation, the main issues affecting performance were capacity weaknesses, although these were alleviated in 2015, after the Mid-Term Review and project restructuring, at which time staffing and technical support were enhanced, thus contributing to accelerated implementation during the latter part of the project.

The government ensured compliance with World Bank procurement guidelines and with environmental and social safeguards, both for Environmental Assessment and indigenous peoples, and there were no qualified audits. The government proactiveness increased around midcourse, and it sought to make up for the initial implementation delays and allowed communities that had successfully completed their subprojects to submit more than one proposal in the subsequent cycle of proposals. The government responded very effectively to nutrition and sanitation needs resulting from the 2015 earthquake, by promptly entering into a contract with UNICEF to provide the required relief and development activities, with outputs agreed with the World Bank and the government.

## **8. Quality of Monitoring and Evaluation: Substantial**

### **Design**

Project objectives were well specified, but the indicators could not grasp the overall PDO in view of the large number of practices in different goals, and because the objective on improving attitudes could not be adequately measured. The sources, frequency, and responsibility for data collection were adequately defined. The earthquake relief

objective, which was added after the 2015 earthquake, was reasonably well specified in terms of meeting emergency nutrition needs and the provision of hygiene and sanitation needs to vulnerable households.

The Ministry of Federal Affairs and Local Development had overall responsibility for M&E and planned to directly monitor the collection of data related to the implementation of RRNI and earthquake relief. An impact evaluation was planned, and surveys were to be undertaken by consulting firms, including the baseline, midterm, and endline survey. The design of the impact was adequate overall in its methodology, but with a shortcoming that was revealed ex post. The gains were calculated based on all village development committees, regardless of choices and achievements made by wards. This prevented the project from reflecting ward achievement in goals that were less often chosen in the larger pool of wards.

## **Implementation**

The project restructuring of 2015 sharpened the results framework to focus on practices and dropped improved attitudes. The results framework and its indicators were revised to ensure better alignment with expected outcomes. Measurable indicators pertaining to the earthquake relief objective were added.

M&E implementation experienced initial delays and did not use digital reporting that was envisaged at appraisal. Manual collection of data continued throughout implementation. Since the capacities of the government's project management team were overstretched, the project provided additional support through the hiring of three M&E officers in the first quarter of 2016. The officers provided technical support to the coaches and to the development process of RRNI subprojects. Independent third-party monitoring was also provided and was able to cover two-thirds of RRNI subprojects, as an added layer of verification. UNICEF contributed to data collection for earthquake-related activities.

## **M&E Use**

M&E findings were used to track progress in subprojects and overall project implementation. 85 percent of subprojects were publicly audited, and regular sharing of information focused on local stakeholders involved in each subproject. There were no substantive shifts in strategic directions attributable to M&E, but new indicators with outcome targets were chosen at restructuring to correspond to the goals that were most commonly chosen by communities. Although there were moderate shortcomings, M&E arrangements, implementation, and findings were sufficient to assess the achievement of objectives and to test the links in the results chain.

## References

- Horton, Sue, Harold Alderman, and Juan Rivera. 2008. Copenhagen Consensus 2008 Challenge Paper Hunger and Malnutrition.
- Horton, Susan, Meera Shekar, Christine McDonald, Ajay Mahal, and Jana Krystene Brooks. 2010. *Scaling Up Nutrition: What Will It Cost?* Directions in Development. Washington, DC: World Bank.
- Nepal, Ministry of Health and Population. 2011. *Nepal Demographic and Health Survey 2011*. Kathmandu: MOHP/MOHP/Nepal, New ERA/Nepal, and ICF International.
- Nepal, Ministry of Health and Population. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu: MOH/Nepal, New ERA/Nepal, and ICF International.
- Nepal, National Planning Commission. 2010. "Three-Year Plan Approach Paper (2010/11–2012/13)." Kathmandu: National Planning Commission.
- Nepal, National Planning Commission. 2017. *Multi-Sector Nutrition Plan 2018–2022*. Kathmandu, Nepal: National Planning Commission.
- World Bank. 2006. *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*. Directions in Development. Washington, DC: World Bank.
- World Bank. 2009. "Nepal—Interim Strategy Note, FY10–11." Interim Strategy Note 48297-NP, World Bank, Washington, DC.
- World Bank. 2012a. *Accelerating Progress in Reducing Maternal and Child Undernutrition in Nepal: A Review of Global Evidence of Essential Nutrition Interventions for the Nepal Health Sector Plan II and Multisectoral Nutrition Plan*. Washington, DC: World Bank.
- World Bank. 2012b. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Project Appraisal Document 65693-NP, World Bank, Washington, DC.
- World Bank. 2018. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Implementation Completion and Results Report ICR00004261, Independent Evaluation Group, World Bank, Washington, DC.

# Appendix B. Fiduciary, Environmental, and Social Aspects

## Financial Management and Procurement

A financial management assessment was carried out before appraisal and was updated after appraisal. The financial management risk was deemed to be substantial. Overall, financial management performance was inadequate throughout the project implementation period and was rated as **moderately unsatisfactory** in the last two Implementation Status and Results Reports. Financial management processes complied with expected standards, except for timeliness, and low performance was related to delays resulting from weak capacities, largely at the district level. Also, there was no dedicated accountant during the first year of the project. The delays in the provision of statements of expenditures by subprojects in turn delayed financial settlements. There were no qualified audits.

World Bank procurement guidelines were complied with. The project had two high-value procurements. The engagement of the United Nations Children’s Fund for earthquake relief activities proceeded as planned. Contracting of consulting agencies (known as national service providers), which were responsible for hiring of Rapid Results for Nutrition Initiative coaches, suffered from extended processing delays. Despite these notable delays, the planned procurements were completed by project closing.

## Environmental and Social Safeguards

The project was classified as category B, Partial Assessment, triggering the World Bank safeguard policy, Environmental Assessment (OP/BP 4.01), since community proposals were expected to include small-scale civil works such as for latrines in schools and water supply. The project also triggered safeguard policy OP/BP 4.10—Indigenous Peoples. Environmental and Social Risk Screening and Management Guidelines were disclosed and followed. There were instances in two districts where some subprojects were not fully compliant with environmental safety standards, but these were satisfactorily rectified. According to the Implementation Completion and Results Report, in most cases, environmental safety standards were followed (World Bank 2018, 27). However, a World Bank visit to Sindhuli and Ramechhap districts on May 30, 2017, revealed that a few subprojects were not fully compliant with the environmental safety standards and have been encouraged to stick to safeguard compliance when designing the work plan for the subprojects. The project ensured that benefits were culturally appropriate, with no adverse effects on indigenous populations. It also ensured the inclusion of women

and minorities in the project Rapid Results for Nutrition Initiative teams. The percentage of women among hired coaches was 64 percent, exceeding the target of 40 percent, and the percentage of minority participation was 63 percent, exceeding the target of 40 percent.

## Reference

World Bank. 2018. "Nepal—Community Action for Nutrition Project (Sunaula Hazar Din)." Implementation Completion and Results Report ICR00004261, Independent Evaluation Group, World Bank, Washington, DC.

## Appendix C. Methodology

This report is a Project Performance Assessment Report (PPAR). This instrument and its methodology are described at <https://ieg.worldbankgroup.org/methodology/PPAR>.

### Identification of Project Development Objectives

This PPAR uses the restructured project development objective (PDO) as the benchmark of the evaluation, parsing it as follows: (i) improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two, and (ii) provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas (see table C.1). A split-rating methodology is not undertaken based on the following: (i) the revised PDO did not make a material difference from the original PDO and, at the same time, it expanded the objectives' scope to include emergency nutrition support to the populations affected by the earthquake; (ii) the downward revision of targets in two PDO indicators would not affect assessment results since the final value exceeded neither the original nor the revised target; (iii) the PPAR's value added is to bring more information on relevant indicators not necessarily included in the project's results framework, and therefore no targets are defined for such additional data, making little sense to apply split rating. This is the case of qualitative data gathered in the field from beneficiaries as evidence of sustainability of the project's achievements.

**Table C.1. Project Development Objectives**

Financing Agreement/PAD	Restructuring	ICRR
improve attitudes and practices known to improve nutritional outcomes of women of reproductive age and children under the age of two	improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two, and to provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas	(i) improve attitudes and practices known to improve nutritional outcomes of women of reproductive age and children under the age of two  (ii) improve practices that contribute to reduced undernutrition of women of reproductive age and children under the age of two  (iii) provide emergency nutrition and sanitation response to vulnerable populations in earthquake affected areas

*Source:* Independent Evaluation Group.

*Note:* ICRR = Implementation Completion and Results Report Review; PAD = Project Appraisal Document; PDO = project development objective.

## Value Added of PPAR for Learning

The PPAR has a dual purpose of accountability and learning, adding value to the World Bank's self-evaluation of the project (in the Implementation Completion and Results Report) in terms of:

1. **New PPAR structure.** The goal of the renovated PPAR structure is to improve the influence of the Independent Evaluation Group (IEG) evaluations by emphasizing the learning aspect and making it more accessible to the principal audiences, in particular to World Bank operational staff.
2. **Theory of change.** The IEG team reconstructed the project theory of change through a visualization that shows how project activities were expected to contribute to intermediate and final outcomes. The theory of change focused on the higher objectives that the project contributed to and showed the boundaries of the project's achievements, identifying enabling factors, and assumptions leading to the achievement of proposed outcomes.
3. **Stakeholders' interviews and focus groups.** The IEG team met with a series of key stakeholders including World Bank staff, government counterparts at relevant line ministries, other donors and international agencies, and project beneficiaries (see full list of people met in appendix E).
4. **Site visits.** During the mission, the IEG visited three districts (Saptari, Udayapur, and Dhanusha) purposely selected on the basis of the type of Rapid Results for Nutrition Initiative goals chosen in their communities.
5. **Outcome harvesting analysis.** Outcome harvesting is an evaluation approach inspired by outcome mapping and informed by utilization-focused evaluation. It is particularly suitable to assess social behavior change interventions by collecting (harvesting) evidence of what has changed (outcomes) and, then, working backward, determining whether and how an intervention has contributed to these changes (Wilson-Grau 2015). The IEG team collected qualitative data through interviews with beneficiaries, coaches, and other stakeholders on five to eight key outcomes influenced by the project, and distilled what happened, who was involved, when, why it was significant, and what the contribution of the project was. Findings were further validated by sharing the outcomes with coaches and community leaders for feedback (see table 2.3).
6. **Review of World Bank Group and country documents.** The PPAR included the review of project documents, Bank Group strategies, impact evaluations, national

policies, and documents on nutrition and community-based interventions. In addition, the World Bank had a range of analytical work (including policy dialogue) to reinforce the PDO, and synergistic lending projects. The team reviewed the World Bank portfolio, focusing on products that supported the PDO or synergistic aspects of the project's theory of change (see table D.3).

7. **Collection of secondary data sources:** review of available data sources relevant to project outcomes and indicators, including administrative data from districts that implemented Rapid Results for Nutrition Initiatives and those that did not, to review trends in outcomes before and after Rapid Results for Nutrition Initiative support; survey data collected by the project; and Demographic Health Surveys (Nepal 2011, 2017).

## References

Wilson-Grau, R. 2015. "Outcome Harvesting." BetterEvaluation.

[http://betterevaluation.org/plan/approach/outcome\\_harvesting](http://betterevaluation.org/plan/approach/outcome_harvesting).

Nepal, Ministry of Health and Population. 2011. *Nepal Demographic and Health Survey 2011*.

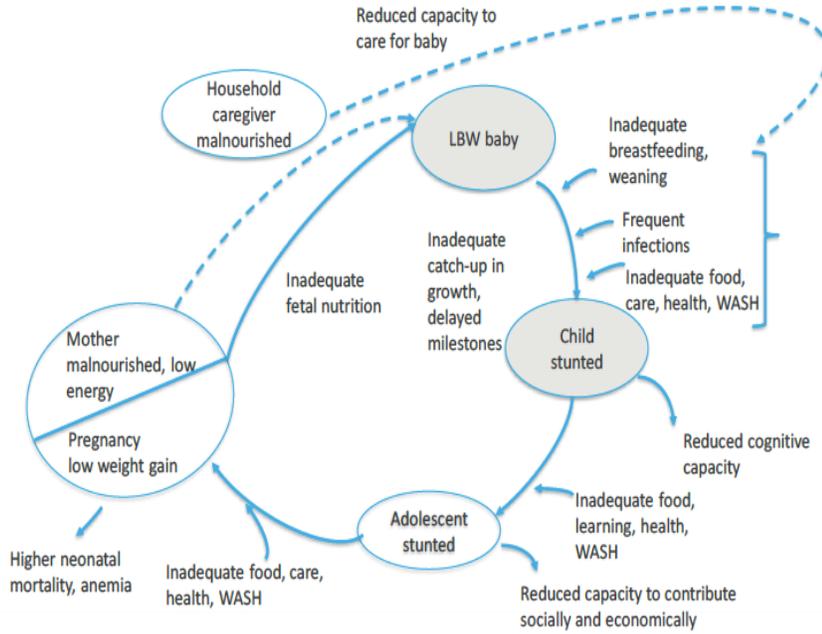
Kathmandu: MOHP/MOHP/Nepal, New ERA/Nepal, and ICF International.

Nepal, Ministry of Health and Population. 2017. *Nepal Demographic and Health Survey 2016*.

Kathmandu: MOH/Nepal, New ERA/Nepal, and ICF International.

# Appendix D. Additional Data

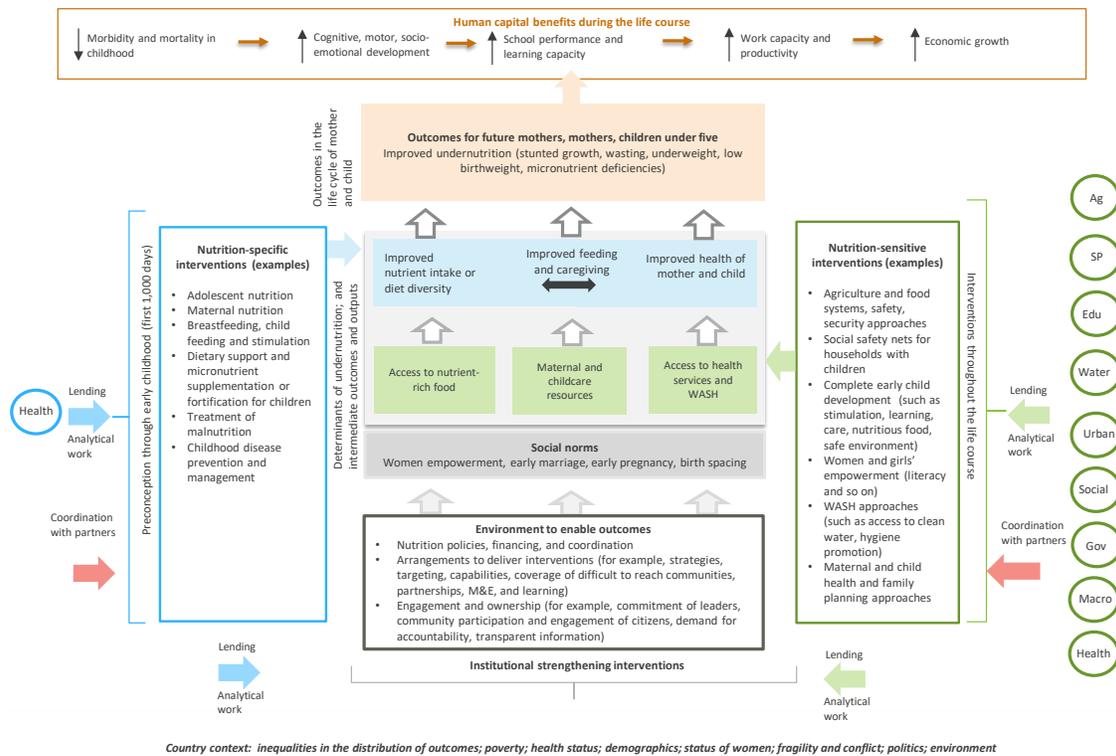
Figure D.1. Nutrition in the Life Cycle of Mother and Child



Sources: Adapted from United Nations Administrative Committee on Coordination Sub-Committee on Nutrition 2000 and United Nations Commission on the Nutrition Challenges of the 21st Century (UNCNC21) 2000.

Note: LBW = low birthweight; WASH = water, sanitation, and hygiene.

Figure D.2. Conceptual Framework of Child Undernutrition



Sources: Adapted from Maternal and Child Nutrition Study Group 2013 and UNICEF 1990, 2015.

Note: The assessment of the contribution of the World Bank's nutrition support to human capital benefits is outside the scope of the evaluation. Ag = Agriculture; Edu = Education; Gov = Governance; Social = Social Development; Macro = Macroeconomic; M&E = monitoring and evaluation; SP = Social Protection; WASH = water, sanitation, and hygiene.

**Table D.1. Nepal's Nutrition-Related Indicators at National Level**

Indicator	Value	Year	Value	Year	Average Annual	
	(percent)	(current)	(percent)	(baseline)	Change	(percent)
Nutrition outcomes						
No stunted growth of children	64.0	2016	50.8	2006	↑	2.3
No anemia	57.0	2016	—	—		n.a.
No low birthweight	78.2	2015	76.1	2008	→	0.4
No wasting	90.4	2016	87.4	2006	→	0.3
No underweight	73.0	2016	61.4	2006	↑	1.7
Food and care						
Minimum dietary diversity	45.0	2016	30.7	2006	↑	3.9
Children with iodized salt	94.5	2016	96.7	2011	→	-0.5
Exclusive breastfeeding	65.2	2016	53.2	2006	↑	2.0
Care seeking for diarrhea	64.4	2017	38.0	2011	↑	9.2
Financial inclusion (percentage of women with bank account)	41.6	2014	—	—		n.a.
Water, sanitation, and hygiene						
Access to water, at least basic	88.8	2017	80.0	2000	→	0.6
No open defecation	78.5	2017	33.1	2000	↑	5.2
Access to basic handwashing	47.8	2017	—	—		n.a.
Health care						
DPT3	91	2018	82.0	2008	→	1.0
Skilled birth attendant	58	2017	18.7	2006	↑	10.8
PNC	56.7	2017	44.6	2011	↑	4.1
Distance to health facility is NOT a barrier	47.0	2016	59.5	2006	↓	-2.3
Four ANC	69.4	2017	29.4	2006	↑	8.1
Iron tablets during ANC	92.2	2016	62.8	2006	↑	3.9
Vitamin A supplementation	82.5	2016	87.5	2006	→	-0.6
Social norms						
Women's decision power	37.7	2016	38.1	2006	→	-0.1
No first birth before 18	92.5	2016	93.1	2006	→	-0.1
Modern contraceptive use	33.2	2016	34.4	2006	→	-0.4
Literacy (women)	69.1	2016	54.5	2006	↑	2.4

Source: Independent Evaluation Group, from United Nations Children's Fund; World Health Organization, and World Bank 2019; USAID 2020; and World Bank 2017.

Note: ANC = antenatal care; DPT3 = diphtheria, pertussis, and tetanus vaccine; PNC = postnatal care; — = not available; n.a. = not applicable.

Table D.2. Nepal's Nutrition-Related Indicators in Project Districts (2011–2018)

Indicator	Year	Central Terai						Central Hills			Eastern Terai			Eastern Hills																	
		Bara	Dhanusa	Mahottari	Parsa	Rautahat	Sarlahi	Makwanpur	Ramechhap	Sindhuli	Saptari	Siraha	Sunsari	Khotang	Okhaldhunga	Udayapur															
New growth monitoring (percentage under one year)	2011	88.1	77.2	114.4	—	76.3	88.3	103.0	93.1	105.2	95.5	120.1	76.1	91.6	144.8	84.6															
	2012	80.6	74.7	131.9	—	84.5	96.8	85.4	80.1	97.0	96.9	104.2	69.7	98.0	159.2	222.3															
	2013	80.6	66.0	125.1	↔ -1.5	152.2	↓ -15.4	114.5	↓ -3.3	86.5	↓ -2.9	94.5	↓ -3.0	92.7	↔ -0.2	92.0	↓ -5.1	98.7	↔ 4.0	108.6	↓ -5.0	68.3	↔ 2.0	130.4	↔ 8.5	93.3	↓ -14.5	110.4	↔ 9.8		
	2014	78.7	66.7	109.5	128.8	68.9	80.9	94.1	92.4	89.8	107.6	102.9	80.7	117.2	90.6	112.0															
New growth monitoring (percentage under five years)	2011	43.0	42.3	50.3	—	49.3	49.7	29.2	33.3	41.4	36.7	35.8	29.5	26.2	69.6	35.8															
	2012	41.6	40.5	89.0	—	52.4	52.9	26.1	30.0	39.7	35.9	24.8	28.3	31.9	69.6	70.8															
	2013	42.9	↔ -0.1	36.3	↔ 1.2	57.9	↔ 3.3	26.3	↓ -7.8	76.4	↔ -0.6	52.0	↔ 2.4	28.3	↔ 1.8	32.8	↔ 10.7	38.7	↔ 1.5	44.0	↔ 13.5	23.6	↓ -12.2	23.8	↔ -0.1	56.5	↔ 30.7	72.0	↓ -1.8	40.5	↔ 3.9
	2014	42.9	43.9	55.5	24.2	48.4	53.4	30.8	45.1	43.3	53.6	24.2	29.4	58.4	65.9	40.2															
Children among new visits (percentage malnourished)	2011	6.3	4.0	3.0	—	4.7	4.4	2.4	0.6	1.3	2.2	1.5	3.3	1.5	2.3	1.6															
	2012	3.7	↓ -21.6	3.2	3.2	1.8	↔ 0.0	5.1	↓ -15.1	5.3	↓ -6.3	3.2	↓ -18.2	1.6	↓ -15.0	0.4	↓ -21.5	0.9	↓ -18.2	2.4	↔ 10.3	1.5	↓ -12.6	2.2	↓ -12.3	1.5	↓ -12.7	2.0	↓ -10.4	0.8	↔ 14.4
	2013	3.6	3.5	3.5	3.5	5.1	↓ -15.1	5.3	↓ -6.3	3.9	2.7	1.6	0.4	0.4	0.4	0.9	0.4	4.8	1.3	2.1	2.1	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	
	2014	3.0	3.3	3.0	4.3	3.9	2.4	1.5	0.3	0.7	3.0	1.0	2.2	1.0	1.7	2.3															
Children treated with Vitamin A for chronic diarrhea (percent)	2011	0.2	0.2	0.2	—	0.2	0.3	0.1	0.2	0.1	0.2	0.1	0.1	0.5	0.2	0.1															
	2012	0.1	↔ 1.9	0.2	↓ -6.7	0.2	↔ 20.5	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1															
	2013	0.2	0.1	0.3	↔ 0.0	0.3	↔ 48.4	0.8	↓ -7.2	0.2	0.3	↓ -6.3	0.1	↓ -12.6	0.0	↓ -59.5	0.2	↔ 19.7	0.3	↔ -14.8	0.1	↓ -14.5	0.1	↓ -47.7	0.5	↔ 18.0	0.1	↓ -43.3	0.1	↓ -24.6	
	2014	0.2	0.1	0.3	0.5	0.6	0.2	0.0	0.0	0.2	0.1	0.2	0.1	0.1	0.0																
Children treated with vitamin A for severe malnutrition (percent)	2011	0.5	0.3	0.1	0.2	0.8	0.7	0.1	0.1	0.2	0.2	0.1	0.3	0.2	0.2	0.1															
	2012	0.3	0.2	0.1	0.2	0.7	0.4	0.2	0.1	0.1	0.1	0.4	0.1	0.2	0.2	0.1															
	2013	0.2	↓ -19.5	0.2	↔ 11.5	0.4	↔ 14.5	0.1	↓ -7.2	1.0	↓ -8.6	0.2	↓ -26.5	0.2	↔ 2.3	0.1	↓ -55.0	0.1	↓ -20.6	1.4	↔ 74.4	0.1	↓ -5.9	0.1	↓ -42.8	0.2	↔ 35.7	0.1	↔ 22.2	0.1	↔ 0.2
	2014	0.2	0.4	0.2	0.2	0.6	0.3	0.2	0.0	0.1	0.1	1.1	0.1	0.1	0.5	0.3															
Treated with ORS (percent)	2011	98.9	98.8	98.7	—	98.6	97.2	95.5	98.6	99.4	97.6	98.8	98.7	98.5	99.2	98.4															
	2012	98.6	↔ 0.2	99.1	85.6	↔ -0.1	97.9	93.3	97.4	97.9	94.2	98.4	99.2	98.2	95.0	98.1															
	2013	99.1	98.0	97.1	97.1	↔ -0.9	95.9	97.0	97.0	93.2	↔ -0.4	99.3	96.6	98.7	99.3	97.1															
	2014	99.5	97.8	98.5	96.0	94.7	96.8	97.4	99.3	97.7	98.8	99.4	99.3	99.5	98.5	97.4															
Pregnant woman receiving iron tabs repeated (percent)	2011	130.8	37.4	132.1	—	73.9	118.2	173.2	100.8	84.4	180.6	196.7	148.2	70.2	55.2	91.7															
	2012	129.8	↔ 2.5	41.5	↔ 46.2	76.6	↔ 9.6	—	n.a.	86.4	↔ 11.5	128.3	↔ 2.8	98.3	↓ -14.3	109.0	↔ 7.1	79.6	↔ 0.3	188.2	↔ 6.7	162.1	↓ -4.4	145.1	↓ -5.6	75.2	↔ 9.2	90.5	↔ 37.6	99.5	↔ 15.6
	2013	134.8	112.5	165.7	—	158.0	130.5	111.5	143.1	94.4	↔ 0.3	206.5	↔ 6.7	182.4	138.9	103.1															
	2014	140.7	116.7	174.0	—	102.5	128.4	108.9	123.8	85.2	219.7	171.9	124.6	91.5	143.8	141.5															
Postpartum mothers receiving iron tabs (percent)	2011	81.6	50.6	67.8	—	59.5	62.6	55.8	32.0	35.2	44.4	58.9	65.4	46.0	40.2	43.7															
	2012	63.3	↓ -10.8	45.5	↔ 2.9	79.8	↔ 6.0	52.9	↔ 0.5	51.4	↔ 3.9	57.5	↔ 9.3	25.7	↓ -1.9	37.9	↔ 5.8	40.9	↔ -0.5	54.6	↔ 5.3	54.8	↔ -1.3	44.8	↔ -1.2	39.7	↔ 12.4	41.4	↔ 17.2	35.8	↓ -2.6
	2013	56.4	51.5	78.8	—	54.0	↔ 0.5	87.6	↔ 3.9	69.1	↔ 9.3	32.8	43.6	44.2	60.1	61.3															
	2014	58.0	55.1	80.6	—	60.4	70.2	72.9	30.2	41.7	43.8	68.8	63.0	44.4	57.2	64.4															
Postpartum mothers receiving vitamin A (percent)	2011	71.7	58.4	76.3	—	60.5	73.1	57.8	41.8	37.4	44.2	61.8	65.7	95.0	42.5	43.8															
	2012	66.7	↓ -6.1	54.1	↔ -3.9	81.0	↔ 1.5	61.2	↔ 0.9	63.3	↔ -1.3	62.1	↔ 8.6	33.6	↓ -5.6	38.9	↔ 3.6	47.3	↔ -0.4	56.2	↔ 4.3	57.6	↔ -1.1	95.4	↔ 11.9	71.6	↔ 19.3	42.1	↓ -2.9		
	2013	58.3	51.7	81.0	—	57.4	↔ 0.9	92.1	↔ -1.3	69.3	↔ 8.6	33.9	43.8	44.1	62.3	61.7															
	2014	59.4	51.9	79.8	—	62.2	70.2	74.0	35.2	41.7	43.7	70.2	63.6	58.5	59.6	65.4															

Indicator	Year	Central Terai						Central Hills			Eastern Terai			Eastern Hills		
		Bara	Dhanusa	Mahottari	Parsa	Rautahat	Sarlahi	Makwanpur	Ramechhap	Sindhuli	Saptari	Siraha	Sunsari	Khotang	Okhaldhunga	Udayapur
Newborns with low birthweight (< 2.5 kg) among total deliveries by HWs (percent)	2015	7.7	2.3	6.3	5.7	6.2	5.8	3.0	3.4	3.2	3.3	19.4	5.4	3.7	5.6	4.9
	2016	4.7	3.3	4.7	6.7	6.1	6.8	5.9	5.0	2.6	4.0	16.7	5.9	2.3	7.9	7.1
	2017	3.1	1.6	5.7	26.1	9.5	6.9	2.8	5.1	3.2	7.4	18.9	7.8	2.1	6.8	4.7
	2018	14.6	3.7	8.3	8.8	9.7	10.1	3.0	5.0	3.9	6.6	10.3	9.4	2.5	8.2	4.9
Children ages 0–23 months registered for (new) growth monitoring (percent)	2015	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	2016	54.3	56.1	99.9	56.3	45.7	53.3	59.6	63.0	69.5	69.6	41.4	42.3	77.0	113.7	67.6
	2017	63.3	52.1	84.2	69.4	55.7	45.7	61.6	63.7	82.6	86.0	53.6	48.5	78.6	113.8	63.7
	2018	67.8	61.1	99.3	61.1	46.1	51.8	72.6	52.7	82.9	83.4	55.8	51.8	91.9	107.5	67.2
Children ages 0–23 months registered for growth monitoring (new) who were underweight (percent)	2015	5.1	1.7	4.0	2.1	3.4	2.6	1.3	1.0	1.7	2.7	3.8	2.9	1.6	1.5	2.0
	2016	4.3	2.2	2.7	4.4	3.7	2.7	2.0	3.3	4.5	2.3	4.6	2.7	1.0	3.1	1.9
	2017	6.9	2.3	3.4	6.0	6.0	5.3	4.0	4.4	3.7	4.7	4.7	4.7	1.1	3.3	1.9
	2018	11.3	6.7	9.4	6.5	6.1	5.4	2.5	1.3	1.8	5.7	9.1	4.3	3.6	1.6	2.6
Children ages 6–59 months who received vitamin A supplements (percent)	2015	185.3	125.8	171.1	154.7	157.0	201.1	199.7	188.5	206.9	190.2	159.7	111.3	267.9	200.1	126.7
	2016	153.1	110.2	98.7	208.9	167.4	119.6	183.7	164.9	170.9	103.7	109.5	79.1	250.9	168.4	219.3
	2017	81.9	76.2	74.5	97.6	104.5	54.6	86.7	83.7	88.2	63.4	82.5	60.0	118.5	96.2	103.9
	2018	94.8	80.2	67.1	91.3	124.4	60.5	76.5	68.9	81.2	83.7	84.0	87.9	112.3	82.4	71.6
Children under five years with diarrhea treated with zinc and ORS (percent)	2015	93.6	101.8	97.5	87.6	99.2	95.1	90.6	86.8	120.0	84.0	97.2	79.3	91.3	78.9	92.2
	2016	93.8	89.3	92.8	87.2	97.8	85.3	86.7	76.6	92.3	84.6	85.3	74.9	82.4	79.4	88.1
	2017	101.5	85.9	94.6	94.7	100.8	98.7	84.5	89.0	95.2	95.0	89.0	75.0	83.4	83.8	86.0
	2018	96.7	102.9	94.6	95.9	96.6	90.5	90.5	95.0	103.5	104.5	90.6	72.7	95.1	93.1	88.1
Women who received a 180-day supply of iron–folic acid during pregnancy (percent)	2015	42.8	30.7	65.2	34.1	59.0	45.8	42.5	43.8	37.3	84.9	44.0	58.0	58.5	48.8	50.1
	2016	44.6	28.4	50.9	29.6	39.9	33.3	33.3	42.2	36.7	81.5	38.2	101.7	60.5	44.2	39.9
	2017	35.9	28.8	56.8	35.1	55.0	30.7	55.4	38.6	41.3	58.2	43.3	43.0	60.6	54.3	48.4
	2018	26.2	32.4	74.7	32.7	38.7	30.6	39.3	32.1	38.3	66.9	70.6	38.5	62.3	37.6	41.1

Source: Independent Evaluation Group from Health Management Information System data.

Note: HW = health worker; ORS = oral rehydration salts; — = not available; n.a. = not applicable.

**Table D.3. World Bank Nutrition-Related Portfolio in Nepal (lending and nonlending)**

Approval Fiscal Year	Project ID	Project Name	Project Status	Exit Fiscal Year	Product Line	Global Practice	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2012	P130089	Zoonoses Control Project (ZCP)	Closed	2014	Grant	Agriculture																		
2013	P128905	Nepal Agriculture and Food Security Project	Closed	2018	Grant	Agriculture																		
2019	P164319	Food and Nutrition Security Enhancement Project	Active	2023	Grant	Agriculture																		
2008	P099296	Irrigation & Water Resources Management Project	Closed	2018	IBRD/IDA	Agriculture																		
2008	P105860	Poverty Alleviation Fund II	Closed	2019	IBRD/IDA	Agriculture																		
2008	P110463	NP: AF Second Rural Water Sup. & San.	Closed	2013	IBRD/IDA	Water																		
2008	P110731	Nepal - Health Sector Program Project Additional Financing	Closed	2011	IBRD/IDA	HNP																		
2009	P087140	Project for Agriculture Commercialization and Trade (PACT)	Closed	2018	IBRD/IDA	Agriculture																		
2009	P114912	Irrigation & Water Resources Management Supplemental	Active	2018	IBRD/IDA	Agriculture																		
2009	P113002	Social Safety NetsProject	Closed	2015	IBRD/IDA	SPJ																		
2010	P120538	Additional Financing for the Nepal Social Safety Nets Projec	Closed	2015	IBRD/IDA	Agriculture																		
2010	P117417	Nepal: Second HNP and HIV/AIDS Project	Closed	2016	IBRD/IDA	HNP																		
2011	P124088	Additional Financing to the Poverty Alleviation Fund II	Active	2019	IBRD/IDA	Agriculture																		
2012	P125359	Community Action for Nutrition Project (Sunaula Hazar Din)	Closed	2017	IBRD/IDA	HNP																		
2012	P118179	Modernization of Rani Jamara Kulariya Irrigation Scheme - Phase 1	Closed	2018	IBRD/IDA	Water																		
2013	P128304	Additional Financing for the Project for Agriculture Commercialization and Trade	Active	2018	IBRD/IDA	Agriculture																		
2013	P128303	Second Additional Financing for the Poverty Alleviation Fund	Active	2019	IBRD/IDA	Agriculture																		
2014	P144474	AF for IWRMP	Active	2018	IBRD/IDA	Agriculture																		
2014	P143036	NP Rural Water Supply and Sanitation Improvement Project	Active	2020	IBRD/IDA	Water																		
2018	P156797	Nepal Livestock Sector Innovation Project	Active	2023	IBRD/IDA	Agriculture																		
2018	P158364	Modernization of Rani Jamara Kulariya Irrigation Scheme - Phase 2	Active	2024	IBRD/IDA	Water																		
2012	P127709	NP: Nutrition Policy Dialogue II	Closed	2014	TA Nonlending	HNP																		
2014	P149901	Nepal Nutrition Policy Dialogue III	Closed	2015	TA Nonlending	HNP																		
2014	P143931	DIME - SHD-CANP Impact Evaluation	Closed	2018	Trust fund	HNP																		
2016	P155592	Qualitative Study for SHD-CANP	Closed	2018	Trust fund	HNP																		
2019	P168568	PER for Nutrition in Nepal	Active	2020	Trust fund	HNP																		
2019	P168830	Addressing Malnutrition and Investing in Early Years in Nepal in a federalized context	Active	2021	Trust fund	HNP																		

Source: Independent Evaluation Group from World Bank Business Intelligence Warehouse data.

Note: HNP = Health, Nutrition, and Population; SPJ = Jobs and Social Protection.

**Table D.4. Commitments of Official Development Assistance in Basic Nutrition for Nepal**

(current US\$, millions)

<b>Donors</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>Total</b>	<b>Total (percent)</b>
Official donors, total	45.3	16.5	44.0	12.3	9.5	9.9	137.6	100
Development Assistance Committee countries	4.9	15.8	13.6	11.6	8.7	9.4	64.1	46.61
Australia	0.5	0.1	0	0.6	0	0	1.2	0.91
Austria	0	0	0	0	0.5	0	0.5	0.37
Canada	1.0	0	0	6.5	0.7	0	8.2	5.99
France	0	..	0	0	..	0	..	..
Germany	0	0	0	1.2	0	1.6	2.8	2.02
Italy	0	0	0	0	..	0	..	0.01
Korea, Rep.	0	0	..	..	0	0	..	0.03
United States	3.4	15.7	13.6	3.3	7.5	7.9	51.3	37.27
Multilaterals	40.4	0.7	30.4	0.6	0.8	0.5	73.4	53.39
European Union institutions	0	0	30.1	0	0	0	30.1	21.85
AH.	0.4	0.7	0.4	0.6	0.8	0.5	3.4	2.46
Food and Agriculture Organization	0	0.1	0	0	0	0	0.1	0.09
United Nations Children's Fund	0.3	0.4	0.3	0.6	0.8	0.5	2.9	2.08
World Health Organization	0.1	0.2	0.1	0.1	..	..	0.4	0.29
World Bank Group (International Development Association)	40.0	0	0	0	0	0	40.0	29.08

Note: .. = negligible; 0 = zero.

Source: Organisation for Economic Co-operation and Development Stat, Creditor Reporting System as of April 10, 2019.

## References

- Maternal and Child Nutrition Study Group. 2013. Maternal and Child Nutrition Series. Lancet 382 (9890). <https://www.thelancet.com/series/maternal-and-child-nutrition>.
- United Nations Administrative Committee on Coordination Sub-Committee on Nutrition (ACC/SCN). 2000. Fourth Report on the World Nutrition Situation. Geneva: ACC/SCN in Collaboration with International Food Policy Research Institute.
- UNICEF (United Nations Children’s Fund). 1990. Strategy for Improved Nutrition of Children and Women in Developing Countries, UNICEF, New York.  
[http://ceecis.org/iodine/01\\_global/01\\_pl/01\\_01\\_other\\_1992\\_unicef.pdf](http://ceecis.org/iodine/01_global/01_pl/01_01_other_1992_unicef.pdf).
- . 2015. “UNICEF’s Approach to Scaling Up Nutrition for Mothers and Their Children.” Discussion Paper, Programme Division, UNICEF, New York, June 2015.
- United Nations Commission on the Nutrition Challenges of the 21st Century (UNCNC21) 2000. Ending Malnutrition by 2020: An Agenda for Change in the Millennium. Geneva: United Nations. <https://www.unscn.org/uploads/web/news/2000-FEB-Ending-Malnutrition-by-2020-Agenda-for-Change-in-the-Millennium-Report.pdf>.
- USAID (United States Agency for International Development). 2020. DHS Program STATcompiler. <https://www.statcompiler.com/en/>.
- World Bank. 2017. Global Findex database: <https://globalfindex.worldbank.org/>.
- World Bank. 2019. Worldwide Governance Indicators: <https://info.worldbank.org/governance/wgi/>.

## Appendix E. List of Persons Met

### World Bank Country Office Nepal

Dr. Manav Bhattarai	Team Leader—Community Action for Nutrition Project
Ms. Gogji Grewal	Lead impact evaluation of Community Action for Nutrition project, Development Impact Evaluation
Mr. Faris H. Hadad-Zervos	Country Director for Maldives, Nepal, and Sri Lanka

### Government, Stakeholders, and Development Partners

#### Country Level

Mr. Babu Ram Shrestha	Joint secretary, Ministry of Federal Affairs and General Administration
Mr. Dilaram Panthi	Undersecretary, Ministry of Federal Affairs and General Administration
Dr. Kiran Rupakheti	Chief, Good Governance and Social Development Division, National Planning Commission
Dr. Usha Jha	Member, National Planning Commission
Mr. Indra Bhujel	Consultant for Community Action for Nutrition Project, Ministry of Federal Affairs and General Administration
Mr. Debendra Adhikari	Nutrition focal person, USAID Nepal
Ms. Dale Davis	Country Director, Helen Keller International
Mr. Sujay Bhattacharya	Head, Nutrition and Health, Action Against Hunger, Nepal
Mr. Kedar Parajuli	Chief, Nutrition Section, Family Health Division, Department of Health Services
Mrs. Anjana Maharjan & Mr. Chok Dhital	Focal persons, Ministry of Water Supply
Mr. Shyam Paudel	Chief, Global Agriculture and Food Security Project (GAFSP) implemented by Ministry of Agriculture

#### Province

Dr. Surendra Jha	Member, provincial level of the food and nutrition security coordination committee (province 2)
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#### District level staff Community Action for Nutrition

Mr. Purna B. Chemjong	Team Leader, Renaissance Society Nepal (local implementing NGO)
Mr. Manish Thakur	Saptari district
Mr. Hemant Jha	Dhanusha district
Mr. Gopal Niraula	Udayapur district

#### Coaches

Roshani Kumari, Sanju, Mala Yadav	Saptari district
Sujit Mandal, Subita Yadav, Shova Basnet	Dhanusha district
Lila Magar and Khil Kumari Karki	Udayapur district

#### Health facility

Health post in charge and auxiliary nurse midwife	Health post, Saptari district
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