**EXECUTIVE SUMMARY**

Lao PDR is a Least Developed Country (LDC) ranked 133rd out of 182 countries in the UNDP Human Development Index. Despite Lao PDR’s economic improvement in recent years, about 85 percent of the country’s 5.6 million people in rural areas still face food insecurity, poverty and recurring natural disasters. As a result, the nutritional status of the population remains a serious concern, with no significant change in chronic malnutrition rates over the past decade.

The economy is largely subsistence based, with over 80 percent of the population living in rural areas. Agricultural practices are mostly subsistence-oriented, with low input farming systems, weak rural infrastructure, a lack of an educated and skilled work force, and poor access to extension services. Rice production remains low compared to neighbouring countries and local seasonal rice deficits occur each year.

According to the WFP’s Comprehensive Food Security and Vulnerability Analysis (CFSVA), it is estimated that approximately two thirds of the rural population are either food insecure or are at risk of becoming food insecure should a shock occur. Malnutrition rates in Lao PDR are among the highest in the region and contribute significantly to child morbidity. Nearly one out of two children under five are stunted and one out of three children under five under weight. The highest prevalence of chronic malnutrition (stunting) is found in the northern, southern and central highlands with chronic malnutrition among some ethnic groups averaging over 60 percent. One third of pregnant and lactating women are undernourished and at higher risk of delivering low-birth weight infants.

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1 Adjusted to avoid overlap between years.
2 UNDP Human Development Report, 2009 report
3 IFAD, Rural Poverty in Lao PDR, 2006
4 WFP Comprehensive Food Security and Vulnerability Analysis (CFSVA) report; 2007
5 WFP Comprehensive Food Security and Vulnerability Analysis (CFSVA) report; 2007
6 Ministry of Health (2006), National Health Survey/MICS3
This Maternal and Child Health and Nutrition (MCHN) development project is a pilot intervention aimed at addressing stunting among children 6-23 months. The project follows the Country Portfolio Evaluation conducted in 2009 which recommended that WFP sharpen its focus on nutrition in the Lao PDR. The objective of the project is to contribute to national efforts to reduce maternal, neonatal and child mortality and maternal and child malnutrition in Lao PDR\(^7\) (WFP Strategic Objective 4: Reduce Chronic Hunger and Undernutrition).

WFP will assist the Government of the Lao PDR through an integrated nutrition intervention for women and children comprising two components: i) Provision of a ready-to-use supplementary food (Plumpy’ Doz\(^\circ\)) for children 6-23 months; and ii) a nutrition education initiative for pregnant and lactating women.

This development project supports Millennium Development Goal (MDG) 4: Reduced Child Mortality and the Lao MDG 5: Improved Maternal Health and WFP’s Gender Policy and Corporate Action Plan (2010-2011). The project is also in line with the priorities of the United Nations Development Assistance Framework (UNDAF) 2007-2011, the Lao Government’s National Nutritional Strategy (November 2009) and WFP’s partnership on the REACH Initiative.

An expanded phase of this project is expected to be included in the new Lao PDR country programme to commence in 2012.

\[\text{The Deputy Executive Director and Chief Operating Officer approves, under the Executive Director’s delegated authority, the proposed Development Project Lao PDR No.200129, subject to availability of resources.}\]

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Signature: Deputy Executive Director and Chief Operating Officer

Dated: ______________________

\(^7\) Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009-2015; Ministry of Health, Lao PDR.
PART I – SITUATION ANALYSIS

1. Lao PDR’s robust economic growth of nearly 10 percent over the last decade has not translated into an improved nutritional status of a large proportion of the population, with malnutrition rates remaining virtually unchanged over this period. Malnutrition rates in Lao PDR are among the highest in the region and contribute significantly to child morbidity.  

2. Nearly 40 percent of children under five are stunted, 37 percent underweight, and about 7 percent are wasted. More than 30 percent of pregnant and lactating women are undernourished and thus are at higher risk of delivering low-birth weight babies. While the national average of low-birth weight babies is 11 percent, in remote areas this figure is much higher. Micronutrient deficiencies such as that of iron, iodine and of vitamin A continue to be a public health concern in Laos PDR. 45 percent of children under five (CU5) suffer from Vitamin A deficiency and 23 percent of women between 12 and 49 years of age suffer from sub-clinical Vitamin A deficiency. Iron deficiency in women of reproductive age is approximately 22 percent. The 2006 National Nutrition Survey showed that 64 percent of children under two (CU2), 41 percent of CU5, and 36 percent of women of reproductive age (WRA) suffered from anaemia.

3. The Comprehensive Food Security and Vulnerability Assessment (CFSVA) found that the most food insecure provinces are located in the northern, central and southern highlands of Lao PDR. Farmers engaging in upland rice production form the majority of food-insecure households, with 42 percent reported to have poor food consumption. Limited access to land for cultivation due to mountainous terrain also affects food availability in these areas. Levels of food insecurity are also found to be higher among ethnic communities. The CFSVA found that the Hmong-Mien ethnic group had some of the highest levels of food insecurity at 28 percent.

4. Poor maternal and child health is the result of many factors, including poor consumption of nutritious foods, unfavourable complementary feeding practices such as the early introduction of nutritionally poor foods, the unsafe preparation of foods and poor childcare practices. Additionally, limited knowledge of the appropriate utilisation of foods from the local environment is a strong contributing factor to poor diets, despite the availability of diverse food sources in some areas.

5. The causes of malnutrition also include poor access to health care and sanitation facilities. The LECS 3 survey showed that in rural upland areas, it takes an average of three hours to reach a health facility. The 2009 Emergency Food Security Assessment (EFSA) conducted in northern Laos found that 40 percent of households interviewed had no latrines and used open fields. Women continue to have fewer

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8 Ministry of Health (2006), National Health Survey/MICS3
11 WHO 2000. Serum/plasma retinol concentration < 0.7 μmol/l.
12 National Nutrition Survey 2006. Proportion of children < 5 with Haemoglobin(HB) < 110 g / L.
13 National Nutrition Survey 2006. Proportion of WRA with HB < 120 g / L.
14 Lao Expenditure and Consumption Survey (LECS3) (2004), National Statistics Centre, Lao PDR.
rights, lower education and health status, less income and lower access to resources and decision making than men.

6. The Lao diet is based largely on staple foods. The CFSVA shows that rice is consumed on average 6.4 days per week whereas meat (small wildlife, poultry, pigs) is consumed one or less days per week. Green leafy vegetables are consumed on average 4.7 days per week but oil or lard is consumed only 2 days per week. Traditionally, sources of fat and protein are largely derived from wild animals and forest products. Access to these food sources is increasingly limited due to the expansion of commercial farming, deforestation, over-harvesting of non-timber forest products and resettlement of the population. Vegetable oil has not become part of people’s diet and pulses are used in small quantities in only sweet dishes15.

7. The United Nations is working with the Government of the Lao PDR (GoL) to achieve the Millennium Development Goals (MDGs), including MDG 1: to halve the proportion of people who suffer from hunger; MDG 4: to reduce child mortality; and MDG 5: to improve maternal health. The MDG progress report, prepared in 2008 by the Government and the UN, identifies malnutrition as the biggest obstacle to achieving the MDGs. While GDP doubled in the Lao PDR between 2000 and 2007, rates of child malnutrition remained constant16.

8. Despite some progress in the decline of infant mortality rates from 104 per 1,000 live births to 70 per 1,000 live births between 1995 and 200517, and the decline of the Maternal Mortality Rate (MMR) from 656 per 100,000 live births to 405 per 100,000 live births18 during the same period, Lao PDR is unlikely to achieve relevant MDGs by 2015, especially MDGs 1 and 519. The Government concurs that the targets of reducing maternal mortality by three-quarters and achieving universal access to reproductive health care 20 will not be achieved by 2015.

9. The Government has set specific targets for 201021: underweight malnutrition rates to be reduced to 32 percent; maternal mortality to be reduced to 330 per 100,000 live births; infant mortality to be reduced to 55 per 1,000 live births and under 5 mortality to be reduced to 75 per 1,000 live births. It is also committed to further reducing malnutrition rates by 2020. In view of the complex and multi-sectoral nature of food security and nutrition, the combined and coordinated efforts of the Government, UN agencies, non-government entities and civil society are required, working across the relevant sectors as outlined in the Vientiane Declaration on Aid Effectiveness22.

10. WFP has worked with the Ministry of Health on key strategy and policy documents. The MoH’s strategy and planning framework for an Integrated Package of Maternal, Neonatal and Child Health Services (2009-2015) guides stakeholders engaged in this sector. The MoH-led National Nutrition Strategy (NNS) and National Plan of Action

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15 Comprehensive Food Security and Vulnerability Analysis (CFSVA) (2007), World Food Programme Lao PDR.
16 GDP data World Bank; nutrition from MICS III, 2006.
18 Ibid.
19 Ibid.
21 Ibid.
22 Signed at the Ninth Round Table Meeting on 29 November 2006, in Vientiane, Lao People’s Democratic Republic.
on Nutrition (NPAN) are key frameworks for addressing malnutrition in the Lao PDR.

11. Additionally, WFP is a leading partner in the REACH Initiative, for which Laos is the first pilot country in Asia. REACH is a Government-led, joint initiative with development partners aimed at accelerating progress on MDG 1, Target 2 (halve the proportion of underweight children under 5) through scaling up proven, cost effective interventions addressing child undernutrition.

PART II – PAST COOPERATION AND LESSONS LEARNED

12. WFP food assistance to Lao PDR started in 1975. Between 2005 and 2008, WFP assisted between 300,000 and 500,000 people each year and in 2009, over 800,000 people received WFP support. Currently, three operations are ongoing: two development projects and one protracted relief and recovery operation.

13. The projects and operation have the following objectives: (i) food for relief: to address emergency needs in times of mostly natural disasters and livelihood transitions; (ii) food for work: to improve livelihoods or reduce long-term food insecurity among food-insecure people, households, and communities; and (iii) school feeding: to contribute to the improvement of school enrolment, attendance rates and reduction of the gender gap in primary schools.

14. A Country Portfolio Evaluation (CPE) undertaken in 2009 found WFP’s activities to be generally well aligned with national policies, systems and processes. In the area of nutrition, WFP has been playing an instrumental role through its analytical and advocacy work by raising awareness and contributing to a process that led to the formulation between 2008 and 2009 of a National Nutrition Policy, Strategy and Plan of Action.

15. WFP participates in Government-led processes in health and education. The school feeding programme is implemented in collaboration with UNICEF’s schools of quality and complements the Asian Development Bank’s investment in basic education in the same districts and communities.

16. According to the CPE, WFP in Laos performed well by reaching between 75-100 percent of intended beneficiaries, including on average an equal number of men and women. The age distribution of the beneficiaries shows however that WFP did not prioritize groups found to be vulnerable in the comprehensive food security and vulnerability analysis, namely pregnant and lactating women and infants in the age group up to 2 years.

17. A formulation mission conducted in 2009 concluded that a MCHN project was technically feasible and socially acceptable. This resulting project has been reflected and incorporated into the national health and nutrition development plans of the Government, which supports mobilization and awareness at village and community levels.
18. As supplementary feeding on its own would be insufficient to address the underlying causes of malnutrition in Laos, the components of this development pilot will be integrated into other health and nutrition-related interventions, including WFP-specific (e.g. food for work) and other UN agency-related interventions. Complementary activities by other UN agencies include immunisation and deworming campaigns, exclusive breastfeeding campaigns, capacity building in nutrition and salt iodisation. Coordination with other agencies will be important to achieve the desired impact of WFP assistance. WFP is also present in the target provinces with other activities such as school feeding and food for work. Synergies to improve household level food security will be explored in the target villages.

PART III – PROJECT STRATEGY

19. The long-term objective of this development project is to contribute to national efforts to reduce maternal, neonatal and child mortality and maternal and child malnutrition in Lao PDR. This involves assisting the Government to strengthen the quality of its health service provision in line with the existing policy framework.

20. Short-term to medium objectives are (i) to improve the nutritional and health status of pregnant/lactating women and young children; (ii) to increase the uptake of health services (at provincial and district hospitals and health centres) by pregnant/lactating women and young children; and (iii) to increase the nutritional knowledge of women and caretakers of children (including men).

21. This MCHN project takes a two-pronged approach using complementary components. First, to address malnutrition in children under two years of age, Plumpy’ Doz® will be provided, together with rice for pregnant and lactating women to encourage utilisation of health facilities for ante and post-natal care. Second, a nutrition education component will seek to increase the nutritional knowledge of mothers and caretakers of children (including men). The training course is community-based and targeted at remote rural populations. The nutrition education component was developed, tested and evaluated by WFP in Laos in 2008 and 2009. The total estimated beneficiaries are shown in Table 1 and 2, Annex 2.

22. The MCHN project will start in Luang Namtha and Oudomxay provinces. These provinces were chosen due to high levels of chronic malnutrition as demonstrated by the WFP CFSVA in the northern highlands agro-ecological zone, under which these provinces fall. The 2004 Lao Expenditure and Consumption Survey (LECS3) shows that health seeking behaviour is very low in these provinces. In Luang Namtha province approximately 17 percent of people attend health facilities when unwell and in Oudomxay this is as low as 9 percent. Both these provinces were covered by the EFSA in 2009 and were recently affected by shocks that impacted the food security and nutrition of these populations.

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24 Lao Expenditure and Consumption Survey (LECS3) (2004), National Statistics Centre, Lao PDR
23. In Luang Namtha province, the project will target Long, Nalae, Sing and Viengphouka districts. These are among the 47 districts identified by the Government as poor, and thus priority areas for assistance by WFP. Additionally, in recent assessments, Long district was found to have poor/borderline food consumption (40 percent of households, EFSA 2009). Oudomxay province has been identified as one of the areas most affected by the rat infestations in the north (EFSA, 2009). In Oudomxay province, Xay and La districts will be targeted as rates of malnutrition and food insecurity are very high in both these districts.

24. The project will be implemented initially in one district (Nalae) of Luang Namtha province. The district has 79 villages and 8 health facilities. The project will provide a blanket coverage of all villages. These include all school feeding villages and additional extra villages in the district centre (which are not part of school feeding but which are served by the district hospital). Following lessons learnt from this activity in Nalae district, the project will be expanded in 2011 to the remaining three districts in Luang Namtha and two districts in Oudomxay.

25. The project will be undertaken in villages and at fixed health sites including provincial and district hospitals, and health posts. At the village level, Plumpy’Doz® will be distributed to all children 6–23 months of age. The entry and exit criteria for receiving Plumpy’ Doz® is age. All children in this age group are eligible to receive Plumpy’ Doz® since the prevalence of chronic malnutrition in these populations is greater than 15 percent. Once children reach 24 months, they will exit the programme. An acceptability study was completed in February 2010 and Plumpy’ Doz® was found to be well accepted by the target population and much preferred to other alternative commodities such as corn-soya blend.

26. In health facilities, pregnant and lactating women will receive a maximum of 60 kilos of rice (10 kilos per visit). The rice ration will be provided as an incentive for up to 4 ante-natal care visits and 2 post-natal care visits. All women who deliver their baby at a health facility will receive a one-time incentive of 10 kilos of rice. The aim is to ensure that women access pre and post-natal care and have safe deliveries assisted by health staff at a facility rather than in the village. While the food ration will contribute to meet the caloric needs of PLW, there is also need for a more nutritious supplement in the food basket. WFP will therefore also carry out a trial of Nutributter® (or another fortified food) for PLW in the last 6 months of the project. This will allow WFP time to set up and consolidate project activities and to determine if Nutributter® is the an appropriate commodity for this group of beneficiaries in any future scale-up of the project. Planned rations are shown in Table 3, Annex 2.

27. The nutrition education component targets women in the reproductive age and other caretakers from ethnic communities who are suffering from high levels of chronic malnutrition. It will take a life skills approach and aim to empower communities with relevant nutritional information to bring about positive changes in their nutrition-related behaviour. Information on the need and importance of distributing Plumpy’

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25 Plumpy’ Doz® is a lipid-based high nutrient commodity, which meets the recommended micronutrient requirements of children 6–23 months.

26 The rice ration will compensate for opportunity costs due to travel and the loss of labour or income earning opportunities.
Doz® and Nutributter® as part of the project will also be incorporated in the training curricula.

28. WFP’s training fills a gap in the area of nutrition education by providing culturally appropriate training. The training will be delivered in local languages in an interactive manner while refresher training will be regularly provided and closely monitored. The training is innovative in that it makes full use of food sources from the natural environment27. Culture-specific training tools such as photographs, posters and cooking sessions will also be used to encourage a change in nutritional behaviour which should lead to improvement in the quality of villagers’ diets by using locally available foods prepared in clean kitchens. Nutrition champions will also be identified at the village level to help spearhead these efforts. The training package was piloted in 2008-2009 as part of WFP’s ‘Feeding the Future’ nutrition initiative and evaluation of the project was positive. The evaluation results from the pilot show that there was good overall recall of the training messages. Over 80 percent of all trainees across the 4 pilot villages were able to recall most of the training messages and simple changes in behaviour had also taken place.

29. Partners for the two project components will include the Ministry of Health (MoH), provincial and district governments, village development committees, village health volunteers, the Lao Women’s Union (LWU) and the Lao Front for National Construction (LFNC). LWU will be responsible for monitoring the overall intervention.

30. Provincial and district authorities have already participated in the implementation of the nutrition training and are fully supportive of both components of this project. The Lao Women’s Union (LWU) at central and provincial level has also expressed strong interest in playing a monitoring role. WFP will train the LWU at the provincial level to monitor the implementation of the project at the villages and health facilities.

31. Given the ethnic diversity in Luang Namtha and Oudomxay provinces, the role of the Lao Front for National Construction will be instrumental as it is already undertaking outreach programmes to ethnic villages. They have also expressed interest in monitoring the activities.

32. At the village level, the health volunteers will be the main implementers of the project. In line with government requirements, at least one village health volunteer is required to be present in every village. In some villages, there are 2-3 village health volunteers but this depends on the size of the village and the willingness of people to volunteer. Village health volunteers will be trained in anthropometry, monitoring and record keeping prior to food distribution. UNICEF and FAO are both conducting complementary training with all village health volunteers on Infant and Young Child Feeding (IYCF) which will add to the capacity of the village health volunteers to advise women on better nutrition and child care practices. The implementation of this project by the village health volunteer will be a way for the village to contribute to this project, and take ownership of the activities. As such, no incentive will be

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27 In upland Laos, the natural environment is a significant source of food, whether it be wild meats from the forest or bony fish from the rivers. Being aware of the crucial role of the natural environment and its link to nutrition is imperative and this is emphasized in training. WFP takes into account the existing laws on protected species of flora and fauna, which is highlighted in the training.
provided to the village health volunteers. WFP has learnt from its school feeding project, which is currently being handed over to the Government, that provision of an incentive is unsustainable in the long-term.

33. To implement the nutrition education component, WFP will partner with INGOs working in the same areas targeted by the MCHN component. The WFP-INGO partnership will provide the capacity to reach out to more villages. INGOs that are already implementing programmes at the village level will be able to complement their activities with nutrition training, thus offering villagers a holistic service and supporting inter-sectoral cooperation (agriculture, natural resource management, non-formal education). It is estimated that at least two INGOs per district will deliver the training. The people receiving training will be women and other caretakers of children including grandparents and fathers. The training will be implemented at the village level and target groups will be invited by the village chiefs to participate. However, the training will also remain open to any other villagers interested to attend.

34. An INGO consortium will be set up and coordinated by WFP under the leadership of the Ministry of Health, providing a forum for knowledge exchange (lessons learnt) and a platform to feed into the current policy dialogue on issues of nutrition and sustainable development. The consortium responds to the need to have a platform for effective coordination and implementation of assistance among the large number of INGOs working in the health and nutrition sector in the country.

35. Under the Ministry of Health’s leadership, the Maternal, Neonatal and Child Health (MNCH) package has been designed to promote a more programme-based approach to address malnutrition in Laos. The MNCH package also focuses on improving facility-based services, with WFP’s project contributing to the creation of demand for these services. There are clear synergies between WFP, UNICEF and UNFPA in supporting the MNCH package through the provision of joint trainings, joint delivery of interventions (e.g. nutrition education with outreach services) and joint monitoring, which will not only have a major impact on cost savings but also add to a strengthening of response at the community level.

36. UNICEF is delivering an integrated package of complementary safe motherhood and promotion of breastfeeding in the same areas as the WFP intervention. UNICEF’s Community Action for Early Childhood Development project targets 40 villages across Long and Nalae districts of Luang Namtha province and provides integrated MCHN services including vitamin A, iron and de-worming, as well as exclusive breastfeeding, immunization and nutrition counselling. WFP’s nutrition training aims to improve nutrition knowledge from a life skills perspective, i.e. helping families make better nutrition choices using available resources in their environment, while UNICEF focuses on health through the identification of complementary foods and feeding practises. Furthermore, WFP delivers training at the village level, whereas UNICEF has a district level approach. The Ministry of Health, in collaboration with FAO is coordinating the content of nutrition education materials nationwide to ensure that the messages given are complementary and not contradictory. The partners trained by UNICEF, including the Department of Health staff and LWU in Luang Namtha province who may also be involved in WFP activities.
37. Potential synergies also exist with UNFPA’s support to the Ministry of Health in training skilled birth attendants for health facilities in the country. UNFPA has community-based distributors as part of its reproductive health interventions who will support efforts to increase awareness on WFP’s MCHN project at the village level.

38. In the longer-term, WFP envisions that the project will be handed over to the Government. However, WFP recognises that Plumpy’ Doz® is an expensive commodity to distribute by the Government on a long-term basis. WFP is therefore looking into the possibility of setting up a factory to produce RUSFs locally. If feasible, WFP will support the Government in setting up a factory for local production of the product once the pilot phase of the project has been completed and lessons learnt have been incorporated.

PART IV – MANAGEMENT, MONITORING AND EVALUATION

39. This development project is planned as a small-scale pilot, with plans for a scale up of activities in line with the new 2012-2016 UNDAF, based on the lessons learnt during the pilot phase. In addition to collaboration with the Ministry of Health (MoH), and other governmental partners, new partnerships will also be explored with UN agencies and INGOs. Standardized agreements detailing responsibilities for implementation and reporting will be signed with cooperating partners.

40. Under the WFP-supported school feeding development project, WFP delivers food directly to 319 schools in Luang Namtha province and 417 schools in Oudomxay province. These same logistics arrangements will be used to deliver Plumpy’ Doz® to the villages and rice to the health facilities under this development project. The Commodity Movement Processing and Analysis System (COMPAS) will be used to track commodities from the point of origin to the beneficiaries. WFP already provides storage management and logistics training to Government and other partners, which will be essential for the MCHN project. For the few villages in remote areas where there are no school feeding activities, the delivery of the Plumpy Doz® will be undertaken to the nearest school feeding village. The food will then be taken directly to target villages by LWU or WFP staff. For villages that are close to the district centre, food will be stored at the WFP district warehouse and distributed according to the agreed schedule.

41. WFP will deliver food every three months to the villages and the health facilities. Plumpy’Doz® distributions to beneficiaries will take place on a monthly basis at the village level. The distribution of rice at health centres (10 kilos per person) will take place when pregnant or lactating woman attend the health facility for ante or post-natal check ups. Any woman delivering a baby will also receive 10 kilos.

42. The village storekeeper (the same person who manages the school feeding warehouse in the villages), village health volunteers, Lao Women’s Union (LWU) and health clinic staff will receive training on food storage, distributions and handling. The current utilisation of health facilities is very low which will allow health staff to participate in food distribution to PLW. However, given the likely increase in the utilisation of health facilities due to the effects of this project, a review of these arrangements will be conducted after the first 6 months of project implementation.
Greater involvement VHV and the LWU representatives in food distributions will be sought after the first six months.

43. The village health committees in each village will assist with implementation. Food distributions will take place in villages once a month. During the distribution, the village health volunteer, supported by the Lao Women’s Union (LWU) representative from the village will weigh all children 6-23 months of age, before distributing the rations for the following month. WFP staff will maintain regular contact with the LWU representatives and will ensure that monitoring proceeds smoothly. Records will be kept on the amount of food distributed and the weight of children.

44. Immediate objectives, as well as indicators for outcomes and outputs of the project, are in line with the Lao PDR National Nutrition Strategy and Plan of Action on Nutrition Plan 2010-2015 and WFP corporate indicators as outlined in the Results and Resources Matrix in Annex 2. The selected targets are based on standard nutritional benchmarks for a feeding programme combined with complementary activities.

45. The MOH will have primary responsibility for monitoring and reporting on project activities. WFP will organise regular meetings of all stakeholders and project sites and distributions will be visited on a regular basis by WFP monitors who will verify whether all components of the project are being satisfactorily carried out using standardised check-lists.

46. Output and process indicators will be measured and reported in quarterly progress reports produced by the MOH. An internal mid-term review to be conducted in mid-2011 and lessons learnt will be used to improve performance, taking into consideration complementary inter-agency efforts.

47. Given that access to health centres is already very low (28 percent), it is estimated that an incentive will increase access by at least 25 percent in the first 6 months and another 25 percent in the following 6 months. Expected results include increased use of health centres and district hospitals, improved nutritional status by targeted beneficiaries (from Plumpy’Doz), and improved knowledge of nutrition by beneficiaries. Strong advocacy efforts will have to be made by WFP, the Government and its partner agencies to achieve these results.

48. There are a number of potential risks identified with the MCHN project. These include the incentive effect of food incentives, the extent of regular outreach by district-level health authorities, the availability of children’s ages, and the effective conduction of regular growth monitoring at the clinic level. Further assumptions are that the MoH will maintain/construct health facilities and provide medical supplies, food will arrive on time to target beneficiaries, and adequate training will be conducted for all partners on the project.

49. As the provision of weighing scales and reporting forms are critical, funds have been budgeted in the project to procure supplies if some partners, such as the MoH, are unable to ensure funding. A baseline survey will be conducted at the start of the project against which project performance will be measured to determine project effectiveness.
50. The anthropometric measurements planned in the project are height and weight measurements. For children, weight/age and height/age will be plotted on a graph. Weight and height will be collected on the basis of a survey sample once a year supported by the VHV, LWU and WFP.

51. It is expected that there will be no negative environmental impact resulting from this project. The proposed food commodity, Plumpy’ Doz® is packaged in plastic tubs and villagers will be educated on how best to re-use these plastic tubs for storage of salt and other food items used in the kitchen.

52. The project is aligned with WFP’s Gender Policy and Corporate Action Plan (2010-2011). While many of the direct beneficiaries of the project are female, the project will work with families to promote nutritional and healthcare knowledge among both men and women, actively involving husbands, boys, elderly people and community leaders in the project. A preliminary survey on barriers to accessing health facilities for pregnant women identified men’s reluctance as one of the factors limiting women’s access to professional health services during pregnancy and for deliveries, thus showing the importance of involving both female and male members of the families and the communities.
Annexes:

1. Budget Summary (refer Annex 1)
2. Results and resources matrix – Logical Framework (refer Annex 2)
3. Map
4. List of acronyms
## ANNEX I: WFP PROJECT COST BREAKDOWN

<table>
<thead>
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<th>Average cost (US$) per mt</th>
<th>Value (US $)</th>
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<td>A. Direct operational costs</td>
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</tbody>
</table>

28 This is a notional food basket used for budgeting and approval purposes. The precise mix and actual quantities of commodities to be supplied to the project, as in all WFP-assisted projects, may vary over time depending on the availability of commodities to WFP and domestically within the recipient country.
## ANNEX 2

### TABLE 1: TOTAL BENEFICIARIES BY ACTIVITY TYPE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCHN</td>
<td>4,180</td>
<td>6,634</td>
<td>10,814</td>
</tr>
<tr>
<td>Nutrition Education</td>
<td>1,200</td>
<td>2,400</td>
<td>3,600</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,380</td>
<td>9,034</td>
<td>14,414</td>
</tr>
</tbody>
</table>

### TABLE 2: BENEFICIARIES BY ACTIVITY TYPE AND YEAR

<table>
<thead>
<tr>
<th>Beneficiary Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children age 6 to 23 Months</td>
<td>913</td>
<td>8,057</td>
<td>8,358</td>
</tr>
<tr>
<td>Pregnant/Lactating Women</td>
<td>213</td>
<td>2,350</td>
<td>2,456</td>
</tr>
<tr>
<td><strong>Total Beneficiaries (Food)</strong></td>
<td>1,126</td>
<td>10,407</td>
<td>10,814</td>
</tr>
<tr>
<td>Nutritional Education (Non-food)</td>
<td>1,200</td>
<td>2,400</td>
<td>3,600</td>
</tr>
<tr>
<td><strong>Total Beneficiaries</strong></td>
<td>2,326</td>
<td>12,807</td>
<td>14,414</td>
</tr>
</tbody>
</table>

* adjusted total to avoid overlap

### TABLE 3: DAILY FOOD RATION/TRANSFER BY ACTIVITY (g/person/day)

<table>
<thead>
<tr>
<th>Commodity Type/ Cash &amp; voucher</th>
<th>MCHN Children</th>
<th>MCHN PLW</th>
<th>MCHN (deliveries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>0</td>
<td>333</td>
<td>333</td>
</tr>
<tr>
<td>Plumpy’ Doz®</td>
<td>46.3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Nutributter®</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>46.3</strong></td>
<td><strong>333</strong></td>
<td><strong>333</strong></td>
</tr>
<tr>
<td><strong>Total kcal/day</strong></td>
<td><strong>247</strong></td>
<td><strong>1307</strong></td>
<td><strong>1307</strong></td>
</tr>
<tr>
<td>% kcal from protein</td>
<td><strong>9.5</strong></td>
<td><strong>7.33</strong></td>
<td><strong>7.33</strong></td>
</tr>
<tr>
<td>% kcal from fat</td>
<td><strong>58</strong></td>
<td><strong>2.50</strong></td>
<td><strong>2.50</strong></td>
</tr>
</tbody>
</table>
### ANNEX 3 – Results and Resources Matrix Summary

<table>
<thead>
<tr>
<th>Results-Chain (Logic Model)</th>
<th>Performance Indicators</th>
<th>Risks, Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRATEGIC OBJECTIVE (SO4): Reduce Chronic Hunger and Undernutrition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome 4.3:</strong> Improved nutritional status of targeted girls and boys between 6-24 months</td>
<td>4.3.1 Decrease in the prevalence of stunting among targeted children 6-24 months (height-for-age as %) by 10% from baseline (Baseline to be collected prior to start of project). Current estimated prevalence rate in the proposed target areas is approximately 50% so a 10% decrease to 45% is anticipated.</td>
<td>Σ Baseline data available</td>
</tr>
<tr>
<td></td>
<td>4.3.2 Decrease in prevalence of underweight among targeted children under 5 (weight for height as %) by 10% from baseline.</td>
<td>Σ Availability of skilled health staff</td>
</tr>
<tr>
<td></td>
<td>4.3.4 Attendance at health facility/ uptake of basic health services</td>
<td>Σ Nutritional status in target areas not compromised by major external shocks such as natural disasters</td>
</tr>
<tr>
<td></td>
<td>25% Increase in supported pregnant women who received at least 4 ante-natal check-ups (ANC) during pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% increase in percentage of supported lactating women who received a post-natal check-up (PNC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.3.10 Infant and young feeding practices: Dietary diversity: 25% increase in children 6-23 months of age who receive foods from 4 or more food groups.</td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.1 and 4.2</strong></td>
<td>Number of women, men, girls and boys receiving food and non-food items, by category and as percentage of planned figures.</td>
<td>Σ Acceptance of training messages by the villagers</td>
</tr>
<tr>
<td></td>
<td>Tonnages of food distributed, by type, as % of planned distributions</td>
<td>Σ Environment – access to villages, health facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Σ Capacity – change in staffing structure (government and INGO) affecting the number of people available to deliver village trainings</td>
</tr>
</tbody>
</table>
ANNEX 4 - Maps

LAO PDR
WFP MCHN Target Districts in Luangnamtha and Oudomxay Provinces - 2010

The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.


Source:
United Nations Centre for Geographic Information and Research (UN-CIGIR), North-South, Department of Statistics, National Geographic Information, Department of Forestry, Veterinary and WFP MCHN UNICEF.

Map produced by ISVAM Unit, Lao PDR, March 2018.
### ANNEX 5 - List of acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFSVA</td>
<td>Comprehensive Food Security and Vulnerability Analysis</td>
</tr>
<tr>
<td>COMPAS</td>
<td>Commodity Movement Processing and Analysis System</td>
</tr>
<tr>
<td>CPE</td>
<td>Country Portfolio Evaluation</td>
</tr>
<tr>
<td>GoL</td>
<td>Government of Lao PDR</td>
</tr>
<tr>
<td>LDC</td>
<td>Least Developed Country</td>
</tr>
<tr>
<td>LFNC</td>
<td>Lao Front for National Construction</td>
</tr>
<tr>
<td>LWU</td>
<td>Lao Women’s Union</td>
</tr>
<tr>
<td>MCHN</td>
<td>Mother, Child, Health and Nutrition</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NFI</td>
<td>Non Food Inputs</td>
</tr>
<tr>
<td>NNS</td>
<td>National Nutrition Strategy</td>
</tr>
<tr>
<td>NPAN</td>
<td>National Plan of Action on Nutrition</td>
</tr>
<tr>
<td>NTFP</td>
<td>Non-Timber Forest Products</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United National Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United National Children’s Fund</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>