



Grant Assistance Report

Project Number: 42155
February 2009

Proposed Grant Assistance Mongolia: Reducing Persistent Chronic Malnutrition in Children in Mongolia (Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 6 February 2009)

Currency Unit	–	togrog (MNT)
MNT1.00	=	\$0.00066
\$1.00	=	MNT1,517

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
EA	–	executing agency
FGP	–	family group practice
HSMP	–	Health Sector Master Plan
IEC	–	information and education communication
IMCI	–	integrated management of child illness
IYCF	–	infant and young child feeding
JFPR	–	Japan Fund for Poverty Reduction
MOFA	–	Ministry of Food and Agriculture
MOH	–	Ministry of Health
NGO	–	nongovernment organization
NRC	–	Nutrition Research Center
PHC	–	primary health care
PHN	–	public health nutrition
PIU	–	project implementation unit
PLW	–	pregnant and lactating women
PSC	–	project steering committee
SHC	–	soum health center
SOE	–	statement of expenditures
THSDP	–	Third Health Sector Development Project
TWG	–	technical working group
UNICEF	–	United Nations Children's Fund
WVM	–	World Vision Mongolia

GLOSSARY

aimag	–	administrative unit (province)
duureg	–	administrative subunit of Ulaanbaatar (district)
ger	–	traditional tent
khoroо	–	administrative subunit of duureg (subdistrict)
soum	–	administrative subunit of aimag (district)
ward	–	administrative subunit of khoroо

NOTES

- (i) The fiscal year (FY) of the Government of Mongolia ends on 31 December.
- (ii) In this report, "\$" refers to US dollars.

Vice President	C. Lawrence Greenwood, Jr., Operations 2
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Director	A. Leung, Social Sectors Division, EARD
Team leader	C. Bodart, Senior Health Specialist, EARD
Team members	I. Lonjid, Social Sector Officer, EARD W. Walker, Social Development Specialist, EARD

JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR Grant Proposal

I. Basic Data

Name of Proposed Activity	Reducing Persistent Chronic Malnutrition in Children in Mongolia
Country	Mongolia
Grant Amount Requested	\$2,000,000
Project Duration	4 years
Regional Grant	No
Grant Type	Project

II. Grant Development Objectives and Expected Key Performance Indicators

<p>Grant Development Objectives: The overall objective is to improve the nutritional status of children under 36 months of age in Mongolia. The specific development objectives are to</p> <ul style="list-style-type: none"> (i) conduct a participatory analysis of obstacles that are preventing the Ministry of Health (MOH), private sector, nongovernment organizations (NGOs), and communities from effectively addressing chronic child malnutrition; (ii) in project areas with contrasting socioeconomic resource settings, (a) identify and test various nutrition delivery approaches with emphasis on micronutrients for children and women; and (b) develop and implement parallel, tailor-made information, education, and communication (IEC) and/or behavior change communication (BCC) to increase the awareness, skills, and habits for reduced chronic malnutrition in disadvantaged communities; (iii) pilot test and institutionalize a revised public health nutrition (PHN) training curriculum for primary health center (PHC) workers; and (iv) capture the experience and produce evidence of successful approaches by rigorous monitoring and evaluation, then use the results to inform and improve the nutrition policies of the Government of Mongolia. 	
<p>Expected Key Performance Indicators:</p> <ul style="list-style-type: none"> (i) At least 35,000 under-3-year-old children in project areas have received methods, products, and services through PHC services aimed to reduce their chronic malnutrition, followed by evidence of improved performance and effectiveness of PHC services in the delivery of the approach. (ii) Project <i>aimags</i> have been provided IEC/BCC campaigns to improve awareness, skills, and behaviors for reducing chronic malnutrition. (iii) At least 10 innovative nutrition approaches (methods, products, and services) have been delivered in combination with the improved PHC approach, tested, and evaluated for their effects on reducing chronic malnutrition in disadvantaged communities. (iv) A PHN training curriculum has been tested in the regular undergraduate and graduate training of PHC workers and submitted for acceptance by the Health Sciences University. (v) The Project has submitted draft guidelines and policy recommendations to the Government that will improve the nutritional status of infants and young children in Mongolia. 	

III. Grant Categories of Expenditure, Amounts, and Percentage of Expenditures

Category	Amount of Grant Allocated in \$	Percentage of Expenditures
1. Civil works	0	0.0
2. Equipment and supplies	452,150	22.6
3. Training, workshops, seminars, and public campaigns	149,650	7.5
4. Consulting services	482,200	24.1
5. Grant management	306,000	15.3
6. Other inputs	410,000	20.5
7. Contingencies	200,000	10.0
Total	2,000,000	100.0

JAPAN FUND FOR POVERTY REDUCTION

**JFPR Grant Proposal
Background Information**

A. Other Data

Date of Submission of Application	
Project Officer	Claude Bodart, Senior Health Specialist
Project Officer's Division, E-mail, Phone	East Asia Department, Social Sectors Division (EASS) cbodart@adb.org, +632 632-5616
Other Staff Who Will Need Access to Review the Report	Wendy Walker, Social Development Specialist, EASS, wwalker@adb.org Itgel Lonjid, Social Sector Officer, Mongolia Resident Mission, ilonjid@adb.org
Sector	Health, nutrition, and social protection
Subsector	Health programs
Theme	Inclusive social development
Subtheme	Human development
Targeting Classification	Targeted intervention—non-income Millennium Development Goals (TI-M)
Was JFPR Seed Money Used to Prepare This Grant Proposal?	Yes
Have Staff Review Committee Comments Been Reflected in the Proposal?	Yes
Name of Associated Asian Development Bank (ADB) Financed Operation	Third Health Sector Development Project (THSDP)
Executing Agency	Ministry of Health (MOH)
Grant Implementing Agency	Ministry of Health J. Altantuya, State Secretary Olympic Street – 2 Ulaanbaatar 48 Mongolia

B. Details of the Proposed Grant

1. Description of the Components, Monitorable Deliverables and/or Outcomes, and Implementation Timetable

Component A	
Component Name	Analysis of obstacles in the performance of MOH, private sector, nongovernment organizations (NGOs), and communities in addressing chronic child malnutrition
Cost	\$63,615
Component Description	Component A will produce an in-depth analysis of the behavioral, operational, and structural issues that prevent the MOH, private sector, NGOs, and communities from delivering effective services aimed at reducing chronic malnutrition. The analysis will inform the MOH and its partners in the nutrition sector of policy and strategy shortcomings, procedural and coordination imperfections, and practical constraints on the performance of MOH and partners in delivering public health nutrition (PHN) services, and indicate directions for potential improvement. The analysis will also provide a basis for communities, primary health center (PHC) workers, local government, NGOs, and the private sector to develop and test nutrition delivery approaches as part of component B. In addition,

	<p>the analysis will offer information relevant to the revision and development of undergraduate and graduate PHN training programs in the Medical Sciences University (component C).</p> <p>Core activities under component A include (i) carrying out a comprehensive inventory of the food and nutrition sector and an assessment of its existing delivery systems;¹ (ii) conducting an in-depth functional analysis of the institutional arrangements, mandates, funding and expenditures, and capacities in MOH institutions to deliver services, education, and research on nutrition of disadvantaged groups; (iii) analyzing the constraints faced by the private sector, NGOs, and communities in delivering effective services and goods aimed at reducing chronic malnutrition; (iv) holding a policy seminar and technical workshops for dialogue with and among the range of stakeholders and generating proposed improvements and solutions; and (v) producing a situational analysis report with draft policy recommendations.</p> <p>The expected outcomes of component A include</p> <ul style="list-style-type: none"> (i) analysis of strengths, weaknesses, opportunities, and threats of the Government's institutions, private sector, NGOs, and communities in addressing chronic child malnutrition with proposed approaches to increase access by the disadvantaged; (ii) characterization of the operational constraints on MOH's institutional performance in delivering improved nutrition to the disadvantaged, and proposed solutions involving stakeholder and partner participation; (iii) information that can be used for increasing the support and performance of MOH and its partners in improving the nutrition situation of pregnant and lactating women (PLW) and children (component B) and for revising and developing a formal PHN training curriculum (component C); and (iv) draft policy recommendations submitted by the Project for consideration to Government.
Monitorable Deliverables/Outputs	<ul style="list-style-type: none"> (i) Full inventory and preliminary assessment of the food and nutrition delivery system inside and outside the Government's institutional setting; (ii) comprehensive analysis of the capacity of MOH institutions, the private sector, and NGOs to improve the nutrition situation, with recommendations on how to improve access by disadvantaged and vulnerable population groups; (iii) discussion of results in a policy seminar and technical workshops involving partners and stakeholders concerned with the nutrition sector, leading to considered, feasible draft policy recommendations; (iv) operational linkages to the PHC channel of delivering nutrition services in project areas, and to the revision, testing, and institutionalization of a PHN training program; and (v) draft policy recommendations submitted to MOH.
Implementation of Major Activities: Number of months for grant activities	12 months

¹ The term "food and nutrition sector" in this document is used to denote the collective public and private organizations, institutions, and enterprises that produce, enhance, and/or deliver products, services, and information that affect the food consumption and nutritional status of the population.

Component B	
Component Name	Pilot approaches: Reduce chronic malnutrition in mothers and children
Cost	\$1,178,604
Component Description	<p>Component B will develop and implement improved nutrition services (subcomponent B.1) and IEC/BCC methods and materials (subcomponent B.2) in all project areas;² and identify, implement, and pilot test at least 10 pilot food and nutrition approaches (methods, products, and services) aimed at preventing and treating chronic malnutrition in infants, children below 3 years of age, and PLW in selected areas of Mongolia.</p> <p>Subcomponent B.1 will implement in all project areas improved nutrition services as part of community integrated management of child illness (IMCI),³ managed by family group practices (FGPs) and soum health centers (SHCs). Core activities under subcomponent B.1 include (i) tailoring, delivering, and testing of in-service and on-the-job training of FGPs and SHCs in community IMCI, with special focus on improved counseling skills on exclusive breastfeeding and appropriate timing, frequency, adequacy, and composition of complementary feeding of infants and young children; (ii) providing support to technical improvements and increased coverage of the growth monitoring and promotion of under-2-year-old children managed by FGPs and SHCs; (iii) procuring, delivering, and promoting the use of MOH-agreed sprinkles⁴ among children 6–24 months old and PLW; and (iv) treating malnourished and low birth weight infants and children under 3 with supplemental iron and vitamin D for anemic and rickety children, respectively, and for PLW.</p> <p>The expected outcomes of subcomponent B.1 include</p> <ul style="list-style-type: none"> (i) tailor-made community IMCI training (conducted and tested) of existent PHC staff, with strong emphasis on counseling to improve maternal, infant, and child nutrition; (ii) improved quality and coverage of regular growth monitoring and promotion services through PHC workers of under-2-year-old children; (iii) increased access and adherence to the appropriate use of sprinkles by PLW and infants and children 6–24 months old; and (iv) better diagnosis and treatment by PHC staff of anemic and rickety children and of their mothers in project areas.

² Project areas for the JFPR Project will be the same as for the Third Health Sector Development Project, i.e., five aimags (Arkhangai, Dundogov, Gobi Altai, Sukhbaatar, and Tuv) that have been selected based on poverty levels, health status, and levels of development investment, as well as two duuregs of Ulaanbaatar (Chingeltei and Songinokhairkan) having significant populations of poor and disadvantaged people living in *ger* (traditional tent) areas. Extent of soum and district coverage will be determined during grant implementation.

³ IMCI aims to provide good quality health care to promote health while preventing and treating common diseases in infants and young children. Community IMCI, often also referred to as the third component of IMCI, addresses 16 key family practices, starting out with and including four optimal nutrition practices, namely: (i) exclusive breastfeeding of newborns until 6 months of age; (ii) appropriate complementary feeding of infants and children 6–24 months old; (iii) provision of micronutrients; and (iv) proper feeding during common illnesses, especially diarrhea. Mongolia's Health Sector Strategic Master Plan (2006–2015) has adopted IMCI as one of its key policy elements.

⁴ Sprinkles is an innovative multiple micronutrient powder that is sprinkled over and mixed once daily into the commonly eaten major dish. To assist in harmonizing composition with existent nutritional deficiencies, the United Nations Children's Fund (UNICEF) has submitted a request to MOH to authorize one vitamin-mineral mixture that will be universally used in Mongolia.

	<p>Subcomponent B.2 will develop and implement in all project areas IEC/BCC methods and materials to improve the community and family awareness, skills, and behaviors for reducing chronic child malnutrition. Core activities under subcomponent B.2 include (i) in contrasting socioeconomic resource environments, carrying out a study of the constraints that mothers face in providing good infant and young child feeding (IYCF); (ii) capturing locally available knowledge, attitudes, and skills of mothers on good IYCF practices; (iii) developing informed, tailor-made educational materials and methods focused on good mother, infant, and child care, as well as IYCF practices; and (iv) selecting and subcontracting a reputable, community-based NGO with a track record in public social education to deliver IEC/BCC campaigns on good community and household behaviors for mother and IYCF and nutrition practices, in time-coordination with the delivery of approaches (subcomponents B.1 and B.3).</p> <p>The expected outcomes of subcomponent B.2 include</p> <ul style="list-style-type: none"> (i) factors identified constraining mothers from practicing good IYCF in contrasting resource environments; (ii) locally available good IYCF practices discovered in various resource environments; (iii) informed package of IEC/BCC methods and materials on improved mother and IYCF nutrition in communities and households developed, implemented, and tested; and (iv) awareness increased at all levels among officials and the public as to the importance of, and the key approaches offered by, the Project to address the poor maternal and child nutrition situation in disadvantaged communities. <p>Subcomponent B.3 will execute a fund for financing pilot approaches costing up to \$40,000 each in response to proposals by partners in the food and nutrition sector willing and able to implement community-based innovative approaches aimed at the Project's general objective and that complement the PHC approach through FGPs and SHCs (subcomponent B.1). The Project will initiate at least three rounds of invitations for proposals, spaced approximately 6 months apart. Pilot approaches can be of different scale and duration and will not be allocated exclusively to the traditional community-oriented food and nutrition development organizations. Specific selection criteria will be publicly announced by the Project in a dedicated effort to mobilize the broad nutrition sector of potential partners at all levels. Examples of pilot approaches are described in Supplementary Appendix A. Core activities under subcomponent B.3 include (i) active solicitation of short letters of intent to develop and deliver innovative, promising approaches, followed by transparent selection and invitation to submit complete proposals, while offering assistance if needed; (ii) review and priority ranking of high-quality proposals; (iii) project funds permitting, entering into subcontracts for implementation by MOH partners of the prioritized approaches; (iv) provision of supportive supervision during the implementation of pilot approaches; and (v) advocacy for promoting continuation and/or scaling up of successful approaches upon subcontract expiry.</p> <p>The expected outcomes of subcomponent B.3 include</p> <ul style="list-style-type: none"> (i) a broad-based system for solicitation, promotion, and objective selection to identify innovative approaches for
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	<p>addressing persistent chronic malnutrition in disadvantaged communities;</p> <p>(ii) at least 10 innovative approaches or combinations of approaches generated, funded, implemented, and tested in contrasting resource environments;</p> <p>(iii) lessons from the delivery of various combinations of PHC worker-delivered and partner-implemented approaches in different resource environments; and</p> <p>(iv) agreement on continuation and/or scaling up of successful approaches promoted.</p>
Monitorable Deliverables/Outputs	<p>(i) Results from delivery of the community IMCI approach through PHC workers reported and discussed with ministries and partners concerned;</p> <p>(ii) increased skills of PHC workers in specific nutrition activities;</p> <p>(iii) IEC/BCC campaigns provided to improve community awareness, skills, and behaviors for reducing chronic child malnutrition;</p> <p>(iv) at least 35,000 under-3-year-old children in project areas received methods, products, and services through PHC services; and</p> <p>(v) at least 10 innovative approaches identified, developed, delivered, and tested.</p>
Implementation of Major Activities: Number of months for grant activities	42 months

Component C	
Component Name	Development and institutionalization of formal undergraduate and graduate PHN training
Cost	\$64,449
Component Description	<p>The component will coordinate the Health Sciences University and MOH in the revision, development, and testing of a PHN training curriculum for adoption in undergraduate and graduate health education programs for PHC workers of Mongolia. Experiences and information from project implementation (components A and B) will be used to inform and continuously update the PHN training modules. Core activities under component C include (i) agree on terms of reference and support the Health Sciences University; (ii) conduct an assessment of PHN training needs that responds to the key nutritional problems and the needs for research and services; (iii) develop a PHN training curriculum across undergraduate and graduate levels and support the provision of key teaching resources to effectively test and deliver PHN training in existent preservice PHC training programs; and (iv) advocate for acceptance of PHN training as a formal module in the health training colleges (undergraduate) and in the medical, public health, and nursing schools (graduate) of the Health Sciences University.</p> <p>The expected outcomes of component C include</p> <p>(i) learning requirements and resources for tackling malnutrition problems of Mongolia by a public health approach characterized at undergraduate and graduate levels;</p> <p>(ii) revised PHN curriculum drafted according to the needs assessment, project experience, and agreed terms of reference;</p>

	<ul style="list-style-type: none"> (iii) required key training resources to deliver and test the PHN training sourced; (iv) draft PHN training curriculum tested at an undergraduate and a graduate school, then adjusted as needed; and (v) PHN training modules promoted for insertion into the formal medical, public health, and nursing education.
Monitorable Deliverables/Outputs	<ul style="list-style-type: none"> (i) Needs assessment offering comprehensive articulation of skills and competencies essential for effective PHN services that respond to the nutrition situation in the population, (ii) key training resources secured for delivering PHN training, and (iii) a PHN training curriculum tested in the regular undergraduate and graduate training of PHC workers and submitted for acceptance by the Health Sciences University.
Implementation of Major Activities: Number of months for grant activities	42 months

Component D	
Component Name	Project management and health policy development
Cost	\$693,331
Component Description	<p>The component will monitor and support effective implementation of the institutional analysis (component A), the food and nutrition delivery approaches (subcomponents B.1 and B.3), IEC/BCC (subcomponent B.2) in project areas, and the PHN training development (component C); it will facilitate interinstitutional coordination and support policy analysis and development based on the results (knowledge output) of the approaches. Core activities under component D include (i) establishing the project implementation unit (PIU); (ii) preparing the grant implementation manual; (iii) procuring and distributing expendables; (iv) performing annual audits; (v) providing oversight of progress in the deliveries of subcomponent B.3 activities by MOH partners; (vi) conducting studies, follow-up surveys, and experience-sharing workshops during implementation; (vii) monitoring and evaluating outcomes of the approaches and combinations of approaches in the project areas; (viii) conducting policy seminars; (ix) using the project data and experiences to produce a knowledge product; and (x) submitting draft policies to the Government.⁵</p> <p>The expected outcomes of component C include</p> <ul style="list-style-type: none"> (i) monitoring and evaluation established for capturing the key essential evidence of processes, outcomes, and outputs attributable to the Project; (ii) managerial support in implementation of the pilot approaches by the project coordinator, subcontractors, and consultants hired under the Project; (iii) support to MOH in interinstitutional coordination; (iv) documentation of the processes and outcomes in implementing the approaches through PHC workers and MOH partners, as well as dissemination of findings, outputs, and results to communities, central and local governments, PHC providers, and across the broader food and nutrition

⁵ Supplementary Appendix B (terms of reference) details the scope of work and responsibilities of the entities and individual consultants involved in the monitoring, evaluation, and production of a knowledge product.

	sector; and (v) results assessment for each implemented approach and a review of policy implications, drawing on project outputs and consultations with the project coordinator, PIU, and project steering committee (PSC) of the Third Health Sector Development Project (THSDP); FGPs; aimag, soum, duureg, and khoroo governments; ward representatives; community groups; and other involved stakeholders.
Monitorable Deliverables/Outputs	(i) PIU and technical working group of the PSC established; (ii) grant implementation manual prepared; (iii) updates on project progress distributed twice a year to other funding agencies, partners, NGOs, government officials, and communities; (iv) a monitoring and evaluation system is put in place within the first 6 months of implementation; (v) a policy seminar held with key partners, stakeholders, and at least five international participants in decision-making positions from countries facing similar issues; (vi) workshops organized at the end of years 2 and 3 on follow-up surveys and progress made in implementing the pilot approaches (component B) with the participation of stakeholders and community members; (vii) the Project submits draft guidelines and policy recommendations to the Government; (viii) summary documentation, including costs and impact of each implemented approach, prepared for policymakers and for the planning and decision levels; (ix) quarterly monitoring reports completed on implemented pilot approaches, the institutional delivery analysis, and the PHN training development; (x) final evaluation report delivered; and (xi) audit reports completed.
Implementation of Major Activities: Number of months for grant activities	48 months

2. Financing Plan for Proposed Grant to be Supported by JFPR

Funding Source	Amount (\$)
JFPR	2,000,000
Government	127,550 (in-kind)
Other Sources	
Local Government Contributions	22,000 (in-kind)
Community Contributions	5,000 (in-kind)
Total	2,154,550

3. Genesis

1. The Government of Mongolia and administrations at the municipal, aimag, district, and subdistrict levels need help to reduce persistent, chronic malnutrition in infants and young children. Malnutrition in children is a key underlying determinant not only of child mortality, but also of permanent physical and mental disability of children at a very young age. When children are undernourished before their second birthdays, they can suffer irreversible cognitive and physical damage, thus impacting their future health, economic well-being, and welfare. The consequences continue into adulthood, accumulate to cause poor social development and

lowered economic productivity in affected communities, and are passed on to the next generation as undernourished girls and women have children of their own.

2. Although successive national surveys in Mongolia show that some nutritional indicators in women and children have slowly improved, stunting among children under 5 years old is persistent and may even be on the increase recently. The Multiple Indicator Cluster Survey carried out by the National Statistical Office in 2005 with United Nations Children's Fund (UNICEF) support showed that one quarter of each new generation of infants in Mongolia becomes seriously growth retarded during the first 2 years of life. Growth retardation, or stunting, indicators are higher in soum centers and the rural countryside, in remote aimags, in families with more than two children under 5 years old, in families with a mother with low or no formal education, and among the 60% of poorest households.

3. The breastfeeding situation in Mongolia is unclear. Government health policies and programs have created a situation in which almost all newborns in Mongolia are delivered in health facilities with skilled medical attention. The introduction of breastfeeding is practically universal, and infants are exclusively breastfed until the age of 3 months on average. Recent survey results show that exclusive breastfeeding up to 6 months is 51%.⁶ Breastfeeding has a slightly decreasing trend compared to findings of studies done since 1992.

4. Complementary infant feeding practices in addition to breastfeeding are commonly poor. Already by age 5 months, almost half of Mongolian mothers have introduced additional feeds. In nomad families, in contrast, it is common to delay introducing complementary feeds beyond the age of 6 months. Against World Health Organization (WHO) and UNICEF infant and young child feeding standards, the frequency and composition of complementary food and feedings are also inadequate. As to the frequency of complementary feeding, on average only 31% of infants 6–8 months old are fed twice a day and only 12% of those 9–11 months old three times a day. In addition, according to national surveys and small-scale studies, customary complementary foods are typically monotonous, leading to feedings that are low or lacking in essential vitamins and minerals. Most infants before their first birthday are fed with diluted gruels based on water with wheat or rice, with or without meat. Dairy products (such as yogurt), legumes, fats and oils, and vegetables and fruits form only a very small part of the customary foods during the age range of 6 months to 2 years.

5. Not surprisingly, nutritional anemia, rickets, and deficiencies of micronutrients such as vitamin A and zinc are common nutritional problems among infants and young children in Mongolia. The National Nutrition Survey estimated that 20% of children below age five are anemic, 80% of which is shown to be due to iron deficiency, while low biological vitamin D levels affect 40% of under-fives across all ages, regions, and household wealth categories, irrespective of the breastfeeding or complementary feeding status of children. Yet-unpublished research is also suggesting a high prevalence of zinc deficiency. Anemia and vitamin D deficiency are also affecting a sizable proportion of pregnant and lactating women, although more precise statistics are as yet lacking for these biologically vulnerable groups. Vitamin D deficiency uniquely affects a large proportion of mothers and children in Mongolia.

6. In 2001, the Government of Mongolia adopted a National Program on Food Security, Food Safety and Nutrition for 2001–2005. This program has been evaluated (report is pending), and the results will inform a new policy being developed under the Ministry of Food and Agriculture (MOFA). Targeted supplementation and fortification of common foods have been adopted as public health nutrition approaches under the Ministry of Health's micronutrient strategy of 2005. National surveys show that the extent and severity of chronic malnutrition, or

⁶ UNICEF. 2005. *Multi-Indicator Cluster Survey*. Ulaanbaatar.

growth stunting, has not changed, however, and, as mentioned above, there is even evidence lately of an increase. Informal reports as well as an in-depth assessment of the household food security situation by MercyCorps in 2007 indicate that the monitoring and growth promotion by family group practices (FGPs) of infants and young children leaves much to be desired. Coverage, frequency, and quality of growth measurements are often poor, while FGPs often fail or underperform in infant and young child feeding (IYCF) counseling for mothers in follow-up to growth faltering or failure among their infants and young children. These issues point to a pressing need to improve the nutrition training of frontline primary health care (PHC) providers.

7. Vitamin A supplementation is delivered in nationwide campaigns twice annually through PHC services among children 12–59 months old. Salt fortification with iodine and wheat flour fortification with a multi-micronutrient mixture have been introduced and legislated for the food industry in Mongolia.⁷ It is estimated that 65% of the target beneficiaries receive vitamin A supplementation, and that iodized salt and multi-fortified flour are consumed in more than 80% and almost 35% of households, respectively. Importantly, a large-scale effectiveness assessment of sprinkles for children 6–24 months old has demonstrated that the use of sprinkles in households over an average period of 2 years can reduce childhood anemia by 40–50%, indicating the potential for anemia's complete elimination. Access to vitamin D supplements for prevention and treatment of rickets is seriously constrained due to supply issues, however. To date, projects and efforts to improve nutrition, and especially regarding micronutrients, have mostly been targeted to geographical areas where donor-subsidized actions are focused on disadvantaged groups. Among the Government's partners, Asian Development Bank (ADB), UNICEF, World Vision Mongolia (WVM), Action Contre la Faim, and WHO have played, and continue to play, major roles in delivering these approaches.

8. To coordinate and harmonize efforts for tackling the poor nutrition status of mothers and children in Mongolia, the Ministry of Health (MOH) has adopted a mother and child micronutrient deficiency prevention strategy for the period 2005–2010, allocating a leadership role to the Public Health Institute (Nutrition Research Center) in strategy development and technical and methodological support to municipal and aimag health departments, as well as stating financing responsibilities for MOH's Financial Planning Division and International Cooperation Department. The strategy paper (Ministerial Order No. 85, dated 15 April 2005) articulated the existence of major challenges in coordination among government, agency, and nongovernment organization (NGO) micronutrient programs and projects; inadequate information management systems for effective monitoring of micronutrient and fortified food supplies; and unresolved financing models for sustainable program delivery.

9. In the past few months, a multisectoral working group arranged by MOH has analyzed the problems and underlying factors for malnutrition in the child population and identified three areas for priority attention, namely: (i) persistent child stunting, mostly interrelated and overlapping with micronutrients deficiencies; (ii) low level of awareness, knowledge, and skills in the population about good nutritional habits; and (iii) deficiencies in formal nutrition education resulting in health workers (including doctors) that are not prepared to tackle nutrition issues (promotion, counseling, prevention, and treatment). Securing adequate and safe food supplies in the population are also burning priorities in Mongolia, especially with the currently soaring prices for common foods. These issues will be covered separately by ADB.

10. Mongolia has recently experienced drastic increases in food prices. Prices for key food staples such as flour and meat contributed the most to inflation (rising by some 25% and 45%,

⁷ ADB. 2001. *JFPR 9005-REG: Grant Assistance to Asian Countries in Transition for Improving Nutrition for Poor Mothers and Children*. Manila and ADB. 2005. *JFPR 9052-REG: Sustainable Food Fortification*. Manila. These regional projects have played a significant role in raising the access of the population to iodized salt and fortified flour products in Mongolia.

respectively, from the beginning of 2008 despite Government efforts to regulate their increases). Over the last 10 years, higher income levels have led to lower percentages of total income spent on food (35% in 2007) overall, but the poor, and particularly the urban poor, experience relatively greater distress from price increases.

11. ADB has supported health sector reform in Mongolia since the mid-1990s. Particularly with the view to improve food and nutrition of poor mothers and children in the period of transition, ADB, through two consecutive regional projects funded by JFPR, provided major support during 2001–2007 to the start-up and expansion of food fortification. The projects focused principally on providing a mixture of micronutrients via the supply and consumption of salt and wheat flour-based food products as a self-sustainable delivery mode. By piloting improved health service-based and alternative delivery approaches for increased access to and consumption of micronutrients in disadvantaged groups, the Project feeds into the broader objectives of the Third Health Sector Development Project (THSDP), which provides grant funding to address policy and financial issues in the sector. The Project has also been designed to support the Government's Health Sector Master Plan (HSMP),⁸ which calls for the "provision of essential health services to the people of Mongolia with emphasis on the elderly, adolescents, and vulnerable groups such as the poor, with the full participation of the community and other stakeholders."

12. Selection of project areas was part of the various consultations with stakeholders and MOH. Of the estimated 250,000 under-fives in Mongolia, nearly 15%, or 35,000 children, reside in THSDP project aimags. Half of their families are disadvantaged. The project aimags have very poor infrastructure, a relative lack of skilled human resources, and insufficient local government capacity. The areas include strong contrasts between aimag centers (urban), soum centers (rural), and the remote countryside, thus allowing the testing of approaches in significantly different socioeconomic environments and resource endowments.

4. Innovation

13. By improving the nutrition situation of mothers and children through PHC workers providing community integrated management of child illness (IMCI), complemented by parallel food and nutrition deliveries by MOH partners, the Project will generate innovative models, and combinations thereof, for reducing malnutrition among mothers and children in disadvantaged communities. The design and demonstration of successful approaches will provide MOH with tested models for use in carrying out reforms and rationalizing health services, including to scale up and extend proven models to other aimags. The Project's outputs will also contribute to the THSDP's reform efforts and the efforts of other international partners active in Mongolia's health sector.

14. Conducting focused, policy-oriented studies, interviews, and observations among beneficiary families in contrasting ecologies will enable the Project to identify specific obstacles and positive deviant factors in communities and households for proper maternal nutrition and adequate IYCF, thus informing the development of tailor-made messages and materials for information and education communication and for behavior change communication (IEC/BCC).

15. The collection of a full inventory and preliminary assessment of the overall food and nutrition sector in Mongolia and the potential and current role of MOH's institutions in addressing food and nutrition problems in the population have not been carried out. The in-depth analysis of the MOH institutional system involved in the delivery of public health nutrition

⁸ Government of Mongolia. 2005. *Health Sector Master Plan*. Ulaanbaatar (Government of Mongolia Resolution of April 2005).

services through family practitioners is innovative. It will assist in rationalizing the Government's health services and help determine the realistic potential, role, and contribution of partners in securing an adequate nutrition situation for Mongolia's population.

16. Promising pilot approaches for improving maternal and child nutrition will be mobilized and tested based upon ideas and initiatives introduced by MOH partners in the broader food and nutrition sector, some of which will be new to the Government's health delivery system.

17. A PHN training needs assessment is innovative, because it will enable the academic community and MOH to introduce relevant nutritional competencies into the training curriculum of health workers.

5. Sustainability

18. The externalities linked to micronutrient deficiencies justify government funding. To guarantee program sustainability, MOH needs to fix its institutional constraints (partly addressed by the Project) and to fund provision of micronutrients in the short and medium terms. The complementary roles of the private sector, NGOs, and communities will be explored, as well, through component A of the Project and through the small grant component. Involvement of the existing MOH institutions in developing, operating, and evaluating the PHC worker-delivered component, combined with PHC worker training, will strengthen the official health care system. Institutional sustainability will also benefit from capacity built by broadening staff experience through the Project's implementation of pilot approaches. The Project will pay particular attention to stimulating model approaches that are financially sustainable, monitoring investment and recurrent costs, and identifying potential sources of funding at various levels of government, the private sector, and the community. Although local governments have very little room to absorb the budget for continuing the FGP's and SHC's nutrition services, a visibly improved food and nutrition situation plus better nutritional health condition of children would contribute to a bottom-up demand for continuing the schemes through formal administrative channels.

19. The revision and combination of existing nutrition training elements presently taught in medical school into a formal PHN training curriculum will enable the country to institutionalize training in a new competence as part of the preparation of PHC workers. This will add to their capacity and promote sustainable nutrition delivery in the formal PHC systems.

20. In the current context of increasing public finance—essentially due to mining revenues—the Government will find it easier to earmark funding for nutrition activities. The Project will provide evidence in support of nutrition programs, seek collaboration of the private sector, and advocate for sustainable financing of the programs. Close oversight of the delivery of partner-initiated approaches, FGP and SHC involvement in assessing their progress, and continued dialogues with the MOH partners who deliver the pilot approaches all are tactics that the Project will use to stimulate the potential that proven combinations of approaches through PHC workers and pilot channels will continue even beyond the present project.

21. A thorough analysis of the MOH institutional delivery system together with the policy implications of the pilot approaches, and the submission of draft policy amendments to the Government, will pave the way for sustaining the Project's outputs. Testing approaches in various socioeconomic and resource environments will enhance the potential for replicating successful approaches throughout the country in similar circumstances.

6. Participatory Approach

22. The Project was designed through a participatory process involving key stakeholders, who invariably expressed their agreement with the objectives, the proposed project components, and the overall implementation approach. The Project will continue to involve key stakeholders in (i) selecting project locations to implement combinations of approaches; (ii) generating, delivering, and testing pilot models; and (iii) assessing current practices, as well as the needs and priorities of disadvantaged communities and families. Many activities stimulated by the Project will require active participation by communities and beneficiaries. Stakeholders will also take part in project monitoring and evaluation, as well as in policy advisory roles. Local governments will be closely involved throughout the Project. They will be mainly solicited through their support to the local health system (FGPs and SHCs), involvement in monitoring and evaluation activities, and participation in workshops. Ethnic minorities will be targeted and involved in consultations; they will not be adversely affected by the Project.

23. A major underlying project objective is to enhance responsiveness of governments, society, FGPs and SHCs, private entrepreneurs, and community activists to the food, health, and nutrition needs of disadvantaged groups, especially women, infants, and children. Community organizations, private businesses, activists, and community leaders will be mobilized to play key roles in advocacy, needs assessment, and identification of approaches to improve access, generation, and delivery of adequate nutrition for mothers and children.

24. Interviews with supervisors of FGPs and SHCs suggest that they are well aware of the dire need for more attention and better services for improved mother and child nutrition. There are, however, shortcomings in the PHC system (e.g., irregularity or lack of supplies, migration leading to demand overload) that tend to reduce FGP and SHC performance and limit their service range to the minimum predetermined package. The Project's processes will provide FGPs and SHCs with opportunity and means to plan their work in a consultative manner and in better response to those needs that hitherto have been underemphasized. They can improve their facilities, equipment, treatment, and prevention services in ways tailored to what they identify as their poor clients' particular needs. This will increase the effectiveness of FGPs and SHCs, increase the trust and confidence of clients, and improve the morale of staff.

25. This participatory approach will be extended to relevant stakeholders at all levels, encouraging their contribution through collaboration, information sharing, and annual workshops that will assess findings and outcomes. Stakeholders will thereby contribute to the Project's general objective.⁹

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
<p>About 35,000 children under 3 years old and their mothers in selected aimags and duuregs who will benefit from PHN activities and pilot approaches to improve micronutrients intake</p> <p>Local governments of five aimags (Arkhangai, Dundogov, Gobi Altai, Sukhbaatar, and Tuv) and two duuregs of Ulaanbaatar (Chingeltei and Songinokhairkan), which will participate in project implementation</p>	<p>MOH, the Executing Agency of the Project, which will benefit from the FGP- and SHC-based activities and support for policy development</p> <p>MOFA, which will benefit from clarifying the overlap and boundaries of strategies to address food security, food safety, and nutrition</p> <p>Aimags and soums authorities, which will receive technical assistance in assessing ways and means to address</p>

⁹ Appropriate measures in line with ADB's *Policy on Indigenous Peoples* (1998) will be taken should negative impact on ethnic minorities be identified during JFPR implementation.

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
<p>At least 20 FGPs and 30 soum health centers that will participate in implementing approaches through PHC</p> <p>At least 10 MOH partners who will submit and implement proposals for pilot approaches</p> <p>Almost 700,000 people living in the targeted project areas will benefit from IEC/BCC campaigns relating to PHN.</p>	<p>food and nutrition issues in disadvantaged communities and families</p> <p>MOH institutions (Public Health Institute, Nutrition Research Center) and Medical Sciences University (Medical School, Public Health School, and Nursing School), which will benefit from experience obtained through their involvement in project implementation</p> <p>UNICEF supports a nutrition improvement project using sprinkles in aimags of Western Mongolia. WHO is promoting IMCI as a key approach in PHC and provides international norms and standards for IMCI conduct by frontline workers.</p> <p>Action Contre la Faim has detailed experience with PHC activities in treating and rehabilitating severely malnourished children by intensive feeding, improved counseling, and practical demonstrations of IYCF. World Vision Mongolia has large-scale experience with effectiveness testing of sprinkles and continues their provision in selected aimags of Central Mongolia.</p> <p>The Consumer Rights Association of Mongolia has experience in delivering IEC/BCC on issues of food and nutrition.</p>

7. Coordination

26. The Project was designed with inputs from MOH, MOFA, Nutrition Research Center, WVM, School of Public Health faculty, Action Contre la Faim, Health Sciences University faculty, the Consumer Rights Association, and representatives of United Nations agencies and NGOs working on food and nutrition issues.

27. The project management structure will be integrated with that of the THSDP, greatly facilitating the processes. The Project will also benefit from THSDP experience with policy reforms and development in the sector, and the THSDP's project implementation unit (PIU) will facilitate access to decision makers of MOH, MOFA, and the Ministry of Finance. In turn, the Project will serve as a testing ground for innovative community-based approaches that will contribute to the THSDP's broad goal of strengthening PHC in Mongolia. The Project will also coordinate with the JFPR Project on Access to Health Services in Ulaanbaatar,¹⁰ as both JFPR projects will work through THSDP. Increasing access to health services will facilitate access to nutrition services provided through FGPs in Ulaanbaatar.

28. The Project will liaise, cooperate, and harmonize processes with the UNICEF project for improved maternal and child nutrition in aimags of Western Mongolia and with the WVM area development program in aimags of Central Mongolia (both organizations are providing micronutrients). The Project will encourage cooperation between NGOs such as the Consumer Rights Association, FGPs, and stakeholders in the broader nutrition sector (particularly food manufacturing enterprises).

¹⁰ ADB. 2007. *JFPR 9115-MON: Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila.

29. The Embassy of Japan was briefed about the proposed JFPR project in May and July 2008 and indicated its support for the initiative.

8. Detailed Cost Table

30. Please refer to Appendix 1 for the summary of costs, Appendix 2 for the detailed cost estimates, and Appendix 3 for the fund flow arrangement.

C. Linkage to ADB Strategy and ADB-Financed Operations

1. Linkage to ADB Strategy

31. The proposed assistance is in line with the development agenda for inclusive economic growth of ADB's long-term strategic framework 2008–2020 (Strategy 2020)¹¹ and supports the Mongolia country partnership strategy pillar of inclusive social development. The proposed Project is consistent with the health, nutrition, and social protection priority sector of the country operations business plan 2008–2010.¹² The health sector is a key focus of ADB assistance to Mongolia, and ADB is the main funding agency in the sector. The HSMP stresses the need to provide essential health services to the people of Mongolia, with emphasis on vulnerable groups such as the poor and remote. Approaches to malnutrition deserve a special focus in view of the persistent inter-generational perpetuation of lowered educability and productivity. The HSMP also calls for the full participation of communities and other stakeholders.

32. In addition to meeting the Government's and ADB's sector goals, the expected outcome of the Project will also satisfy several poverty reduction objectives of the Government's economic growth and poverty reduction strategy.¹³ The Project directly addresses Millennium Development Goals 1: Poverty and Hunger, 2: Child Health, and 3: Maternal Health.

Document	Document Number	Date of Last Discussion	Objective
Mongolia Country Operations Business Plan 2008–2010	IN315-07		In relation to the JFPR: — Supporting the Government's explicit commitment to achieving the Millennium Development Goals

2. Linkage to Specific ADB-Financed Operation

Project Name	Third Health Sector Development Project
Project Number	Grant 0086-MON
Date of Board Approval	19 November 2007
Grant Amount (\$ million)	14.0

3. Development Objective of the Associated ADB-Financed Operation

33. The THSDP will improve health infrastructure and service delivery in aimags not covered by previous ADB support, and build on and refine the policy reforms initiated with ADB support in the past. These include expanding and improving PHC, improving financial expenditure for

¹¹ ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*. Manila.

¹² ADB. 2007. *Country Operations Business Plan: Mongolia 2008–2010*. Manila.

¹³ Government of Mongolia. 2003. *Economic Growth Support and Poverty Reduction Strategy*. Ulaanbaatar.

increased system efficiency, improving development and management of human resources, and strengthening sector capacity. Health policy reform in Mongolia requires continued support to maintain momentum in line with the Government's HSMP and in coordination with recently established intersectoral coordinating mechanisms.

4. Main Components of the Associated ADB-Financed Operation

No.	Component Name	Brief Description
1.	Strengthen health services	<p>1.1 Improve urban and rural FGPs, soum health centers, and aimag general hospitals through infrastructure upgrades, equipment, and training</p> <p>1.2 Strengthen aimag general hospitals and duureg hospitals in Ulaanbaatar</p>
2.	Improve health care financing and health insurance	<p>2.1 Improve health resource allocation, essentially by pooling funding for the health sector and establishing a single purchaser of health services with strong fiscal leverage to reform health care and promote quality</p> <p>2.2 Improve financial protection by expanding health insurance coverage and benefits</p> <p>2.3 Improve hospital financial efficiency by introducing market elements in hospital service provision</p>
3.	Improve human resources development	<p>3.1 Strengthen health human resources management by developing work force models, assisting in career development, and providing training in human resource development</p> <p>3.2 Develop incentive systems to increase key health staff in areas of critical shortage, and especially rural areas</p>
4.	Sector capacity development and management	<p>4.1 Improve capacity and governance in the health sector through increased capabilities in planning, monitoring, and evaluation</p> <p>4.2 Strengthen the regulation of the private health sector</p> <p>4.3 Improve the capacity of the MOH to implement the HSMP, and engage in intersectoral dialogue</p>

5. Rationale for Grant Funding versus ADB Lending

34. The Project's poverty focus and its innovative character (pilot initiatives) make it eligible for JFPR grant funding. The THSDP (funded by an Asian Development Fund grant) focuses on broad policy reforms, health infrastructure, and service delivery. Because it does not focus on any particular health problems, such as malnutrition, it cannot cover the present project activities. THSDP gives less attention to community and local government inputs in policy and program making. The Project will complement the THSDP approach with strengthened linkages across the food and nutrition sector and a bottom-up planning and implementation process.

35. The Project will be implemented in poor, remote, and mostly rural aimags of Mongolia, whose governments face enormous difficulties providing health services to their populations,

and especially to nomadic herders. Through strengthened PHC worker performance in providing nutrition services, in combination with the associated piloting of food and nutrition approaches, the Project will provide an opportunity to test schemes for improving accessibility and effectiveness of health promotional services for disadvantaged groups. Close coordination between the Project and THSDP will ensure that the issues affecting the disadvantaged are not neglected in the policy dialogues and activities of THSDP.

36. The Project will also address a relative weakness in government planning: insufficient dialogue by ministry officials with agencies and partners. Though nutrition is understood as an issue that requires partnership across sectors, the MOH has a tendency to plan and implement programs in isolation, missing the benefits of interacting with key partners in solving the nutrition-related problems. The Project will bring together stakeholders from different ministries, different levels of government, different sectors, and NGOs to discuss improved access and provision of foods and nutrition services for mostly disadvantaged groups.

D. Implementation of the Proposed Grant

1. Implementing Agency	Ministry of Health
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37. The THSDP's project steering committee (PSC) will act as the PSC for the Project, providing strategic orientation and overall guidance on implementation, including advice to MOH to nominate temporary technical working groups for supportive oversight of selected project elements. The Project will be implemented by a PIU established within THSDP's PIU. The PIU of the THSDP will be responsible for recruiting (i) the project PIU staff; (ii) two national consultants; (iii) a national organization in charge of studies, assessment, monitoring, and evaluation;¹⁴ (iv) an NGO to deliver IEC/BCC campaigns; (v) a department of the Health Sciences University to revise, develop, and test the PHN training component; and (vi) a health worker training college for delivering FGP and SHC training in community IMCI. Based on previous JFPR experience and for reason of efficiency, the Executing Agency has requested ADB to select the international consultant who will enter into a contract with it. Recruitment will be conducted in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). Summary terms of reference for consulting services are in Supplementary Appendix B.

38. The Project will recruit two national consultants for (i) the food and nutrition inventory, and (ii) to support the international consultant.

39. An international health policy management consultant with experience in cross-sector analysis (preferably including the private food industry) will (i) carry out an in-depth analysis of the structural-functional constraints preventing the existing government health institutions from effectively addressing persistent chronic malnutrition and produce a report with main findings; (ii) validate and assist the national organization (Nutrition Research Center) responsible for studies, assessments, monitoring, and evaluation; (iii) carry out a policy end-appraisal and validate a quantitative analysis of nutritional outcomes of the pilot approaches; (iv) draft policies—including institutional, financial, and operational implications—for submission to the Government based on the lessons from the proposed JFPR Project; (v) participate actively in the policy seminars; (vi) produce a final report, including a knowledge product (outline to be determined during implementation), and assist the Project Coordinator in preparing the JFPR completion report; and (vii) assign work and supervise the outputs of the national evaluation and policy expert.

¹⁴ The Nutrition Research Center (under the Public Health Institute) is the only national organization in Mongolia with the required competence.

40. A national organization will be contracted to (i) obtain and report on an inventory of the major influential actors in the food and nutrition sector of Mongolia related to the Project's objective; (ii) support the conduct of an in-depth institutional performance analysis across sectors focused on the role of MOH institutions; (iii) design, conduct, and report on a study of knowledge, attitudes, and behaviors that determine IYCF practices in contrasting resource environments; (iv) design and produce IEC/BCC methods and materials for mothers, families, and communities on improved mother and child nutrition; (v) develop and conduct three promotional campaigns to mobilize promising innovative approaches, as well as assist the selected MOH partners in project development for implementation; (vi) organize and conduct a policy seminar and technical workshops to discuss and disseminate findings and generate policy recommendations; (vii) monitor, test, and evaluate the implementation and outcomes of approaches and combinations of approaches piloted in project areas; and (viii) carry out annual follow-up workshops, including reports on the progress of the pilot schemes.

41. A legally registered national NGO will be recruited and contracted for conducting IEC/BCC campaigns in project areas. A department of the Health Sciences University will be selected to lead and coordinate selected university faculty members and staff of MOH training institutions in the revision, development, and testing of the PHN curriculum. A health worker training college will be selected to tailor and deliver in-service and on-the-job community IMCI training of FGPs and SHCs focused on nutrition counseling.

42. A department of the Health Sciences University will be contracted to lead the revision and trial implementation of a public health nutrition training curriculum. A health training college will be recruited to further develop the required competencies and train PHC workers of all project areas in delivering nutrition activities as part of community IMCI.

43. Letters of intent and final proposals for pilot approaches will be reviewed and selected by a technical working group to be established by MOH. Once a proposal is approved, an agreement will be signed with the MOH partner(s) involved in their implementation.

44. Procurement related to the Project's management will be conducted by the PIU of THSDP in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). The procurement plan is in Supplementary Appendix C. Implementation arrangements are detailed in Appendix 4.

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Governance	Problems of corruption or nepotism may affect distribution of assistance funds or appointments.	Strict financial control. Strong management mechanisms. Transparent appointment procedures. Transparent proposal appraisal and selection processes for subcontracts. Clear and agreed beneficiary selection. Annual audits.
Policy environment	Development by MOFA of a new food security and safety policy and a crisis situation due to soaring food prices may negatively affect proposals for pilot approaches.	Regularly assess the implications of new policy development and of any food price fluctuations and/or mitigation efforts, and, if necessary, change the focus of planned support activities. One mechanism may be to appeal for private philanthropy and/or government subsidy.
Professional career issues	Because public health nutrition, compared to clinical nutrition, has low	Use (social) marketing and/or communication through the University's

Type of Risk	Brief Description	Measure to Mitigate the Risk
	status with the medical professions, the University may not be able to realize sufficient momentum among the present faculty members for creating a PHN curriculum, and health students may not be keen to take the new training.	and MOH's media channels to emphasize and raise the profile of public health nutrition as a profession.
Infrastructure	Bad road conditions, transport difficulties, or extreme weather conditions may impede surveys and regular household and follow-up visits by project personnel, SHCs, and FGPs.	Funding for public transportation to the PIU, and for selected implementers of pilot schemes.

3. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for Monitoring and Evaluation
At least 35,000 children under 3 years old in project areas have received methods, products, and services through PHC services aimed to reduce their chronic malnutrition; followed by evidence of improved performance and effectiveness of PHC services in the delivery of the approach.	Survey results	Situation analysis in year 1 Repeat surveys in years 2 and 3 Final survey year 4
Project aimags have been provided IEC/BCC campaigns to increase awareness, skills, and behaviors for reduced chronic malnutrition.	Quarterly project reports Final evaluation report	Quarterly monitoring Repeat surveys in years 2 and 3 Final survey year 4
At least 10 innovative nutrition approaches (methods, products, and services) delivered in combination with the improved PHC approach are tested and evaluated for their effects on reduced chronic malnutrition in disadvantaged communities.	Quarterly project reports Final evaluation report	Quarterly monitoring Repeat surveys in years 2 and 3 Final survey year 4
A PHN training curriculum is tested in the regular undergraduate and graduate training of PHC workers and submitted for acceptance by the Health Sciences University.	Quarterly project reports Final evaluation report	Yearly meeting with university board
The Project submits draft guidelines and policy recommendations to the Government that will improve the nutritional status of infants and young children in Mongolia.	Evaluation and report on policy implications submitted to Government Project completion report	Final evaluation year 4

4. Estimated Disbursement Schedule

Fiscal Year (FY)	Amount (\$)
FY2009 (from June)	250,000
FY2010	400,000
FY2011	600,000
FY2012	550,000
FY2013 (up to May)	200,000
Total Disbursements	2,000,000

Appendixes

1. Summary Cost Table
2. Detailed Cost Estimates
3. Fund Flow Arrangements
4. Implementation Arrangements
5. Design and Monitoring Framework
6. Summary of Poverty Reduction and Social Strategy

Supplementary Appendixes

- A. Notes on Pilot Approaches
- B. Terms of Reference for Consulting Services
- C. Procurement Plan
- D. Implementation Schedule

SUMMARY COST TABLE
(\$)

Inputs/ Expenditure category	Grant Components				Total (input)	Percent
	Component A: Analysis of obstacles to the performance of MOH, private sector, NGOs, and communities in addressing chronic child malnutrition	Component B: Pilot approaches: Reduce chronic malnutrition in mothers and children	Component C: Development and institutionalization of formal undergraduate and graduate PHN training	Component D: Project management and health policy development		
1. Civil Works	0	0	0	0	0	0.0
2. Equipment and Supplies	0	424,150	28,000	0	452,150	22.6
3. Training, Workshops, Seminars, and Public Campaigns	42,250	60,600	3,000	43,800	149,650	7.5
4. Consulting Services	15,000	166,000	27,000	274,200	482,200	24.1
5. Grant Management	0	0	0	306,000	306,000	15.3
6. Other Inputs	0	410,000	0	0	410,000	20.5
7. Contingencies	6,365	117,855	6,449	69,331	200,000	10.0
Subtotal JFPR Grant Financed	63,615	1,178,605	64,449	693,331	2,000,000	100.0
Central Government Contribution	0	66,350	3,000	58,200	127,550	
Local Government Contributions	0	22,000	0	0	22,000	
Communities' Contributions (mostly in-kind)	0	5,000	0	0	5,000	
Total Estimated Cost	63,615	1,271,955	67,449	751,531	2,154,550	

JFPR = Japan Fund for Poverty Reduction, MOH = Ministry of Health, NGO = nongovernment organization, PHN = public health nutrition.

Source: Asian Development Bank estimates.

DETAILED COST ESTIMATES

(\$)

Supplies and Services Rendered	Unit	Costs			Contributions			
		Quantity Units	Cost Per Unit	Total	JFPR Amount	Central Government	Local Govern- ment	Communities
						Method of Procurement ^a		
		Subtotal		57,250	57,250	0	0	0
Component A: Analysis of obstacles to the performance of MOH, private sector, NGOs, and communities in addressing chronic child malnutrition								
1.1 Civil Works								
1.2 Equipment and Supplies								
1.3 Training, Workshops, and Seminars								
1.3.1	Technical workshops for dialogue with stakeholders and generation of proposed improvements and solutions	person-day	175	50	8,750	8,750		
1.3.2	Participatory policy seminars to analyze and recommend reforms to MOH (for institutional reforms)	person-day	90	50	4,500	4,500		
	International experts input for policy seminars	expert-day	15	1,000	15,000	15,000		
1.3.3	Dissemination workshops in each project area on situation analysis and to develop eligibility criteria for pilot approaches (NRC)	person-day	280	50	14,000	14,000		
1.4 Consulting Services								
1.4.1	Situation analysis (institutional capacity for PHN), with draft policy recommendations	lump-sum	1	15,000	15,000	15,000		
1.5 Management and Coordination of Component A								
1.6 Other Project Inputs								

Supplies and Services Rendered	Unit	Costs			Contributions				
		Quantity	Cost	Total	JFPR	Central Government	Local Government	Communities	
		Units	Per Unit						Amount
Component B: Pilot approaches: Reduce chronic malnutrition in mothers and children			Subtotal	1,154,100	1,060,750		66,350	22,000	5,000
2.1 Civil Works									
2.2 Equipment and Supplies									
2.2.1 Procurement of MOH agreed sprinkles (micronutrients)	package	7	27,000	189,000	169,000		20,000		
Procurement of iron and vitamin D supplementation ^b	package	7	13,500	94,500	84,150		10,350		
IEC/BCC material for mothers, families, and communities on improving mother and child nutrition	package	7	25,000	175,000	171,000		4,000		
2.3 Training, Workshops, and Seminars									
2.3.1 In-service and on-the-job training of FGPs and SHCs in community IMCI (counseling, growth monitoring, use of sprinkles, and proper feeding during child illness) (HTC)	person-contact	12,600	6	75,600	60,600		5,000	10,000	
2.4 Consulting Services									
Comprehensive situation analysis (baseline) of maternal and child chronic malnutrition and related PHC worker services (NRC)	lump-sum	1	15,000	15,000	15,000				
2.4.1 Design and pilot testing of IMCI-based training for FGPs and SHCs (HTC)	lump-sum	1	20,000	20,000	16,000		2,000	2,000	
2.4.2 Study of local skills and the constraints mothers face in good IYCF, including a baseline study on knowledge, attitude and behavior for IYCF practices (NRC)	lump-sum	1	10,000	10,000	10,000				
2.4.3 Develop informed, tailor-made educational materials and methods focused on good mother, infant, and child care, as well as IYCF practices	lump-sum	1	20,000	20,000	20,000				

Supplies and Services Rendered	Unit	Costs			Contributions			
		Quantity	Cost	Total	JFPR	Central Government	Local Government	Communities
		Units	Per Unit					
2.4.4 Design IEC/BCC campaign strategies and deliver IEC/BCC campaigns in project areas targeting officials and the public (NGO)	lump-sum	1	70,000	70,000	70,000			
2.4.5 Design and produce IEC/BCC methods and materials for mothers, families, communities on improving mother and child nutrition (NRC)	lump-sum	1	25,000	25,000	25,000			
2.4.6 Select candidates for pilot approaches and provide technical support for proposal development (NRC)	lump-sum	10	1,000	10,000	10,000			
2.5 Management and Coordination of Component B								
2.6 Other Project Inputs								
2.6.1 Grants for complementary approaches (pilot testing)	lump-sum	10	45,000	450,000	410,000	25,000	10,000	5,000
Component C: Development and institutionalization of formal undergraduate and graduate PHN training								
			Subtotal	61,000	58,000	3,000	0	0
3.1 Civil Works								
3.2 Equipment and Supplies								
Provision of teaching resources to effectively test and deliver PHN training programs	lump-sum	1	30,000	30,000	28,000	2,000		
3.3 Training, Workshops, and Seminars								
3.3.1 Workshops on the promotion of PHN training as a formal module in the health training colleges (undergraduate) and in the medical, public health, and nursing schools (graduate) of the Health Sciences University (Department)	person-day	80	50	4,000	3,000	1,000		

Supplies and Services Rendered	Unit	Costs			Contributions			
		Quantity	Cost	Total	JFPR	Central Government	Local Government	Communities
		Units	Per Unit					
3.4 Consulting Services								
3.4.1 Prepare terms of reference to assess PHN training needs and develop and test PHN curriculum at undergraduate and graduate levels	lump-sum	1	2,000	2,000	2,000			
3.4.2 Assess existing nutrition training courses and PHN training needs to tackle malnutrition (Department)	lump-sum	1	5,000	5,000	5,000			
3.4.3 Develop and test a PHN training curriculum across undergraduate and graduate levels and report to medical training authorities and MOH (Department)	lump-sum	1	20,000	20,000	20,000			
3.5 Management and Coordination of Component C								
3.6 Other Project Inputs								
Component D: Project management and health policy development								
			Subtotal	682,200	624,000	58,200	0	0
4.1 Civil Works								
4.2 Equipment and Supplies								
4.3 Training, Workshops, and Seminars								
4.3.1 Public information campaign (leaflet, billboards, radio and TV broadcasts)	lump-sum	1	50,000	50,000	22,800	27,200		
4.3.2 Annual workshop in years 2 and 3 for findings dissemination, experience sharing, and planning	person-day	300	50	15,000	13,000	2,000		
4.3.3 Policy development seminars (on community IMCI, pilot approaches, and IEC/BCC)	person-day	240	50	12,000	8,000	4,000		
4.4 Consulting Services								
4.4.1 International policy development and evaluation specialist	person-month	4	21,000	84,000	84,000			
4.4.2 Travel costs for policy development and evaluation specialist	trips	3	6,000	18,000	18,000			
4.4.3 National policy development and evaluation specialist	person-month	12	2,000	24,000	24,000			

Supplies and Services Rendered	Unit	Costs			Contributions				
		Quantity	Cost	Total	JFPR	Central Government	Local Government	Communities	
		Units	Per Unit						Amount
4.4.4 Domestic travel cost for national policy development and evaluation specialist	trips	24	300	7,200	7,200				
4.4.5 Quarterly monitoring in project areas, including pilot approaches (pilot tests) (NRC)	lump-sum	10	8,000	80,000	80,000				
4.4.6 Surveys in project areas, including pilot approaches during years 2 and 3 (NRC)	lump-sum	2	7,000	14,000	12,000	2,000			
4.4.7 Final evaluation in project areas, including pilot approaches (NRC)	lump-sum	17	1,000	17,000	17,000				
4.4.8 External audit	contract	4	8,000	32,000	32,000				
4.5 Management and Coordination of Component C									
4.5.1 Project coordinator	person-month	48	1,500	72,000	72,000				
4.5.2 Financial assistant	person-month	48	1,000	48,000	48,000				
4.5.3 Administrative assistant	person-month	48	700	33,600	33,600				
4.5.4 Driver	person-month	48	600	28,800	28,800				
4.5.5 Office vehicle ^c	lump-sum	1	40,000	40,000	40,000				
4.5.6 Office space	lump-sum	1	15,000	15,000		15,000			
4.5.7 Office furniture	lump-sum	1	7,000	7,000	4,000	3,000			
4.5.8 Office equipment	lump-sum	1	12,000	12,000	9,000	3,000			
4.5.9 Travel and per diem (for PIU staff)	lump-sum	30	500	15,000	13,000	2,000			
4.5.10 Operational costs	monthly	48	1,200	57,600	57,600				
4.6 Other Project Inputs									
Components A to D = Subtotal				Subtotal	1,954,550	1,800,000	127,550	22,000	5,000
Contingency (maximum 10% of total JFPR contribution)					200,000	200,000			
Total Grant Cost				Total	2,154,550	2,000,000	127,550	22,000	5,000

FGP = family group practice, HTC = health teaching college, IEC/BCC = information and education communication and/or behavior change communication, IMCI = integrated management of child illness, IYCF = infant and young child feeding, JFPR = Japan Fund for Poverty Reduction, MOH = Ministry of Health, NGO = nongovernment organization, NRC = Nutrition Research Center, PHC = public health care, PHN = public health nutrition, PIU = project implementation unit, SHC = soum health center.

^a Procurement under the Project will be conducted in accordance with the *Procurement Guidelines* (2007, as amended from time to time) and the *Guidelines on the Use of Consultants* (2007, as amended from time to time) of the Asian Development Bank (ADB). Goods and services estimated to cost the equivalent of \$10,000 or less

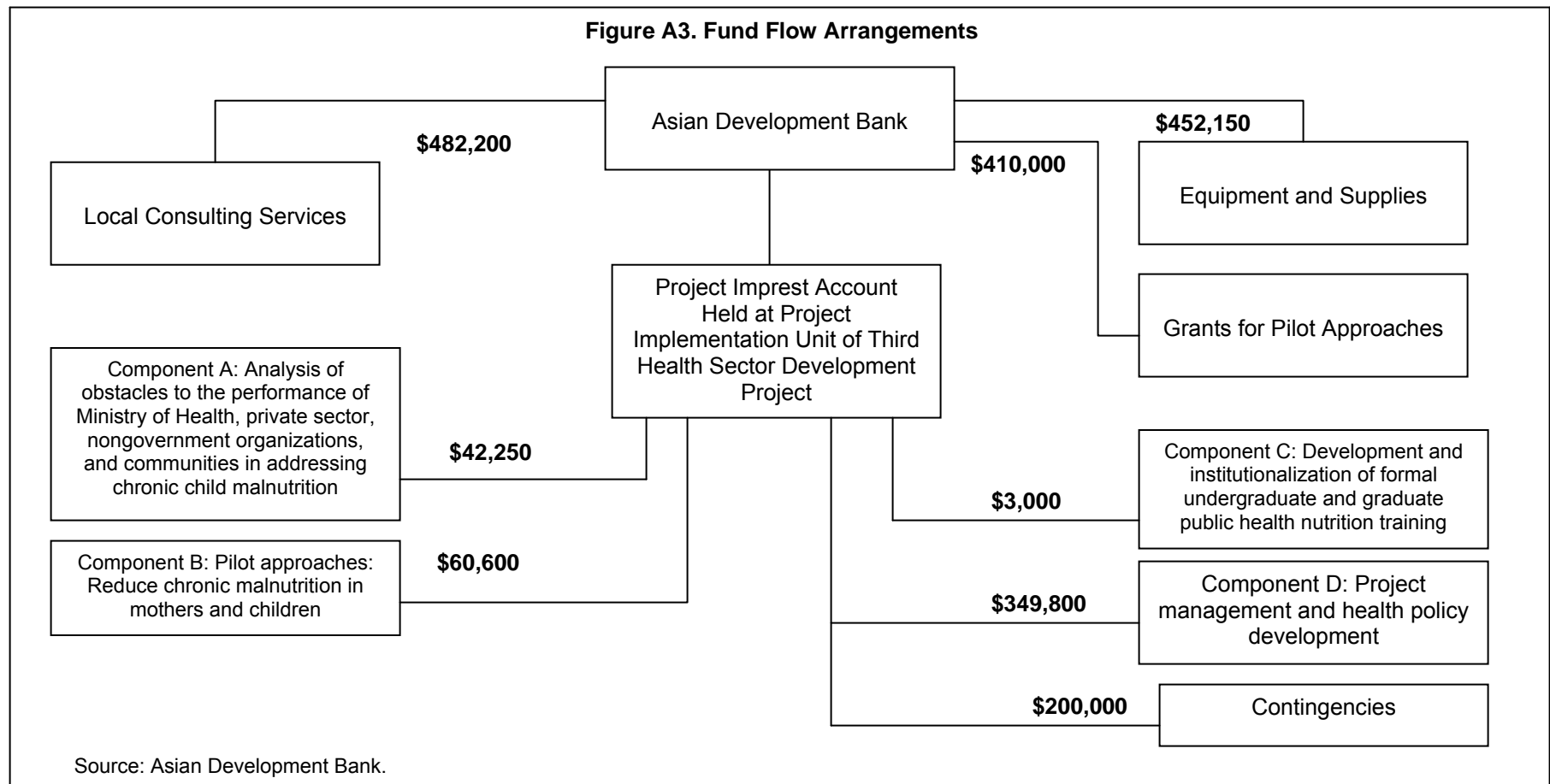
will be procured using ADB's direct purchase procedure. Goods and services estimated to cost more than \$10,000 and less than \$100,000 will be procured using ADB's shopping procedure. The project implementation unit of the Third Health Sector Development Project will be responsible for procurement, with technical inputs from the implementation unit of the Japan Fund for Poverty Reduction Project.

- ^b Will be procured in several yearly batches. Bulk procurement with the United Nations Children's Fund (UNICEF) and other organizations active in Mongolia could occur.
- ^c The Project covers five widely distributed aimags, which will require extensive travel on a regular basis to follow up on project activities (especially for component B). Although the Project will work in close cooperation with the Third Health Sector Development Project, the latter has only a single vehicle, which cannot cover the need of both projects. The vehicle will be transferred to the Executing Agency at the end of the Project.

Source: Asian Development Bank.

FUND FLOW ARRANGEMENTS

The Asian Development Bank (ADB) will channel the Japan Fund for Poverty Reduction (JFPR) funds directly to the JFPR imprest account (except those for local consulting services, equipment and supplies, and grants for pilot approaches) that will be opened and maintained by the project implementation unit of the Third Health Sector Development Project at a commercial bank in Ulaanbaatar acceptable to ADB and endorsed by the Ministry of Health (the Executing Agency). Disbursement from the imprest account will be supported by an appropriate withdrawal application and related documentation. Such documentation will demonstrate that the goods and/or services are (i) produced and procured from ADB's member countries, and (ii) eligible for JFPR financing. Advances should not exceed estimated eligible expenditure for the next 6 months to be financed through the imprest account or 10% of the grant amount, whichever is lower. The statement of expenditures (SOE) procedure will be used for reimbursing, replenishing, and liquidating eligible expenditures; and individual payments to be reimbursed, replenished, or liquidated under the SOE procedure will not exceed \$10,000. The establishment and liquidation of the imprest account and the use of SOE procedures will be in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time). The schematic fund flow for the Project is shown in Figure A3.



IMPLEMENTATION ARRANGEMENTS

A. Project Management

1. Executing Agency

1. The Ministry of Health (MOH) will be the Executing Agency (EA) for the Japan Fund for Poverty Reduction (JFPR) Project.

2. Project Steering Committee

2. The project steering committee (PSC) of the Third Health Sector Development Project (THSDP) will act as PSC for the Project, providing strategic orientation and overall guidance on project implementation. The PSC will be chaired by the state secretary of MOH and composed of senior officials from the Public Health Institute at MOH, Ministry of Food and Agriculture, Ministry of Finance, and the Health Sciences University of Mongolia, as well as selected senior representatives of the food industry and the nongovernment organization community.

3. Implementing Agency

3. The project implementation unit (PIU) for the Project will be established within the PIU of THSDP. The PIU will be headed by a project coordinator and will comprise a financial assistant, an administrative assistant, and a driver. The PIU members will be recruited by the MOH and approved by the Asian Development Bank (ADB). The project coordinator will guide implementation and administer the Project, reporting to ADB and the Government of Mongolia. The PIU will prepare a grant implementation manual, for ADB approval, during the first quarter of implementation, including disbursement methods for the pilot schemes (subcomponents B.1 and B.3). The project coordinator will work under the supervision of the project manager of the PIU of THSDP for disbursement; procurement; financial management; monitoring and evaluation; and preparing detailed project implementation plans and budgets, annual reports, and quarterly progress reports. The financial assistant, under the supervision of the project coordinator, will work closely with the finance officer of the PIU of THSDP. The PIU of THSDP will be in charge of procurement.

4. Flow of Funds

4. Disbursement of the imprest fund will be made by the project manager of the PIU of THSDP. The imprest account will be replenished by ADB based on budget requests prepared by the project coordinator and endorsed by the project manager of the PIU of THSDP. The withdrawal applications will be signed by the THSDP project manager. The interest earned on the imprest account, net of bank charges, can be used for the Project, subject to ADB's approval and within JFPR's approved total amount. Any balance should be refunded to the JFPR fund account maintained at ADB before the financial closing of the account. ADB will ensure that the PIU has sufficient financial management capability to establish adequate accounting procedures and control to efficiently administer the imprest fund.

5. Procurement

5. Procurement under the Project will be conducted in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). Goods, services, and works estimated to cost the equivalent of \$100,000 or less will be procured using ADB's shopping procedure. Goods,

services, and works with estimated value of \$500,000 or less will be procured using national competitive bidding procedure. The PIU of THSDP will be responsible for procurement, with technical inputs from the project coordinator. To procure items costing \$10,000 or below, the PIU of THSDP may purchase the items directly from the supplier. In such cases, ADB should be satisfied that the price paid is reasonable. International competitive bidding is not envisaged under this Project. The procurement plan is in Supplementary Appendix C.

6. National competitive bidding procurement and procedures will be in accordance with the Mongolian Procurement Law, subject to modifications agreed with ADB.

6. Consulting Services

7. The Project will recruit one international (4 person-months, intermittent) and two national (12 person-months, intermittent) consultants on an individual basis. Based on previous JFPR experience and for reason of efficiency, the EA has requested ADB to hire the international consultant who will enter into a contract with the EA. The Project will also recruit several entities: (i) a national organization in charge of studies, assessment, monitoring, and evaluation; (ii) a nongovernment organization to deliver information and education communication and/or behavior change communication campaigns; (iii) Health Sciences University to revise, develop, and test the public health nutrition training component; and (iv) a health worker training college for delivering family group practice and soum health center training in community integrated management of child illness (IMCI). The national consultants and organizations will be recruited by the PIU of THSDP, with technical input from the project coordinator, in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). The Nutrition Research Center under the Public Health Institute is the only national organization in Mongolia having the necessary competence to meet the requirements under (i). Health Sciences University is the only national organization in Mongolia having the necessary competence to meet the requirements under (iii). The Nutrition Research Center and the department of the Health Sciences University will be hired through single source selection. All other entities will be hired through consultant qualification selection using biodata proposal. The terms of reference for consulting services are in Supplementary Appendix B.

7. Reporting

8. The PIU will prepare quarterly and annual reports on project implementation, the form and content of which will be agreed upon with ADB. The PSC will officially endorse these reports to ADB, with comments. The PIU will maintain separate accounts for all project components financed by the JFPR and by the Government, and it will have them audited by an independent auditor that has adequate knowledge of, and experience with, international accounting practices and is acceptable to ADB. The audit report should include separate opinions on the use of the imprest account and the statement of expenditures procedure. The audited project accounts and the auditor's reports will be submitted to ADB within 6 months after the end of each fiscal year. The Government will be informed of ADB's requirement of the timely submission of audited project accounts and financial statements, including the suspension of disbursements in case of noncompliance. ADB will also finance, through the Project, annual audits by an independent audit company acceptable to ADB.

9. The Government will provide a project completion report to ADB with the support of the project coordinator within 3 months of physical completion of the Project. All reports will comprise an assessment of the project impact and outputs, project performance monitoring and evaluation, as well as suggestions for further improving project implementation.

8. Monitoring and Evaluation

10. The framework for monitoring and evaluation is described in Appendix 5. At the beginning of implementation, the national organization for studies, assessment and monitoring, and evaluation will consolidate existing baseline information on beneficiaries. These data will be used to refine the monitoring and evaluation framework, as well as to monitor and evaluate implementation of the nutrition approaches. The final evaluation of the JFPR will include a report on the Project's policy implications and lessons, including preparation of a knowledge product.

9. Project Review

11. ADB and the Government will jointly undertake reviews of the Project at least twice a year. The reviews will assess progress, identify issues and constraints, and determine necessary remedial action and adjustments. A midterm review will be conducted toward the end of the second year of implementation. It will (i) review the scope, design, and implementation arrangements, then identify adjustments required; (ii) assess progress of the project implementation against performance indicators; and (iii) recommend changes in the design or implementation arrangements, if necessary.

B. Implementation of Component B

12. **Subcomponents B.1 and B.2.** The Project will fund the training, inputs, and delivery of nutrition improvement services (growth monitoring and promotion, micronutrients, and infant and young child feeding counseling) through family group practices and soum health centers as part of their regular public health care (PHC) responsibilities as well as the associated information and education communication and/or behavior change communication campaign in all project areas.

13. **Subcomponent B.3.** The Project will finance at least 10 pilot approaches implemented by MOH partners of the food and nutrition sector in various contrasting project areas, thereby complementing the PHC nutrition subcomponents B.1 and B.2. Partner-implemented approaches may be of different scale and duration. Examples of partners submitting letters of intent include local or national individuals or activists, philanthropists, subject specialists (e.g., agriculture, education, and community mobilization), business people, (food) industries, and community development oriented (chapters of) organizations.

1. Selection Process and Criteria

14. **Subcomponent B.3.** Solicitation, development, and final selection of MOH partner-implemented approaches will be staged as follows:

- (i) The national organization contracted by the Project will develop an active solicitation campaign for obtaining short letters of intent to develop and deliver innovative approaches aimed at the Project's objectives from among the food and nutrition sector in Mongolia, and it will organize three rounds of solicitation spaced approximately 6 months apart, starting in the second quarter of project duration. Letters of intent will clearly articulate (a) the general description and intent of the proposed mother and child nutrition improvement activity (method, product, and/or service) and how the proposed activity relates to the Project's objective in the proposed project area; (b) the capacity, and any previous experience, of the MOH partner in delivering the intended activity; and (c) a

- rough indication of costs to be assumed by the MOH partner and incurred to the Project, as well as any local government or community contribution(s).
- (ii) Letters of intent will be reviewed by a technical working group (TWG) nominated by the PSC on (a) innovative character, (b) likelihood of successful completion, and (c) anticipated effect on child malnutrition in the proposed project area. After reviewing, the TWG will submit all the intents in order of priority to the project coordinator, who will consult the PSC on a final selection after reviewing fund availability for the given solicitation round.
 - (iii) MOH partners who submitted letters of intent and passed the preliminary review will be assisted, when needed, by the national organization in developing detailed proposals. A final assessment of eligibility will be conducted using the following criteria: (a) existence of a clear and feasible implementation plan, with budget details; (b) quality of the proposed monitoring and evaluation; (c) the need for capacity development defined and guaranteed; (d) whether sustainability concerns are considered; (e) the level of community and/or beneficiary participation in implementation; and (f) local government contribution, in cash and kind.
 - (iv) Final selection will be made by the TWG and announced within 4 weeks of formal proposal submission. The successful proposals will be submitted to PIU and ADB's Mongolia resident mission for approval. ADB's assessment will be announced within 3 working days, otherwise the pilot scheme is considered approved. Results of the screening and awarding of grants for pilot schemes will be advertised in at least two local newspapers by the PIU. The Project anticipates that 3–4 full project proposals will be approved per solicitation round.

2. Approval and Implementation

15. Once a partner approach has been approved for implementation and testing, the PIU will prepare, in conformity with the grant implementation manual: (i) an approval letter detailing the steps the beneficiary MOH partner must take prior to implementing the pilot scheme; and (ii) an agreement, to be signed by all parties, detailing the obligations and responsibilities of each party (local government, PIU, the organization responsible for monitoring and evaluation, and the MOH partner). The responsible officer and the implementation team for each pilot approach will be clearly identified and should represent local parties (e.g., local governments, social welfare officers, a local industry or community development organization's chapter).

3. Technical Assistance and Monitoring During Implementation

16. The project coordinator and the national organization recruited at the beginning of the project implementation will be responsible for technical assistance and monitoring of the pilot approaches implemented by PHC workers and by MOH partners.

C. Implementation Schedule

17. The Project will be implemented over a period of 4 years, tentatively from April 2009 to March 2013. Project preparation is expected to start in April 2009 with establishment of the PIU and hiring of the national organizations, as well as of the international and national evaluation and health policy experts. Component A is expected to be completed by July 2010, and the first pilot approaches will be implemented from March 2010. The detailed implementation schedule is in Supplementary Appendix D.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
Impact Improved nutritional status of children under 36 months	Reduced prevalence of stunting ¹ (from 20% in 2004 ²) by 2015	National Nutrition survey	Assumption <ul style="list-style-type: none"> Evidence from project outputs is turned into proper policies, which are adopted and funded by the Government Risk <ul style="list-style-type: none"> Food security issues take precedence over food quality and nutrition improvement
Outcome Availability, awareness and demand for micronutrients ³ are increased in project areas	<p>Increased consumption of micronutrients (sprinkles; fortified foods; supplements) among children 0–24 months old by 2013⁴ (disaggregated by sex and urban-rural location)</p> <p>Increased community awareness in project sites on the importance of micronutrients by 2015</p>	<p>Pre-post survey results</p> <p>Pre-post survey results</p>	Assumption <ul style="list-style-type: none"> Government willing to coordinate and support nutrition activities to address stunting through PHC and pilot approaches Risk <ul style="list-style-type: none"> Increased awareness and knowledge without increased demand for micronutrients because of competing issues at household level (e.g. food insecurity)
Outputs <u>Component A:</u> 1. Analysis of obstacles in the performance of MOH's institutions, private sector, non-government organizations (NGOs) and communities in addressing chronic child malnutrition	<p>1.1. Full inventory and preliminary assessment of the food and nutrition delivery system inside and outside the Government's institutional setting by 2009</p> <p>1.2. Comprehensive analysis of the capacity of MOH institutions, private sector and NGO to improve the nutrition situation with recommendations on how to improve access</p>	<p>Consultancy report</p> <p>Consultancy report and JFPR Project reports</p>	Assumptions <ul style="list-style-type: none"> Support and commitment of central authorities, especially MOH and MOA Partnerships with private companies, NGOs, activists, philanthropists and the scientific community Risks <ul style="list-style-type: none"> Interest in engagement and collaboration among MOH partners is limited

¹ Stunting (low height for age) is a sign of chronic malnutrition.

² Ministry of Health – Unicef. 2004. Third Nutrition Survey – Mongolia.

³ The MOH will decide on the exact type of micronutrients before signing of the Letter of Agreement.

⁴ Once the specific micronutrients will be determined, some biological markers could be measured to verify project effectiveness.

⁵ These approaches should ideally be implemented in different settings (rural - urban; central – remote).

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Component B: Pilot approaches: Reduce chronic malnutrition in mothers and children</p> <p><i>Subcomponent B.1.</i> 2. Approaches⁵ (sprinkles, fortified foods, supplements) for increased access to micronutrients, addressing children under 24 months of age and PLW, designed, delivered by PHC workers and tested</p> <p>3. Community IMCI training for PHC workers tailor-made and delivered</p> <p><i>Subcomponent B.2.</i> 4. A package of informed IEC and BCC methods, materials and activities for increased awareness, knowledge and skills for good nutritional habits, primarily micronutrient intake for children and mothers, developed and implemented</p> <p><i>Subcomponent B.3.</i> 5. Pilot approaches (methods, products and/or services) for increased access to mother and child nutrition generated and supported, and delivered through MOH partners in</p>	<p>by disadvantaged and vulnerable population groups by 2009</p> <p>1.3. Discussion of results in a policy seminar and technical workshops involving partners and stakeholders concerned with the nutrition sector, leading to considered, feasible draft policy recommendations by 2009</p> <p>1.4. Draft policy recommendations submitted to MOH by 2010</p> <p>2.1. Results from the delivery of the community IMCI approach in urban, rural and/or remote settings through PHC workers reported and discussed with concerned ministries and partners by 2012</p> <p>3. Increased skills of PHC workers in specific nutrition activities by 2011</p> <p>4.1. IEC/BCC campaigns provided by 2011</p> <p>4.2. At least 35,000 under-three-year-old children in Project areas have received methods, products and services through PHC services by 2012</p> <p>5. At least 10 innovative approaches identified, developed, delivered and tested for their additional effect above the deliveries through PHC channels by 2013</p>	<p>JFPR project reports</p> <p>JFPR project reports</p> <p>Pre and post surveys JFPR project reports</p> <p>JFPR project reports</p> <p>NCHD data base</p> <p>Quarterly project reports</p> <p>Pre and post surveys JFPR project reports</p>	<ul style="list-style-type: none"> Food insecurity and burden of soaring food prices is overwhelming families, communities and society, and erodes the political commitment in Government Low interest for the subject of public health nutrition in university schools and among medical students

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>selected project areas, and tested</p> <p><u>Component C:</u> Development and institutionalization of formal under-graduate and graduate PHN training</p> <p>6. Public health nutrition training for PHC workers designed and tested</p> <p><u>Component D:</u> Project management and health policy development</p> <p>7. Guidelines and policies to institutionalize proven approaches and lessons learned from components A-C are developed and submitted to the Government</p> <p>8. Monitoring and evaluation system developed and put in place to produce evidence based on outputs 1-6 of the project</p> <p>9. Data and results collected during project implementation from at least two urban, rural and/or remote settings used for developing and submitting a manuscript for publication in a scientific journal</p>	<p>6. A PHN training curriculum tested in the regular undergraduate and graduate training of PHC workers and submitted for acceptance by the Health Sciences University by 2012</p> <p>7. The project submits draft guidelines and policy recommendations to the Government by 2013</p> <p>8. A monitoring and evaluation system is put in place within the first six month of implementation (2009)</p> <p>9. Summary documentation, including costs and impact of each implemented approach prepared for policymakers, and for the planning and decision levels by 2013</p>	<p>Final evaluation report Quarterly project reports</p> <p>JFPR project documents</p> <p>Data, including gender sensitive baseline, and follow-up surveys and reports from the monitoring and evaluation system</p> <p>JFPR project reports and scientific manuscript</p>	

Activities:	Inputs (\$)
<p>Component A: Analysis of obstacles in the performance of MOH's Institutions in addressing chronic child malnutrition (by 2010)</p> <p>A.1. Obtain a comprehensive inventory of the nutrition sector and an assessment of their existing delivery systems⁶</p> <p>A.2. Conduct an in-depth functional analysis of the performance of MOH institutions in delivering services, education and research on the nutrition situation of disadvantaged groups</p> <p>A.3. Hold a policy seminar and technical workshops for dialogue with and among the range of stakeholders and generate proposed policy improvements and solutions</p> <p>A.4. Produce a situational analysis report with draft policy recommendations</p> <p>Component B: Pilot Approaches: Reduce chronic malnutrition in mothers and children</p> <p>Subcomponent B.1: Delivery of nutrition improvement approaches by PHC workers in all project areas through community IMCI</p> <p>B.1.1. tailor, deliver and test in-service training of FGPs in community IMCI, with special focus on improved counseling skills on nutrition of mothers and children</p> <p>B.1.2. Support technical improvements and increased coverage of GMP of under-two-year-old children</p> <p>B.1.3. Procure, deliver and promote the use of sprinkles⁷ among 6-24 month-old children and PLW</p> <p>B.1.4. Treat malnourished and low birth weight infants and children under three and their PLW by iron and Vitamin D supplementation</p> <p>Subcomponent B.2: Implement in all project areas informed, tailor-made IEC/BCC (methods and materials) for improved mother and child nutrition</p> <p>B.2.1. Study the constraints that mothers face in good IYCF practices in contrasting socio-economic resource environments</p> <p>B.2.2. Capture locally available knowledge, attitudes and skills of mothers on good IYCF practices</p> <p>B.2.3. Develop informed, tailor-made educational materials and methods focused on good mother, infant and child care and IYCF practices</p> <p>B.2.4. Support a reputed, community-based NGO to deliver IEC/BCC on improved community and household behaviors of mother and IYCF and nutrition practices</p> <p>Subcomponent B.3: In selected project areas and complementary to the PHC approach (Subcomponent B.1) , finance and oversee pilot approaches of MOH partners for execution of community-based innovative approaches aimed at the Project's general objective</p> <p>B.3.1. Solicit short letters of intent to deliver innovative, promising approaches, followed by selection and invitation to submit complete proposals, while offering assistance if needed</p> <p>B.3.2. Review, rank and recommend high-quality proposals</p> <p>B.3.3. Project funding permitting, enter into subcontracts for implementation by MOH partners of the selected approaches</p> <p>B.3.4. Provide supportive supervision during implementation of pilot approaches</p> <p>B.3.5. Advocate for continuation and/or scaling up of successful approaches</p>	<p>Inputs (\$)</p> <p>ADB: \$2,000,000 financed by the Japanese Fund for Poverty Reduction</p> <p>Government: \$154,550 equivalent as in-kind contribution</p> <p>Private Sector: To be determined</p>

⁶ The term "nutrition sector" encompasses the collective public and private organizations, institutions and enterprises that produce, enhance and/or deliver products and services affecting the food consumption and nutritional status of the population.

⁷ Sprinkles is an innovative multiple micronutrient powder that is sprinkled over and mixed once daily into the commonly eaten major dish. To assist in harmonizing composition with existent nutritional deficiencies, UNICEF has submitted a request to MOH to authorize one vitamin-mineral mixture that will be universally used in Mongolia.

<p>Component C: Development and institutionalization of formal undergraduate and graduate PHN training (by 2012)</p> <p>C.1. Identify lead University faculty and revise existing training programs C.2. Conduct an assessment of PHN training needs that respond to the key nutritional problems under the Project, including associated needs for research and service C.3. Analyze and revise PHN training curriculum across under-graduate and graduate levels, provide key teaching resources, deliver and test PHN training in existent pre-service PHC training programs C.4. Advocate for acceptance of PHN training as a formal module in the health training colleges (under-graduate) and in the medical, public health and nursing schools (graduate) of the Health Sciences University</p> <p>Component D: Project management and health policy development (continuous)</p> <p>4.1. Establish leadership capacity and operations for the Project in MOH 4.2. Provide oversight of progress and capture results of various combinations of approaches (Components B.1. and B.3) 4.3. Conduct studies and follow-up surveys, and hold experience-sharing workshops 4.4. Monitoring and evaluate pilot schemes, packages and approaches 4.5. Develop guidelines and policy proposals for the Government on the results of main outputs 4.6. Use project data and experiences to prepare a knowledge product of evidence-based good practices and lessons learned in a scientific manuscript</p>	
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ADB = Asian Development Bank, BCC = behavior change communication, GMP = growth monitoring and promotion, IEC = information, education and communication, IMCI = integrated management of child illness, IYCF = infant and young child feeding, JFPR = Japan Fund for Poverty Reduction, KAB = knowledge, attitude and behavior; MOA = Ministry of Food and Agriculture, MOH = Ministry of Health, NCHD = National Center for Health Development, NGO = non-government organization, PHC = primary health care, PHN = public health nutrition, TA = technical assistance.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country/Project Title: Mongolia/Reducing Persistent Chronic Malnutrition in Children

Lending/Financing
Modality: Grant

Japan Fund for Poverty Reduction (JFPR)

Department/
Division:

EARD/EASS

I. POVERTY ANALYSIS AND STRATEGY

A. Linkages to the National Poverty Reduction Strategy and Country Partnership Strategy

Based on the country poverty assessment, the country partnership strategy (CPS), and the sector analysis, describe how the Project would directly or indirectly contribute to poverty reduction and how it is linked to the poverty reduction strategy of the partner country.

Despite gains in Mongolia's gross domestic product (GDP), the proportion of people below the poverty threshold was still estimated at 36% nationwide in 2002. Although there have been improvements in monetary and non-monetary indicators of poverty over the past few years, the links between pervasive poverty and under-nutrition are reflected in the persistence of chronic malnutrition today among children (stunting¹), especially for those in rural areas. Undernutrition of children is a key underlying determinant not only of child mortality, but also of permanent physical and mental disability of children at very young age.

This JFPR is directed at targeting the linkages between under-nutrition and poverty by providing direct nutritional interventions and creating the enabling environment to put in place long-term solutions at the community and health practitioner levels. Improved nutrition contributes directly to six out of eight Millennium Development Goals (MDGs) and is a key factor in addressing poverty. The CPS update for Mongolia (2007-2009) confirmed a priority focus on poverty reduction and MDGs. The health road map of the CPS (2009–2013), in preparation, identifies persistent chronic malnutrition among children (stunting) and disparities in nutritional status between urban and rural areas as important issues in Mongolia. The Health Sector Master Plan (2006-2015) identifies nutrition as a priority issue and makes the improvement of the nutritional status of the population, particularly micronutrient status among children and women, part of the overall outcomes to be attained until 2015. The project directly supports Mongolia's efforts to address the MDGs and creates an enabling environment for poverty reduction directly and indirectly in the Project areas (covering almost 700,000 people) by promoting:

- Improved nutritional status of children through provision of micronutrients
- Extensive outreach and IEC to mothers and communities on nutrition and basic health
- Capacity building among health care workers on nutrition and appropriate outreach and support for communities

B. Poverty Analysis

Targeting Classification: MDG-TI

1. Key Issues

The Project is classified as MDG-TI because of its focus on alleviating maternal and child malnutrition both of which are MDG targets. The Project directly addresses Mongolia's priority focus on the MDGs in its Poverty Reduction Strategy and directly addresses the priorities of the Health Sector Strategy. The main beneficiaries of the program will be women, children and health practitioners.

When children are undernourished before their second birthday, they can suffer irreversible cognitive and physical damage, thus impacting their future health, economic well-being and welfare. The consequences continue into adulthood, result in limited social development and lowered economic productivity in affected communities, and are passed on to the next generation as undernourished girls and women have children of their own. The Multiple Indicator Cluster Survey carried out by the National Statistical Office with UNICEF support in 2005 showed that one quarter of each new generation of infants in Mongolia becomes seriously growth retarded during the first two years of life. Growth retardation, or stunting, indicators are higher in soum centers and the rural countryside, in remote aimags, in families with more than two under-5-year-old children, families with a mother with low or no formal education, and among the 60% poorest households. The project strategies of: (i) distribution of micronutrient supplements; (ii) efforts at IEC to address low levels of awareness, knowledge and skills in the population about good nutritional habits for mothers; and (iii) training for health workers to be better able to identify and address nutritional issues directly addresses MDGs 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality), and 5 (improve maternal health).

¹ Stunting (low height for age) is a sign of chronic malnutrition.

2. Design Features. The Project aims to provide a comprehensive approach to addressing malnutrition in Mongolia by focusing on: (i) participatory assessment of the underlying causes of malnutrition within households, (ii) direct outreach and extensive IEC with mothers and communities, (iii) assessment of constraints within the MOH system, and (iv) capacity building among key health worker stakeholders with a particular emphasis on monitoring and evaluation. Local NGOs will be used for the IEC outreach activities in communities.

II. SOCIAL ANALYSIS AND STRATEGY

A. Findings of Social Analysis

Mongolia spends more on health care than any other transition country, but health outcomes for the poor and those in rural areas appear to be declining. Inequality is prominent in the health sector, where the better off have access to extensive health services and often bypass FGPs and soum hospitals. Child and maternal mortality is directly linked to poverty. Infants and undernourished pregnant women from poor families are much more likely to die or suffer complications than are well-nourished mothers and their offspring. Currently, one in 20 children in Mongolia does not live to his or her fifth birthday. Child mortality is high in rural areas and is particularly low in the capital city. Maternal mortality rate (MMR) is still high at 93 per 100,000 live births. The rural/urban MMR gap is substantial, 105.7 and 73.3 per 100,000 live births respectively. Low birth weight is another poverty related health indicator, which shows mother's health and nutrition status. According to the latest survey carried out by the National Statistical Office in partnership with UNICEF, the proportion of babies who weigh less than 2,500 gram at birth is 5.5%. The risk of being born underweight varies from 4.9% in urban areas to 6.1 in rural areas but is by far the highest among children born to mothers with no education (10%).

Four percent and 27.3% of the population in the project aimags and districts are poor respectively. 51.4% of target population are women and 28.7% are children under 16. In addition to the resident population, primary health care service providers in the project locations will benefit greatly from the Project. It is estimated that about 1,200 doctors and mid-level health personnel in the project aimags will benefit directly.

Key social issues related to improved nutrition outcomes identified in the social analysis include:

The need for extensive public information campaigns: To modify negative beliefs and attitudes (low quality and for the poor) among the population about primary health services and to counter the perception that good services are only provided by specialists in hospitals, extensive outreach is needed.

The need for public health and health education programs: To improve community and local government involvement.

Importance of and need for preventive health services: FGPs must provide preventive services rather than curative services including health promotion and protection. Clients expressed greater need for preventive health services. They agree that receiving preventive services will prevent them from illness and from medical conditions before they become serious.

B. Consultation and Participation

1. Provide a summary of the consultation and participation process during the project preparation.

The Project was designed with inputs from MOH, MOA, Nutrition Research Center, World Vision Mongolia, School of Public Health faculty, Action Contre la Faim, Health Sciences University faculty, Consumer Rights Association, and representatives of United Nations agencies and NGOs working on food and nutrition issues. Specific social analysis and perspectives of communities was generated during the comprehensive social assessments carried out for the JFPR-MON: Access to Health Services for the Poor and Vulnerable Groups In Ulaanbaatar and for the Third Health Sector Program.

2. What level of consultation and participation (C&P) is envisaged during the project implementation and monitoring?

Information sharing Consultation Collaborative decision making Empowerment

3. Was a C&P plan prepared? Yes No

Each component has a specific focus and an implicit consultation and participation plan which is required for implementation and is outlined in the project proposal.

C. Gender and Development

1. Key Issues. Child and maternal mortality is directly linked to poverty. Infants and undernourished pregnant women from poor families are much more likely to die or suffer complications than are well-nourished mothers and their offspring.² This Project is directly focused on addressing immediate micronutrient needs of children in the project areas, and long-term education of mothers, communities and health workers on nutrition and health.

2. Key Actions. Measures included in the design to promote gender equality and women's empowerment—access to and use of relevant services, resources, assets, or opportunities and participation in decision-making process:

Gender plan Other actions/measures No action/measure

This Project is primarily focused on mothers and their children. A large majority of the beneficiary health workers are women and the focus and key indicators overall is on improving maternal and child health.

III. SOCIAL SAFEGUARD ISSUES AND OTHER SOCIAL RISKS

Issue	Significant/Limited/ No Impact	Strategy to Address Issue	Plan or Other Measures Included in Design
Involuntary Resettlement	No Impact		<input type="checkbox"/> Full Plan <input type="checkbox"/> Short Plan <input type="checkbox"/> Resettlement Framework <input checked="" type="checkbox"/> No Action
Indigenous Peoples	No Adverse Impact	IEC outreach activities will use appropriate language in Ethnic Minority areas.	<input type="checkbox"/> Plan <input checked="" type="checkbox"/> Other Action <input type="checkbox"/> Indigenous Peoples Framework <input type="checkbox"/> No Action
Labor <input type="checkbox"/> Employment opportunities <input type="checkbox"/> Labor retrenchment <input type="checkbox"/> Core labor standards	No impact		<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input checked="" type="checkbox"/> No Action
Affordability			<input type="checkbox"/> Action <input type="checkbox"/> No Action
Other Risks and/or Vulnerabilities <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Human trafficking <input type="checkbox"/> Others(conflict, political instability, etc), please specify	No impact		<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input checked="" type="checkbox"/> No Action

IV. MONITORING AND EVALUATION

Are social indicators included in the design and monitoring framework to facilitate monitoring of social development activities and/or social impacts during project implementation? Yes No

² NSO, ADB, World Bank, 2006. Participatory Poverty Assessment Mongolia. p.80.