



Grant Assistance

JFPR: MON 38066

**Grant Assistance to Mongolia
for the Maternal Mortality
Reduction Project
(Financed by the Japan Fund
for Poverty Reduction)**

February 2005

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 1 February 2005)

Currency Unit	-	togrog (MNT)
MNT1.00	=	\$0.00083
\$1.00	=	MNT 1212

ABBREVIATIONS

ADB	-	Asian Development Bank
ANC	-	antenatal care
FGP	-	family group practice
GTZ	-	Deutsche Gesellschaft für Technische Zusammenarbeit
HSDP2	-	Second Health Sector Development Project
KAP	-	Knowledge, attitude, and practice
MCHRC	-	Maternal and Child Health Research Center
MDG	-	Millennium Development Goal
MFAT	-	multifunctional <i>aimag</i> team
MMR	-	maternal mortality ratio
NGO	-	nongovernmental organization
PAU	-	project administration unit
PHC	-	primary health care
PIU	-	project implementation unit
UNFPA	-	United Nations Population Fund
WHO	-	World Health Organization

GLOSSARY

aimag	-	province
bag	-	community
feldsher	-	community nurse
soum	-	district

NOTES

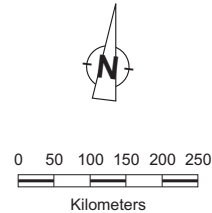
- (i) The fiscal year of the Government of Mongolia end on 31 December.
- (ii) In this report, "\$" refers to US dollars.



RUSSIAN FEDERATION

MONGOLIA MATERNAL MORTALITY REDUCTION

- Project Province
 - National Capital
 - Provincial Capital
 - City/Town
 - Main Road
 - Provincial Road
 - Railway
 - River
 - Provincial Boundary
 - International Boundary
- Boundaries are not necessarily authoritative



JAPAN FUND FOR POVERTY REDUCTION (JFPR)
JFPR Grant Proposal

I. Basic Data

Name of Proposed Activity	Maternal Mortality Reduction Project
Country	Mongolia
Grant Amount Requested	\$1,000,000
Project Duration	3 years
Regional Grant	No
Grant Type	Project

II. Grant Development Objective(s) and Expected Key Performance Indicators

<p>Grant Development Objectives (GDO): The Project's goal is to reduce the maternal mortality ratio (MMR)¹ in Mongolia. The objective is to allow universal usage of quality reproductive health services, by reaching underserved mothers with reproductive health information and quality services. To do this, the Project will: (i) design reforms to respond to reproductive health needs, specifically, in resource allocations, service organization, and service provider performance; (ii) expand information channels and health services options; (iii) mobilize social support to promote mothers' healthy behavior and proper health-seeking behavior; (iv) improve the quality of reproductive health services; and (v) continue assessing local actions for improving access to and quality of services for the medically indigent and the socially and culturally displaced. The Project will have four components: A: Support to Rural Mothers; B: Support to Urban Mothers; C: Information Strategy Development and Implementation; and D: Assessment of Maternal Deaths and Local Actions.</p> <p>The Project will work in three <i>aimags</i> (provinces) (Bayanhongor, Dzavhan, and Hentiy) and two districts of Ulaanbaatar (Bayanzurkh and Songino-Kherkhan). The selected <i>aimags</i> show higher MMRs and poorer access to reproductive health services. They are also among the Second Health Sector Development Project (HSDP2) <i>aimags</i> where health reforms will be piloted from January 2005. The selected urban districts are affected by an influx of migrants, who are mostly poor, unregistered, and uninsured.</p>
<p>Expected Key Performance Indicators (maximum 5 indicators): (i) The percentage of mothers who know and use reproductive health services in project areas: increased level of knowledge about contraceptives from 60% to 100%; early pregnancy consultation from 60% to 90%; and 100% coverage of attended births from 99%; (ii) use of the contract with primary health care (PHC) providers in project areas that lists the standard reproductive health services; (iii) maternal complication rates in project areas reduced from 50% to 30%, which is an international average; and (iv) the MMR in project areas reduced by 47% from 130 per 100,000 live births to 69 per 100,000.</p>

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

Category	Amount of Grant Allocated in \$	Percentage
1. Civil works	0	0.0
2. Equipment	159,000	15.9
3. Supplies	45,000	4.5
4. Training/Public Information/Research	300,000	30.0
5. Consultants	91,000	9.1
6. Project Management, including Audit	51,000	5.1
7. Nongovernment Organization (NGO)s/ Aimag Team/Others	300,000	30.0
8. Contingencies	54,000	5.4
Total	1,000,000	100.0
Incremental Cost	50,000	5

¹ The MMR is calculated as the number of maternal deaths per 100,000 live births.

JAPAN FUND FOR POVERTY REDUCTION

**JFPR Grant Proposal
Background Information**

A. Other Data	
Date of Submission of Application	15 November 2004
Project Officer (Name, Position)	Takako Yasukawa, Health Specialist
Project Officer's Division, E-mail, Phone	Social Sectors Division (ECSS) tyasukawa@adb.org 632-632-5766
Other Staff Who Will Need Access to Edit/Review the Report	Miriam Perocho, Assistant
Sector	Health
Theme	Inclusive social development
Was JFPR Seed Money used to prepare this grant proposal?	Yes [] No [<input checked="" type="checkbox"/>]
Have SRC comments been reflected in the proposal?	Yes [<input checked="" type="checkbox"/>] No []
Name of Associated ADB Financed Operation(s)	Second Health Sector Development Project (HSDP2)
Executing Agency	Ministry of Health
Grant Implementing Agency	Ministry of Health Olympic Street-2 Ulaanbaatar 48 Mongolia

B. Details of the Proposed Grant**1. Description of the Components, Monitorable Deliverables/Outcomes, and Implementation Timetable**

Component A	
Component Name	Support to Rural Mothers
Cost (\$)	480,000
Component Description	<p>Component A will have three subcomponents: A1: Rural reproductive health services improvement; A2: Multifunctional <i>aimag</i> team (MFAT) support; and A3: Community-based social and health services.</p> <p>Subcomponent A1 will improve the quality of reproductive health services in rural areas in the project <i>aimags</i>. The <i>soum</i> (district) health center's contract and <i>bag feldsher</i> (community nurse) terms of reference will be developed to include the standard protocols of reproductive health services. Capitation payment for a <i>soum</i> health center will be finalized to ensure that standardized reproductive health services are covered by the capitation rate, which will be financed by the government budget. <i>Bag</i> and <i>soum</i> health services quality will be improved by training and provision of equipment and supplies. <i>Soum</i> health centers will replenish supplies based on the capitation rate. The referral system will be strengthened through training where <i>aimag</i> hospital staff, including obstetrician, internal medicine, anesthetist, and blood bank specialists will be trained. HSDP2 will provide equipment at the hospital level. Complication rates will be recorded.</p>

	<p>Subcomponent A2 will strengthen <i>aimag</i> hospitals to supervise <i>soum</i> and <i>bag</i> health services and to help expand health service options. The MFAT will be created in each project <i>aimag</i> by rotating experienced hospital staff of internal medicine and obstetrics. Its terms of reference include (i) supervising <i>soum</i> center staff and <i>bag feldshers</i> through on-site consultation and supervision, and assessment of training impacts; (ii) providing consultation and advice on direct and indirect maternal health conditions, including anemia; and (iii) providing services to those who need confidentiality in consultation. The MFAT members will be trained in Ulaanbaatar under the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) staff rotation service training and then dispatched for fieldwork. The Project will provide necessary transportation costs to the MFAT that will be replaced by rationalization savings planned under HSDP2.</p> <p>Subcomponent A3 will link socially disadvantaged pregnant women with needed health services. A local nongovernment organization (NGO) in each project <i>aimag</i> will be contracted to help <i>soum</i> health centers and <i>bag feldshers</i> provide social and health support to disadvantaged women. Many pregnant women in remote areas may give up government maternity benefits due to cumbersome bureaucratic procedures or because of the long distance to <i>soum</i> administration offices. The NGO will assess the level of implementation of the maternity benefit and provide support if the implementation rate is low or if pregnant women have difficulties in obtaining the benefits. The NGO will consolidate benefit requests and receive and deliver cash to pregnant women. The NGO will get a predetermined commission for each benefit request by those to whom the NGO delivers the maternity benefits (for instance, a little less than the travel cost required for each family to go by itself.) The NGO will accumulate the commissions and use the amounts saved for further community-based social support. The Project will computerize the registration of maternal benefits at selected <i>soum</i> welfare offices.</p> <p>The NGO will also be provided with a mobile maternity bed, equipped with communication and obstetric equipment that will enable a midwife to monitor conditions. It is desirable for a woman to be hospitalized if she has medical indications for rest under professional (midwife) monitoring. The mobile bed will provide an alternative for such a woman to stay under monitoring in her <i>bag</i>. Once conditions warrant doctors' assistance during monitoring, the mobile bed will bring her to a hospital. The costs involved, the distances to the remote areas, and the operation and maintenance costs are likely to pose risks to the concept. This scheme will be closely monitored, reviewed, and adjusted to ensure that the needs of this particularly vulnerable group of mothers are met sustainably.</p>
Monitorable Deliverables/Outputs	(i) About 100 <i>bag feldshers</i> , 50 <i>soum</i> health staff, and 50 <i>aimag</i> hospital staff will be trained; (ii) 90% of pregnant women will use consultations and antenatal care (ANC) within 3 months of pregnancy; and (iii) 100% of deliveries will take place with professional attendants.
Implementation of Major Activities: Number of months for grant activities	36 months

Component B	
Component Name	Support to Urban Mothers
Cost (\$)	300, 000
Component Description	<p>Component B will have two subcomponents: B1: Quality improvement of urban reproductive health services with outreach services provision; and B2: Social service provision. Family group practices (FGPs) will play a central role for both subcomponents. Under subcomponent B1, the FGP contract in the project areas will be evaluated with regard to the standard protocols of reproductive health services. If a gap is identified, the contract will be amended to ensure that the FGP contract fully responds to reproductive needs. FGP performance will also be evaluated and improved with training, equipment, and supplies. FGPs are expected to replenish supplies based on the capitation rate. The referral system will be strengthened by training.</p> <p>FGP outreach services will be established so that FGP can serve the unregistered and uninsured. The Project will meet operational costs with incentives for outreach services, but after project completion, it is planned that the government budget will finance services for uninsured urban migrants and replace the project budget. Complication rates will be monitored and recorded at the FGP and district hospital levels.</p> <p>Subcomponent B2 will link socially disadvantaged migrant women with needy health services. FGPs will take a leading role with support of local legal and poverty advisors. FGPs and the legal advisor will help implement rights of pregnant women to receive social benefits. The poverty advisor will help FGPs identify barriers for the urban poor, vulnerable, and migrants to use reproductive services. The poverty advisor will also advise FGPs on available social support and volunteer organizations in Ulaanbaatar.</p>
Monitorable Deliverables/Outputs	(i) About 100 FGP staff will be trained, (ii) 90% of pregnant women will use consultations and ANC within 3 months of pregnancy, and (iii) 100% of deliveries will take place with professional attendants.
Implementation of Major Activities: Number of months for grant activities	36 months
Component C	
Component Name	Information Strategy Development and Implementation
Cost (\$)	120,000
Component Description	<p>This component will target project areas, but the outputs and achievements will be shared at the national level. This will help develop a national information strategy.</p> <p>Component C will be implemented by an agency selected competitively among marketing companies, United Nations agencies, NGOs, and national agencies. The message contents are already available within the health sector but effective message delivery measures have not yet been identified. The strategy will propose (i) cost-effective but diversified measures to deliver the messages to hard-to-reach populations; (ii) arrangements attractive enough to raise interest in the message among the poor, vulnerable, and migrants; (iii) clear and simple messages for people in all social strata and all educational levels; and (iv) implementation</p>

	arrangements based on full participation of health and social service stakeholders. The agency will (i) develop the delivery strategy, (ii) organize a national workshop to discuss and finalize the proposed strategy before the implementation, (iii) implement the strategy, (iv) undertake an impact analysis, and (v) organize a second national workshop to share the experience and propose a national information strategy.
Monitorable Deliverables/Outputs	(i) 100% of mothers in project areas will know the message content, and (ii) two national conferences will be organized.
Implementation of Major Activities: Number of months for grant activities	12 months
Component D	
Component Name	Assessment of Maternal Deaths and Local Actions
Cost (\$)	100,000
Component Description	<p>Maternal deaths are the combined result of a large number of factors. Avoiding maternal complications and deaths depends on whether comprehensive local actions are taken in response to these factors. It is important to analyze the impact of the Project by assessing the local actions surrounding dead mothers and severe complications in project areas. Assessment methods include: assessment of unmet obstetrical needs; and identification of avoidable deaths through confidential inquiries, audits, and systematic verbal autopsies.</p> <p>The Maternal and Child Health Research Center (MCHRC) will take a lead in evaluating maternal deaths and local actions. The Project will contract with MCHRC for such assessments in project areas. MCHRC will standardize assessment forms with support of an international consultant, and train <i>aimag</i> obstetricians, <i>soum</i> staff, <i>bag feldshers</i>, FGPs, and Ulaanbaatar district obstetricians to fill out the forms, conduct an assessment annually, and share the results widely. MCHRC will also organize a national workshop to evaluate national and international assistance, and help the Government finalize the draft national reproductive health plan.</p>
Monitorable Deliverables/Outputs	(i) Standardized assessment forms of local actions will be developed; (ii) about 50 <i>soum</i> health staff, 100 <i>bag feldshers</i> , 50 <i>aimag</i> hospital staff, and 100 FGP staff will be trained; (iii) annual assessment reports will be prepared; and (iv) a national workshop will be organized.
Implementation of Major Activities: Number of months for grant activities	36 months

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

Financier	Amount (\$)
JFPR	1,000,000
Government, in-kind	160,000
Other Sources (Please identify)	0
Total	1,160,000
Incremental cost	50,000

3. Genesis

A JFPR grant is sought for complementing Loan 1998-MON for HSDP2 and for advancing the maternal health agenda in sector reforms. Mongolia's MMR is still high and its improvement has stagnated. Major causes of MMR include (i) hemorrhage; (ii) eclampsia, including pre-eclampsia; (iii) abortion; and (iv) sepsis. Indirect causes of maternal deaths, including pneumonia, hepatitis, and cardiac and renal diseases, are also high. The World Health Organization (WHO) and Ministry of Health report on maternal deaths in 2001–2002 indicated that 47% of deaths could have been prevented under the existing standard of services and 39% more could have been avoided if the skills of doctors and midwives and the level of equipment had been upgraded to modern standards. Maternal complication rates are also very high. More than half of the pregnant women encounter complications during pregnancy, delivery, and postdelivery, and a too many of these women die. Against this background, the Government requested ADB to provide JFPR funding to plan and test innovative approaches to reducing the MMR.

A significant number of maternal deaths (66%) occurred among those who never used ANC or used it at a late stage of pregnancy. About 90.4% of the mothers received ANC from the early or mid-stages of pregnancy in Mongolia in 2003. However, 9.6% of mothers (about 4,300 mothers) did not meet ANC requirements and accounted for a disproportionately larger number of deaths. In 2003, the country average MMR was about 110 per 100,000 live births. The MMR among those who received early ANC was only 42, while that of non-compliant mothers was 769, or 18 times higher. To reduce the MMR, services must be brought universally without omitting this small pocket of underserved mothers.

WHO and the Ministry of Health identified two categories of underserved mothers: (i) those who are underserved because of difficult access, including mothers living in rural areas and urban immigrant mothers lacking knowledge about registration and local services; and (ii) those who have access but do not use services. About 27% of dead mothers were unmarried or the female head of a household. Some may have tried to hide their pregnancy and could not use services in small communities where everybody knows each other. Expanding options of services is a key strategy.

There is a lack of information and understanding on the importance of ANC and attended births. The public needs to be universally educated to ensure that every mother knows the benefits of ANC and attended births, and the hazards of inadequate care and avoidable deaths. However, awareness is not enough. Cases were often reported of people who had sought care and received but did not follow advice. Social and welfare services need to be combined with health care.

Another issue is the low quality of services. Even when pregnant women come to service delivery points, they may not be properly cared for because of poor service quality. An understanding of basic obstetric pathology was often lacking or outdated among health personnel, in particular at the *soum* level. The Project will improve health services quality in project areas. Pregnancy and delivery care is provided free to pregnant women, but is not adequately budgeted for in the public health budget. The Government fully depends on donor supply for basic tests and services, such as provision of iron tablets. The Project and the HSDP2 will help the government budget for basic service needs and help implement the Government's policies in PHC and reproductive health. In summary, in project areas the Project will improve the use and the quality of ANC and case management of prevalent maternal complications, and aims to reduce the MMR by 47%.

4. Innovation

The Project is innovative in how it addresses the health needs and health-seeking behavior of underserved and hard-to-reach mothers. The targeted populations are (i) rural mothers who have difficult access because of difficult geographic and social conditions and those who have access but do not use services, and (ii) urban immigrant mothers who lack knowledge about and access to local services. The Project responds comprehensively to constraints and problems of these mothers in using health services.

The Project will expand options of services to meet the needs of underserved mothers and organize services at times and in places acceptable to users. An MFAT in the project *aimags* will provide an opportunity for early pregnancy consultation to those who hesitate to consult *bag feldshers* and *soum* health workers. Currently, these women, without being able to find time and money to go all the way to

the *aimag* hospital secretly, miss an opportunity for good pregnancy management. The MFAT is an innovative and practical solution to provide confidential and professional consultations to rural women.

The Project will improve health services quality. The training modalities used under the Project are based on lessons learned to compensate for classroom training deficits and the country situation where a small number of people are widely scattered. A recent review mission on training impacts by the Directorate of Medical Services, United Nations Population Fund (UNFPA), and GTZ revealed that knowledge and skills obtained through classroom training are not practiced well. They recognized it as important to arrange in-service training and on-site supervision to follow classroom training. The Project will organize a package of training, namely classroom training, in-service training, on-site supervision, and impact analysis. Furthermore, to allow *soum* health workers (doctors and midwives) to experience more cases, in-service training at the *aimag* level is proposed.

The Project will combine health services with social support to allow disadvantaged mothers to take advantage of health services. This will be done by empowering FGPs, *soum* health centers, and *bag feldshers* in mobilizing social support to vulnerable mothers and by arranging mobile maternity beds to bring professional care next to their *ger* (tent). It is important for PHC providers to give holistic support, including social support as necessary. The Project is innovative in putting such a practice in place. The mobile maternity bed is a new solution for mothers who cannot leave their communities despite medical indications. The mobile bed works as a maternal resting home and can be transferred when maternal conditions require hospital procedures.

5. Sustainability

Operational, financial, and technical replicability and sustainability are considered in the project design. A first sustainability strategy is to root project activities in reforms, make them national programs, and ensure financing under the government budget. The Project will arrange it so that the standard set of reproductive health services will be listed and budgeted for in the contracts of FGPs and *soum* health centers. FGPs and *soum* health centers are expected to implement the set of services defined in the contract, and the public budget is expected to finance them. Second, the Project will promote savings by rationalizing system inefficiencies, and by serving populations at an acceptable commission charge. A high potential exists for savings to be created by pursuing staff and hospital rationalization, as indicated by the reform policy.

Third, the Project will share its experience and outcomes widely with stakeholders, review effectiveness and replicability, and formulate national strategies, in close coordination with HSDP2. HSDP2 will consolidate the health sector reforms over 5 years. A midterm review of HSDP2 in 2006 may adjust its scope to build on the success of the Project and facilitate the Project's outputs to be expanded and nationalized. When the reforms are expanded nationwide, the rationalization is pursued nationwide, and the national strategies are adopted, the project activities could be replicated nationwide.

6. Participatory Approach

NGOs, *bag feldshers*, *soum* health workers, and community representatives will be involved in designing and implementing community social services. Communities and all levels of the health and social welfare systems will be involved in monitoring and evaluating the Project and local actions.

List of Primary Beneficiaries and Other Affected Groups and Relevant Description	List Other Key Stakeholders and Brief Description
Primary beneficiaries are the underserved and hard-to-reach mothers who suffer a high risk of maternal deaths. Their constraints and problems in implementing health practices and use of necessary services were fully analyzed and addressed in the project design.	Community representatives, community organizations, NGOs, <i>bag feldshers</i> , and <i>soum</i> health workers are the next level of key stakeholders. They will be empowered to take the lead in designing and implementing project activities.

7. Coordination

Other funding agencies working in reproductive health are UNFPA, WHO, and GTZ. The presence of Japanese aid agencies in this subject is limited. The Japan International Corporation of Welfare Services (JICWELS) is helping the Ministry of Health develop the comprehensive health sector policy, including the reproductive health policy. The Project has been and will continue to closely communicate with JICWELS at the policy level.

The Project will collaborate with the GTZ in Dzavhan and with UNFPA in Bayanhogor. GTZ will withdraw in mid-2006, and it is important to avoid declined reproductive health services after its exit. UNFPA has developed and standardized reproductive health services together with WHO and GTZ. UNFPA will continue its activities but would like to see coordinated aid agency actions and absorption of aid agency-supported programs in the national programs. Collaboration will bring about significant benefits, including facilitating the exit of the GTZ program without creating a vacuum, and avoidance of reinventing new technical standards under the Project.

8. Detailed Cost Table

Please refer to Appendix 1 for the detailed cost estimates.

C. Linkage to ADB Strategy and ADB-Financed Operation

1. Linkage to ADB Strategy

Name of Document	Document Number	Date of Last Discussion	Objective
Poverty Partnership Agreement			To improve efficient and effective social services delivery to the poor and ensure equitable access.

2. Linkage to Specific ADB-Financed Operation

Project Name	The Second Health Sector Development Project (HSDP2)
Project Number	MON-1998
Date of Board Approval	June 2003
Loan Amount (\$ million)	14 million

3. Development Objective of the Associated ADB-Financed Operation

The goal of the HSDP2 is to improve the health status of the people, especially the poor and vulnerable, including women and children, in targeted rural areas. To contribute to this goal, HSDP2 has two objectives: (i) to improve quality and utilization of health services in rural areas, especially of the poor and vulnerable; and (ii) to build capacity of health sector built on the reform achievements and institutional developments of HSDP in sector efficiency, effectiveness, and sustainability.

4. List the Main Components of the Associated ADB-Financed Operation

No.	Component Name	Brief Description
1.	Integrated improvement of rural health services	This component focuses on improving access to, utilization of, and quality of basic PHC services in an integrated way in the HSDP2 <i>aimags</i> . Investments will be made at the three levels of <i>bag</i> , <i>soum</i> , and <i>aimag</i> . Factors and challenges affecting service quality and utilization will be comprehensively addressed, including: improving working conditions by rehabilitating facilities and providing equipment,

		upgrading knowledge and skills of staff, providing appropriate incentives to increase motivation to work efficiently in rural areas and to address the need of poor and vulnerable people, and providing participatory and informative public health campaigns to create demands and improve community and family health and nutrition practices.
2.	Institutional capacity development and reform consolidation	The first Health Sector Development Program had initiated a reform process that defined the direction, and provided the basis, for health sector development. To further develop the health sector and improve sector efficiency, equity, quality, and sustainability, the component consolidates ongoing reforms and strengthens sector capacity to plan, manage, coordinate, and monitor system development.

5. Rationale for Grant Funding versus ADB Lending

The loan (HSDP2), with which the Project will be associated, pursues health policy reform and institution building. The six policy agenda items include strengthening PHC, involving the private sector, improving health financing and management, rationalizing hospitals, rationalizing health human resources, and protecting the poor. HSDP2's approach is comprehensive and universal, covering the whole health system. To complement this approach, the Project targets reproductive health and focuses on underserved mothers in rural areas and among urban migrants. It involves many innovative measures to reach the underserved and hard-to-reach mothers with health services.

Given the nature of the JFPR Project and its target of beneficiary groups, grant financing is essential. Furthermore, innovative approaches proposed under the Project need to be tested and adjusted under grant financing prior to replication and expansion nationwide. In addition, the Project uses participatory approaches and works with NGOs, community organizations, and commercial companies, approaches that are new to the country. Hence, effective operational modalities must be developed first before scaling up to the national level. Grant financing will enable this process.

D. Implementation of the Proposed Grant

1. Provide the Name of the Implementing Agency	Ministry of Health
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All procurements under the JFPR grant will be conducted in accordance with ADB's *Guidelines for Procurement*. The NGOs, for supporting rural mothers and an agency in information strategy will be recruited by ADB in accordance with ADB's *Guidelines on the Use of Consultants*. Consultants will be contracted by the grant implementation unit (GIU) in accordance with ADB's *Guidelines on the Use of Consultants*. The Maternal and Child Health Research Center will be contracted directly.

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Limited capacity of NGOs and community organizations in managing the Project	Local NGOs and community organizations are not active or strong in Mongolia	The Project will train NGOs and community organizations during the initial phase
Traditional perception valuing hospitals among the population	People value hospital services rather than community services and PHC, and may bypass the services that are strengthened under the Project and directly visit hospitals	Information strategy includes the importance of the community and PHC services. Service quality at this level will be improved to obtain people's trust

3. Incremental ADB Costs

Component	Incremental Bank Cost
Amount requested	\$50,000
Justification	Recruitment of consultants and conducting specific surveys to prepare background documents for the JFPR midterm and final reviews and impact analysis.
Cost breakdown	International consultant for 1.5 person-month: \$28,000 Domestic consultant for 4 person-months: \$2,000 Two surveys: \$20,000
Type of work to be rendered by ADB	(i) Inception advice on the impact analysis method and the baseline data survey, (ii) midterm and final review, and (iii) advice on the final survey.

4. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for M&E
(i) Percentage of mothers who know and use reproductive health services, including ANC and births attended by trained staff, 100% knowledge about reproductive health, including contraceptives and 90% practice in early pregnancy consultation from 60%, in ANC from 90%, and 100% in attended births from 99% in pilot areas.	Knowledge, attitudes, and practices studies among different groups of populations. Local governments' health reports.	Annual exercises
(ii) Use of the performance-based contract with PHC providers, that lists the standard set of reproductive health services in pilot areas.	National Government's health report.	Annual exercises
(iii) Maternal complication rates in pilot areas reduced from 50% to 30%, the international average as a proxy indicator to MMR.	Local governments' health report.	Annual exercises
(iv) MMR in pilot areas reduced from 130 per 100,000 live births to 69 per 100,000.	Project monitoring reports. Local governments' reports.	Annual exercises

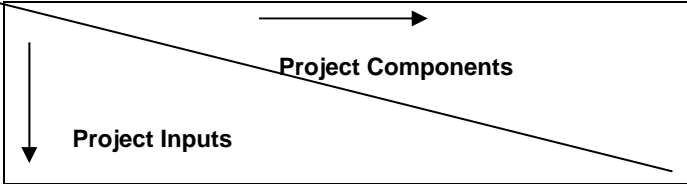
5. Estimated Disbursement Schedule

Fiscal Year (FY)	Amount (\$)
FY2001	450,000
FY2002	300,000
FY2003	250,000
Total Disbursements	1,000,000

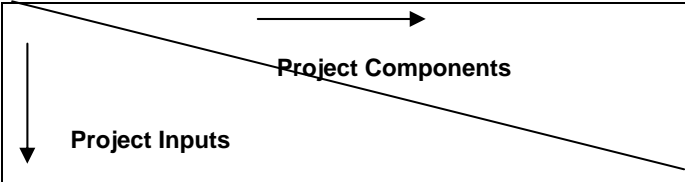
Appendixes

1. Summary and Detailed Cost Tables
2. Fund Flow Arrangements
3. Implementation Arrangements
4. Outline Terms of Reference for Nongovernment Organizations and Consulting Services

DETAILED COST ESTIMATES
Table A1.1: Summary Cost Table
(\$)

	Component A Support to Rural Mothers	Component B Support to Urban Mothers	Component C Information Strategy Development and Implementation	Component D Assessment of Maternal Deaths and Local Actions	Total (Input)	Percent
1. Civil Works: (incl. technical surveys and designs, and supervision of constructions)	0	0	0	0	0	0.0
2. Equipment, Hardware and material (e.g. power tools, wind turbines, pico/micro hydro generators, post-harvest and cold storage materials, communications, audio-visual equipment, furniture, etc.)	120,000	39,000	0	0	159,000	15.9
3. Consumable Supplies: (e.g. packaging material, hardware and tools for training purposes, training manuals and textbooks, basic training supplies, O&M basic kits, stationery, etc.)	25,000	20,000	0	0	45,000	4.5
4. Training, workshops, seminars, public information campaign, research, surveys	60,000	40,000	120,000	80,000	300,000	30.0
5. Consulting Services: (e.g. for surveys, assessments, technical specialists, advisors, etc. including related costs such as travel, accommodation and per diem)	28,000	43,000	0	20,000	91,000	9.1
6. Project Management: (including management of the PIU and the specific components, wages for staff, per diem for government staff and local volunteers, office equipment, rental, O&M, recruitment costs, and audit)	30,000	21,000	0	0	51,000	5.1
7. Other Project Inputs: (NGOs/ <i>Aimag</i> teams/soum teams/community organization inputs)	180,000	120,000	0	0	300,000	30.0
8. Contingencies, including audit (5.4% of total estimated grant fund): Use of contingencies requires prior approval from ADB.	37,000	17,000	0	0	54,000	5.4

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	Component A Support to Rural Mothers	Component B Support to Urban Mothers	Component C Information Strategy Development and Implementation	Component D Assessment of Maternal Deaths and Local Actions	Total (Input)	Percent
Subtotal JFPR Financed	480,000	300,000	120,000	100,000	1,000,000	100.0
Government contribution, in-kind (e.g. Salaries for government counterparts; provision of project office; land acquisition for buildings and constructions, participation in workshops/meetings) Private sector or Other Donor(s) Contributions: Community's Contributions	80,000	20,000	20,000	40,000	160,000	
Total project costs	560,000	320,000	140,000	140,000	1,160,000	
Incremental costs					50,000	

Source: ADB estimates.

Table A1.2: Cost Estimates by Component

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost per Unit	Total (\$)	JFPR		Govt.	Other Donors	Communities
						Amount	Method of Procurement			
Component A. Support to Rural Mothers				Subtotal:	560,000	480,000		80,000		
1.1	Civil Works			Subtotal:						
1.2	Equipment, Furniture and Furnishing			Subtotal:	120,000					
1.2.1	Medical equipment for soums and bags	Package	120	150	18,000		DP/IS			
1.2.2	Internal mobile units	Unit	3	30,000	90,000		IS			
1.2.3	Computers at soum of social welfare	Unit	6	2,000	12,000	12,000	DP			
1.3	Goods and Consumable Supplies			Subtotal:	25,000	25,000				
1.3.1	Medical supply (diagnostic kits, iron tables, etc.)	Package	5	5,000	25,000	25,000	DP/IS			
1.4	Training, Workshops, Seminars, Surveys, Public Campaign			Subtotal:	60,000	60,000				
1.4.1	Training/workshop	Lump sum			60,000	60,000				
1.5	Consulting Services			Subtotal:	28,000	28,000				
1.5.1	International	Person-months	1.5	17,000	25,000	25,000				
1.5.2	Domestic	Person-months	6	500	3,000	3,000				
1.6	Management and Coordination of the Component			Subtotal:	110,000	30,000		80,000		
1.6.1	Component 1 – Staff	Person-months	36	500	18,000	18,000				
1.6.2	Travel and per diem	Monthly average			6,000	6,000				
1.6.3	Operational Costs	Monthly average			6,000	6,000				
1.6.4	Government contributions (staff salaries, travel, per diem and operational cost)				80,000			80,000		

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost per Unit	Total (\$)	JFPR		Govt.	Other Donors	Communities
						Amount	Method of Procurement			
1.7	Other Project inputs (NGOs/community organizations inputs)			Subtotal:	180,000	180,000				
1.7.1	Multi-functional <i>aimag</i> team	Lump sum			120,000	120,000				
1.7.2	Nongovernment organization	Lump sum			60,000	60,000				
1.8	Contingencies and audit			Subtotal:	37,000	37,000				
1.8.1	Contingencies				25,000	25,000				
1.8.2	Audit	Unit	3	4,000	12,000	12,000				
Component B. Support to Urban Mothers				Subtotal:	320,000	300,000		20,000		
1.1	Civil Works			Subtotal:						
2.2	Equipment, Furniture and Furnishing			Subtotal:	39,000	39,000				
2.2.1	Medical Equipment	Package	60	500	30,000	30,000	DP/IS			
2.2.2	Computers at office of social welfare	Unit	6	1,500	9,000	9,000	DP			
2.3	Goods and Consumable Supplies			Subtotal:	20,000	20,000				
2.3.1	Medical supply to FGP	Package	50	400	20,000	20,000	DP/IS			
2.4	Training, Workshops, Seminars, Surveys, Public Campaign			Subtotal:	40,000	40,000				
2.4.1	Training/Workshop	Lump sum			40,000	40,000				
2.5	Consulting Services			Subtotal:	43,000	43,000				
2.5.1	International	Person-month	2	15,000	30,000	30,000				
2.5.2	Domestic	Person-month	26	500	13,000	13,000				

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Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost per Unit	Total (\$)	JFPR		Govt.	Other Donors	Communities
						Amount	Method of Procurement			
2.6	Management and Coordination of this Component			Subtotal:	41,000	21,000		20,000		
2.6.1	Component 1 – Staff	Person-month	36	500	18,000	18,000				
2.6.2	Travel and per diem	Monthly average			1,000	1,000				
2.6.3	Operational costs	Monthly average			2,000	2,000				
2.6.4	Government contribution (Staff salaries, travel, per diem and operational cost)				20,000			20,000		
2.7	Other Project Inputs (NGOs/community organizations inputs)			Subtotal:	120,000	120,000				
2.7.1	FGP outreach incentives and logistic support	Lump sum			120,000	120,000				
2.8	Contingencies			Subtotal:	17,000	17,000				
Component C. Information Strategy Development and Implementation				Subtotal:	140,000	120,000		20,000		
3.1	Equipment, Furniture and Furnishing			Subtotal:						
3.2	Goods and Consumable Supplies			Subtotal:						
3.3	Training, Workshops, Seminars			Subtotal:	120,000	120,000				
3.3.1	Conference	Times	2	10,000	20,000	20,000				
3.3.2	Public information campaign/health education	Lump sum			100,000	100,000				
3.4	Consulting Services			Subtotal:						
3.5	Management and Coordination of this Component									

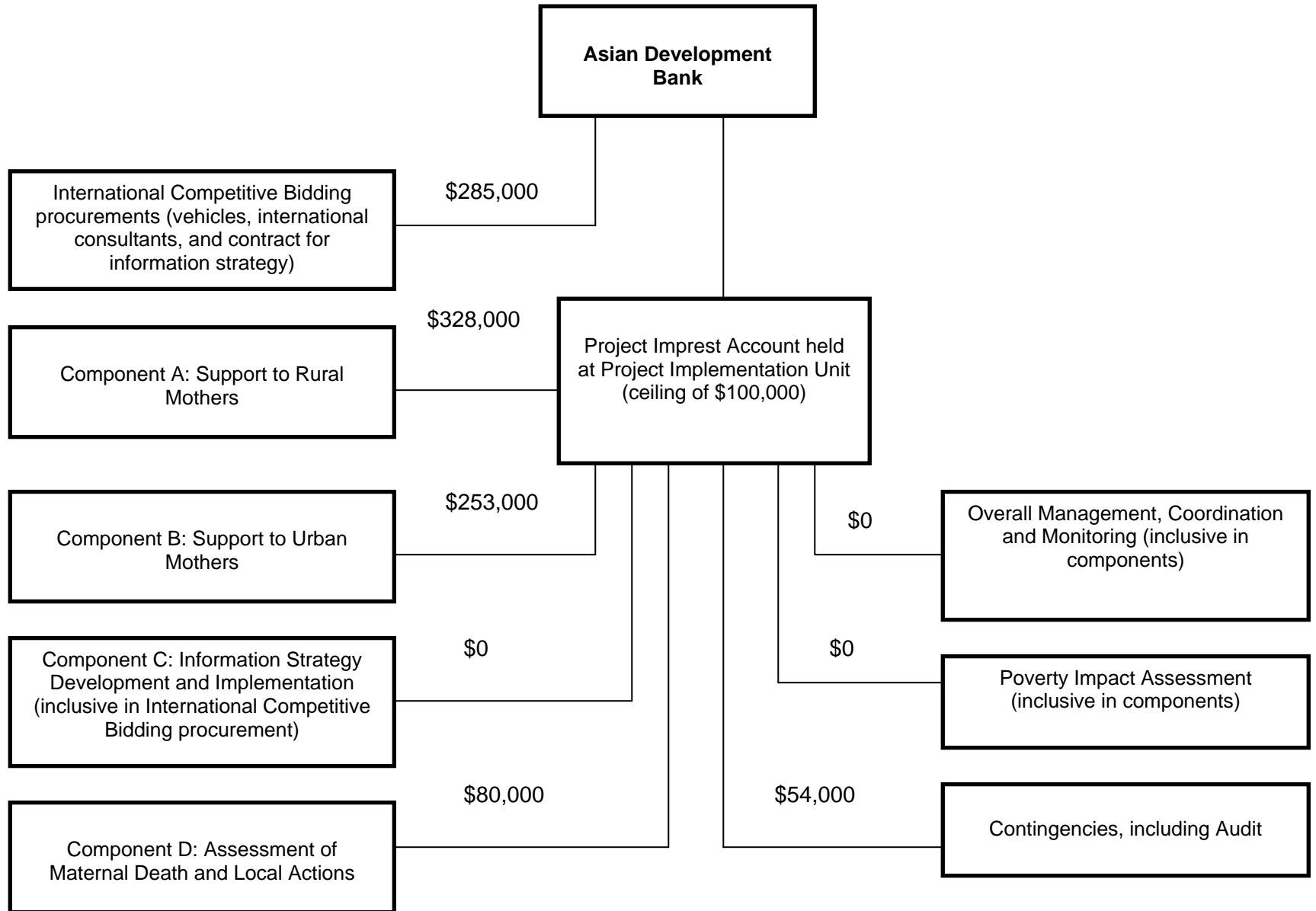
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Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost per Unit	Total (\$)	JFPR		Govt.	Other Donors	Communities
						Amount	Method of Procurement			
3.5.1	Component 1 – Staff			Subtotal:	20,000			20,000		
3.5.2	Travel and Per diem									
3.5.3	Operational Costs									
3.5.4	Government Contributions (travel, per diem and operational cost)				20,000			20,000		
Component D. Assessment of Maternal Death and Local Action				Subtotal:	140,000	100,000		40,000		
4.1	Equipment, Furniture and Furnishing									
4.1.1	Office/campaigns/training equipment			Subtotal:						
4.2	Goods and Consumable Supplies			Subtotal:						
4.3	Training, Workshops, Seminars									
4.3.1	Conference	Times	1	Subtotal:	80,000	80,000				
4.3.2	Research	Multiple			20,000	20,000	20,000			
4.4	Consulting Services			Subtotal:	20,000	20,000				
4.4.1	International	Person-month	1		20,000	20,000	20,000			
4.4.2										
4.5	Management and Coordination of this Component									
4.5.1	Component 1 – Staff			Subtotal:	40,000			40,000		
4.5.2	Travel and per diem									
4.5.3	Government contributions (staff salaries, travel, per diem and operational costs)				40,000			40,000		

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Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost per Unit	Total (\$)	JFPR		Govt.	Other Donors	Communities
						Amount	Method of Procurement			
Total Grant Cost				Total:	1,160,000	1,000,000		160,000		
Incremental Cost Details:										
	International Consultants	Person-month	1.5		28,000	28,000				
	Domestic Consultants	Person-month	4		2,000	2,000				
	Survey for preparation of background documents for JFPR midterm and final reviews, and impact analysis		2		20,000	20,000				
Total Incremental Cost					50,000	50,000				

FUND FLOW ARRANGEMENTS FOR JFPR FUNDS



IMPLEMENTATION ARRANGEMENTS

1. The Japan Fund for Poverty Reduction (JFPR) Project will commence in March 2005 and will be completed by February 2008. The implementation arrangements will be in line with the ongoing Second Health Sector Development Project (HSDP2) with which the JFPR grant is associated. The Ministry of Health (MOH) is the Executing Agency (EA) and MOH with support of consultants is the implementing agency (IA). The national steering committee and *aimag* level supervisory groups set for HSDP2 will supervise JFPR's activities at the national and district levels, respectively.

2. The JFPR will be implemented in three HSDP2 pilot *aimags* (Bayanhongor, Dzavhan, and Hentiy) and two districts of Ulaanbaatar (Bayanzurkh and Songino-Kherkhan). The areas are selected for their maternal mortality ratio (MMR) and poorer access to reproductive health services. The proposed JFPR Project and HSDP2 will advance the maternal health agenda to build on ongoing reform efforts in Mongolia.

3. A JFPR team comprising JFPR coordinator and component specialists will form a JFPR coordination unit that will be established at Project Implementation Unit (PIU/HSDP2) in MOH. The PIU/HSDP2 will help administer JFPR implementation. The PIU/HSDP2 will manage the JFPR imprest account with assistance of a JFPR accountant. The JFPR imprest account will be opened separately from that of HSDP2 and its ceiling is \$100,000. Staff of the JFPR coordination unit will be selected through local competitive bidding by the Asian Development Bank (ADB) and endorsed by MOH. The key responsibilities of the JFPR coordination unit are to (i) prepare the JFPR work plans, budget, and progress reports; (ii) propose JFPR expenditures and procurement needs; and (iii) implement JFPR activities as per the annual work plan. At the *aimag* level, HSDP2 management staff will work for the JFPR.

4. Procurement under the project will be conducted in accordance with ADB's Guidelines for Procurement. Goods and related services below \$100,000 will be procured using ADB's direct purchase procedure. Goods and services above \$100,000 will be procured using ADB's international shopping procedure. The procurement of civil works will follow local competitive bidding procedures acceptable to ADB. PIU/HSDP2 will be responsible for procurement with technical inputs from the JFPR coordination unit and MOH.

A. Steering Committee

5. The steering committee will be chaired by a state secretary of MOH and consist of key stakeholders including MOH, the Directorate of Medical Services, the Maternal and Child Health Research Center, *aimag* and Ulaanbaatar representatives, and a PIU Director. The committee will meet on a quarterly basis and will be responsible for (i) approving the annual sector plan, and (ii) reviewing implementation progress and resolving any implementation bottlenecks that may require high-level interventions and intergovernment consultation.

B. JFPR Director in the Executing Agency and JFPR Coordinator

6. The state secretariat will be the JFPR Director and be responsible for the timely and efficient execution of the work of the JFPR as approved by the steering committee. The JFPR Coordinator will be selected by ADB in consultation with the Government and PIU/HSDP2. The Coordinator will (i) coordinate the implementation of annual work plan as approved by the steering committee, (ii) review JFPR expenditures and procurement and ensure that they are done in line with approved plans and pertinent administrative procedures, and (iii) be the main

focal point for the Government on policy coordination and JFPR implementation review discussions with ADB.

C. Aimag Supervisory Group

7. The *aimag* supervisory group comprising the *aimag* health department, *soum* staff, *bag feldshers*, a selected nongovernment organization, and selected *bag* leaders, will guide the preparation of *aimag* plans, review progress on a quarterly basis, and coordinate and implement all *aimag*-level activities.

D. Reporting Requirements

8. PIU/HSDP2 will be responsible for reports to ADB and the Executing Agency with technical inputs from the JFPR coordination unit. PIU/HSDP2 will prepare (i) quarterly project progress reports, (ii) annual audited project accounts within six months of each fiscal year and (iii) a project completion report within 3 months of project completion, if appropriate.

OUTLINE TERMS OF REFERENCE FOR NONGOVERNMENT ORGANIZATIONS AND CONSULTING SERVICES

A. Rural Social Support

Nongovernment Organizations

1. Local nongovernment organizations (NGOs) (one NGO per *aimag*) will be recruited to help *bag feldshers* and *sum* health centers mobilize social support to disadvantaged rural mothers. The contract duration is for 3 years. The NGO will be located in each *aimag* and selected either from community-based organizations, women's groups, professional groups—such as a *bag feldsher* association, nurse association, or herdsmen's association—the business community, or other social welfare NGOs.
2. The NGO will be selected through local competitive bidding, and the evaluation committee will be created, composed of representatives of the Ministry of Health, Japan Fund for Poverty Reduction (JFPR) coordination unit, *aimag* health departments, and *soum* governments. Evaluation criteria include: (i) the NGO should have a close network with *soum* health centers, *bag feldshers*, social welfare offices, and communities; (ii) the NGO should have poverty reduction and community participation working experience; and (iii) the NGO should have legal advisory capability and accounting capacity, in addition to its specific advantages. The selection criteria will be elaborated and finalized with the assistance of an international social protection specialist and domestic poverty advisor. The NGO will be trained at the beginning by consultants and *aimag* health and social welfare departments on poverty reduction, social welfare, and reproductive health requirements.
3. The NGO will (i) review and analyze the scope of maternal social benefits, the implementation level and the coverage, and their administration structure and procedures; (ii) train *bag feldshers* about the welfare system and procedures; (iii) arrange with *soum* and *aimag* offices for the NGO to consolidate benefit requests and receive benefits on behalf of pregnant and postdelivery women, as necessary; (iv) provide legal advice to *bag feldshers* on possible social benefits for vulnerable groups of pregnant women identified by *bag feldshers*; (v) monitor the implementation of the maternity benefits, identify those who are left out of the scheme, and help mothers apply for the scheme; (vi) help *bag feldshers* propose and implement options of social services to facilitate vulnerable groups' use of reproductive health services, in particular, antenatal care (ANC) and a professionally attended delivery; and (vi) manage and operate a mobile maternal bed.
4. The NGO will get commissions from mothers to whom the NGO delivers the maternity benefits. The commissions will be of an acceptable level for each benefit request (for instance, a little less than the travel cost required for each family to go by itself.) The NGO will accumulate the commissions and use the amounts saved for further community-based social support, as requested by and discussed with *soum* health centers and *bag feldshers*. The NGO and *bag feldshers* will be trained to design social support.
5. The mobile bed will be equipped with obstetric equipment for a midwife to assist deliveries and communication equipment. The mobile maternal bed is one of the social service options for a woman who has medical indications for rest under professional (midwife) monitoring but cannot move far from her *bag*. Upon the request of *bag feldshers*, the NGO will dispatch the bed, while the *soum* health center will send a midwife as necessary.

Consultants

6. **Reproductive Health Specialists** (1.5 person-months of an international consultant and 6 person-months of a domestic consultants) will be recruited for the following terms of reference (TOR): (i) reviewing the *soum* health center's contract and *bag feldshers'* TOR and including reproductive health services in its contract and TOR; (ii) reviewing the reproductive health service performance of *soum* health centers and *bag feldshers* and identifying training needs; (iii) reviewing existing training courses of other external agencies; and (iv) preparing a training curriculum and material, as necessary, and initiating training with the Directorate of Medical Services. The international specialist will also work for component 2 and do the same for family group practices (FGPs).

B. Urban Social Support

7. **Reproductive Health Specialist** (6 person-months of a domestic consultant will be recruited for the following TOR. With the international reproductive health specialist recruited under component 1, (i) reviewing the FGPs' contract and including reproductive health services in its contract and TOR; (ii) reviewing reproductive health service performance of FGPs and identifying training needs; (iii) reviewing existing training courses of other external agencies; and (iv) preparing a training curriculum and material, as necessary, and initiating training with the Directorate of Medical Services.

8. **Social Protection Specialist** (2 person-months of an international consultant) will be recruited for the following TOR: (i) identifying, assisted by the domestic poverty and legal advisors below, social support needs of disadvantaged urban mothers; (ii) reviewing existing social support to urban mothers; (iii) proposing possible and innovative social support; and (iv) training the legal and poverty advisors and building their capacity to advise FGPs on social support. The social protection specialist will also do the same thing for rural areas with NGOs selected for component 1.

9. **Legal Advisor and Poverty Advisor** (10 person-months of domestic consultants, each) will be recruited to advise FGPs on social support to disadvantaged urban mothers, in particular immigrant mothers.

10. The legal advisor will: (i) review and analyze the immigrant registration procedures and the scope of maternal benefits and their administration structure and procedures in Ulaanbaatar; (ii) train FGPs about the registration and welfare systems and procedures; and (iii) provide legal advice to FGPs on possible social benefits for vulnerable groups of pregnant women identified by FGPs.

11. The poverty advisor will help FGPs (i) identify barriers for urban poor, vulnerable, and immigrants to use reproductive services, in particular, ANC and a professionally attended delivery; (ii) mobilize available informal and formal social support and volunteer organizations in Ulaanbaatar to remove barriers; and (iii) propose and implement social services options to facilitate vulnerable groups to use reproductive health services.

C. Information Strategy Development and Implementation

12. An agency will be selected to develop and implement information strategies, on a competitive basis, among commercial marketing companies, United Nations, NGOs, national

agencies, and so on. The contract duration is 1 year. The TOR of the agency are to: (i) collect various information, education, and communication material worldwide; (ii) develop the delivery strategy; (iii) organize a national workshop to discuss and finalize the proposed strategy before its implementation; (iv) implement the strategy; (v) undertake an impact analysis; and (vi) organize a second national workshop to share the experience and to propose measures for possible nationwide implementation.

13. The agency will be selected through local competitive bidding and the evaluation committee will be created, composed of representatives of the Ministry of Health, Ministry of Labor and Social Welfare, JFPR coordination unit, Directorate of Medical Services, Ulaanbaatar health department, *aimag* health departments, and *soum* governments. Evaluation criteria will include: (i) the agency should have expertise and working experience in marketing and information, education, and communication; (ii) the agency should have both global and domestic knowledge about reproductive health and health-seeking behavior (or have staff who have such knowledge); and (iii) the agency's poverty reduction and community participation working experience would be an asset. The selection criteria will be elaborated and finalized during initial months.

14. The agency will start its activities when intended JFPR services, social and health, start. The messages will be delivered on (i) importance of early pregnancy consultation, ANC, and attended deliveries; (ii) avoidable deaths and hazards of inadequate care; (iii) healthy behavior during pregnancy and postdelivery; (iv) benefits and methods of contraceptives; (v) available health and social services during pregnancy and postdelivery; (vi) registration benefits; and (vii) call for actions by pregnant women. This component will target JFPR pilot areas, but the outputs and achievements will be shared at the national level.

15. The message contents are already available within the health sector but effective message delivery measures have not yet been identified. The strategy should propose: (i) cost-effective but diversified measures to deliver the messages to hard-to-reach populations, both in urban and rural areas; (ii) arrangements attractive enough to raise interest among the population, in particular the poor, vulnerable, and immigrants, in the messages; (iii) clear and simple messages so that people in all social strata and all educational levels can understand them easily; and (iv) implementation arrangements based on full participation of health and social service stakeholders.

D. Monitoring and Assessing Maternal Complications and Deaths and Local Actions

1. Maternal and Child Health Research Center

16. The JFPR will directly contract with the Maternal and Child Health Research Center (MCHRC) for Monitoring and Assessing Maternal Complications and Deaths and Local Actions in pilot areas. The research capacity of MCHRC has been strengthened by the World Health Organization since 1993 and it produces, annually, various reliable assessment reports, including one on unmet obstetrical needs and have justified selecting it for carrying out the assessments.

17. MCHRC will standardize assessment forms with the support of an international consultant, train *aimag* obstetricians, *soum* staff, *bag feldshers*, FGPs, and Ulaanbaatar district obstetricians to fill out the form, conduct an assessment annually, and share the results widely. MCHRC will also organize a national workshop to evaluate and consolidate external agency

assistance, including the JFPR, and help the Government finalize the national reproductive health action plan.

2. Consultant

18. **Maternal Public Health Specialist** (1 person-month of an international consultant) will be recruited for the following TOR: (i) conduct with MCHRC confidential inquiries into maternal deaths that occurred in the JFPR pilot areas in 2004, (ii) help MCHRC standardize the assessment forms, and (iii) initiate training to health workers in filling out the form and analyzing the results.