

ASIAN DEVELOPMENT BANK

JFPR: KGZ 32143

GRANT ASSISTANCE
(Financed by the Japan Fund for Poverty Reduction)

TO THE

KYRGYZ REPUBLIC

FOR

REDUCING NEONATAL MORTALITY

September 2004

CURRENCY EQUIVALENTS

(as of 30 June 2004)

Currency Unit	–	som (Som)
Som1.00	=	\$0.0231
\$1.00	=	Som43.1624

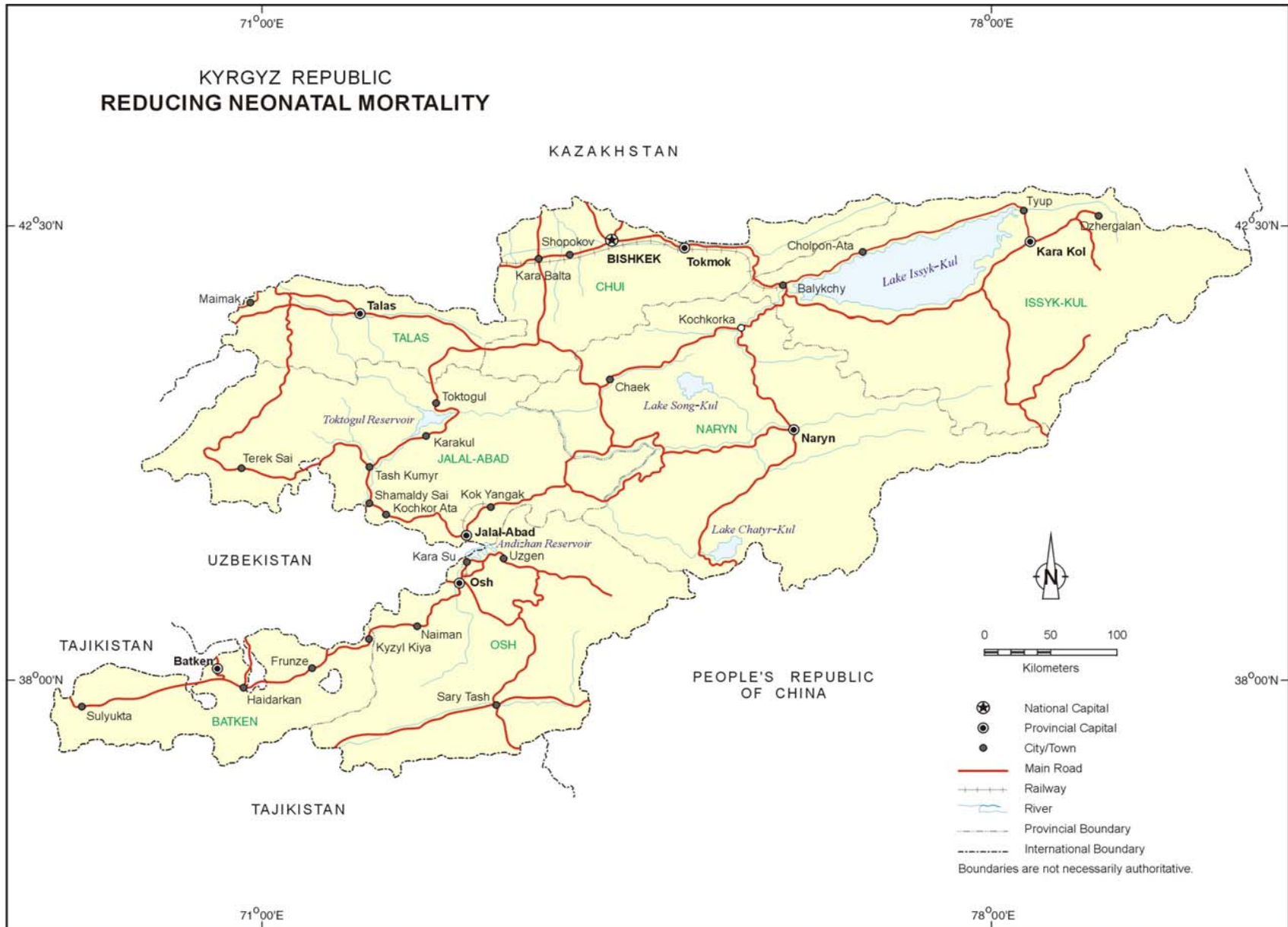
ABBREVIATIONS

ADB	–	Asian Development Bank
CBECDP	–	Community-Based Early Childhood Development Project
CBO	–	community-based organization
CRH	–	central raion hospital
FAP	–	feldsher accoucher point (primary health care post)
FGP	–	family group practice
GIU	–	grant implementation unit
IDA	–	iron deficiency anemia
IDD	–	iodine deficiency disorder
IEC	–	information, education, and communication
IMR	–	infant mortality rate
JICA	–	Japan International Cooperation Agency
LBW	–	low birth weight
MDG	–	Millennium Development Goal
MOH	–	Ministry of Health
NGO	–	nongovernment organization
NMR	–	neonatal mortality rate
PEPC	–	promoting effective perinatal care
PHC	–	primary health care
UNICEF	–	United Nations Children's Fund
USAID	–	United States Agency for International Development
WHO	–	World Health Organization

NOTES

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

KYRGYZ REPUBLIC REDUCING NEONATAL MORTALITY



JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR Grant Proposal

I. Basic Data	
Name of Proposed Activity	Reducing Neonatal Mortality
Country	The Kyrgyz Republic
Grant Amount Requested	\$ 1,000,000
Regional Grant	No
Grant Type	Capacity building

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

<p>Grant Development Objectives (GDO): The goal of the proposed grant is to reduce the neonatal mortality rate (NMR)¹ in the four poorest <i>raions</i> (districts) in Osh <i>oblast</i> (province) in the Kyrgyz Republic, thereby reducing the infant mortality rate (IMR), one of the key Millennium Development Goals (MDGs). Neonatal deaths account for about 50% of infant deaths in the Kyrgyz Republic. Reducing NMR will greatly contribute to reducing IMR. Specific objectives of the grant are (i) to improve the capacity of primary and first referral health care by providing refresher training to health workers and promoting best practices in antenatal, delivery, and neonatal care; and (ii) to improve maternal health care, knowledge, practice on maternal health—especially maternal nutrition—through an information, education, and communication (IEC) campaign.</p>
<p>Expected Key Performance Indicators: Proposed monitoring indicators are (i) NMR, (ii) the incidence of still births, (iii) the prevalence of anemia in pregnant women and infants; (iv) the incidence of premature delivery and low birth weight (LBW),² and (v) the incidence of neonatal infections among newborns less than 14 days of age.</p>

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

Category	Amount of Grant Allocated (\$)	Percentage of Expenditures
1. Equipment/Supplies	183,030	18.0
2. Training/Workshops/Conferences	191,357	19.0
3. Consulting Services (consultants, surveys, audit)	317,400	32.0
4. Management	88,320	9.0
5. Other Inputs	130,000	13.0
6. Contingency	89,893	9.0
Total	1,000,000	100.0
Incremental Cost	50,000	5.0

¹ The probability of dying during the first 28 days of life, expressed per 1,000 live births.

² Less than 2500 grams.

JAPAN FUND FOR POVERTY REDUCTION

JFPR Grant Proposal Background Information

A. Other Data	
Date of Submission of Application	1 June 2004
Project Officer	Rie Hiraoka, senior social sectors specialist
Project Officer's Division, E-mail, Phone	Social Sectors Division, East and Central Asia Department, rhiraoaka@adb.org , 632-6811 (local), 632-5426 (direct)
Other Staff Who Will Need Access to Edit/Review the Report	Carolina Navarro, cnavarro@adb.org Minnie Zarah Ramas, mzramas@adb.org
Sector	Health, Nutrition, and Social Protection
Theme	Inclusive Social Development
Name of Associated ADB Financed Operation(s)	Community-Based Early Childhood Development Project (CBECDP) ³ and the Second CBECDP ⁴
Executing Agency	Ministry of Health Kyrgyz Republic Tel No: (996-312) 228697 Fax No: (996-312) 660493
Grant Implementing Agency	The same as above.

B. Details of the Proposed Grant

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

Component A	
Component Name	Improving Primary and First Referral Health Care Services for Antenatal, Delivery and Neonatal Periods
Cost (\$)	374,957
Component Description	This component aims to improve the quality of antenatal, delivery, and neonatal care provided by the primary health care (PHC) system, including home visits by health care workers, PHC facilities, and the first referral health care at <i>raion</i> hospitals. Health workers require training and essential supplies for providing effective care. Few health workers have been trained in up-to-date knowledge and methodology for antenatal, delivery, and neonatal care. While training on inpatient antenatal and delivery care has been developed in the country, training for outpatient care needs to be reviewed and modified, and neonatal care needs to be strengthened.

³ ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kyrgyz Republic for the Community-Based Early Childhood Development Project*. Manila.

⁴ Project preparatory technical assistance is scheduled in 2006.

	<p>The grant will support:</p> <ol style="list-style-type: none"> a. Improving training for antenatal, delivery, and neonatal care, with a focus on preventing premature deliveries, caring for LBW children, and preventing and managing birth asphyxia and hypothermia (low body temperature). b. Training of primary and first referral health care workers, including neonatologists, obstetricians, family group practice (FGP) doctors, feldshers (primary health care workers), midwives, and patronage nurses. Additional training will be conducted for neonatologists and obstetricians at Osh Central Hospital. Training of trainers and intensive on-site supervision after training will also be supported. c. Supply of kits of essential tools for home visits by midwives and patronage nurses. The government will be responsible for supplying other medical supplies for regular use at the health facilities. d. Studies on neonatal deaths, illnesses, or other relevant topics.
Monitorable Deliverables/Outputs	<ol style="list-style-type: none"> (i) Updated and improved training modules (ii) Number of health care workers trained (iii) Number of detected early signs of neonatal illnesses (iv) Number of detected early danger signs in pregnancy
Implementation of Major Activities: Number of months for grant activities	36 months

Component B	
Component Name	Improving Maternal Health Care and Practices in the Community
Cost (\$)	336,800
Component Description	<p>Data available at <i>raion</i> hospitals shows that 70-90% of pregnant women in the participating four <i>raions</i> are anemic. This reflects the poor status of overall maternal nutrition and health. This component aims to improve the maternal health care and practices, especially at the community level. Women's knowledge of maternal health and anemia is uneven at the community level, and women want more information on their health through mass media or health workers. The government plans to organize a roundtable meeting to review the problems of maternal health and existing programs, and to develop and implement an affordable iron supplementation pilot program for poor pregnant women.</p> <p>The grant will support:</p> <ol style="list-style-type: none"> a. An intensive communication campaign on nutrition, maternal health, and best practices on neonatal care (including breast feeding), involving mass media and stakeholders, including women, secondary school children, communities, aiyl

	<p>okmotus (village authorities), nongovernment organizations (NGOs), and health workers.</p> <p>b. Roundtable meeting and workshops on maternal health.</p> <p>c. Studies and surveys relevant to maternal health (e.g. women's and families' behaviors during pregnancy, diet patterns).</p> <p>d. The development and implementation of pilot activities for reducing iron deficiency anemia (IDA) among pregnant women.</p>
Monitorable Deliverables/Outputs	<p>(i) Balance of diet and behaviors relevant to health promotion</p> <p>(ii) Development of a pilot program for anemia prevention for pregnant women</p> <p>(iii) Communication materials</p> <p>(iv) Study and survey reports</p>
Implementation of Major Activities: Number of months for grant activities	42 months

Component C	
Component Name	Project Management, Monitoring, and Evaluation
Cost (\$)	198,350
Component Description	<p>The component will support project implementation, and monitoring and evaluation. The grant will support a grant implementation unit (GIU) in Osh that will oversee daily project activities in the participating <i>raions</i>, and a liaison unit in Bishkek.</p> <p>The grant will also support monitoring and supervision activities, and evaluation studies that include baseline and endline surveys designed to evaluate the outcomes of project interventions. Monitoring and evaluation will make maximum use of data routinely collected by the health care system. Data on health care practice will be collected by training supervisors and health workers based on a checklist developed to monitor the practice of health workers. A sample survey will be conducted for specific indicators, including change in food intake patterns and knowledge of maternal health needs.</p>
Monitorable Deliverables/Outputs	<p>(i) Quarterly progress reports</p> <p>(ii) Monthly financial reports</p> <p>(iii) Annual audited financial reports</p> <p>(iv) Midterm review reports</p> <p>(v) Project completion report</p> <p>(vi) Baseline and endline surveys</p>
Implementation of Major Activities: Number of months for grant activities	48 months

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

Financier	Amount (\$)
JFPR	1,000,000
Government	69,900
Other Sources (Please identify)	13,000
Total	1,082,900

3. Genesis

INTRODUCTION

The Kyrgyz Republic has a population of 5 million. Annual per-capita income is about \$300—the second lowest among the Central Asian Republics—and poverty is prevalent. According to the National Statistical Committee, 40% of the urban population and 47% of the rural population lived in poverty in 2002. The country had achieved a high level of education and had developed extensive education and health care networks before independence. However, recent years have seen declines in budgets, coverage, and quality of social services. Rural and urban disparities are widening. Scarce resources are concentrated in the major cities and towns, and training and supplies reach remote, impoverished rural health posts and schools last. Major efforts will be required to meet the target of reducing IMR, one of the key MDGs supported by both the Kyrgyz Republic and the Asian Development Bank (ADB).

A reliable picture of the current IMR is not readily available, as the definition of live births that the former Soviet Union used makes IMR appear about one third of the figure under the World Health Organization's (WHO) standard definition. This means that the real IMR in 2003 is about 60, based on the government IMR figure of 20. The 1997 Demographic and Health Survey, which used the WHO standard definition, indicated an IMR of 61. This is an unexpectedly high IMR for the country with 95% institutional delivery, universal immunization coverage, and high education levels of parents, and places the country in a league of countries with poor human development. More than 50% of these infant deaths occur during the neonatal period.

Neonatal death is a tragic, high-cost reproductive loss. Newborn health and survival may be improved in several ways. Many newborn lives can be saved in PHC settings if health professionals recognize and treat serious infections early enough. Improved education and better status for women leads to better health for all household members, including newborns. The health of newborns must be considered with that of their mothers. Causes related to pregnancy and delivery account for substantial numbers of newborn deaths.

Very little has so far been done in the Kyrgyz Republic to reduce neonatal deaths, partly because the data has only recently disclosed how significant the share of neonatal deaths in infant deaths actually is. The ADB-financed CBECDP includes major interventions for reducing mortality in the post-neonatal period, but does not have sufficient interventions targeted at newborns. The proposed grant will work closely with CBECDP to provide the complete set of interventions required for reducing deaths of infants in the neonatal and postneonatal periods. Interventions that prove successful will be included under the second CBECDP.

SITUATION OF NEONATAL MORTALITY IN OSH

Causes of Neonatal Mortality

The government requested ADB to pilot the project in Osh, which is the most populous oblast (1,247,000) with the highest IMR in the country. The proposed grant will focus on the four poorest *raions* in Osh, which are also covered by CBECDP: Alay, Chon-Alay, Kara-Kulja and Nookat. These *raions* had a poverty rate above 70% in 2002,⁵ and showed the highest IMRs in Osh. The key relevant indicators of the four *raions* are presented in Table 1.

Table 1. The Neonatal Mortality Rate and Other Key Indicators in the Four Raions 2003

	Population	Births	Still Births	LBW %	NMR
Alay	68,800	943	12	5.8	12.7
Chon Alay	23,700	693	4	9.6	2.9
Kara Kulja	63,500	1,140	16	6.3	17.5
Nookat	205,600	4,122	36	4.7	5.8

LBW = low birth weight, NMR = neonatal mortality rate.

Source: Government data.

The main direct causes of neonatal deaths in Osh are prematurity, asphyxia, congenital anomalies, and birth trauma (Table 2). The major contributory factor is LBW. While the overall early NMR⁶ was 8.2 in the four participating *raions* in 2003, it was 105.7 for LBW newborns.

Table 2. Causes of Neonatal Deaths in Osh in 2003

Pregnancy Complication	Contribution to Neonatal Deaths (%)
Prematurity	42.2
Asphyxia	24.4
Congenital Anomalies	17.8
Birth Trauma	8.9
Intrauterine Infections	6.7
Total	100.0

Source: Government data.

These findings suggest that the quality of health care services and poor maternal health contribute to pregnancy complications and neonatal mortality. Reducing LBW and premature deliveries through improved maternal health will increase newborns' chances of survival. Many neonatal illnesses are preventable and can be treated if they are detected early and proper PHC and referrals are provided. The proposed grant intends to focus on (i) improving the capacity of the PHC and first referral health care systems to manage pregnancies, deliveries, and neonatal illnesses; and (ii) improving maternal health care to reduce pregnancy complications and premature/LBW deliveries that contribute to newborn deaths.

⁵ The 2002 social passport data.

⁶ The mortality rate during the first 7 days of birth.

Antenatal, Delivery, and Neonatal Care at Primary and First Referral Health Facilities

Rural health care is provided by PHC facilities comprising primary health care posts known as FAPs, FGPs, central raion hospitals (CRHs) and their affiliates. Midwives or nurses visit pregnant women on average once a month, and visit newborns at home after birth. Most women visit health care facilities for antenatal care. Almost all deliveries take place at health facilities with health workers' assistance; 70-80% of deliveries take place at CRHs or their affiliates and the rest at FAPs. Transportation and telephone communication are problems for remote health facilities. As a result, women suspected of experiencing obstetric risk are generally referred early to CRHs for hospitalization until they deliver. Early referral may be the best option available now for remote areas.

PHC facilities and workers are in place in rural areas and are delivering services despite difficult conditions. Quality care leaves significant scope for improvement. First, knowledge and detection of early danger signs in pregnancy, and neonatal illnesses, need improvement. Few health care workers received refresher training on antenatal, delivery, or neonatal care beyond the initial preservice training. Health care workers also lack basic equipment and tools necessary to detect early danger signs. For example, hypertension is a common complication in Osh, but many of FGPs and FAPs lack the equipment to detect it.

Delivery and neonatal care at the *raion* and affiliated hospitals also need to be improved. Hygiene should be reinforced, and retraining on newborn resuscitation and management of asphyxia is needed. The management of premature and LBW infants needs to be emphasized. While the WHO and United Nations Children's Fund (UNICEF) assisted the government in piloting the promoting effective perinatal care (PEPC) program in Chui oblast, very little of PEPC suggestions is known to health workers in Osh. For example, PEPC introduced "kangaroo-care," which involves constant skin-to-skin contact between mother and newborn. This is a highly cost-effective way to prevent hypothermia, especially for LBW infants. Kangaroo care is known to only a few physicians, however, and has not been practiced in Osh. MOH is currently revising the PEPC to be more useful for outpatient care, and is also expanding the training on neonatal care. The grant will provide revised and extended training to all neonatologists, obstetricians, midwives, feldshers, and nurses in the four *raions*, followed by intensive on-the-job supervision. The grant will develop trainers in Osh as part of capacity building for oblast health care. Trainers' training will be conducted in collaboration with WHO, UNICEF, and United States Agency for International Development (USAID).

The CRHs are generally well equipped as they have received recent equipment for delivery rooms and neonatal care units. By contrast, some of the more basic, less costly equipment is old or lacking. Across the board there is a lack of medical supplies, and essential pharmaceuticals and sanitation facilities are inadequate. The situation is expected to improve as the copayment system was introduced in Osh in 2004. Copayments will allow for formal cost recovery (compared to prevalent informal payment) and investment of recovered costs in health care items in the hospitals. The governor of Osh agreed to earmark budget funds for these essential supplies for the *raions*.

Maternal Health and Neonatal Mortality

Numerous factors—including maternal anemia, hypertension, and repeated pregnancies—trigger premature delivery and LBW. Health workers at all levels in the Kyrgyz health care system singled out maternal anemia as the foremost risk encountered during pregnancy.

Available data confirms their concern: 60-90% of women who delivered at CRHs or Osh Central Hospital were anemic in 2003. Anemia was the top cause of still births at Osh central hospital, followed by preterm delivery and maternal hypertension.

Table 3. Causes of Still Births at Osh Central Maternity Hospital (2002)

Pregnancy Complication	% Contribution to Still Births^a (n=33)
Maternal Hypertension	36.4
Anemia	60.6
Kidney Disease	6.1
Post-term Delivery	9.1
Preterm Delivery	42.2

^aThese percentages are not mutually exclusive, mothers may present with more than one diagnosis.

Source: Osh Central Hospital.

Further data analysis showed that pregnancy outcomes dramatically worsen for moderately or severely anemic women compared to women who are mildly anemic or not anemic at all.

Table 4. Key Pregnancy Outcome Indicators by Level of Maternal Anemia in Project Raions

Anemia Degree	Number of Cases (%)	LBW (%)	Prematurity (%)	Still Birth (/1000)	Mortality for the First 7 Days (/1000)	Asphyxia (%)
Not Anemic	374 (9.9)	15 (4)	8 (2.1)	0	0	44 (11.8)
Mild	1091 (32.1)	82 (7.5)	85 (7.8)	12 (11.0)	20 (18.5)	118 (10.8)
Moderate or Severe	2304 (67.9)	167 (7.2)	167 (7.2)	34 (14.8)	29 (17.2)	551 (23.9)

LBW = low birth weight.

Source: Central raion hospitals.

The negative impact of maternal anemia on pregnancy and newborn health is a well established fact. Anemia has been associated with early and late reproductive loss and is an important contributing factor to LBW. The high prevalence of anemia in pregnancy is a result of a complex and interrelated set of circumstances. Health specialists in the Kyrgyz Republic suspect that anemic women suffer from other micronutrient deficiencies as well, and that anemia reflects overall poor nutrition among women. The general diet is poor in iron, and iron-fortified wheat flour has not yet reached the public in Osh. High consumption of tea interferes with iron absorption. Prevalent iodine deficiency disorders (IDD) also contribute to anemia, as do parasitic infestations.

Mothers' knowledge about nutrition and health—including danger signs in pregnancy and of neonatal illnesses—is inconsistent. Few pregnant women take iron supplements because they are not available, unaffordable, or women simply do not know how significant the problem is. Mothers in the project *raions* expressed interest in receiving more information on health and nutrition through mass media, or health care workers. Experience shows that school children

are good messengers of health and nutrition information, and NGOs can play a useful role in social mobilization and educating communities.

MOH requested that the grant support a roundtable to discuss maternal health, especially maternal anemia, to review the problem and past experiences, and to develop new approaches to tackling the problem. A further study on risks during pregnancy will be conducted in the first year of the grant implementation. The grant will also support activities for improving maternal health through an IEC campaign. A pilot anemia prevention program will also be developed during the grant based on the roundtable and studies.

4. Innovation

The grant will be the Kyrgyz Republic's first attempt to reduce NMR. Historically, pregnancies and neonatal illnesses have been treated as clinical and tertiary care matters. Although PHC is available, not enough attention has been paid to prevention and detection of pregnancy complications, or detection and treatment of neonatal illnesses in which PHC should play a major role. The proposed grant intends to change this tertiary-care-oriented approach.

The grant will target the reduction of neonatal mortality through an integrated approach that spans community intervention, primary and first referral preventive services, and curative services. This change in approach is based on an essential newborn care framework developed based on global experience, but also based on the analysis of available Kyrgyz data. The health care system routinely collects large amounts of data that has not been effectively analyzed or utilized. The key monitoring and evaluation indicators for the grant have been selected from among routinely collected data to ensure feasibility and sustainability of monitoring, as well as to provide an opportunity for health workers to use the data they collect.

The grant involves a wide range of partners, including communities, NGOs, and health workers. The project intends to mobilize the community and health care providers to combat a significant contributing factor to newborn deaths.

The project's success will depend on integrating preventive and curative approaches toward this serious problem, and will include:

- (i) A community awareness campaign to support a health promotion initiative focused on prevention and treatment of maternal health problems, early danger signs of pregnancy, and early signs of neonatal illness
- (ii) A competency-based training program for primary and secondary health care providers
- (iii) An upgrade of technical and professional capabilities of the health outreach program for pregnant women.

The implementation of a comprehensive approach in the country is new and promising, and should respond to the need to explore effective solutions to one of the most menacing health problems in the perinatal setting.

5. Sustainability

The grant focuses on capacity building for health care workers to deliver antenatal, delivery, and neonatal care. It also builds awareness of pregnant women, secondary school children

and communities to improve maternal health. Training of health care workers will be followed by regular supervision until the workers are able to practice what they learned. By training health specialists in Osh to be trainers, the grant will develop the capacity of Osh health care system, and will reduce dependency on overloaded, Bishkek-based trainers. Training will be organized by an existing institute and will be integrated into its regular refresher training. An IEC campaign targeted at women, communities, and others will communicate the message until it is fully understood. By the end of the project, the capacity of health workers is expected to have reached sustainable levels.

6. Participatory Approach

Local governments, MOH, pregnant women, communities, and health workers—especially outreach workers—were consulted during the preparation of the grant proposal. Focus group meetings were organized with health care workers and pregnant mothers in the project *raions* and their opinions are reflected in the project design. The findings from the fieldwork were intensively discussed with the MOH working group, and validated by MOH data. Local NGOs will be mobilized during grant implementation for social mobilization and education on nutrition.

For the maternal health component, one of the key interventions is an IEC campaign to improve awareness about nutrition, especially during pregnancy. NGOs and community-based organizations (CBOs) will be involved in information dissemination. Community-based activities may also be supported under the village initiative fund established under CBECDP.

No Japanese NGOs are working in Osh, so there is no opportunity to involve them.

7. Coordination

A donor coordination meeting was organized to discuss the grant design and coordination of training for health workers. The proposed grant will receive technical guidance from WHO in the design of training modules and training trainers, and trainers' training will be conducted in coordination with UNICEF, USAID, and WHO. WHO is exploring the possibility of including training for master trainers in its 2004 work program to accommodate a request from partner agencies.

ADB and the Japan International Cooperation Agency (JICA) have had regular coordination meetings in the health sector. JICA plans to provide equipment to the pediatrics department of Osh Central Hospital, while the proposed project covers services up to the CRH level. Thus, support of ADB and JICA will be complementary. The World Bank has been the major investor in health sector reform, but has no specific investment on child health or interventions for reducing neonatal mortality.

8. Detailed Cost Table

Please refer to Appendix 1 for the detailed cost estimates.

C. Linkage to ADB Strategy and ADB-Financed Operations

1. Linkage to ADB Strategy

Document	Document Number	Date of Last Discussion	Objective(s)
ADB Policy for the Health Sector		1999	The policy is intended to make ADB's efforts in addressing challenges in the health sector more effective and efficient.
Millennium Development Goals (MDGs)		2001	MDGs include reducing the maternal mortality ratio (MMR) and infant mortality rate. Reduction of IDD and IDA will contribute to the reduction of MMR and IMR. ADB is committed to achieving the MDGs.
Kyrgyz Poverty Reduction Strategy Paper 2003-2005		2003	The introduction of the WHO live birth definition to improve medical assistance rendered to pregnant women and upgrade care of low birth weight neonates.
Kyrgyz Republic Country Strategy and Program (CSP)		2004-2006	CSP objectives include assisting the government in MDGs and support for human development.

2. Linkage to Specific ADB-Financed Operation

Project Name	Community-Based Early Childhood Development Project
Project Number	2007 KGZ
Date of Board Approval	29 September 2003
Loan Amount (\$ million)	10,500,000

3. State the above-mentioned project's development objective

Project's Development Objective:

The goal of the project is to improve the health, nutrition, and psychosocial development of children from birth up to 8 years of age in the 12 poorest districts. Specific objectives are to (i) reduce IMR and under-5 mortality rate, (ii) reduce IDD, (iii) reduce IDA both among children and pregnant women, and (iv) improve the psychosocial development of preschool children.

4. List the project's main components

No.	Component Name	Brief Description
1.	Child Health and Nutrition	<p>Sustaining universal immunization of children. The project will support the purchase of vaccines and procure equipment necessary for maintaining an effective cold chain from participating district centers to PHC facilities.</p> <p>Reducing child mortality. The project will support the training of PHC workers (feldshers) on integrated</p>

No.	Component Name	Brief Description
		<p>management of childhood illnesses in the project districts. The project will also support essential drugs and medical supplies required by PHC facilities to implement IMCI, and rehabilitation of PHC facilities.</p> <p>Reducing IDD and IDA. The project will finance social mobilization, especially monitoring of iodized salt by communities and retailers. The project will provide salt testing kits and IEC materials.</p>
2.	Early Childhood Care and Education	Community- and home-based preschools. The project will support (i) community- or home-based preschool programs in the community; (ii) one resource kindergarten per <i>raion</i> as a resource center for community- or home-based preschools; (iii) providing instructional materials and supplies necessary for children's activities, as well as other necessary supplies to village authorities; and (iv) training for teachers of kindergarten preparatory courses and community- or home-based preschools, and monitoring their performance.
3.	Capacity Building	Strengthening village authorities' capacity. Village authorities' capacity to plan and implement project activities will be strengthened by training on management and by child family coordinators (CFCs).

5. Rationale for Grant Funding versus ADB Lending

The proposed grant focuses on a very specific issue, reduction of neonatal mortality. Reducing neonatal mortality is a significant challenge worldwide. While a general list of recommended interventions for reducing NMR exists, the feasibility and effectiveness of each intervention on reducing NMR varies by country. Piloting the selected interventions with JFPR support is needed to identify the effective set of interventions before assisting the government in reducing NMR through ADB lending operations.

D. Implementation of the Proposed Grant

1. Name of the Implementing Agency

The implementing agency is MOH, which is also the executing agency. The GIU will be located in the Osh project coordination office of CBECDP. MOH will appoint a project director. The MOH working group for CBECDP will be responsible for providing technical guidance to the proposed grant. All procurement under the JFPR grant will be conducted in accordance with ADB's *Guidelines for Procurement*. Consultants will be recruited by ADB in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements acceptable to ADB for the recruitment of domestic consultants to provide the services for implementation, management, and progress monitoring of the JFPR grant. Detailed implementation arrangements are in Appendix 3.

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Supplies	Inadequate access to affordable iron supplements	Review of drug prices and distribution by MOH
Health Reform	Slow progress in copayment system	Continuous dialogue with the government in coordination with other major donors (World Bank, WHO)

3. Incremental ADB Costs

Component	Incremental Bank Cost
Amount requested	\$50,000
Justification	The incremental costs will be utilized for developing a monitoring and evaluation guideline and format, and for assisting the government in analyzing the data.
Type of work to be rendered by ADB	One additional supervision mission per year covering the remote areas, with the support of a local or international consultant, depending on problems that arise during implementation. Improving the quality of monitoring and evaluation activities.

4. Monitoring and Evaluation

Key performance indicators and targets were selected in close consultation with the MOH working group. A 20% reduction of NMR by 2009 is required if the Kyrgyz Republic is to meet the relevant MDG.⁷

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for M&E
Neonatal mortality rate	MOH statistics	20% reduction from the 2004 level by 2009
Incidence of still births	MOH statistics	20% reduction from the 2004 level by 2009
Prevalence of anemia in pregnant and women	MOH statistics, and sample survey	20% reduction of maternal anemia from the 2004 level by 2009
Incidence of LBW, premature deliveries	MOH statistics, sample survey	20% reduction from the 2004 level by 2009
Incidence of neonatal infections	MOH statistics, sample survey	20% reduction from the 2004 level by 2009

⁷ The government statistics on infant mortality rate and neonatal mortality rate will be adjusted to the World Health Organization's standard definition of live births in 2004. The grant will use the 2004 NMR figures as a baseline.

5. Estimated Disbursement Schedule

Fiscal Year (FY)	Amount (\$)
FY 1	150,000
FY 2	350,000
FY 3	350,000
FY 4	150,000
Total Disbursements	1,000,000

Appendixes

1. Cost Estimates
2. Fund Flow Arrangement
3. Implementation Arrangements

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

Inputs and Expenditure Category	Component 1	Component 2	Component 3	Total (Input)	Percent
1. Civil Works					
2. Equipment and Supplies	89,000	80,000	0	169,000	15.6
3. Training, Workshops, Seminars, Roundtable Meeting	108,357	62,000	21,000	191,357	17.7
4. Consulting Services	177,600	64,800	75,000	317,400	29.3
5. Project Management		0	88,320	88,320	8.1
6. Other Project Inputs		130,000	0	130,000	12.0
7. Contingencies				103,923	9.6
Subtotal JFPR Financed	374,957	336,800	184,320	1,000,000	92.3
Government Contribution	28,800	22,000	19,100	69,900	6.5
Other Donors' Contributions					
Community Contributions		13,000		13,000	1.2
Total Estimated Costs	403,757	371,800	203,420	1,082,900	100.0
Incremental Costs				50,000	

JFPR = Japan Fund for Poverty Reduction.
Source: Asian Development Bank estimates.

Table A1.2: Detailed Cost Estimates
(\$)

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
Component A. Improving Primary and First Referral Health Care Services				Subtotal	403,757	374,957		28,800		
1.1	Equipment and Supplies				106,800	89,000		17,800		
1.1.1	Home visit kits (95+53)	Health workers	150	72	10,800	9,000	IS	1,800		
1.1.2	Visual material, brochures, posters	Lump sum			96,000	80,000	LCB	16,000		
1.2	Training, Workshops, Seminars, and Roundtable				119,357	108,357		11,000		
		Lump sum								
1.2.1	Launching roundtable		1	3,000	3,000	3,000				
1.2.2	Study		3	5,000	15,000	15,000				
1.2.3	Perinatal, antenatal, and neonatal training	Number	0	0	80,626	80,626				
1.2.3.1	Trainees				50,688					
1.2.3.2	Trainers				29,938					
1.2.4	Supervision after training				3,881	3,881				
1.2.5	Training of trainers				5,850	5,850				
1.2.6	Training premise				11,000			11,000		
1.3	Consulting Services				177,600	177,600				
1.3.1	International Consultants				168,000	168,000				
1.3.1.1	Neonatologist	Person-months	4	22,000	88,000	88,000				
1.3.1.2	Obstetrician	Person-months	4	20,000	80,000	80,000				
1.3.2	Local Consultants				9,600	9,600				
1.3.2.1	Neonatologist, Obstetrician, etc.	Person-months	12	800	9,600	9,600				
Component B. Improving Maternal Health Care and Practices in the Community				Subtotal	371,800	336,800		22,000	13,000	
2.1	Equipment and Supplies				96,000	80,000		16,000		
2.1.1	Visual material, brochures, and posters	Lump sum			96,000	80,000	LCB	16,000		

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Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
2.2	Training, Workshops, Seminars, and Roundtable Meetings				68,000	62,000		6,000		
2.2.1	Study	Lump sum			50,000	50,000				
2.2.2	Roundtable on Maternal Anemia	Lump sum	2	6,000	12,000	12,000		6,000		
2.2.3	Roundtable premises				6,000					
2.3	Consulting Services				64,800	64,800				
2.3.1	International Consultants				60,000	60,000				
2.3.1.1	Nutritionist		3	20,000	60,000	60,000				
2.3.2	Local Consultants				4,800	4,800				
2.3.1.2	Nutritionist etc.		6	800	4,800	4,800				
2.4	Other Project Inputs				143,000	130,000			13,000	
2.4.1	NGO (3 NGOs x 4 raions x 12 x 4)	Number	10	5,500	55,000	50,000			5,000	
2.4.2	Pilot initiatives	Lump sum	2	44,000	88,000	80,000			8,000	
Component C. Grant Management, Monitoring, and Evaluation					Subtotal	203,420	198,350		19,100	
3.1	Equipment and Supplies				16,836	14,030	LCB	2,806		
3.2	Review and Final Conferences	Lump sum	3	7,700	23,100	21,000		2,100		
3.3	Consulting Services				79,000	75,000		4,000		
3.3.1	Baseline surveys	Lump sum			20,000	20,000				
3.3.2	Endline surveys	Lump sum			20,000	20,000				
3.3.3	Office space for surveyors				4,000					
3.3.4	Local consultants				5,000	5,000				
3.3.4.1	Short-term (procurement specialist, etc)	Person-months	10	500	5,000	5,000				
3.3.5	External Audit	Person-months	3	10,000	30,000	30,000				
3.4	Management and Coordination of this Component				101,320	88,320		13,000		

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Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
3.4.1	Component 1 – Staff	Person-months			60,000	60,000				
3.4.1.1	Project Manager		48	500	24,000	24,000				
3.4.1.2	Finance Specialist		48	400	19,200	19,200				
3.4.1.3	Health Specialist (Liaison)		24	400	9,600	9,600				
3.4.1.4	Office Manager		48	150	7,200	7,200				
3.4.2	Travel and Per Diem				6,720	6,720				
3.4.2.1	Transportation		48	80	3,840	3,840				
3.4.2.2	Hotel Accommodation		48	40	1,920	1,920				
3.4.2.3	Per Diem		48	20	960	960				
3.4.3	Operational Costs				34,600	21,600				
3.4.3.1	Communication		48	300	14,400	14,400				
3.4.3.2	Consumables		48	150	7,200	7,200				
3.4.3.3	Office Space				13,000					
Components 1 to 3 = Subtotal					978,977	910,107		69,900	0	13,000
Contingency					103,923	89,893				
Total Costs					1,082,900	1,000,000		69,900	0	13,000
Incremental Costs										
	Consultants	Person-months	2.5	20,000	50,000	50,000				

IS = international shopping, JFPR = Japan Fund for Poverty Reduction, LCB = local competitive bidding, NGO = nongovernment organization.

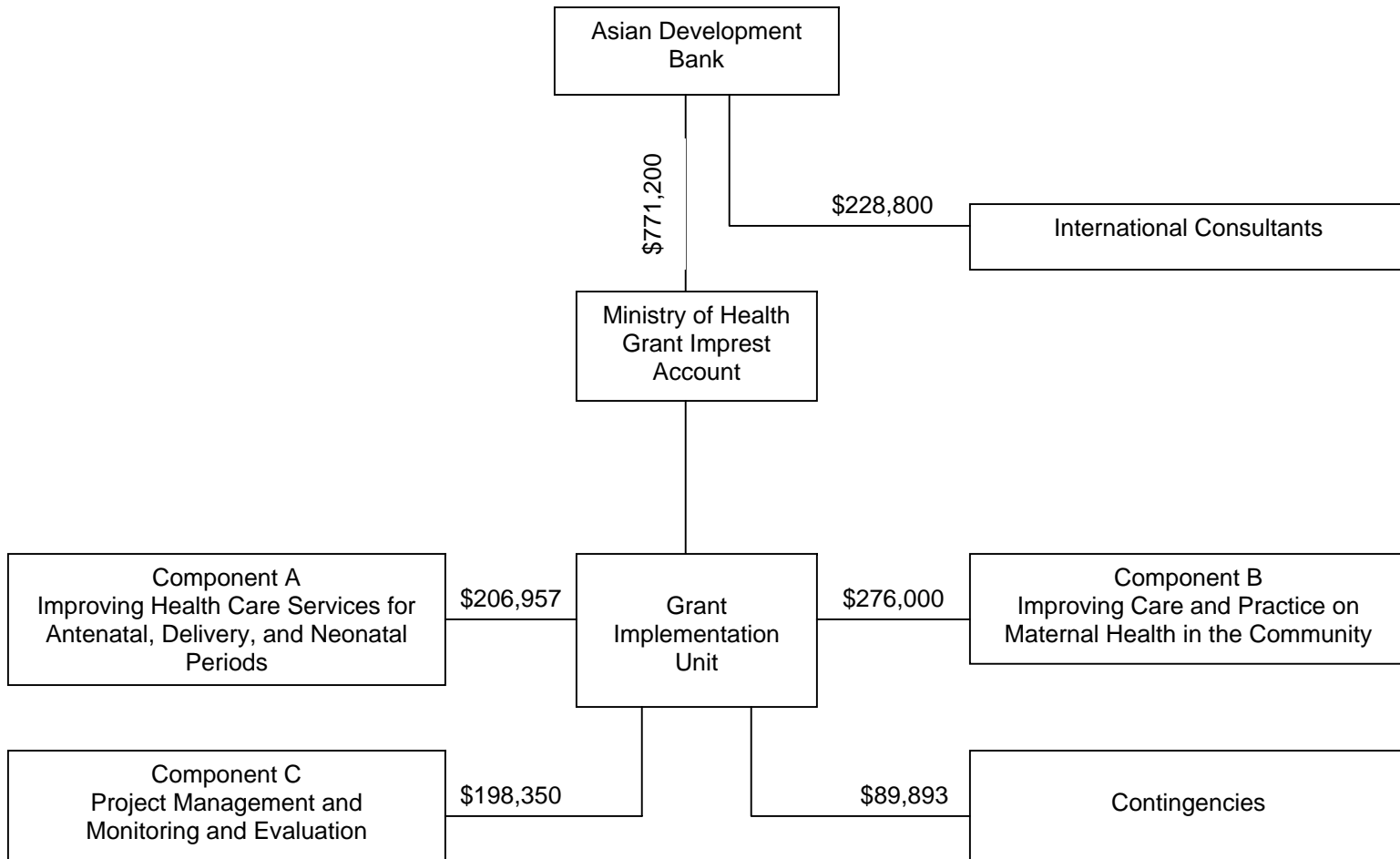
Source: Asian Development Bank estimates.

FUND FLOW ARRANGEMENT

1. An imprest account will be established after the letter of agreement for the grant to be financed from the Japan Fund for Poverty Reduction (JFPR Letter of Agreement) has been signed. The account will be maintained and operated by the Ministry of Health (MOH), the executing agency, in Bishkek at a bank approved by the Ministry of Finance and acceptable to the Asian Development Bank (ADB). This aims to facilitate day-to-day local expenditures of the grant. The JFPR imprest account will be managed by the MOH, initially based on the first six-month activity plan and related budget, and afterwards based on the approved annual work plan and budget. The grant implementation unit (GIU) will manage the expenditures for the grant and submit all relevant documents to MOH for liquidation and replenishment of the imprest account by ADB. It will also receive copies of all financial statements and audit reports.

2. ADB will initially channel \$50,000 to the imprest account as advance for day-to-day project implementation during the inception period, and will replenish funds every 3-6 months to the imprest account, based on the replenishment requests from the GIU through the executing agency and in accordance with ADB's statement of expenditures procedure. Total outstanding advances to the imprest account should not exceed 10% of the JFPR amount. The statement of expenditures procedure will be used for reimbursement and replenishment under \$3,000 to ensure speedy project implementation. Implementation arrangements, such as the flow, replenishment, and administrative procedures will be detailed in the grant implementation manual, and be established between ADB and the government through the JFPR Letter of Agreement. The schematic fund flow for the JFPR grant is shown in Figure A2.

Figure A2: Fund Flow Arrangements for the Project



IMPLEMENTATION ARRANGEMENTS

A. Project Management

1. The executing agency will be the Ministry of Health (MOH). The MOH working group for the Community-Based Early Childhood Development Project (CBECDP) will provide technical assistance and guidance for the proposed grant.
2. The grant implementation unit (GIU) will be located in the Oblast Project Coordination Office that has been established under CBECDP. The GIU will be staffed by a project manager, a financial specialist, and an office manager financed by the grant. A liaison unit will be established in Bishkek to facilitate coordination of the project activities between the field and national levels. GIU will be allowed to hire local consultants as necessary with prior approval of ADB.

B. Implementation Schedule

3. The grant will be implemented over 4 years, from the last quarter of 2004.

C. Consultants, NGOs, and Community-Based Organizations

4. GIU may propose to engage local consultants with specific terms of reference. Upon ADB's approval of the terms of reference, the GIU will select and engage domestic consultants in accordance with ADB's *Guidelines on Use of Consultants* or other procedures acceptable to ADB for the selection and engagement of domestic consultants. GIU will engage nongovernment organizations (NGOs) or other community-based organizations (CBOs) for social mobilization and information, education, and communication campaigns, in accordance with procedures acceptable to ADB. GIU will propose NGOs or CBOs based on criteria agreed with ADB, and submit TOR and contracts for ADB's review and approval.
5. ADB will select and engage individual international consultants. The international consultants will report to the executing agency and ADB. The work program of international consultants will be agreed among the executing agency, ADB and the consultants. The proposed international consultants are:
 6. A neonatologist (4 person-months) will review the situation of neonatal mortality and illnesses, and case management of neonatal illnesses in the participating *raions*; propose measures for improvements; assist the working group and GIU in developing training modules; develop a checklist for performance monitoring; and design an evaluation study for the improvement of neonatal care.
 7. An obstetrician (4 person-months) will review obstetric practices in raion hospitals, antenatal care, and maternal health; propose measures for improvements; train selected obstetricians on site on improved practices; and assist the working group and GIU in improving or developing training modules on antenatal care, and developing a checklist for performance monitoring.
 8. A nutritionist (3 person-months) will examine the nutrition status of pregnant women; study causes of high prevalence of anemia; propose a cost-effective program for reducing

maternal anemia; and help the development of a pilot for reducing the prevalence of maternal anemia.

D. Training

9. Training courses for health workers on antenatal, delivery, and neonatal care will be conducted by qualified trainers who have themselves been trained in accordance with modules adopted by MOH. The grant will support trainer's training for 10 staff based in Osh. Organization of the training in Osh will then be contracted out to an institution in Osh with experience training health care workers. The selection of a training institution will be competitive, in a manner acceptable to ADB. All neonatologists, obstetricians, FGP doctors, feldshers (primary health care workers), midwives, and patronage nurses in the four participating *raions* will be trained under the grant. Additional training will be organized for health workers of Osh Central Hospital. In total, about 570 health workers will be trained. The Osh-based trainers will be initially assisted by national trainers to ensure the quality of training.

10. Supervision after training is integral part of the training. Each of central raion hospitals and affiliate hospitals will receive 4 two-day supervision visits. Each visit will be conducted by a team of 2 supervisors, who will cover various aspects of antenatal, delivery, and neonatal care conducted at the hospitals, and PHC facilities. The first few supervision visits will be conducted by a pair of a local and a national trainer to ensure the quality of supervision.