

ASIAN DEVELOPMENT BANK

TAR:INO 38117

**TECHNICAL ASSISTANCE
TO THE
REPUBLIC OF INDONESIA
FOR PREPARING THE
URBAN NUTRITION PROJECT**

September 2004

CURRENCY EQUIVALENTS

(as of 03 September 2004)

Currency Unit	–	rupiah (Rp)
Rp1.00	=	\$0.000108
\$1.00	=	Rp9,275

ABBREVIATIONS

ADB	–	Asian Development Bank
ADTA	–	advisory technical assistance
MDG	–	Millennium Development Goal
MOH	–	Ministry of Health
MDG	–	Millennium Development Goal
NGO	–	nongovernment organization
RRP	–	report and recommendation of the President
SPAR	–	subproject appraisal report
TA	–	technical assistance

TA CLASSIFICATION

Poverty Classification	–	Core poverty intervention
Sector	–	Health, nutrition, and social protection
Subsector	–	Nutrition
Thematic	–	Sustainable economic growth, inclusive social development

NOTES

- (i) In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. As requested by the Government of Indonesia (the Government) an advisory technical assistance (ADTA) for public health and nutrition¹ in the amount of \$500,000 has been implemented since September 2003. The purpose of the ADTA was to (i) design a model of public-private partnerships in the nutrition sector, and (ii) prepare a project design for improved urban nutrition management in three cities² in Indonesia. During ADTA implementation the need for a comprehensive sector strategy for urban nutrition became apparent. The Government requested the Asian Development Bank (ADB) for additional technical assistance (TA) to prepare the Urban Nutrition Project³ for six cities.⁴ The Project aims to help meet Millennium Development Goal (MDG) 1 (eradicate extreme poverty and hunger) and target 4 (reduce prevalence of underweight children under 5 years of age). The scope of work, implementation arrangements, financing arrangements, and time frame of this TA⁵ to prepare the Project were discussed with the Government during the final Review Mission for the ADTA undertaken in May 2004. Appendix 1 provides the logical framework for the Project.

II. ISSUES

2. Recent data⁶ for Indonesia show that improvement in nutritional status has steadily slowed down over the last 10 years. Stunting or low height for age remains a problem for 33.8% of children, and wasting or low weight for height is estimated to occur in 11.4%. Urbanization exacerbates the transition toward sedentary lifestyles and high-fat diets that carry potential risk factors for diet-related diseases. A unique issue emerging from this transition is the double burden of under- and overnutrition in the same household. In urban slum areas, nutritional surveillance data suggest that undernutrition occurs in 22% of households with obese mothers. Given that diet-related diseases are spreading rapidly among the urban poor and the fact that current nutrition strategies are not appropriate to respond to over- and undernutrition, policymakers and health-care providers are increasingly under pressure to develop innovative nutrition strategies especially for poor urban communities.

3. Existing nutrition policies and programs are based on the paradigm that malnutrition is primarily caused by a lack of protein and energy due to insufficient food intake and supply, which affects largely the poor rural population. Nutrition issues in urban areas have been widely neglected so far. Nutrition interventions such as growth monitoring and dietary counseling largely address the reduction of protein and energy deficiency and focus to a lesser extent on dietary quality, which is the key in reducing urban malnutrition problems. Such services are provided in health centers and clinics, which prevent many of the urban poor to utilize such services due to high opportunity costs. Indonesia has limited nutrition outreach or community-based programs for nutrition education. In 2003, about 3% of the total health budget was spent on nutrition, of which 80% was allocated to distribution of complementary feeding⁷ alone, leaving a limited budget for essential preventive nutrition and educational interventions. Under

¹ ADB. 2003. *Technical Assistance to the Republic of Indonesia on Public Health and Nutrition*. Manila. TA implementation was completed on 30 June 2004.

² Makassar, Medan, North Jakarta.

³ A project preparatory TA for preparing the Project was included by the Country Program Confirmation Mission in April 2004, with an ensuing loan of \$40 million scheduled for approval in 2005.

⁴ Selection of cities will be finalized in consultation with Government taking into account ADB's criteria for limiting the geographical scope of projects.

⁵ The TA first appeared in the *ADB Business Opportunities* (Internet version) on 30 May 2004.

⁶ RAND. 2004. *Indonesian Living Standards Before and After the Financial Crisis*. Singapore.

⁷ The process of introducing semisolid foods into the diet of young children, in addition to continued breastfeeding, from 6 months of age.

decentralization, the Ministry of Health (MOH) established minimum service standards⁸ and guidelines on nutrition and food quality, and monitors the performance of districts and provinces, which are responsible for implementing nutrition programs. Given the limited technical and human resource capacity to plan and manage nutrition programs, current interventions are not adapted to local realities, and nutrition programs have not been adjusted to the specific needs of the urban poor.

4. The poorer the household the larger the proportion of income spent on food.⁹ In some poor areas of Jakarta, households spend about 70% of their income on food-related expenses. Unlike in rural areas, where food is prepared at home, the urban poor have to purchase processed food that is of inferior dietary quality. Results of the ADTA confirmed that urban poor communities do not necessarily face a shortage of food but have to survive on nutritionally inferior food, purchased from street vendors. Food vendors often use inadequate equipment and unsafe additives. While laws and regulations on food sanitation exist, compliance with them is inadequate. Improved monitoring systems and upgrading of local food laboratories are required to increase food safety.

5. Nutritional deficiencies of poor urban dwellers can be addressed through fortification of processed foods with vitamins, minerals, and calories. Food fortification is already key in meeting Indonesia's national nutrition goals of reducing anemia and vitamin A and certain mineral deficiencies. Stronger public-private partnerships are required to go beyond iron fortification of wheat flour¹⁰ to, for instance, fortification of palm oil with vitamin A. Research indicates that food fortification programs are the most cost-effective interventions for addressing nutritional deficiencies, followed by education for dietary behavioral change. Given the complexity of urban malnutrition, additional public-private alliances beyond food fortification and food safety must be explored.

6. The World Bank funded the Iodine Deficiency Control Project in Indonesia, which was completed in 2003. The World Bank recently finalized a nutrition sector review, which highlighted the need for expanding food fortification and food supplementation as a key strategy in fighting micronutrient deficiencies. The United Nations Children's Fund (UNICEF) has supported various micronutrient initiatives such as salt iodization, iron fortification of wheat flour, as well as supplementary feeding programs and vitamin A distribution. The United States Agency for International Development (USAID) is funding the distribution of wheat flour by the World Food Program (WFP) to poor rural and urban communities in selected areas. Most nutrition programs in Indonesia focus on reducing rural malnutrition and, therefore, largely neglect the growing malnutrition among urban poor communities. Based on ADB's previous sector work,¹¹ the TA will help operationalize recommendations to reduce micronutrient deficiencies as part of a new strategic public-private sector approach to tackle urban malnutrition.

⁸ Minimum service standards for community nutrition include, among others, distribution of Vitamin A capsules to children under five years of age, distribution of iron tablets to pregnant women, supplementary feeding for infants of poor families and therapeutic feeding for children under five years.

⁹ Vulnerability and poverty in urban areas differ significantly from those in rural areas in four distinct ways: (i) the urban poor live in a cash economy and purchase processed food rather than grow their own, (ii) livelihood opportunities are limited, (iii) informal safety nets to help people cope in times of shock are different, and (iv) environmental conditions can be harmful to the health.

¹⁰ While iron fortification of wheat flour is already in place, regulatory mechanisms have to be established for quality assurance.

¹¹ ADB. 2001. *Regional Initiative to Eliminate Micronutrient Malnutrition in Asia through Public-Private Partnership*. Manila; ADB 1998. *Regional Study of Nutrition Trends, Policies, and Strategies in Asia and the Pacific*. Manila.

7. Nutritional status is a key indicator of poverty. Policies and programs to improve nutrition outcomes are an integral part of social and economic development. Nutrition transition demands a shift from narrowly defined nutrition programs and policies toward multisectoral program approaches and alternative service delivery strategies that respond to the complexity of urban malnutrition. Therefore, the Government has identified the reduction of urban malnutrition as one important pillar of the national nutrition strategy. Given the effectiveness of improved nutrition as a means of reducing mortality, preventing forms of mental and physical retardation, and minimizing productivity losses,¹² the development of new multisectoral strategies using public-private alliances, which address dietary quality, food safety, food fortification, and behavioral change, are required to prevent urban malnutrition and diet-related diseases.

III. THE TECHNICAL ASSISTANCE

A. Purpose and Output

8. The TA will help the Government identify and prepare a project in six cities, comprising (i) integrated nutrition programs for urban poor communities through public-private partnerships and community-based schemes; (ii) programs and policies to address urban malnutrition, especially by strengthening and reinforcing food fortification and food safety; (iii) support for institutional and human resource capacity development of central Government and regional governments to plan and manage integrated urban nutrition programs; and (iv) provision of social infrastructure and equipment to implement urban nutrition programs. The objective of the Project is to implement an integrated nutrition program for the urban poor in selected cities.

B. Methodology and Key Activities

9. Based on the ADTA results, the TA will complete a comprehensive analysis of urban nutrition issues and subproject appraisal reports (SPARs) for six cities. Cities will be chosen based on their fiscal capacity and demonstrated commitment to combat urban malnutrition. The TA team, in collaboration with the MOH technical team, will organize national and regional workshops, involving all relevant stakeholders, to prepare SPARs and recommendations on urban nutrition strategies.

10. In the selected cities, the TA will help local governments prepare integrated urban nutrition interventions using stakeholder consultations and the results of a baseline study on food consumption. The TA will focus on project components like human and institutional capacity building needs in the public and private sectors; strengthening management information systems; developing behavioral change programs for urban communities; restructuring urban health services for improved nutrition management and alternative service delivery strategies; strengthening public-private partnership in food fortification and food safety; and assessing the need for investments in management information systems, urban health infrastructure, equipment, and upgrading food laboratories. The TA will determine the most cost-effective approaches to establish or strengthen community-based initiatives in nutrition monitoring and behavioral change. The TA will develop a policy framework for implementing effective integrated urban nutrition programs catering to the needs of the poor. The TA will separately assess the role of the private sector and communities managing integrated urban nutrition programs.

¹² It is estimated that in Asia the total societal costs of malnutrition are up to 3% of gross domestic product (GDP).

11. The TA will prepare a feasibility study, including fully documented SPARs. The TA report will provide a detailed project description, including rationale and expected development outcomes, benefits, poverty impact analysis, a logical framework, and implementation arrangements and schedules. All outputs will be analyzed for technical, financial, economic, social, environmental, and institutional sustainability.

C. Cost and Financing

12. The total cost of the TA is estimated at \$500,000 equivalent, of which \$286,000 is the foreign exchange cost and \$214,000 equivalent is the local currency cost. The Government has requested ADB to finance \$400,000 equivalent, covering the entire foreign exchange cost and \$114,000 equivalent of the local currency cost. The TA will be financed on a grant basis by ADB's TA funding program. The funds will cover the consultant remuneration (foreign and domestic), national- and city-level workshops, and transportation costs. The Government will finance the balance of the local currency cost, equivalent to \$100,000, by providing office space, experienced counterpart staff, information and data collection, and logistical support. Appendix 2 provides details of the cost and financing plan. The Government has been advised that approval of the TA does not commit ADB to finance any ensuing project.

D. Implementation Arrangements

13. The Directorate General of Community Health in the Ministry of Health (MOH) will be the Executing Agency, which will coordinate with the Bureau of Planning and Budgeting of MOH. MOH will coordinate with oversight agencies and other ministries. The MOH technical team established for the ADTA will continue to supervise the TA and will coordinate with the Provincial Development Planning Board (BAPPEDA), Ministry of Industry and Trade, Ministry of Home Affairs, National Family Planning Coordinating Board (BKKBN), Indonesian Coalition for Food Fortification (KFI), universities, research institutes, and the private sector.

14. The TA will provide technical support to Government and selected municipalities in preparing the Project. An interministerial steering committee will be set up to guide the TA. The committee will be chaired by the director general of community health in MOH, and include representatives from the National Development Planning Agency (BAPPENAS), and the ministries of finance, agriculture, home affairs, social affairs, resettlement, and food and drug administration.

15. The TA is expected to commence in September 2004 and be implemented over 5 months, with the final report delivered in March 2005. ADB will engage a team of international (12 person-months) and domestic (12.5 person-months) consultants with expertise in urban nutrition, health economy, nutrition and food policy, public-private partnerships, financial management, institutional development and decentralization, food fortification policy, gender, and poverty. The consultants will provide technical support to the municipalities in designing and preparing SPARs, including fund-flow mechanisms. The ADTA team had gained valuable experience in working with municipalities on developing urban nutrition interventions. Few other candidates would be able to match the experience and expertise. Therefore, direct selection of consultants is proposed, pursuant to the provisions of Project Administration Instruction (PAI) 2.04, para. 10. The indicative terms of reference for the consultants are in Appendix 3. They will be recruited in accordance with ADB's *Guidelines on the Use of Consultants*.

16. The consultants will produce (i) a midterm report after 8 weeks, with a draft project proposal and logical framework, including three SPARs; (ii) a draft final report, including a total

of six SPARs, using the format of a report and recommendation of the President after 14 weeks; and (iii) a final report after 19 weeks. All reports must be submitted in English, with a summary in Bahasa Indonesia. Tripartite reviews will be held after submission of the midterm, and final reports, which should include inputs from Government agencies, regional governments, civil society, nongovernment organizations, and the private sector.

IV. THE PRESIDENT'S DECISION

17. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$400,000 on a grant basis to the Government of Indonesia for preparing the Urban Nutrition Project, and hereby reports this action to the Board.

PRELIMINARY PROJECT FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
<p>Project Goal</p> <p>Reduction of under- and overnutrition among the urban poor contributes to achieving Millennium Development Goal 1: Eradicate extreme poverty and hunger, especially target 4 (reduce the prevalence of underweight children under 5 years of age)</p>	<p>Child malnutrition reduced from 34% in 1995 to 17% in 2015</p> <p>Stunting reduced by 25% in preschool children by 2010</p>	<p>Standard living surveys</p> <p>Nutrition monitoring system</p> <p>Population census</p>	
<p>Purpose/Objective</p> <p>Nutrition status of poor urban dwellers in six selected cities improved</p>	<p>All six cities are implementing urban nutrition interventions targeting the poor by 2010</p> <p>Number of urban poor households benefiting from improved nutrition status by 2010</p>	<p>As above project management unit and consultant records Household and Nutrition Surveys undertaken by stakeholders and research institutions</p>	<p>Ministry of Health advocacy for effective nutrition interventions targeting the urban poor is successful.</p>
<p>Outputs</p> <p>National policy framework for urban nutrition, including food fortification designed</p> <p>Integrated nutrition programs for urban poor communities implemented using public-private partnership and community-based schemes</p> <p>Institutional and human capacities to implement nutrition interventions improved</p>	<p>National policy approved in 2008</p> <p>Number of urban nutrition interventions</p> <p>Number of nutrition programs effectively targeting the poor</p>	<p>Progress reports and review missions</p> <p>Project performance monitoring system (PPMS)</p>	<p>Selected cities allocate human and technical resources to develop and implement well-targeted urban nutrition interventions.</p> <p>The private sector remains involved in food fortification.</p>

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Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
Improved social infrastructure and equipment made available		Independent assessment of ongoing nutrition program quality	
<p>Activities</p> <p>Assess existing nutrition and food policies as well as laws and regulations on food fortification</p> <p>Conduct a baseline study on food consumption in poor urban households</p> <p>Identify urban nutrition interventions for the public and private sectors</p> <p>Complete institutional and human resources assessment</p> <p>Complete a poverty and social analysis</p>	<p>Consultation held among the private sector, aid agencies, and the Government</p> <p>Food consumption study in target areas completed</p> <p>National and regional governments and the private sector agree to, and determine, urban nutrition interventions</p> <p>Institutional capacity and public-private linkages for the Project identified</p> <p>Poverty and social analysis for the project completed</p> <p>Fully costed SPARs prepared</p>		
<p>Inputs</p> <p>Consultants (12 person-months, international; and 12.5 person-months domestic)</p> <p>National workshops and regional</p>	<p>Midterm report, SPARs, draft final report, and final report</p> <p>Stakeholders agree and understand their roles,</p>	TA review missions	Counterpart staff and budget are available.

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FRAMEWORK—*continued*

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
government consultations Survey	responsibilities, and the coordinating mechanisms for urban nutrition Baseline survey conducted		

COST ESTIMATES AND FINANCING PLAN

(\$'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Asian Development Bank (ADB) Financing^a			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	246.00	0.00	246.00
ii. Domestic Consultants	0.00	50.00	50.00
b. International Travel	20.00	0.00	20.00
c. Local Travel	0.00	12.00	12.00
d. Reports and Communications	5.00	5.00	10.00
2. Project Planning Workshops	0.00	15.00	15.00
3. Baseline Survey	0.00	22.00	22.00
4. Representatives for Contract Negotiations	5.00	0.00	5.00
5. Contingencies	10.00	10.00	20.00
Subtotal (A)	286.00	114.00	400.00
B. Government Financing			
1. Office Accommodation and Transport	0.00	35.00	35.00
2. Supplies		25.00	25.00
3. Remuneration and Per Diem of Counterpart Staff	0.00	20.00	20.00
4. Others			
a. Workshop Expenses	0.00	10.00	10.00
b. Report Production and Dissemination	0.00	5.00	5.00
c. Miscellaneous Administration and Support Costs	0.00	5.00	5.00
Subtotal (B)	0.00	100.00	100.00
Total	286.00	214.00	500.00

^a Financed by ADB technical assistance funding program.

Source: ADB estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The purpose of the technical assistance (TA) is to help the Government prepare a project for developing integrated urban nutrition programs for poor urban communities in six cities using public-private partnership and community-based schemes.

A. International Consultants

1. Nutrition and Health Project Design Specialist (team leader, 4 person-months)

2. The team leader will have experience in leading TA teams that designed nutrition and health sector projects in Indonesia after decentralization. The consultant will (i) coordinate team activities and ensure efficient implementation of all individual consultants' tasks; (ii) coordinate TA activities with central and regional government officials and with civil-society representatives; (iii) organize participatory planning workshops and help facilitate workshops and consultation meetings that aim to define objectives, scope, and methodologies for the Project; (iv) help the central technical team advocate the Project in selected municipalities; (v) ensure adequate coordination between the steering committee, technical committee, and TA team; (vi) take overall responsibility for timely preparation and submission of required reports, and ensure the quality and completeness of reports, including a detailed work plan for the TA and the consultant team, and the completeness of six subproject appraisal reports (SPARs); and (vii) produce a feasibility report for discussion with the Ministry of Health (MOH) and prepare a detailed project proposal using the format of a report and recommendation of the President (RRP), including a fully developed logical framework, and a monitoring and evaluation framework, with measurable indicators and a project administration memorandum delineating project implementation procedures to ensure that the Project is ready for Asian Development Bank (ADB) and Government appraisal.

3. As a specialist, the consultant will (i) provide a draft policy framework on urban nutrition; (ii) prepare a matrix for public-private interventions for urban nutrition in the selected municipalities; (iii) design capacity-building activities for public and private institutions to plan, manage, and monitor urban nutrition interventions; and (iv) design detailed implementation arrangements for the Project.

2. Urban Nutrition Specialist (1.5 person-months)

4. The consultant will have proven working experience in urban nutrition and will help the team identify and prepare the main project components. The consultant will (i) design baseline studies and recommend innovative operations research; (ii) review the efficiency of public nutrition interventions for urban poor communities in Indonesia; (iii) recommend ways to improve nutrition programs through public-private partnerships in the selected municipalities as part of the SPARs; (iv) propose strategies to improve nutritional status for the poorest first and second quartile in the target areas; (v) propose specific community-based interventions appropriate for each target area; (vi) identify cost-effective public-private interventions, especially for malnourished and obese high-risk populations in low-income urban areas as part of the SPARs; (vii) propose alternative interventions to reduce clinical malnutrition; (viii) identify professional associations, academic institutions, and private service providers to deliver cost-effective training programs for nongovernment organizations (NGOs) and civil society on urban nutrition; (ix) design campaigns for decision makers to promote urban nutrition for the poor; (x) work with the food and nutrition analyst and the team leader to identify key components of the

urban nutrition policy framework; (xi) design poverty reduction interventions to complement the urban nutrition policy framework; (xii) design project interventions to facilitate access to a quality diet, reduce the financial burden of diet-related disease and obesity, and promote food safety and hygiene; (xiii) design a project-monitoring approach emphasizing community-based monitoring of urban nutrition interventions; and (xiv) identify public awareness and social marketing campaigns for urban nutrition.

3. Health and Nutrition Economist (1.25 person-months)

5. The consultant will work in cooperation with the urban nutrition specialist and nutrition and food security policy specialist to (i) link the project goal and purpose with national and international objectives for the health sector; (ii) economically justify the project services; (iii) assess demand for and current supply of project-related services; (iv) assess technical design for the Project, including institutional and management arrangements under a least-cost perspective; (v) identify the main beneficiary groups affected by the Project; (vi) propose strategies to establish national nutrition accounts; (vii) assess the cost-effectiveness of alternative service delivery strategies and community-based schemes for preventive services and monitoring and educational activities; (viii) identify the Project's main impacts and consider whether they can be expressed in monetary values; (ix) provide a financial and economic analysis of the Project; (x) design the financing arrangements for the Project, ensuring financial sustainability. Where user charges are to be applied, spell out the implications of different levels of charges for the financial sustainability of the Project and affordability by project beneficiary; (xi) identify the best cost-effectiveness indicator for the Project, such as years of life gained, healthy years of life gained, or disability-adjusted life years; and (xii) identify indicators of project impact that can be used for project monitoring.

4. Nutrition and Food Policy Analyst (1.5 person-months)

6. The specialist will have proven work experience in the sector, including food fortification and food safety policy development, and will provide inputs in developing SPARs. The consultant will (i) identify national urban nutrition goals and objectives and recommend multisectoral strategies to meet such objectives in addressing the specific nutritional needs of the urban poor; (ii) recommend main policy components for the Project; (iii) identify key areas to refine sectoral policies for urban nutrition, including food, nutrition, food fortification, food safety, agriculture, and trade policies; (iv) identify legislative issues that need to be addressed to support urban nutrition programs at the national, provincial, and district level; (v) propose capacity-building activities for public and private agents involved in meeting the nutritional needs of urban poor communities; (vi) recommend a policy framework for food fortification and targeted supplementation, which will benefit the urban poor; (vii) recommend benchmarks and performance criteria for measuring the quality and adequacy of the proposed urban nutrition interventions; (viii) identify gaps in the regulation of food fortification and recommend improvement of licensing, quality assurance, food standards, labeling, and advertising; (ix) propose strategies to integrate fortified food and other micronutrient interventions into ongoing food supplementation, education, and social welfare and other related Government programs; (x) develop a 10-year plan and budget for complementary food, health education, and fortification strategies; (xi) identify key priorities to improve food safety regulations and recommend strategies to improve food safety among street food vendors; (xii) propose medium-term urban nutrition improvement strategies for all participating municipalities; and (xiii) prepare a detailed policy matrix for the Project and propose medium- and long-term policy strategies for improving urban nutrition among the poor.

5. Institutional Development Specialist (1.5 person-months)

7. The specialist will have proven working experience in public-private partnerships in social sector projects and will help the team develop SPARs. The consultant will (i) suggest alternative service delivery methods through the public and private sectors, including communities, to reduce urban malnutrition; (ii) determine the capacity of public and private institutions, including NGOs, to plan, manage, and finance urban nutrition interventions; (iii) propose strategies for institutional development, and reform for public and private institutions, to plan and manage urban nutrition programs; (iv) assess training and human resources development needs for planning and managing urban nutrition programs; (v) prepare an implementation framework for urban nutrition that defines roles and responsibilities of public and private institutions; and (vi) assess the willingness and ability of the private sector to support financing and management of urban nutrition interventions in the target cities.

6. Financial and Management Specialist (1.5 person-months)

8. The consultant will (i) design a project management system, clearly delineating roles, functions, and reporting responsibilities; (ii) create a governance framework for the Project to ensure that project planning, budgeting, resource monitoring, and auditing will follow the highest standards of good governance; (iii) define project implementation arrangements, including required person-months and expertise of consulting staff, central and local government staff, and staff from the private sector and civil society; (iv) develop a monitoring and evaluation system for assessing benefits and results in accordance with ADB's *Project Performance Management System Handbook*; (v) develop a financial flow mechanism from the Government to local governments and beneficiaries, in accordance with Government and ADB rules; (vi) prepare detailed, measurable, time-bound monitoring indicators with reference to relevant baseline data; (vii) prepare a comprehensive analysis that financially justifies the Project; (viii) calculate cost estimates and validated unit costs; (ix) assess the selected executing agency's financial management capabilities, including existing internal control mechanisms; (x) recommend ways to institutionally strengthen financial management; (xi) design the project fund-flow mechanisms; (xii) propose accounting and auditing reporting formats and timetables; (xiii) recommend financial covenants for the loan agreement; (xiv) prepare cost estimates as per ADB's format, including interest during construction, civil works, price contingencies, and taxes and duties, divided into foreign exchange and local currency costs; (xv) prepare annual project cost estimates by category, indicating foreign exchange and local currency costs and including ADB's proposed lending, any prospective cofinancing, and counterpart funds; (xvi) prepare a table projecting preliminary annual disbursements by source of funds; and (xvii) prepare assumptions used for financial projections. The financial and economic analysis will be undertaken in accordance with ADB guidelines.¹

¹ ADB. 2001. *Handbook for Integrating Poverty Impact in Economic Analysis*. Manila; ADB. 1997. *Guidelines for Economic Analysis of Projects*. Manila; ADB. 2002. *Guidelines for the Financial Governance and Management of Investment Projects Financed by ADB*. Manila.

B. Domestic Consultants

1. Nutritionist (deputy team leader, 4 person-months)

9. The consultant will (i) help the team leader plan, manage, and supervise the work of the TA team; (ii) assist the team leader in all aspects of preparation of SPARs and the RRP; (iii) supervise team activities to ensure their integration with health and other related program environments; (iv) support the urban nutritionist in preparing the baseline survey and compiling its results; (v) help the urban nutritionist review community nutrition training activities for public-health nurses and recommend ways to integrate urban nutrition into the curriculum of master's and doctoral training courses; (vi) help the food and nutrition policy analyst identify major policy components for the Project; (vii) support the preparation of project preparatory workshops to define objectives, scope, and methodologies used to develop the Project; (viii) be responsible for day-to-day communication with the Government, municipalities, private sector, NGOs, and civil society; and (ix) carry out other duties as may be required by the team leader.

2. Institutional Development and Decentralization Specialist (2 person-months)

10. The specialist will advise the TA team on all aspects of decentralization and will support the team in the development of SPARs. The consultant will (i) define arrangements for project implementation, clarifying the roles and responsibilities of all relevant institutions and organizations; (ii) estimate person-months and expertise of consulting staff and staff from the Government, municipalities, private sector, and civil society; (iii) develop a financial flow mechanism from the Government to municipalities; urban poor communities; disadvantaged households, including at-risk groups; and other institutions that take part in the Project, in accordance with Government and ADB rules; (iv) develop a monitoring and evaluation system for estimating benefits and results in accordance with ADB's operation procedure for project performance, and with reference to ADB's *Project Performance Management System Handbook*; (v) determine criteria to verify that the cities selected have adequate governance systems to ensure transparent and accountable project implementation; and (vi) review the arrangements for strengthened implementation arrangements set out in the Memorandum of Understanding between ADB and MOH, which will be incorporated into the recommended project administration arrangements; the relevant systems described therein; and others as appropriate, to ensure transparent and accountable project administration.

3. Budget and Finance Specialist (2 person-months)

11. The specialist will support the financial analyst in the preparation of a comprehensive analysis that provides the financial justification of the Project and provides a project cost estimate and validated unit costs under decentralization. The consultant will help (i) assess the executing agency's financial management capabilities, (ii) recommend ways to institutionally strengthen financial management, (iii) help the executing agency's design the project fund-flow mechanisms, (iv) assess the executing agency's financial statements and propose accounting and auditing reporting formats and time tables, (v) prepare a cost table with categories as per ADB's format, (vi) prepare annual project cost estimates by category, (vii) prepare a financial plan as per ADB's format, and (viii) prepare a table projecting annual disbursements by source of funds.

4. Food Fortification Policy Analyst (2 person-months)

12. The specialist will have proven international experience in food fortification and help the international nutrition and food policy analyst prepare SPARs. The specialist will also (i) recommend key strategies for a medium-term action plan for food fortification, ensuring access and affordability of micronutrient-enriched food for poor and vulnerable people in the six cities; (ii) analyze the willingness of food manufacturers to support pro-poor food fortification schemes, and recommend private sector approaches to support the public sector in eliminating micronutrient deficiencies; (iii) define a legislative framework for food fortification, designating roles for Government agencies, and identify major legal reforms required to improve food fortification; (iv) recommend strategies on law enforcement and monitoring of food fortification, and identify strategies to involve the public and consumer groups in food fortification monitoring; (v) propose options for alternative food fortification, such as community-based food fortification; (vi) propose social marketing strategies for food fortification; and (vii) recommend food fortification policy strategies and public-private project interventions on food fortification for the Project.

5. Gender and Poverty Specialist (1.5 person-months)

13. The specialist will have working experience with multilateral banks and work with the TA consultant team to prepare SPARs. The specialist will also (i) conduct a gender analysis as part of the poverty and social analysis; (ii) help identify and address pertinent gender issues; (iii) propose capacity building for institutions; (iv) prepare a poverty and social analysis and strategy for the Project following ADB's *Poverty and Social Analysis* and *Guidelines for Incorporation of Social Dimensions in Bank Operations*; (v) indicate the poverty incidence and characteristics of poverty in the project areas (by income distribution, nutritional status of children below 5 years, or other measures); (vi) identify poor and vulnerable population groups in the targeted areas, and the likely impact of the Project (including externalities); (vii) quantify the poverty impact of project interventions either directly (e.g., numbers of women and children receiving services, expected improvement of nutritional status, etc.) or; (viii) work with the financial analyst to estimate unit benefits to unit costs received by poor and vulnerable households; (ix) estimate the poverty impact ratio, with sensitivity analysis regarding its reliability, as defined in ADB's *Poverty and Social Analysis*; (x) examine the likelihood of benefit leakages to the nonpoor and recommend steps to avoid leakages; (xi) identify instruments for targeting and monitoring poverty impact; and (xii) work with the team leader and management specialist to identify project performance indicators, methodologies, and human resources required to support the project management information system, baseline, and, later, evaluation surveys; and the monitoring of poverty impact in the project areas.

6. Workshop Facilitator and Coordinator (1 person-month)

14. The workshop facilitator and coordinator will have proven experience in goal-oriented project planning methods and will (i) plan and facilitate national and project preparatory planning workshops to prepare SPARs and the RRP; (ii) facilitate cooperation among the consultant team, stakeholders, and partners at decentralized level; and (iii) ensure that workshop results are fully documented.