United Nations Development Programme
Country: Malaysia
Project Document

Project Title	Strengthening community empowerment and participation of population for maternal health problems and health-seeking behaviour of Orang Asli at Peninsular Malaysia
UNDP Strategic Plan (2014-2017) Outcome(s):	1.2: Options enabled and facilitated for inclusive and sustainable social protection
Expected CP Outcome(s):	1(b): The bottom 40% of households receive better access to education, health and social protection programmes and benefit disproportionately from new inclusive growth policies and strategies.
Expected Output(s):	1.1: Principles of inclusive growth are incorporated into national policies and strategies as well as monitoring and evaluation tools
Executing Entity:	Ministry of Health
Implementing Agency:	Institute For Health Management, Ministry of Health

Brief Description

Maternal health care among the *Orang Asli* community continues to be a concern. While the absolute number of maternal deaths has been low, statistically this remains a concern as it is still very much statistically significant due to the relatively small number of total population of *Orang Asli* as compared to other ethnic groups in Malaysia. Furthermore, the rate of home delivery and late antenatal booking is still high among *Orang Asli* women. The rate of safe delivery conducted by trained personnel among the *Orang Asli* mothers ranged from 77.3% to 87.3% over the period of year 2003-2007. It was reportedly to be lower than the recorded national average rate of safe delivery for the same period of time. Given these data, the Institute for Health Management, Ministry of Health proposed that a study be conducted with an aim to determine the health-seeking behaviours among the *Orang Asli* and the viability of promoting a sustainable and effective method of improving the maternal health of *Orang Asli.* The specific objectives of the study will be: to explore the health-seeking behaviour of a targeted *Orang Asli* population especially with regards to their maternal health; introduce the peer support group as an intervention to identified *Orang Asli* participants; and evaluate the effectiveness of the peer support group intervention in improving the maternal health among the *Orang Asli* participants.

Programme Period: 2014 and 2015

Key Result Area (Strategic Plan (2014-2017): 1.2: Options enabled and facilitated for inclusive and sustainable social protection

Atlas Award ID: 00077988
Project ID: 00088507

Start date: May 2014
End Date May 2015

LPAC Meeting Date: 16 April 2014

Management Arrangements NIM

Total resources required: USD76,711

Total allocated resources:
UNDP managed fund:

TRAC	USD28,465
Government CS	USD45,515
GMS 6% of Government CS	USD2,731
Total	USD76,711

Government of Malaysia (GoM):
In-kind Contribution USD 20,000

Agreed by (Government of Malaysia): 19/5/14

Datuk Dr. Rahamat Bivi Yusoff
Director General
Economic Planning Unit of the Prime Minister's Department

Agreed by (UNDP): 21/5/14

Michelle Gyles-McDonnough
Resident Representative
United Nations Development Programme

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATION

10MP	10th Malaysia Plan: 2011-2015
11MP	11th Malaysia Plan: 2016-2020
APR	Annual Progress Report
AWP	Annual Work Plan
CDR	Combined Delivery Report
CPAP	Country Programme Action Plan
CS	Government of Malaysia Cost sharing
DSA	Daily Subsistence Allowance
EPU	Economic Planning Unit
FACE	Funding Authorisation and Certificate of Expenditures
GoM	Government of Malaysia
HACT	Harmonized Approach to Cash Transfer
NIM	National Implementation Modality
NPD	National Project Director
NSC	National Steering Committee
SBAA	Standard Basic Assistance Agreement
TOR	Terms of Reference
TRAC	Target for Resource Assignment from the Core
TWC	Technical Working Committee
UNDP	United Nations Development Programme

I. SITUATION ANALYSIS

Introduction

Orang Asli which literally translated means '*original people*' or '*natural people*' is the indigenous people of Peninsular Malaysia. Based on the *Orang Asli* Act 1954 (revised in 1974), *Orang Asli* is defined as an individual who has at least one *Orang Asli* birth parent or adopted since young by an *Orang Asli* family, who has been raised as an Orang Asli and practices the lifestyle, culture and religion of the *Orang Asli* tribe. The population of *Orang Asli* at Peninsular Malaysia is currently approximately 178,197, which makes up about 0.6% of the total population in Malaysia. The *Orang Asli* is not a homogenous population but forms a multicultural, multi-lingual community with diverse traditions and religious practices between the tribes. They are divided into three main tribes (*suku kaum*): Senoi, Melayu-Proto and Negrito. These three main tribes are each further divided into six sub-tribes (*suku bangsa*).

The largest tribe of *Orang Asli* is the Senoi, which consists of 54% of the total population of *Orang Asli*, followed by Melayu-Proto 42% and the smallest tribe, Negrito is only about 4% of the *Orang Asli* population. The Senoi population can mainly be found near Titiwangsa mountainous area in the interior of Perak, Kelantan and Pahang states. The Senoi sub-tribes are the *Che Wong, Mahmeri, Jahut, Semoq Beri, Semai* and *Temiar.* The Senoi people are usually light skinned and with straight hair. The Melayu-Proto population who normally live in close proximity with the Malays are mainly in the state of Selangor, Negeri Sembilan, Melaka and Johor. The Melayu-Proto is further divided into the *Kuala, Kanaq, Seletar, Jakun, Semelai* and *Temuan* sub-tribes. The majority of Negritos mostly reside around Perak, Kelantan and Kedah. The sub-tribes of Negrito are the *Kensiu, Kintak, Lanoh, Jahai, Mendriq* and *Bateq.*

Since Malaysia achieved her Independence in 1957, much assistance, support and provision have been continuously provided to the *Orang Asli.* Unfortunately, nationally, a large proportion of the *Orang Asli* population are still persistently lagging behind in terms of their socio-economic status, health status, education and other fields. This scenario is disheartening especially due to the fact that the *Orang Asli* population is considerably much smaller in number as compared to other Malaysian ethnic groups.

Poverty rate and life expectancy

Data collected during the Census exercise carried out for the Orang Asli community in 2010 showed that that 31.16% of the *Orang Asli* population remains below the poverty line where 19.97.2% is classified as living in hard-core poverty[1]. This is a huge contrast to the recorded poverty rate which is 1.4% nationally[2]. The average life expectancy for *Orang Asli* is 53 years, compared to the national average of 73 years[3].

Maternal health of the Orang Asli community

Over the 5-year period between 2003 and 2007, there were a total of 17 maternal deaths among the *Orang Asli* mothers. Annually, the absolute number of maternal deaths was low with five deaths in 2004, three deaths in 2003 and 2006 and two deaths in 2005 and 2007[4]. Even though the absolute number of maternal deaths among the *Orang Asli* mothers is considered to be low, it is still very much statistically significant due to the relatively small number of total population of *Orang Asli* as compared to other ethnic groups in Malaysia. Among the *Orang Asli* women in Negeri Sembilan in 2009, the maternal mortality rate was reported to be 35.7 per 100,000 live

[1] Census on the Orang Asli community in 2010. Source: Department of Orang Asli Development (JAKOA).

[2] Mohd Asri Mohd Noor. Journal of International and Comparative Education, 2012, Volume 1, Issue 2 http://crice.um.edu.my/downloads/2Asri.pdf

[3] Rusaslina, I. (2010). Basic rights for the Orang Asli. Viewpoints. Singapore: Institute of South East Asia Studies. http://crice.um.edu.my/downloads/2Asri.pdf

[4] Technical Report on Health Status of the Orang Asli in Peninsular Malaysia, 2003-2007. Institute for Medical Research, Ministry of Health Malaysia, 2012. Pg 20-26.

births which was about 30% higher than the national rate[5]. Based on the information from the Ministry of Health Orang Asli Health Unit, the national maternal mortality target for year 2012 was less than 59.5 deaths per 100,000 live births. The recorded maternal mortality rate for the Orang Asli community in year 2012 was 68.5 per 100,000 live births.

The reports on the Confidential Enquiries into Maternal Deaths (CEMD) in Malaysia year 2006-2008 published by the Division of Family Health Development, Ministry of Health Malaysia revealed that from the total of 10 Orang Asli maternal death cases within the 3-year period, the majority of the maternal deaths (70%) were caused by direct causes i.e. postpartum haemorrhage and obstetric embolism[6]. The documented indirect cause of maternal deaths which made up the 30% of the total maternal deaths was heart disease in pregnancy. The preliminary unpublished data of the maternal deaths for the year 2009-2012 were recorded as 3 cases (2009), 4 cases (2010), 1 case (2011) and 2 cases (2012). 80% of the Orang Asli maternal death cases within the year 2009-2012 were caused by the direct causes i.e. postpartum haemorrhage (2 cases), puerperal sepsis (2 cases), antepartum haemorrhage (1 case), obstetric trauma (1 case), eclampsia (1 case) and abortion (1 case). The indirect causes of the maternal deaths between year 2008-2012 were: septicaemia (2 cases), associated medical condition (1 case) and unspecified pneumonia (1 case).

The rate of home delivery and late antenatal booking is still high among *Orang Asli* women and this is significantly associated with to their approach to antenatal care. In a survey carried out by Rosliza and Muhammad[5] in 2011, about 70% of the respondents had a history of home delivery and 44.2% had experienced at least one high risk pregnancy before. Preference of home delivery has been reported involving *Orang Asli* women which may be due to familiarity and strong influence of traditional health practices[7]. According to a survey done by Lim and Chee[8] in 1998 among *Orang Asli* women in the state of Pahang, only about 64% of them came for early antenatal check up[8]. A similar situation was reported in another rural area in Malaysia where only about 50% of pregnant *Orang Asli* women came for their first antenatal booking in the first trimester[9]. Although the *Orang Asli* group was small, they appeared to be a group that needs further evaluation if ethnic group specific ratios were studied. This is largely due to the fact that *Orang Asli* patients were only seen in the hospital when they developed severe obstetric complication warranting interventional measures[10].

Nutritional Status and Anaemia in Pregnancy

A study done by Zalilah and Tham in 2002 on the Food Security and Child Nutritional Status among *Orang Asli* (Temuan) Households in Hulu Langat, Selangor had showed that the prevalence of significant underweight, stunting and wasting were 45.3%, 51.6% and 7.8%, respectively[11]. Based on the National Obstetrics Registry Preliminary Report of National Obstetrics Registry (July-December 2009), the prevalence of anaemia in pregnancy among the *Orang Asli* women was 32.7%[12]. This is probably attributed by the lower socio-economic background leading to poor dietary intake and resulting in poor body iron stores.

---

[5] Ministry of Health Malaysia. Negeri Sembilan Health Department Report on Maternal Mortality for 2009. Seremban: Negeri Sembilan State Health Department, 2010

[6] Ministry of Health Malaysia. Report on the Confidential Enquiries into Maternal Death in Malaysia, 2006 -2008. Family Health Development Division: Putrajaya.

[7] Ministry of Health Malaysia. Report on the Confidential Enquiries into Maternal Death in Malaysia, 2001 -2005. Family Health Development Division: Putrajaya, 2008

[8] Lim HM, Chee HL. Nutritional status and reproductive health of Orang Asli women in two villages in Kuantan, Pahang. Malaysian J Nutr. 1998; 4: 31-54

[9] Ministry of Health Malaysia. Report on antenatal care attendance for Jempol District in 2010. Seremban: Negeri Sembilan State Health Department, 2011

[10] N Sivalingam, K W Looi. Clinical Experience with Management of "Near-Miss" Cases in Obstetrics. Med J Malaysia Vol 54 No 4 Dec 1999.

[11] M S Zalilah, PhD, B L Tham Food Security and Child Nutritional Status Among Orang Asli (Temuan) Households in Hulu langat, Selangor. Med J Malaysia Vol 57 No 1 Mar 2002

[12] Ravichandran Jeganathan, Shamala Devi Karalasingam. National Obstetrics Registry Preliminary Report Of National Obstetrics Registry July-December 2009

Safe Delivery

The rate of safe delivery conducted by trained personnel among the Orang Asli mothers ranged from 77.3% to 87.3% over the period of year 2003-2007[4]. It was reportedly to be lower than the recorded national average rate of safe delivery for the same period of time. National average rate of safe deliveries in all states of Malaysia increased from 74.2 per cent in 1990 to 97.6 per cent in 2008[13].

Infant and Toddler Mortality

Orang Asli infant mortality rate is at a high of 51.7 as compared to the national infant mortality rate of 8.9 out of 1,000 live births[14]. A study by Wong Swee Lan and Hussain Imam Muhammad Ismail[15] in 2006 had identified disparities among ethnic groups and regions and groups of children who were undernourished and died from two conditions, diarrhoea and pneumonia which were preventable and treatable at low cost. The highest death incidence rate was in the ethnic group 'other Malaysian', which included mainly the *Orang Asli, Bumiputera* Sabah and *Bumiputera* Sarawak children[15].

Global indigenous population health issues

The issues of inequality among the indigenous population are not limited and exclusive to the *Orang Asli* in Malaysia. To date, the indigenous populations in Australia, New Zealand and the Pacific are facing various health and social issues as portrayed in an article published in *The Lancet* (2006) by Prof Ian Anderson. The infant mortality rate (per 1000 live births) of the indigenous populations in Australia, New Zealand, Federated States of Micronesia and Republic of Marshall Islands are 15, 8.6, 21 and 37 respectively[16]. All figures are higher than the respective local non-indigenous populations. The life expectancy of the both the men and women of the above indigenous populations is also significantly lower as compared to the non-indigenous populations. For example, the life expectancy of the Australian Indigenous Aboriginal men is 59.4 as compared to the Australia non-indigenous male population of 76.6 years and indigenous female's life expectancy of 64.8 years as compared to non-indigenous Australian female of 82.0 years[17].

Worldwide rate of maternal death among the indigenous population are still higher as compared to the rate of maternal death non-indigenous population. For example, Australia has one of the lowest maternal mortality rates in the world. Nevertheless, in the Aboriginal and Torres Strait Islander women population, the maternal mortality rates for Indigenous women were between two and five times the maternal mortality rates for non-Indigenous women over the past five 3-year groupings 1991–1993, 1994–1996, 1997–1999, 2000–2002 and 2003–2005.[18] It is said that there is a possibility that incomplete recording of Indigenous status leads to under-coverage of Indigenous mothers in this data collection. As a result of incomplete ascertainment of Indigenous status, the Indigenous maternal mortality rates are likely to be underestimations of the true rates.

---

[13] Malaysia: The Millennium Development Goals at 2010. 2011. United Nations Country Team Malaysia. United Nations 2011. Page 73

[14] Mohd Asri Mohd Noora. Advancing The Orang Asli Through Malaysia's Clusters Of Excellence Policy. Journal Of International And Comparative Education, 2012, Volume 1, Issue 2

[15] Wong Swee Lan, Hussain Imam Muhammad Ismail. A Study on Under Five Deaths In Malaysia In The Year 2006

[16] Ian Anderson, Sue Crengle, Martina Leialoha Kamaka, Tai-Ho Chen, Neal Palafox, Lisa Jackson-Pulver. Indigenous Health 1. Indigenous health in Australia, New Zealand, and the Pacific. Lancet 2006; 367: 1775–85

[17] Closing the Gap- Indigenous Chronic Issues. Wide Bay. Medicare Local http://www.wbml.org.au/programs/indigenoushealth/closingthegap © 2012 Your Health Wide Bay

[18] Maternal Mortality- Health Status and Outcomes (Tier http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442458662, 2013 Australian Institute of Health and Welfare

II. STRATEGY

Given the above scenario, the Institute for Health Management, Ministry of Health proposed that a study be conducted with an aim to determine the health-seeking behaviours among the *Orang Asli* and the viability of promoting a sustainable and effective method of improving the maternal health of *Orang Asli.*

The specific objectives of the study will be:

to explore the health-seeking behaviour of a targeted *Orang Asli* population especially with regards to their maternal health.

to introduce the peer support group as an intervention to the identified *Orang Asli* community

to evaluate the effectiveness of the peer support group intervention in improving the maternal health among the *Orang Asli* participants

Proposed intervention: Peer support group

Peer group support has been proven to improve the Aboriginal maternal and child health problems in Canada as published by the Health Council of Canada in 2010.[19]

A number of studies had conducted peer support coaching to study the impact of the intervention on the study groups. For example, a study by Joseph and Griffin *et al* was conducted in 2001 to determine the value of peer coaching and its influence on behaviour change among the individuals struggling with Diabetes. The outcomes from the participants of the peer coaching were positive and encouraging. The study showed that peer coaching appears to have merit as a viable, low-cost intervention with the potential of helping individuals with diabetes who need to change their behaviour[20]. A community-based participatory research by training peer-led volunteers to facilitate focus-group discussions within Aboriginal and refugees participants among the Marginalized HIV-Populations in Vancouver, Canada was carried out. It was noted that for the participants, as well as for others HIV seropositive individuals, the mobilization of a range of local supporting networks can have a constructive implication to their lives[21]. In this case, social capital surfaces related to networks as the sum of supportive relationships in a given community and a key player in developing individual coping and adaptive strategies in stressful environments[22].

PROJECT OUTPUTS AND ACTIVITIES

There will be 3 Outputs under the study. The study will be implemented and monitored through a 'Community Advisory Team" which will comprise of IHM researchers, community nurses, local community leaders and local health clinic personnel to plan for the field work, data collection and participant recruitment.

Output 1: Situation analysis of the maternal health and care-seeking behaviour of a targeted *Orang Asli* population

A detailed situation analysis will be developed to ascertain the health and care-seeking behavior of a targeted Orang Asli population and a 'Knowledge, Attitudes, Practices' (KAP) report will be

[19]Kitts J et al. Understanding and Improving Aboriginal Maternal and Child health in Canada. Case series. 2010. © Health Council of Canada.

[20] Dayle Hunt Joseph, Martha Griffin, et al. Peer Coaching: An Intervention for Individuals Struggling With Diabetes. The Diabetes Educator September/October 2001 vol. 27 no. 5 703-710.

[21] A. Knowlton, W. Hua, and C. Latkin, "Social support among HIV positive injection drug users: implications to integrated intervention for HIV positives," *AIDS and Behavior*, vol. 8, no. 4, pp. 357–363, 2004.

[22] Community-Based Research among Marginalized HIV Populations: Issues of Support, Resources, and Empowerment. Interdisciplinary. Mario Brondani, Nardin R. Moniri, R. Paul Kerston. Perspectives on Infectious Diseases. Volume 2012, Article ID 601027, 8 pages.

produced. The study will utilize both quantitative and qualitative data to develop the situation analysis. Several methodologies will be used to collect the data:

Identification of two study communities of Orang Asli

The identification of the Orang Asli communities will be through a purposive sampling of the *Orang Asli* as participants in a settlement/village in the states of Perak and Pahang. Study samples with an approximate of 100 participants will be used. These samples will be divided into 2 separate arms with an approximate of 50 participants each, in which will be referred to as the '**intervention group**' and the '**control group**'.

The Orang Asli participants identified will be similar in socio-demographic factors and furthest away from each other. The study sites will comprise of one village from the state of Perak which will be identified as the '**control group**' and one village from the state of Pahang which will be identified as the '**intervention group**'. Both villages chosen will have similar size of population for comparison purposes.

Women of child bearing age (15-45 years of age) belonging to the *Orang Asli* community, residing in the study area for the last one year, and who have provided a written consent to participate in the study.

Questionnaires

Quantitative data will be collected using face-to face questionnaires. The framework of the questionnaire will mainly be based on the 'KAP (*Knowledge, Attitude, Practice*) survey questionnaire'. The questionnaire will be divided into six sections namely the demographic section, general questions on the health seeking behaviour section, knowledge section, attitude section, practice and questions on the quality of health service provided section. In addition, the economic profile and the family planning practice and preferred methods amongst the female Orang Asli community members will also be explored in the questionnaire.

Focus Group Discussions (FGD)

Qualitative data will be collected from FGDs which will cover issues such as the overview of the participants' health-seeking behaviours, knowledge, attitudes, and practices towards their health status, their beliefs in the traditional medicine and suggestions on how to improve their health status. The qualitative data would also seek to examine whether the behaviours of the key community stakeholders listed below also influences the participants' health seeking behaviours and decision-making processes. Apart from the Orang Asli female participants, other key community stakeholders involved in the well-being of the Orang Asli community will be invited to participate such as:

- district health officers
- local health clinic personnel (community nurses)
- local community leaders
- local spiritual/religious leaders
- *Orang Asli* non-governmental organisations (NGOs) representatives
- Department of Orang Asli Development (JAKOA) representatives
- Husbands/spouses/partners of the Orang Asli female participants

In-depth Interviews (IDIs)

Further qualitative data will also be collected by identifying selected Orang Asli participants who are recognised as being proactive, co-operative and keen to share information during the FGDs will be invited for in-depth interviews. Details on the relevant issues will be further clarified with the chosen participants during the in-depth interview.

For all the methodologies above, interpreters, preferably women interpreters, who speak the relevant Orang Asli ethnic language/dialect, if required, will be recruited to assist any participant who has difficulties in communicating in Bahasa Malaysia.

Output 2: An intervention that will address the MCH needs in the community developed and piloted

A pilot intervention using the 'Peer support group' method will be introduced to the targeted participants to examine whether it is effective in influencing a behavioural change among the Orang Asli participants (the "intervention group") in the way they approach their maternal health and care-seeking needs.

In order to conduct the intervention, peer support group leaders among the "intervention group" will be recruited and trained. Recruitment of the peer support group leaders among the 'intervention group' participants will be based on the recommendation by the district health clinic (*klinik desa*) personnel and local *Orang Asli* community leaders.

The main criteria for the peer support group leaders will include individuals who are healthy and possess positive attitudes towards health. The selected peer leaders will subsequently undergo a one-week training and complete the training module provided. Once the training module is completed, the peer leaders will be required to arrange for peer meeting sessions with the group participants once a month.

The main roles of the peer group leaders are as below:

- To act as the role models for the local community members
- To act as an advisory role among the local community members especially on the issue of maternal health and general health nutrition
- To act as a liaison with the local health care service personnel in encouraging the local community members to utilise the health care services provided for to the community

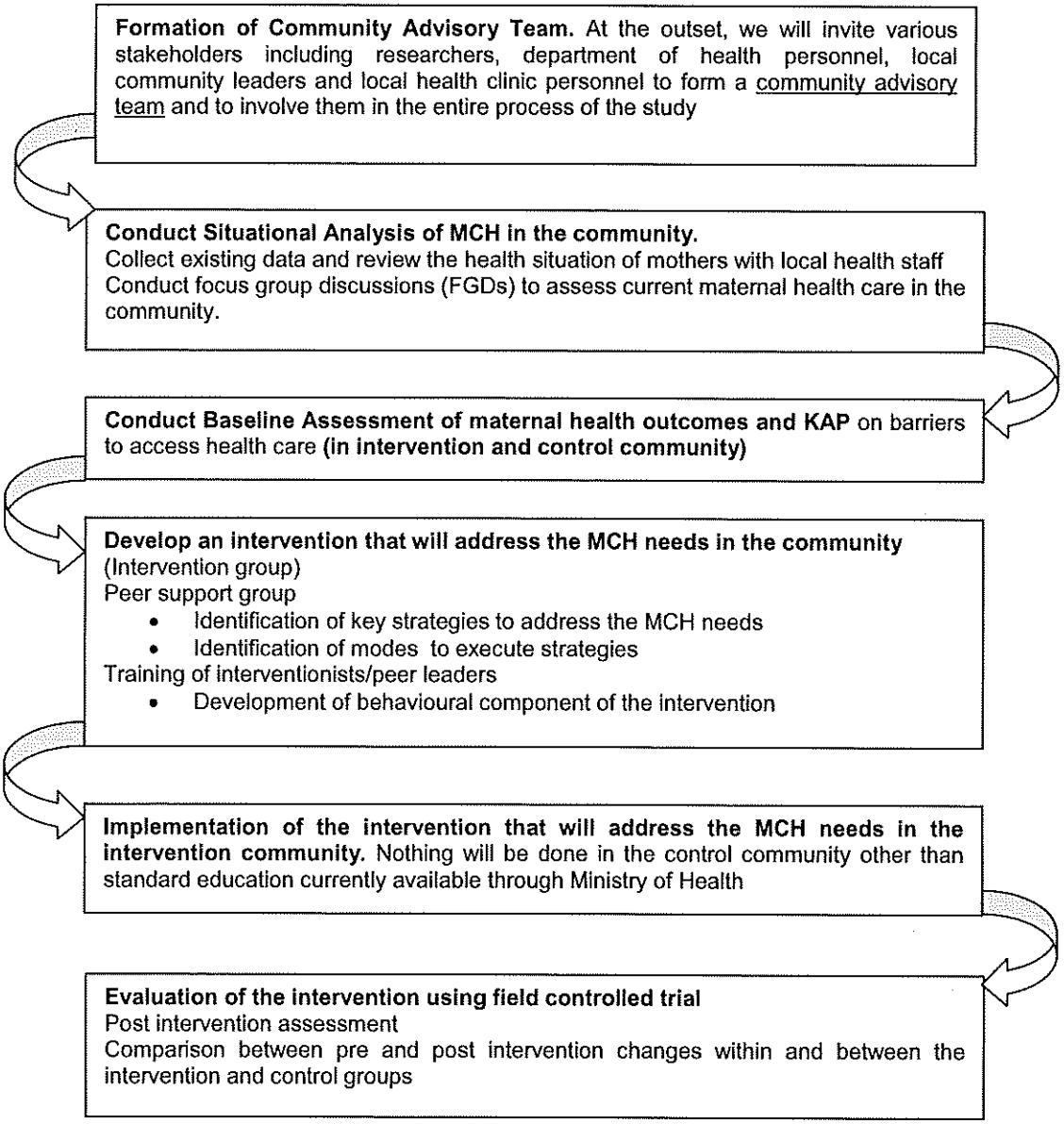
Interpreters, preferably women interpreters who speak the relevant Orang Asli ethnic language/dialect, if required, will be recruited to assist any participant who has difficulties in communicating in Bahasa Malaysia. Provision of healthy food and dietary supplement will be provided to all the participants as a token of appreciation for their participation in the study.

Output 3: Evaluation of intervention conducted and reported

The impact of the intervention will be evaluated by comparing pre-and post-intervention assessments of the chosen maternal health indicators within and among the intervention and control groups at a six-month and 12-month follow up period. The research team will liaise with the local district health clinics to assist in monitoring baseline/pre- and post-intervention maternal health indicators. Periodic blood investigation such the finger-prick haemoglobin level test to monitor the level of anaemia in pregnancy among the participants will be arranged and conducted by the local district clinics. The clinic coordinator will subsequently enter the results into the database.

The evaluation will be used to measure the effectiveness of the peer support group as a community-based intervention that is acceptable and self-sustaining in Orang Asli communities. A report will be produced to record the successes and challenges of the intervention, lessons learnt and recommendations for improvement, and depending on the results of the intervention, for up scaling the initiative to other villages.

Conceptual Framework for This Pilot Study



Sustainability and Replicability

As the healthcare of Orang Asli is now under the purview of the Ministry of Health – and there is a unit overseeing the health status of Orang Asli – IHM will share the results of the study with the management of the Ministry to contribute to the long term development and improvement of the Orang Asli's healthcare system and health indicators respectively. Based on this IHM will seek further funding from MOH as well as other sources of international research funding.

Based on lessons learnt and successes of the project, IHM will also seek to replicate the intervention in different areas as well as expanding health indicators to other health issues that affect Orang Asli communities.

III. ANNUAL WORK PLAN (2014)

EXPECTED OUTPUTS *And baseline, indicators including annual targets*	PLANNED ACTIVITIES *List activity results and associated actions*	TIMEFRAME				RESPONSIBLE PARTY	PLANNED BUDGET		
		Q1	Q2	Q3	Q4		Funding Source	Budget Description	Amount
Output 1: Situation analysis of the maternal health and care-seeking (MCH) behaviour of a targeted *Orang Asli* population **Baseline:** MOH has not developed specific situation analysis **Indicators:** Situation analysis produced	**Activity Results 1: Situation analysis of the maternal health and care-seeking behaviour of a targeted *Orang Asli* population developed** **Associated Actions:** 1. Form the 'Community Advisory Team' 2. Develop and pilot questionnaire 3. Identify participants (for "controlled" and "intervention" groups 4. Conduct field surveys (questionnaire, FGD and IDIs) 5. Input data and collate database 6. Transcribe FGDs and IDIs 7. Analyse data collected 8. Develop situation analysis report		X X X X	 X X X X	 X X X X	Institute of Health Management	COST SHARE	Travel (Daily Allowance) Travel (Road transport for Kg Rangan) Printing and Publication Contract Staff Misc.	USD 17,415 USD 306 USD 412 USD 6,453 USD 13,291
Output 2: An intervention that will address the MCH needs in the community developed and piloted **Baseline:** MOH has introduced such interventions for Orang Asli communities **Indicators:** Intervention conducted	**Activity Results 2: Intervention that will address the MCH needs in the community developed and piloted** **Associated Actions:** 1. Identification of key strategies to address MCH needs of identified participants 2. Identification of modes to execute strategies 3. Training of interventionists/peer leaders (and interpreters if needed) 4. Develop behavioural component of the intervention 5. Implement intervention with participants 6. Monitor progress and impact of intervention			X X	 X X X X	Institute of Health Management	TRAC	Travel (Daily Allowance) Workshop/ Training Contract Staff Misc.	USD 9,288 USD 611 USD 3,226 USD 5,652

Project Management and Monitoring and Evaluation	**Activity Result** - **Project managed, monitored & evaluated** - **Project roles as outlined in the CPAP 2013-2015: National Implementation Modality – Roles and Responsibilities are fully implemented.** **Associated Actions** 1. Monitor the financial management by IHM of project funds 2. Support the activities outlined in Section VI: Monitoring and Evaluation are fully complied and completed by IHM 3. Provision of UNDP related technical and advisory services by UNDP CO and coordination with relevant UN agencies.		X X X	X X X	X X X	UNDP	TRAC COST SHARE	Travel Direct Project Cost Implementing Support Services	USD 200 USD 2,750 USD1,800
								TOTAL	**USD61,404**

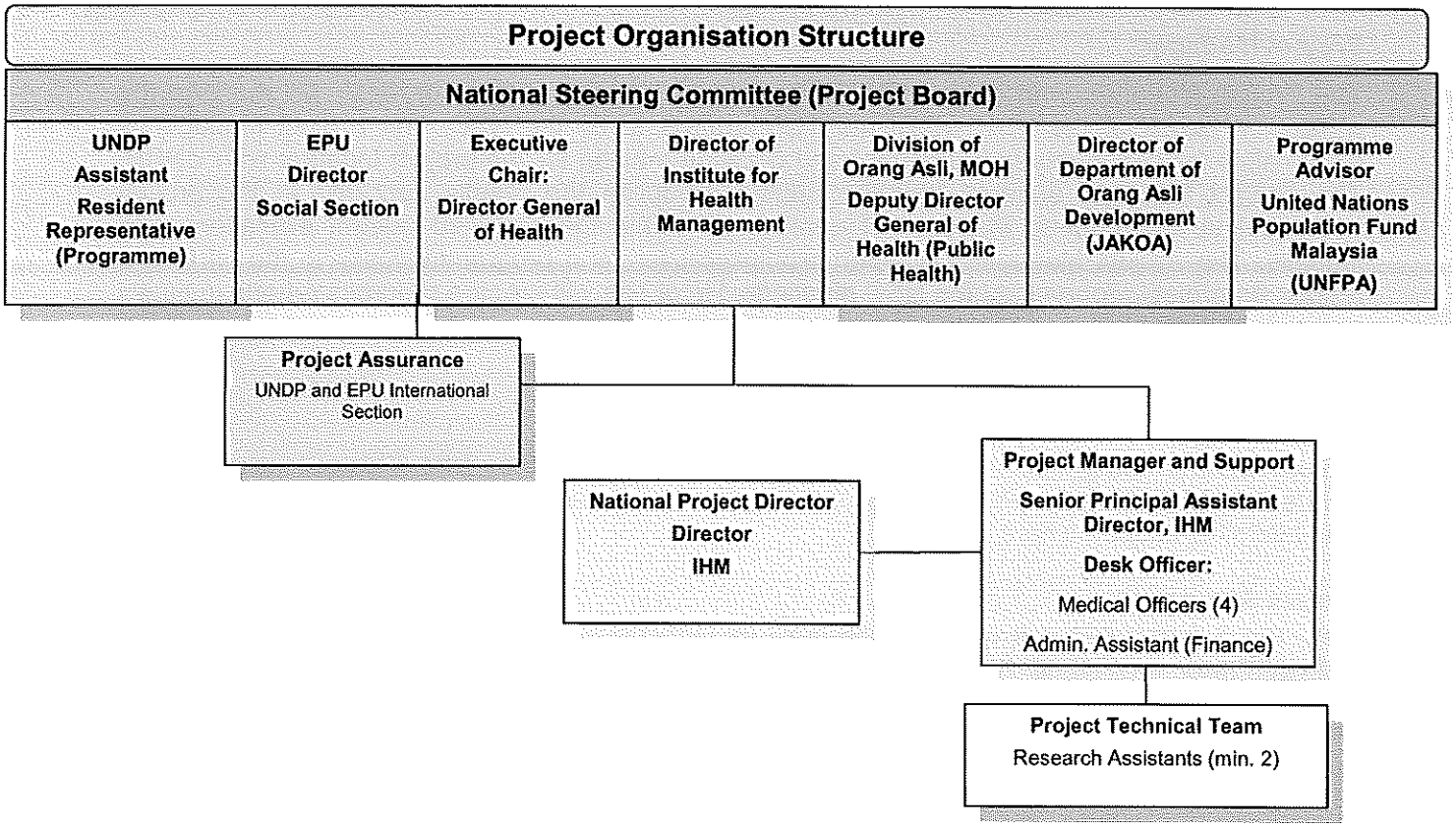
ANNUAL WORK PLAN (2015)

EXPECTED OUTPUTS *And baseline, indicators including annual targets*	PLANNED ACTIVITIES *List activity results and associated actions*	TIMEFRAME				RESPONSIBLE PARTY	PLANNED BUDGET		
		Q1	Q2	Q3	Q4		Funding Source	Budget Description	Amount
Output 3: Evaluation of intervention conducted and reported	**Activity Results 3: Intervention pilot evaluated** **Associated Actions:** 1. Identification and confirmation of methods for evaluation. 2. Coordination with local district health clinics and relevant persons to monitor the health progress of identified participants to evaluate impact of intervention (utilizing questionnaires). 3. Produce and print evaluation report.	X	X X	X X	 X	Institute of Health Management	TRAC	Contract Staff Printing and Publication Misc.	USD 3,226 USD 962 USD 5,194
Project Management and Monitoring and Evaluation	**Activity Result** - **Project managed, monitored & evaluated** - **Project roles as outlined in the CPAP 2013-2015: National Implementation Modality – Roles and Responsibilities are fully implemented.** **Associated Actions** 1. Monitor the financial management by IHM of project funds 2. Support the activities outlined in Section VI: Monitoring and Evaluation are fully complied and completed by IHM 3. Provision of UNDP related technical and advisory services by UNDP CO and coordination with relevant UN agencies.	X X X	X X X	X X X	X X X	UNDP	TRAC COST SHARE	Travel Direct Project Cost Implementing Support Services	USD 106 USD 1,833 USD1,255
								TOTAL	**USD12,576**

IV. PROJECT BUDGET

Outcome/Atlas Activity[1]	Responsible Party	Fund ID	Donor Name	Atlas Budgetary Account Code	ATLAS Budget Description	Amount 2014 (USD)	Amount 2015 (USD)	Total (USD)
Output 1: Situation analysis of the maternal health and care-seeking (MCH) behaviour of a targeted *Orang Asli* population	Institute of Health Management	11888	Cost Share 00157 – Government of Malaysia	71600	Travel (Daily Allowance)	17,415		17,415
				71600	Travel (Road transport for Kg Rangan)	306		306
				74200	Printing and Publication	412		412
				71400	Contract Staff	6,453		6,453
				74500	Misc.	13,291		13,291
Output 2: An intervention that will address the MCH needs in the community developed and piloted	Institute of Health Management	04000	TRAC 00012 - UNDP	71600	Travel (Daily Allowance)	9,288		9,288
				75700	Workshop/Training	611		611
				71400	Contract Staff	3,226		3,226
				74500	Misc.	5,652		5,652
Output 3: Evaluation of intervention conducted and reported	Institute of Health Management	04000	TRAC 00012 - UNDP	71400	Contract Staff.		3,226	3,226
				74200	Printing and Publication		962	962
				74500	Misc.		5,194	5,194
Project Management, including Monitoring and evaluation	UNDP	04000	TRAC 00012 - UNDP	71600	Travel	200	106	306
		11888	Cost Share 00157 – Government of Malaysia	73500	Direct Project Cost	2,750	1,833	4,583
		11888	Cost Share 00157 – Government of Malaysia	73500	Reimbursement to UNDP for Support Services (ISS)	1,800	1,255	3.055
				PROJECT SUB TOTAL		**61,404**	**12,576**	**73,980**
GMS (6% CS)						**2,546**	**185**	**2,731**
Total				**PROJECT TOTAL**		**63,950**	**12,761**	**76,711**

V. MANAGEMENT ARRANGEMENTS



National Steering Committee (NSC)

A National Steering Committee will provide guidance and direction to the project implementation process according to the established detailed work plan monitoring tool. The Committee will be composed of representatives from the Ministry of Health, the Institute of Health Management (IHM), EPU, UNDP Malaysia, the Department of Orang Asli Development, the United Nations Population Fund Malaysia (UNFPA) and other relevant stakeholders to be identified. The TORs of the NSC shall be agreed among the stakeholders within the first two months of the project. Refer Annex 5 for the TOR. The NSC will be chaired by the Director General of Health.

National Project Director (NPD)

The National Project Director will be responsible for coordinating project activities among the main parties to the project. Among these responsibilities are ensuring that the project document and project revisions requiring Government's approval are verified by the IHM and processed through the Government co-coordinating authority in accordance with established procedures and providing direction and guidance on project-related issues. The NPD also has the authority to disburse funds upon the advice from the National Steering Committee or the Project Manager based on the required project milestones. Refer Annex 6 for the TOR. The NPD of the project will be the Director of IHM.

Project Technical Team (PTT)

The study for the project will be undertaken by four medical officers and one research officer from IHM, and two research assistants who will be appointed under the project (Refer to Annex 8 for the TOR). The research assistants will be hired based on temporary basis. They will be given responsibilities such as data entry, data transcription for qualitative component and data analysis. They will also participate in the trips to the study sites to collect the data. In addition, they will assist in the process of writing the report.

Where necessary, the UNDP global knowledge network will provide inputs through best practices and lessons learned from similar experiences in other countries.

Project Manager

The Project Manager, who will be the Senior Principal Assistant Director, IHM, will manage the project on behalf of the NSC within the TOR agreed to by the NSC. The Project Manager is responsible for day-to-day management and decision-making for the project together with UNDP. The Project Manager ensures that the project produces the results specified in the project document to the required standard of quality and within the specified budget allocations and timeline. The Project Manager will report administratively and programmatically to the NPD and reports on project progress during NSC meetings. He or she will prepare progress reports in timely and required manner, and provide the information needed to agree disbursement of funds. Refer to Annex 7 for the TOR.

Support Staff

Support staff for the project and Project Manager will be provided by IHM. This will include short-term secretariat services, photocopying, and finalization of minutes for PTT and NSC and other administrative support where necessary.

Project Assurance

The Project Assurance role supports the NSC by carrying out objective and independent project oversight and monitoring functions. This role ensures that appropriate project management milestones are managed and completed. A UNDP Programme Officer will hold the Project Assurance role for the UNDP together with a representative from the International Cooperation Section, EPU, representing the Malaysian Government. Risk factors as in Annex 1 will be periodically reviewed to ensure the risks are mitigated and manageable. Necessary actions to overcome any project challenges will be discussed as well.

Financial Management

The UNDP Resident Representative ensures that the project has an internal control system that allows it to monitor effectively the financial activity of the project and to support and monitor the progress towards achieving results. UNDP may assist with direct payments to other parties for goods and services provided to the project. In this connection, the government implementing agency will forward to the UNDP a standard form and keep all the original record of the transaction such as purchases orders, invoices, receipts, delivery orders etc.

Based on the approved AWP, UNDP will provide required financial resources to the Implementing Partner to carry out project activities during the annual cycle. Under the Harmonized Approach to Cash Transfer (HACT), the following modalities may be used:

- Direct cash transfers to the Implementing Partner, for obligations and expenditures to be made by them in support of activities;
- Direct payments to vendors and other third parties, for obligations incurred by the Implementing Partner;
- Reimbursement to the Implementing Partner for obligations made and expenditure incurred by them in support of activities

The FACE form as per Annex 3 should be used for all of the above cash disbursements as well as for expenditure reporting.

The Implementing partner and Project Manager will work closely with UNDP to monitor the use of the financial resources and are accountable for

- Managing UNDP's/ CS resources to achieve the expected results
- Maintaining an up to date accounting system that contains records and controls to ensure the accuracy and reliability of financial information and reporting. Expenditures made should be in accordance with the, Annual Work Plans and budgets.

On an annual basis, UNDP prepares a Combined Delivery Report (CDR) which records all disbursements made under the project for verification. The Implementing Partner and UNDP should sign this CDR.

A project revision shall be made when appropriate; to respond to changes in the development context or to adjust the design and resources allocation to ensure the effectiveness of the project provided that the project remains relevant to the Country Programme. A project revision shall be supported by the record of an approval decision made by the project NSC, and an updated and signed AWP.

UNDP Support Services
In addition, UNDP may/ shall provide the following services (if applicable):

- identification and recruitment of project personnel/ consultants;
- procurement of goods and services; and
- identification of training activities and assistance in carrying them out

The above will be carried out based on UNDP policies and procedures following the principles of best value for money, fairness, integrity, transparency, and effective competition (see Annex 11). UNDP shall charge to the project as per the Universal Price List where required (see Annex 6).

UNDP will also charge for the support services provided as follows:

- 6% cost recovery for the provision of general management support (GMS) for activities funded under Government Cost sharing, if any
- Direct cost for implementation support services (ISS) for activities under TRAC and CS funding, if any
- Any other direct and indirect project costs that are incurred by UNDP, which will be communicated and approved by the NSC beforehand.

In-Kind Contribution
In addition to the financial resources through UNDP, the implementing partner will provide the following in-kind contribution:

- Assist in gaining access to all relevant data and information required to for the project that is accessible for public viewing;
- Assist in coordinating with other agencies and ministries
- Office space (i.e. room/workspace) for the Project Manager, consultants and experts at IHM, MOH
- Use of office support facilities by the Project Manager,, consultants and experts (e.g. fax machine, stationary, Xerox machine, telephone), and secretarial support where applicable;
- Facilities for convening meetings, workshops and seminars.

Any reimbursable expenses can be borne by the project fund as agreed in the Annual Work Plan (AWP).

Activities related to Implementation of Nationally Implementation Modality (NIM)
The project will be implemented according to the National Implementation Modality (NIM). The table below encompasses in detail each section related to the effective implementation of the NIM modality, derived from the "Country Programme Action Plan between the Government of Malaysia and the UNDP 2013-2015 NIM: Roles and Responsibilities" document. See Annex 9.

VI. MONITORING FRAMEWORK AND EVALUATION

The project activities will be closely monitored by UNDP Malaysia and EPU International Section. In compliance with UNDP regulations, the following will be conducted:

Project Monitoring and Review Meetings

- National Steering Committee Meetings

The National Steering Committee (NSC) will meet after the receipt of each project report and address project issues raised by the National Project Director / Project Manager, review project progress reports and provide direction and recommendations to ensure that the agreed deliverables are produced satisfactorily according to the project document. A final NSC meeting should also be held at the end of project completion to agree to and endorse the final findings and outcomes of the project and to make recommendations towards project closure. Project budget revision and project extension are not allowed.

- Project Review Meeting/ Project Closure

A Final Project Review meeting will be conducted towards the end of the project completion. Its purpose is to assess the performance and success of the project. It should look at sustainability of the results, including the contribution to related outcomes (and the status of these outcomes) and capacity development. It will also review lessons learned and recommendations that might improve design and implementation of other UNDP-funded projects. The meeting will discuss the Final Project Review Report that should be submitted two weeks prior to the Final Project Review Meeting.

Progress Reporting Documents

- Annual Progress Report (APR)

An Annual Progress Report shall also be prepared by the Project Manager/ Implementing Partner and shared with UNDP and the Economic Planning Unit – International Cooperation Section by the end of the last quarter of each calendar year (regardless of the time the project has begun). The Annual Progress Report shall highlight risks and challenges, the summary of results achieved, and lessons learnt of the project for that reporting year. Refer to Annex 2 for template.

- Final Project Review Report/ Project Closure

This document which is prepared by the Implementing Partner is a structured assessment of progress based on the chain of results initially defined in the Project Document and Annual Workplans and will include information on financial allocations of expenditure. It may be supplemented by additional narrative to meet specific reporting needs of stakeholders, especially the donor(s). The following should be submitted together with the report:

- Lessons learnt log - summarizing information captured throughout implementation of the project
- Minutes of NSC
- Statements of cash position and statements of assets and equipment
- All project outputs – i.e. reports, knowledge products, etc.

This report will be discussed at the Final Project Closure meeting.

Financial Monitoring and Quality Assurance

- Combined Delivery Reports

The Combined Delivery Report (CDR) is the report that reflects the total expenditures and actual obligations (recorded in Atlas) of a Project during a period. This report is prepared by UNDP Malaysia using Atlas and shared with the Implementing Partner on a annual basis. The Implementing Partner is required to verify each transaction made and sign the annual issued CDR report. Statements of cash position as well as assets and equipment should also be submitted together with the CDR on a yearly basis.

Audit

Audit is an integral part of sound financial and administrative management, and of the UNDP accountability framework. The project will be audited at least once in its lifetime and in accordance with the threshold established for the annual expenditures by the Office of Audit and Investigations (OAI). The audit provides UNDP with assurance that resources are used to achieve the results described and that UNDP resources are adequately safeguarded.

The selection of an Audit Firm shall be through a competitive Request for Proposals, in consultation with the Implementing Partner and EPU or if possible shall be performed by the National Audit Authority (Jabatan Audit Negara). UNDP procedures must be followed as per the specific Terms of Reference for Audits of NEX/NIM Projects.

The audit is expected to provide assurance related to the following broad areas:

- Project progress and rate of delivery
- Financial management
- Procurement of goods and /or services
- Human resource selection and administration
- Management and use of equipment and inventory
- Record-keeping systems and controls
- Management structure
- Auditors' comments on the implementation status of prior year audit

VII. LEGAL CONTEXT

This document together with the CPAP signed by the Government and UNDP which is incorporated herein by reference, constitute together a Project Document as referred to in the Standard Basic Assistance Agreement (SBAA); as such all provisions of the CPAP apply to this document. All references in the SBAA to "Executing Agency" shall be deemed to refer to "Implementing Partner", as such term is defined and used in the CPAP and this document.

Consistent with the Article III of the Standard Basic Assistance Agreement (SBAA), the responsibility for the safety and security of the Implementing Partner and its personnel and property, and of UNDP's property in the Implementing Partner's custody, rests with the Implementing Partner. To this end, the Implementing Partner shall:
a) put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
b) assume all risks and liabilities related to the implementing partner's security, and the full implementation of the security plan.

UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the Implementing Partner's obligations under this Project Document [and the Project Cooperation Agreement between UNDP and the Implementing Partner].

The Implementing Partner agrees to undertake all reasonable efforts to ensure that none of the UNDP funds received pursuant to the Project Document are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via: **http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml**. This provision must be included in all sub-contracts or sub-agreements entered into under/further to this Project Document".

ANNEXES

1. Monitoring: Risks And Mitigation
2. Monitoring: Project Annual Report Template
3. Finance: FACE Form
4. Finance: Universal Price List
5. Terms Of Reference: National Steering Committee
6. Terms Of Reference: National Project Director
7. Terms Of Reference: Project Manager
8. Terms of Reference: Research Assistants
9. Management: Letter of Agreement between UNDP and the Government of Malaysia for Provision of Support Services under National Execution
10. Country Programme Action Plan between the Government of Malaysia and the UNDP 2013-2015 NIM: Roles and Responsibilities

ANNEX 1: MONITORING: RISKS AND MITIGATION

Description	Type	Impact & Probability	Mitigation Measures
The value of US Dollars foreign exchange against the ringgit may reduce during the project cycle	Financial	Probability: Low Impact: Medium	There will be a need to regularly monitor the exchange rate to ensure that it does not affect the budget of the project. If there are major changes, the budget will be adjusted accordingly and approved by the NSC. Alternative funding source may be considered.
There may be some delay in the project timeline due to possible challenges of identifying the appropriate Orang Asli target groups	Others	Probability: High Impact: High	There will be close consultation between IHM and Jabatan Kemajuan Orang Asli (JAKOA) and District Health offices to ensure an expedient identification of the participants and ensure the in-depth study is completed on schedule and the objectives of the respective activities are achieved.
Challenges to conduct the study (field survey, FGD and IDIs) and conduct the intervention pilot due to accessibility and logistics.	Others	Probability: Medium Impact: High	There will be close consultation between IHM and Jabatan Kemajuan Orang Asli (JAKOA) and District Health offices to assist with accessibility and logistics advice and support.

ANNEX 2: MONITORING: PROJECT ANNUAL PROGRESS REPORT

COUNTRY PROGRAMME ACTION PLAN 2013-2015

ANNUAL PROGRESS REPORT

Section 1: Overall Implementation of Project Outputs as Per Signed Annual Work Plan

20 AWP Budget:**	**Total Project Expenditure:**
20 Expenditure:**	**Total Project Expenditure (%):**
20 Expenditure (%):**	**In-Kind Contribution:**
In-Kind Contribution:	

OUTPUT 1:

Activity 1:

Target 20:**

Achievement and Results 20:**

Activity 2:

Target 20:**

Achievement and Results 20:**

Remarks if any project activities and targets were not implemented or amended.

OUTPUT 2:

Activity 1:
Target 20:**
Achievement and Results 20:**

Activity 2:
Target 2013:
Achievement and Results 20:**

Remarks if any project activities and targets were not implemented or amended.

OUTPUT 3:

Activity 1:
Target 20:**
Achievement and Results 20:**

Activity 2:
Target 2013:
Achievement and Results 20:**

Remarks if any project activities and targets were not implemented or amended.

Section 2: Project Contribution to National Development Agenda in 20**

2.1 Contribution to Analysis/ Development/ Refinement of National or Sectoral Policies, Strategies and Action Plans

(Note: Please indicate and elaborate on how the outputs have been utilized by the Implementing Partner to contribute to analysis/ development/ refinement of National or Sectoral Policies, Strategies and Action Plans. Please also indicate if the outputs have contributed to the implementation of the 10th Malaysia Plan or inputs into the 11th Malaysia Plan preparatory work.)

☐ Yes	
☐ No	

2.2 Contribution to awareness raising or convening on key thematic issues

(Note: Please indicate the thematic issues, objective of activities and the number of participants and affiliations.)

☐ Yes	Topic: Objective: Participants Pax: Affiliations (Name the Ministries involved and indicate the number of private sector, civil society organizations and academia who participated):
☐ No	

2.3 Contribution to capacity development and institutional arrangements (Mandatory response)

(Note: Please indicate if capacities are being built to implement or sustain systemic changes.)

☐ Yes	
☐ No	

2.4 Contribution to development of new datasets, statistics or models

(Note: Please indicate if datasets, statistics or models have been generated or improved/ updated. Please also indicate on how these have been utilized by the Implementing Partner to strengthen national evidence based policy making.)

☐ Yes	
☐ No	

2.5 Demonstration or Pilot Initiative

(Note: Please indicate if demonstration or pilot initiatives were undertaken and how outputs have contributed to inform decision-making and/or national policy and also if it has led to actual/ planned upscaling or replication.)

☐ Yes	
☐ No	

2.6 Review of Risk Analysis and Action

(Note: Upon reviewing the Risk Analysis stated in the Project Document, please indicate if the risks status were monitored and updated regularly. Please also highlight mitigation steps undertaken, if applicable.)

☐ Yes	
☐ No	

2.7 Areas of Improvement for Project Management and Implementation

(Note: Please indicate any additional comments on areas of improvement that should be taken into consideration by EPU and UNDP Malaysia in the implementation of future projects.)

Section 3: Project Extension into 20**

*(NOTE: APPLICABLE ONLY TO PROJECTS ORIGINALLY SCHEDULED FOR COMPLETION IN 20**)*

Please indicate reasons for the project extension
Proposed duration of project extensions XX Months
Agreement by National Steering Committee: Date of Meeting: Minutes Attached: ☐ Yes ☐ No

Annual Progress Report approved by:

.....

Name

Designation

ANNEX 3: FINANCE: FACE FORM

Funding Authorization and Certificate of Expenditures

UN Agency: XXXXXXXXXX

Date: DD/MM/YYYY

Country: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Programme Code & Title: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Project Code & Title: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Responsible Officer(s): XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Implementing Partner: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Type of Request:
- ☐ Direct Cash Transfer (DCT)
- ☐ Reimbursement
- ☐ Direct Payment

Currency: _____

Activity Description from AWP with Duration	Coding for UNDP, UNFPA and WFP	REPORTING				REQUESTS / AUTHORIZATIONS		
		Authorised Amount MM-MM YYYY A	Actual Project Expenditure B	Expenditures accepted by Agency C	Balance D = A - C	New Request Period & Amount MM-MM YYYY E	Authorised Amount F	Outstanding Authorised Amount G = D + F
XXXXXXXXXXXXXXXXXXXXXXXXX (MM/YYYY - MM/YYYY)								
XXXXXXXXXXXXXXXXXXXXXXXXX (MM/YYYY - MM/YYYY)								
XXXXXXXXXXXXXXXXXXXXXXXXX (MM/YYYY - MM/YYYY)								
Total		0	0	0	0	0	0	0

CERTIFICATION

The undersigned authorized officer of the above-mentioned implementing institution hereby certifies that:

- ☐ The funding request shown above represents estimated expenditures as per AWP and itemized cost estimates attached.
- ☐ The actual expenditures for the period stated herein has been disbursed in accordance with the AWP and request with itemized cost estimates. The detailed accounting documents for these expenditures can be made available for examination, when required, for the period of five years from the date of the provision of funds.

Date Submitted: _____ Name: _____ Title: _____

NOTES: * Shaded areas to be completed by the UN Agency and non-shaded areas to be completed by the counterpart.

FOR AGENCY USE ONLY:

FOR ALL AGENCIES
Approved by:
Name: _____
Title: _____
Date: _____

FOR UNICEF USE ONLY			
Account Charges		Liquidation Information	
Cash Transfer Reference:		DCT Reference:	
CRQ ref. no., Voucher ref. no.		*CRQ ref. no., Liquidation ref. no.*	
GL codes:		DCT Amount	0
Training	0	Less:	
Travel	0	Liquidation	
Meetings & Conferences	0	Amount	0
Other Cash Transfers	0		
Total	0	Balance	0

FOR UNFPA USE ONLY	
New Funding Release	
Activity 1	0
Activity 2	0
Total	0

ANNEX 4: FINANCE: UNDP UNIVERSAL PRICE LIST

Country Office	Cost Band	Country Office	Cost Band	Country Office	Cost Band
Albania	Mid-Low	Ghana	Low	Philippines	Mid-Low
Algeria	Low	Guatemala	High	Poland	High
Angola	High	Guinea	Low	Republic of Montenegro	Mid-High
Argentina	High	Guinea-Bissau	Mid-Low	Romania	Mid-High
Armenia	Low	Guyana	Low	Rwanda	Mid-Low
Azerbaijan	Mid-High	Honduras	Mid-High	Sao Tome and Principe	Low
Bahrain	High	India	Mid-Low	Saudi Arabia	High
Bangladesh	Mid-High	Indonesia	Mid-High	Senegal	Mid-High
Barbados	High	Iran (Islamic Rep)	Mid-High	Serbia	Mid-High
Belarus	Mid-Low	Jamaica	Mid-Low	Slovakia	High
Belize	Mid-Low	Jordan	Mid-Low	South Africa	Mid-High
Benin	Mid-Low	Kazakstan	Mid-High	Sri Lanka	Low
Bhutan	Low	Kenya	High	Swaziland	Mid-Low
Bolivia	High	Kosovo	Mid-Low	Sudan	Mid-Low
Bosnia and Herzegovina	Mid-Low	Kuwait	High	Tajikistan	Low
Botswana	Mid-Low	Kyrgyzstan	Low	Tanzania - U Rep of	Mid-High
Brazil	High	Lao PDR	Low	Thailand	High
Bulgaria	Mid-High	Latvia	Low	Togo	Mid-Low
Burkina Faso	Mid-Low	Lebanon	High	Trinidad and Tobago	Mid-High
Burundi	Low	Lesotho	Low	Tunisia	Low
Cambodia	Low	Lithuania	Mid-Low	Turkey	High
Cameroon	Mid-High	Macedonia	Mid-High	Turkmenistan	Mid-Low
Cape Verde	Mid-Low	Madagascar	Low	Uganda	Mid-High
Central African Republic	Mid-High	Malawi	Low	Ukraine	Mid-High
Chile	High	Malaysia	Mid-Low	United Arab Emirates	High
China	High	Maldives	Low	Uruguay	High
Colombia	High	Mauritania	Mid-Low	Uzbekistan	Mid-Low
Comoros	Low	Mauritius	Mid-High	Venezuela	High
Congo	Mid-High	Mexico	High	Viet Nam	Mid-Low
Costa Rica	High	Moldova - Rep of	Low	Zambia	High
Croatia	Mid-High	Mongolia	Low	Zimbabwe	High
Cuba	Low	Morocco	High		
Djibouti	Mid-Low	Mozambique	Mid-High		
Dominican Republic	Mid-High	Myanmar	Low		
Ecuador	High	Namibia	Mid-Low		
Egypt	Mid-Low	Nepal	Low		
El Salvador	Mid-High	Nicaragua	Low		
Equatorial Guinea	Mid-Low	Niger	Mid-Low		
Eritrea	Low	Nigeria	High		
Ethiopia	Low	Panama	Mid-High		
Gabon	Mid-High	Paraguay	Mid-High		
Gambia	Low	Peru	High		

Principles of the Universal Price List

The UPL consists of a set of standard services, with reasonable cost estimates, that can be provided by UNDP country offices. Note, the UPL is only intended to price specified standard services — not inputs to UNDP projects and programmes. The pricing of inputs to UNDP projects and programmes should be based on actual costs for clearly identifiable transactions. When this is not possible, country offices may use the UPL.

The UPL does not cover specialized or locally provided *ad-hoc* services. The UPL also does not cover local security-related services that might be necessary in certain countries without banking facilities. Both *ad-hoc* and local security services, and their estimated costs, should be covered through locally negotiated agreements between UNDP country offices and concerned Implementing Partner.

1. Not all Implementing Partner require all services. In particular, they may carry out several UPL sub-transactions, thus reducing the overall cost of the service. Each standard service in the UPL takes this into consideration.

2. A certain number of services which were previously categorized as standard administrative services (local driver's licenses, visa requests, customs clearance, etc.) have now been eliminated from the UPL. Any standard service not listed on the UPL is to be considered ad-hoc/non-standard service subject to full cost recovery per locally negotiated prices using transparent prevailing market rates.

3. The request for services under the following exceptional circumstances are subject to a 25% surcharge on top of the regularly accepted cost/price:
   - Urgent requests requiring a turnaround of less than 3 business days.
   - Requests for services before/after normal working hours.

4. Requests for prior year UPL services should always use the latest applicable published rates (not UPLs from prior years) without exception.

5. **Payment Process:** the process includes disbursement only, and requires a written instruction by the budget owner agency. UNDP does not review procurement process supporting documentation other than vendor banking information, unless otherwise stipulated locally. Note that UNDP does not charge Implementing Partner for running a fully automated pay cycle.

6. Staff selection and recruitment process for resident agencies only.

7. In cases where a reciprocity agreement does not exist between UNDP and Implementing Partner, the time spent on joint boards (recruitment, procurement, etc.) will be charged as an ad-hoc service.

8. **Staff HR and Benefits Administration & Management** typically include services such as:
   - Position Data and Budget management
   - Issuance of contract
   - HR and dependent/beneficiary data entry and maintenance
   - Benefits data entry and maintenance (PF/Medical/Life Insurance)
   - Interface with GMC Henner on MIP reimbursements
   - Organization events (within grade increments, secondments, transfers etc)
   - Life events (changes to marital status and dependents)
   - HR data management for ASHI retirees
   - Production of key HR reports such as staffing table & personnel action forms (PAFs)
   - Guidance to staff and managers on HR rules and regulations

9. **Staff Payroll and Banking Administration & Management** are distinct from Global Payroll Services (provided by UNDP Copenhagen) and include services such as:
   - Setting up transactions that impact payroll such as one-time or recurring earnings and deductions, garnishments, positive inputs for overtime payments and transportation allowance.
   - Administration of retroactivity, recoveries and adjustments
   - Maintenance of the absence calendars for that location
   - Management of absence data
   - Validation of trial payroll results prior to the final pay run.
   - Maintenance of employee banking instructions
   - Tracking and adjusting of leave balances that affect pay
   - Reporting of payroll activity to Managers
   - Production of payroll reports and queries
   - Production of pay slips for employees
   - Manage receivables and payables that have an impact in Payroll including benefits billing for retirees and SLWOP. The Administrator GP will be granted access to the Finance Module to process these transactions.
   - Production, follow up and clean-up of the PVR reports

10. As stated above, the UPL is only intended to price services to Implementing Partners — not inputs to UNDP projects and programmes. The pricing of inputs to UNDP projects and programmes should be based on actual costs for clearly identifiable transactions. When this is not possible, country offices may use the UPL. Where the portion of the procurement process that takes place outside Atlas is of a clearly complex (ad-hoc) nature involving specialized supply-chain management processes, dedicated procurement staff, etc., offices are encouraged to determine the actual cost of the exercise and explore with donors/partners the possibility of charging the cost of some of its specific components (e.g. dedicated staff) — in full or in part — to the project budget as a direct input to project delivery (i.e., negotiated transparent, prevailing rates using the UPL as a baseline).

11. If, due to its size and/or complexity, a procurement process must be submitted to a Regional ACP (or regular ACP), it should be treated like ad-hoc service subject to full cost recovery at transparent, prevailing market rates.

Country Cost Bands

Country Office	Cost Band	Country Office	Cost Band	Country Office	Cost Band
Albania	Mid-Low	Ghana	Low	Nigeria	High
Algeria	Low	Guatemala	High	Panama	Mid-Low
Angola	High	Guinea	Low	Papua New Guinea	Mid-Low
Argentina	Mid-High	Guinea-Bissau	Mid-Low	Paraguay	Mid-High
Armenia	Mid-Low	Guyana	Low	Peru	High
Azerbaijan	Mid-High	Honduras	Mid-High	Philippines	Mid-Low
Bahrain	High	India	Mid-High	Poland	High
Bangladesh	Mid-Low	Indonesia	High	Republic of	Mid-High
Barbados	High	Iran (Islamic Rep)	Mid-Low	Romania	Mid-High
Belarus	Mid-Low	Iraq	Mid-Low	Rwanda	Mid-Low
Belize	Mid-Low	Israel/PAPP	High	Samoa	Low
Benin	Mid-Low	Jamaica	Mid-High	Sao Tome and	Low
Bhutan	Low	Jordan	Mid-Low	Saudi Arabia	High
Bolivia	High	Kazakstan	High	Senegal	Mid-High
Bosnia and Herzegovina	Mid-Low	Kenya	Mid-High	Serbia	Mid-High
Botswana	Mid-High	Kosovo	Mid-Low	Slovakia	High
Brazil	High	Kuwait	High	South Africa	High
Bulgaria	Mid-High	Kyrgyzstan	Low	Sri Lanka	Low
Burkina Faso	Mid-Low	Lao PD R	Low	Swaziland	Mid-High
Burundi	Low	Latvia	Low	Syrian Arab Republic	Low
Cambodia	Low	Lebanon	High	Sudan	Mid-High
Cameroon	Mid-High	Lesotho	Mid-Low	Tajikistan	Low
Cape Verde	Mid-High	Libyan Arab	Mid-Low	Tanzania - U Rep of	Mid-Low
Central African Republic	Mid-High	Lithuania	Mid-Low	Thailand	High
Chile	High	Macedonia	Mid-High	Togo	Mid-Low
China	Mid-High	Madagascar	Low	Trinidad and Tobago	Mid-High
Colombia	High	Malawi	Mid-High	Tunisia	Low
Comoros	Mid-Low	**Malaysia**	**Mid-Low**	Turkey	High
Congo	High	Maldives	Low	Turkmenistan	Low
Costa Rica	High	Mali	Low	Uganda	Mid-Low
Croatia	Mid-High	Mauritania	Mid-Low	Ukraine	Mid-Low
Cuba	Low	Mauritius	Mid-High	United Arab Emirates	High
Djibouti	Mid-Low	Mexico	High	Uruguay	High
Dominican Republic	High	Moldova - Rep of	Low	Uzbekistan	Low
Ecuador	High	Mongolia	Low	Venezuela	High
Egypt	Mid-High	Morocco	High	Viet Nam	Low
El Salvador	Mid-High	Mozambique	Mid-Low	Yemen	Mid-High
Equatorial Guinea	Mid-Low	Myanmar	Low	Zambia	High
Eritrea	Low	Namibia	Mid-High	Zimbabwe	Mid-High
Ethiopia	Low	Nepal	Low		
Gabon	Mid-High	Nicaragua	Mid-Low		
Gambia	Low	Niger	Low		

ANNEX 5: TERMS OF REFERENCE: NATIONAL STEERING COMMITTEE

The National Steering Committee (NSC) will monitor the conduct of the project and provide strategic guidance to the project team on the implementation of the project.

The NSC will be chaired by the Director General of Health or someone assigned by the Director General. IHM will act as Secretariat to the NSC. Members of the NSC will consist of representatives from the Ministry of Health, the Institute of Health Management (IHM), EPU, UNDP Malaysia, the Department of Orang Asli Development, the United Nations Population Fund Malaysia (UNFPA) and other relevant stakeholders to be identified.

The NSC will meet after the receipt of each project report or at least twice a year, whichever greater. The NSC will have the following duties and responsibilities:

- Provide policy guidance on matters pertaining to the implementation of the project;
- Provide guidance and decisions on matters pertaining to the technical aspects of the project;
- Monitor and evaluate the implementation of the project towards fulfilment of the objectives stated in the project document;
- Review, approve and endorse proposed work plan and budget;
- Initiate remedial actions to overcome all constraints in progress of the project;
- Review and approve relevant changes to the project design;
- Coordinate the roles of the various organizations involved in the execution of the project and ensure harmony with related activities;
- Advice on the long term sustainability strategy of the project;
- Review and approve all related reports to the projects.

ANNEX 6: TERMS OF REFERENCE: NATIONAL PROJECT DIRECTOR

The main responsibility of the National Project Director (NPD) is to coordinate project activities among the main parties and stakeholders to the project. The NPD will be a staff member of the Government of Malaysia's implementing agency of a UNDP-supported project.

The NPD for this project will be the Director of IHM.

Specifically, she/he works in close collaboration with the Project Manager as well as UNDP and his/her responsibilities include:

- Ensuring that the project document and project revisions requiring Government's approval are processed through the Government co- coordinating authority, in accordance with established procedures;
- Preparing work plans in discussion with the Project Manager and UNDP;
- Mobilizing national institutional mechanisms for smooth progress of the project;
- Providing formal project/deliverable sign-off and acceptance upon verification;
- Reviewing project status reports;
- Providing direction and guidance on project-related issues;
- Providing advice and guidance to the project team; and
- Approve financial transactions (which can be delegated to a specified senior officer in IHM to be identified by the NPD).

ANNEX 7: TERMS OF REFERENCE: PROJECT MANAGER

The Project Manager will be primarily focused on the administrative, financial and operational aspects of the project. The project manager's role is to manage and coordinate the implementation of various project activities in ensuring quality and timeliness of activities and delivery of outputs. For this project, the project manager will be the Senior Principal Assistant Director, IHM.

The specific tasks of the Project Manager are:

- Provide direction for the project, based on the project document and decisions made by the NSC;
- Manage and coordinate the implementation of project activities to ensure the maintenance of quality and timeliness, and delivery of outputs;
- Liaise and work closely with the project partners and beneficiaries;
- Report regularly to the NSC on the project's progress;
- Maintain close contact with designated focal points from UNDP and other stakeholders, indicating any estimated changes to the work plan, and proposing a budget revision when appropriate;
- Ensure that the requisite allocations are available in accordance with the agreed budget and established schedules of payment, if any, in consultation with the NPD and UNDP;
- Coordinate and facilitate the work of multiple component teams engaged in the implementation of project activities;
- Monitor the project funds and resources. Prepare progress and financial reports of the project when required;
- Maintain an up-to-date accounting system to ensure accuracy and reliability of financial reporting;
- Be responsible for the delivery of the project results and final outputs; and
- Establish a monitoring plan for activities implemented by the project team.

ANNEX 8: TERMS OF REFERENCE: RESEARCH ASSISTANTS

The Research Assistants to the project will assist the Project Manager and project team in all tasks related to the project's research initiatives particularly in compiling and processing data. Reporting to the Project Manager, the Research Assistants' duties and responsibilities include the following:

Field Survey

- Assist the project research team to conduct interviews with a variety of stakeholders using a full-range of quantitative and qualitative research techniques;
- Assist in the recruitment and management of enumerators, including providing training, mentoring and on-site monitoring of purposive surveys if needed;
- Assist in collecting and collating questionnaires and ensuring they are complete as well as keeping a log book of the completed questionnaires;
- Assist in monitoring and recording expenditures during field surveys;
- Other duties as required.

Data Entry

- Prepare a data entry screen for the data / questionnaires returned.
- Carry out data entry from the completed questionnaires
- Assist with analyzing the data
- Assist in preparing reports for presentation of research results

Other Duties:

Assist the project team in the administrative support to the project particularly:

- Coordinating meetings (including issuing invitation letters) and taking meeting minutes
- Administration of financial expenditures especially payments made throughout the project period
- Filing of project activities and project expenditures

ANNEX 9: MANAGEMENT: LETTER OF AGREEMENT BETWEEN UNDP AND THE GOVERNMENT OF MALAYSIA FOR PROVISION OF SUPPORT SERVICES UNDER NATIONAL EXECUTION

UNIT PERANCANG EKONOMI
Economic Planning Unit
JABATAN PERDANA MENTERI
Prime Minister's Department
BLOK B5 & B6,
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62502 PUTRAJAYA,
MALAYSIA

Telefon: 88883333
Fax:

Ruj. Tuan:
Your Ref:

Ruj. Kami:
Our Ref: (2))UPE801/100/299

Tarikh:
Date: 13 December 2001

REC'D: 26 DEC 2001

RR	✓
DRR	
ADMIN.	
FINANCE	
CLN SVC	
PROG. 1	
PROG. 2	
PROG. 3	
PROGRAMME/M&E	

to send HQ.

BY FAX: (03)2552870 /BY HAND

Resident Representative
United Nations Development Programme
Wisma UN
Blok C Komplek Pejabat Damansara
Jalan Dungun
Damansara Heights
50490 KUALA LUMPUR

Dear Madam,

Letter of Agreement Between UNDP and the Government For the Provision of Support Services under National Execution

Reference is made to your letter dated 26 October 2001 on the above subject.

2. We are pleased to attach herewith two (2) copies of the duly signed letter of agreement for your further action.

Thank you.

Yours sincerely,

(Patricia Chia Yoon Moi)
for Director General
Economic Planning Unit