



Grant Assistance Report

Project Number: 43136
July 2009

Proposed Grant Assistance Mongolia: Protecting the Health Status of the Poor during the Financial Crisis (Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 30 June 2009)

Currency Unit	–	togrog (MNT)
MNT1.00	=	\$0.00070
\$1.00	=	MNT1,436

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
CPS	–	country partnership strategy
EARD	–	East Asia Department
EASS	–	East Asia Department, Urban and Social Sectors Division
FGP	–	family group practice
FNSWPP	–	Food and Nutrition Social Welfare Program and Project
IEC	–	information and education communication
IMCI	–	integrated management of child illness
JFPR	–	Japan Fund for Poverty Reduction
MDG	–	Millennium Development Goal
MOECS	–	Ministry of Education, Culture and Sciences
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MSWL	–	Ministry of Social Welfare and Labor
PHC	–	primary health care
PIU	–	project implementation unit
PLW	–	pregnant and lactating women
PSC	–	project steering committee
SHC	–	soum health center
SSIGO	–	State Social Insurance General Office
SSSP	–	Social Sectors Support Program
THSDP	–	Third Health Sector Development Project

GLOSSARY

aimag	–	provincial administrative unit
soum	–	district administrative subunit of an aimag

NOTES

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

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JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR Grant Proposal

I. Basic Data

Name of Proposed Activity	Protecting the Health Status of the Poor during the Financial Crisis
Country	Mongolia
Grant Amount Requested	\$3,000,000
Project Duration	18 months
Regional Grant	No
Grant Type	Project

II. Grant Development Objectives and Expected Key Performance Indicators

<p>Grant Development Objectives: The overall objective is to protect the health of the poor in Mongolia during the financial crisis. The specific development objectives are to</p> <ul style="list-style-type: none"> (i) ensure targeted poor households' access to health services during the financial crisis through the implementation of the medicard program, (ii) contribute to the prevention of malnutrition in poor households through the targeted distribution of micronutrients, and (iii) document and analyze the experience and propose policy reforms to lower financial barriers that prevent the poor from accessing health services.
<p>Expected Key Performance Indicators:</p> <ul style="list-style-type: none"> (i) A database of means-tested poor households eligible for benefits under the medicard program is available. (ii) Qualitative information on poor households covered by the medicard program shows their increased satisfaction regarding access to health services. (iii) About 50% of eligible poor households benefit from the medicard program. (iv) At least 15,000 children under 3 years old in project aimags receive micronutrients during the prescribed period. (v) The Project submits draft policy reforms to the Government to reduce financial barriers to poor people's accessing health services.

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

Category	Amount of Grant Allocated in \$	Percentage of Expenditures
1. Equipment and supplies	315,200	10.5
2. Training, workshops, seminars, and public campaigns	109,600	3.7
3. Consulting services	380,600	12.7
4. Grant management	119,600	4.0
5. Other inputs	1,925,000	64.1
6. Contingencies	150,000	5.0
Total	3,000,000	100.0

JAPAN FUND FOR POVERTY REDUCTION

JFPR Grant Proposal Background Information

A. Other Data

Date of Submission of Application	19 March 2009
Project Officer	Claude Bodart, Senior Health Specialist
Project Officer's Division, E-mail, Phone	East Asia Department, Urban and Social Sectors Division (EASS) cbodart@adb.org, +632 632-5616
Other Staff Who Will Need Access to Review the Report	Wendy Walker, Social Development Specialist, EASS, wwalker@adb.org
Sector	Health, nutrition, and social protection
Subsector	Health programs
Theme	Inclusive social development
Subtheme	Human development
Targeting Classification	Targeted intervention—non-income Millennium Development Goals (TI-M)
Was JFPR Seed Money Used to Prepare This Grant Proposal?	Yes
Name of Associated Asian Development Bank (ADB) Financed Operation	Loan 2523/Grant 0151-MON: Social Sectors Support Program
Executing Agency	Ministry of Health (MOH)
Grant Implementing Agency	Ministry of Health Olympic Street – 2 Ulaanbaatar 48 Mongolia

B. Details of the Proposed Grant

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

Component A	
Component Name	Ensuring the Poor's Access to Health Services during the Financial Crisis
Cost	\$2,063,685
Component Description	Component A will design and implement a targeted and conditional health program to reduce eligible households' out-of-pocket expenditures when accessing health services. The component will help to fine-tune and apply a proxy means test to identify poor households eligible for the program. ^a The component will design the medicard program to cover primary and hospital care, provide capacity development to ensure the proper implementation of the program, and monitor and evaluate the performance of the program. During the design phase, the medicard program will explore the viability of including conditions for accessing the benefits of the card. These could include a condition that beneficiary children attend pre-school and primary education and that those under 5 are vaccinated. Core activities under component A include fine-tuning the proxy means test, implementing it across Mongolia, developing a database of eligible households, designing the procedures for the medicard program in coordination with the State Social Insurance Organization (SSIGO), analyzing the viability of including conditions for beneficiaries' use of the program, training the actors involved in implementing the medicard program, and designing and organizing data collection for proper monitoring and evaluation.

	<p>The medicard program will cover paid services in primary health care (PHC) and hospital facilities for the poor with and without health insurance, regardless of their civil registration status.^{b c}</p> <p>The medicard program will be embedded in existing reimbursement mechanisms of the health insurance system to keep transaction costs acceptable. The system will be designed to make it attractive to health care providers to ensure their cooperation and the success of the program. Pharmacies and hospitals will be selected to participate in the medicard program according to pre-defined criteria.</p> <p>The expected outcomes of component A include</p> <ul style="list-style-type: none"> (i) the identification of beneficiaries of the medicard program through means testing; (ii) the design of the medicard program to ensure free health services for beneficiaries in designated PHC facilities (family group practices [FGPs] and soum health centers [SHCs]), hospitals, and pharmacies participating in the program; (iii) a capacity-development package to ensure the proper implementation of the medicard program by participating health facilities, pharmacies, health insurance providers, and MOH; and (iv) a monitoring-and-evaluation tool for the medicard program.
Monitorable Deliverables/Outputs	<ul style="list-style-type: none"> (i) Database of means-tested poor eligible for medicard benefits developed. (ii) List of participating health facilities and pharmacies compiled. (iii) Medicard design approved by joint ministerial order of MOH and Ministry of Social Welfare and Labor (MSWL). (iv) About 50% of eligible poor households benefited from the medicard program.
Implementation of Major Activities: Number of months for grant activities	18 months

^a This component will work closely with the ADB-supported Food and Nutrition Social Welfare Program and Project (FNSWPP) in fine-tuning the proxy means test to target poor households. The households identified under the FNSWPP and the proposed JFPR Project will be identical.

^b With or without health insurance, patients face co-payments for confinement and user charges in hospitals. Uninsured patients (more than 25% of the population, including poor households) are asked to pay for services and products in addition to the official list of paid services. Informal payments have also been reported. In July 2007, the Government approved co-payments for hospital confinement (15% at tertiary hospital and 10% for inpatients at the secondary care level) and user charges. At public hospitals, charged services include x-ray, nuclear diagnosis, computer tomography, magnetic resonance imaging, electrocardiography and electro encephalography, endoscopic diagnosis, ultra-sound diagnosis, laboratory services, preventive services, and voluntary check-ups. Paid outpatient treatments include nuclear treatment, adult dental services and prosthesis, optic laser treatment, plastic surgery, and abortion. Some other services are paid as well, including health services provided to uninsured patients, some medical devices used in surgery, and reactive substances used in angiography. Exemptions, as defined in the health insurance law, apply for co-payments. User charges apply regardless of health insurance status except for children under 16, mothers on maternity leave, the elderly, and the disabled. Tariffs for user charges are set by hospitals in consultation with MOH.

^c At family group practices (FGPs) and soum health centers (SHCs), insured patients can access essential medicines in private pharmacies or in SHCs from drug revolving funds set up with the assistance of United Nations Children's Fund at discounted prices. The list of discounted medicines is limited, the insured poor find it administratively difficult to take advantage of the benefit, and co-payments are still 30–50% of the full price. This makes it very difficult for the poor, even with insurance, to avoid out-of-pocket expenditures for medicines. Uninsured people, including the poor, cannot avail themselves of the discounted prices for medicines and pay the full amount.

Component B	
Component Name	Preventing Malnutrition in Poor Households during the Financial Crisis
Cost	\$398,210
Component Description	<p>Component B will be implemented in eight aimags and the districts of Ulaanbaatar^a to improve nutrition services as part of community integrated management of child illness (IMCI)^b managed by FGPs and SHCs. Information and education communication and behavior change communication will be implemented in all project areas to improve community and family awareness, skills, and behavior to prevent malnutrition. Core activities under this component include (i) delivering on-the-job training to FGPs and SHCs in community IMCI, with a special focus on improved counseling skills regarding exclusive breastfeeding and the appropriate timing, frequency, adequacy, and composition of complementary feeding of infants and young children; (ii) providing support to technical improvements and increased coverage in monitoring and promoting growth in children under 2 years old managed by FGPs and SHCs; (iii) procuring, delivering, and promoting the use of MOH-agreed micronutrients in the form of sprinkles^c among children 6–24 months old and pregnant and lactating women (PLWs); and (iv) treating low-birth-weight and malnourished infants and children under 3, and PLWs, with supplemental iron and vitamin D to treat anemia and rickets.</p> <p>The expected outcomes of component B include</p> <ul style="list-style-type: none"> (i) training existing PHC staff in community IMCI with a strong emphasis on counseling to improve maternal, infant, and child nutrition; (ii) improving the quality and coverage of regular growth monitoring and promotion services for children under 2 years old through PHC workers; (iii) ensuring PLWs, infants, and children 6–24 months old improved access to micronutrients and adherence to their appropriate consumption; (iv) making PHC staff better at diagnosing and treating anemic and rickety children and their mothers in project areas; and (v) increasing awareness among local officials and the public of the importance of micronutrients to address poor child nutrition in disadvantaged communities.
Monitorable Deliverables/Outputs	<ul style="list-style-type: none"> (i) PHC workers' skills in specific nutrition activities improved. (ii) Community awareness, skills, and behavior to prevent malnutrition improved. (iii) At least 15,000 children under 3 years old in project aimags received micronutrients during the prescribed period.
Implementation of Major Activities: Number of months for grant activities	18 months

^a Micronutrients are distributed in 13 aimags of Mongolia. The Project will cover the remaining eight aimags and Ulaanbaatar. The eight aimags are Bulgan, Govisumber, Darhan-Uul, Dornogovi, Orhon, Ovorhangay, Hovsgol, and Hentiy.

^b The proposed JFPR Project will work closely with JFPR 9131-MON: Reducing Persistent Chronic Malnutrition in Children in Mongolia in implementing component B. IMCI aims to provide good health care to promote health while preventing and treating common diseases in infants and young children. Community IMCI, often referred to as the third component of IMCI, addresses 16 key family practices, starting with and including four optimal nutrition practices: (i) exclusive breastfeeding of newborns until 6 months of age; (ii) appropriate complementary feeding of infants and children 6–24 months old; (iii) the provision of micronutrients; and (iv) proper feeding during common illnesses, especially diarrhea. Mongolia's Health Sector Strategic Master Plan (2006–2015) has adopted IMCI as one of its key policy elements.

^c Sprinkles is an innovative powder of multiple micronutrients that is sprinkled once daily into the staple dish. To assist in harmonizing its composition with existing nutritional deficiencies, the United Nations Children's Program has submitted a request to MOH to authorize one vitamin-mineral mixture that will be used universally in Mongolia.

Component C	
Component Name	Project Management and Policy Development
Cost	\$538,105
Component Description	<p>Component C will monitor and support the effective implementation of the medicard program (component A) and the prevention of malnutrition in poor households (component B) during the financial crisis, facilitate institutional coordination, and support policy development based on the results of the medicard program. Core activities under component C include (i) establishing the project implementation unit (PIU), (ii) preparing the grant implementation manual, (iii) procuring and distributing expendables, (iv) performing annual audits,^a (v) conducting workshops to share experiences during implementation, (vi) monitoring and evaluating the medicard program and malnutrition prevention in the project areas, (vii) conducting a final dissemination workshop with broad and senior participation, (viii) using the project data to produce a knowledge product on the medicard experience, (ix) preparing the draft implementation completion memorandum, and (x) submitting a draft policy to the Government on how to ensure access to health services for the poor. Financial management and control implemented by the PIU will include (i) establishing effective financial and accounting controls; (ii) maintaining comprehensive and clear accounts and monitoring PIU expenditures and fund flows; (iii) preparing withdrawal applications; (iv) supervising the maintenance of project accounts; (v) drawing up financial statements and any other activity required to manage the financial operations of the JFPR Project; and (vi) developing the required regulations, guidelines, and forms in connection with strengthening the financial management and channels of the JFPR Project.</p> <p>The expected outcomes of component C include</p> <ul style="list-style-type: none"> (i) managerial support in implementing the medicard program and malnutrition prevention; (ii) monitoring and evaluation established for capturing the key evidence of processes, outputs, and outcomes attributable to the Project; (iii) close coordination with and facilitation of dialogue between MOH and MSWL's State Social Insurance General Office; and (iv) the production of a knowledge product on ensuring the poor access to health services in Mongolia.
Monitorable Deliverables/Outputs	<ul style="list-style-type: none"> (i) PIU established. (ii) Grant implementation manual prepared. (iii) A monitoring and evaluation system designed and put in place within the first 6 months of implementation. (iv) Final dissemination workshops organized and implemented. (v) Draft policy recommendations submitted to the Government. (vi) Knowledge product produced before closure of the Project. (vii) Final evaluation report including implementation completion memorandum delivered. (viii) Audit reports completed.
Implementation of Major Activities: Number of months for grant activities	18 months

^a The PIU will recruit an auditor acceptable to ADB to conduct the annual audit of the project accounts and financial statements.

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

Funding Source	Amount (\$)
JFPR	3,000,000
Government	68,350 in kind
Local Government Contributions	10,000 in kind
Total	3,078,350

3. Background

1. As a consequence of the financial crisis in the West, developing countries are at risk of experiencing the most serious economic downturn since the 1930s. The impact of increases in the cost of food and fuel in 2008 is estimated to have tipped more than 100 million people into poverty. Recent estimates by the United Kingdom's Department for International Development state that progress on the Millennium Development Goals (MDGs) will be pushed back by at least 3 years by the "financial tsunami" sweeping across the world¹ and that another 90 million people will be pushed into poverty by the end of next year. The challenge facing the world now is to prevent the economic crisis from becoming a social and health crisis.²

2. The social consequences of the 1997 Asian financial crisis were large increases in unemployment and poverty, which worsened education and health outcomes. The situation eventually stabilized and improved only after massive government intervention in the affected countries. Analyses of the 1997 crisis indicate that employment-creation programs and cash transfers played a critical role in alleviating poverty; while education, nutrition, and health care programs helped contain the emergence of long-term adverse effects.³ Throughout Asia, the memory of 1997–1998 and the awareness of how rapidly poverty can rise in recessions is still fresh in people's minds. When poverty rises and public finances are tight, the likelihood of increased infant mortality, child malnutrition, and school dropout rates is high.

3. The global financial crisis is strongly affecting the Mongolian economy. Declining prices for mineral exports have sharply cut government revenues. Progress made in reducing poverty in Mongolia is threatened by the evolving economic crisis and the subsequent devaluation of the local currency, increased layoffs, and salary cuts.

4. Slowing growth and prevalent poverty leave many households in Mongolia highly exposed to the global financial crisis, as the Government has limited fiscal and institutional capacity to cope with the impacts of the crisis.⁴ The Government is revising its 2009 expenditures and seeking ways to compress spending. Severe pressure on spending for essential services and social welfare is the likely result. These actions will have a particular impact on the poor, who rely on affordable access and social assistance as basic coping strategies, especially in times of economic stress.

5. Recent household surveys have found these changes to have a significant impact on the poor and immediate impacts on their consumption and access to services. Evidence from developing countries confirms that rapid increases in food prices and food insecurity rapidly worsen maternal and child under-nutrition. In many instances mothers starve themselves to

¹ Seager, A. 2009, 9 Mar. Downturn Will Set Back Millennium Goals by Three Years. *The Guardian*.

² World Health Organization. 2009. *The Financial Crisis and Global Health*. Information Note/2009/1. Geneva.

³ UNICEF. 2008. *Economic Crisis and Its Social Impact: Lessons from the 1997 Asian Economic Crisis*. Prepared for United Nations Children's Fund conference in Singapore, 6–7 January 2009. New York.

⁴ World Bank. 2009. *The Global Economic Crisis: Assessing Vulnerability with a Poverty Lens*. Policy Note. Washington, DC.

protect their children. The effects are particularly severe for babies conceived and weaned during a crisis.⁵

6. In the long term, the combined impact of the food and financial crises will undermine poverty reduction gains and make the MDGs on poverty, child and maternal health, and education more difficult to achieve. Poor households are forced to increase their food expenditures at the expense of other needs such as medical care and education. These reductions will adversely affect the achievement of the MDGs and have a particular and long-term impact on women and children.

7. The poor in Mongolia were disadvantaged in terms of nutrition and health care even before the crisis. The incidence of underweight children, under-5 mortality, stunting, wasting, anemia, and rickets is high in Mongolia compared with other Asian countries, particularly among the poor. The poor face relatively high out-of-pocket expenditures when seeking health care,^{6,7} especially if they are insured or unregistered. PHC is, in theory, fully state funded, but co-payments exist for pharmaceuticals, basic supplies, and diagnostic tests. In hospitals, co-payments are even higher and apply to a wider range of services and products. Survey data from 2003 illustrate the inequitable situation of paying for medicines, as households in the lowest quintile devote three quarters of their total health expenditures on drugs, while the highest quintile spends one third.⁸

8. In 1995, MOH and the Ministry of Finance (MOF) issued a joint order⁹ on paying the costs of hospital services for uninsured homeless and very poor people from the local government budget. The order aims to ensure to the poor and vulnerable equitable access to hospital services. However, it is commonly recognized that the order was never implemented. The tedious claiming procedure is a disincentive for hospitals to treat the poor at no charge and subsequently be reimbursed by local government budget offices.

9. Ensuring the poor free access to essential health services is necessary to mitigate the impact of the financial crisis. The proposed medicard program will ensure free care for a range of services at FGPs, SHCs, and designated hospitals and pharmacies. The program will use existing institutional arrangements of the health insurance system to reimburse participating facilities. The medicard program will target the poor, to be identified through means testing. It is conceived as a temporary program to run as long as health insurance subsidies are poorly targeted to the poor and the health insurance benefit package does not cover essential health services or products. The medicard program seems justified until (i) universal health insurance coverage ensures the inclusion of poor households, (ii) co-payments for hospital care are under 10–20%, and (iii) co-payment is waived for poor households identified through proper means testing.

10. To coordinate and harmonize efforts for tackling the poor nutrition of mothers and children in Mongolia, MOH has adopted a strategy to prevent mother and child micronutrient deficiency in the period 2005–2010. Micronutrients are distributed in 13 of 21 aimags in Mongolia. The proposed JFPR grant to Mongolia for Protecting the Health Status of the Poor during the Financial Crisis (the Project) will cover the remaining 8 aimags using a targeted strategy. At present, micronutrient sprinkles are distributed to all children under 24 months of

⁵ UNICEF. 2008. *The Impact of the Food and Economic Crisis on Child Health and Nutrition*. Prepared for the United Nations Children's Fund conference in Singapore, 6-7 January 2009. New York.

⁶ Official user charges represent about 5% of total Government health expenditure. However, these official figures do not include all official user charges and omit informal payments faced by patients.

⁷ WHO. 2004. National Health Accounts. Geneva. National health accounts for Mongolia report private spending of up to 37.1% of total health expenditures.

⁸ National Statistics Office. 2003. Living Standard Measurement Survey. Ulaanbaatar.

⁹ Joint ministerial order 122/A/84 of 1995. Ulaanbaatar.

age and to pregnant and lactating mothers. A targeted approach to distributing sprinkles will help improve the efficiency of the program and ensure its future sustainability. The targeting methodology (e.g., geographical or means test) will be identified during project implementation.

4. Innovation

11. The Project has two crucial innovations: (i) the adoption of methodologies to target the poor and (ii) the creation of a medicard system that will address important gaps in coverage and benefits in the existing health insurance system for the poor. The lack of proper targeting causes large inclusion and exclusion errors in social assistance and health insurance. A significant portion of social assistance goes to those who are not poor, with 70% of all such households receiving some form of social assistance. And 40% of the poor do not receive any form of social assistance. These errors result in huge expenditures for the Government while excluding a significant portion of poor households that need government assistance. Significant out-of-pocket expenses for the poor who are not properly registered or incapable of keeping up with health insurance payments prevent this group from accessing health care. The poor may be registered but not receive social assistance to which they are entitled because of deficient targeting and the lack of information, skills, or money for transportation. The Project will address these factors through improved targeting, including of unregistered households, and broad stakeholders involvement in implementation (see Appendix 6). The creation of a medicard to bridge this gap until other, more systemic changes can be made in the system will provide an important and immediate safety net for vulnerable populations during the financial crisis.

12. Ineffective benefit targeting and the exclusion of unregistered residents from many social welfare programs mean that poverty reduction arising from social protection has been limited. Recent amendments (January 2008) to the Social Welfare Law (January 2008) revised the eligibility criteria for recipients of benefits but still did not distinguish between beneficiaries with incomes above and below the poverty line. Reforms to improve the targeting of social welfare programs will be limited by public sensitivities, popular expectations, and political demands. Reluctance to undertake targeting can partly be attributed to the lack of capacity, knowledge on targeting mechanisms, or identification of workable models. The current fiscal pressure and the clear need to assist the most vulnerable provide an opportunity to make targeting based on means more acceptable.

13. The Project will work in close collaboration with the Food and Nutrition Social Welfare Program and Project (FNSWPP) to determine eligibility for the medicard program through a proxy means test. It will be the first time that such a targeting method is used in the Mongolian health sector. Successful implementation is expected to lead to policy reforms, especially as the implementation of such a targeting tool is reinforced by the inclusion of a policy measure in ADB's Social Sectors Support Program (SSSP) to support the Government in protecting social sectors during the financial crisis.

14. Micronutrient distribution to households is not innovative per se, but its combination with an appropriate targeting measure is innovative. The appropriate targeting measures will be determined during project implementation and will weigh targeting effectiveness against transaction costs. The experience will be useful for guiding MOH's further policy actions.

5. Sustainability

15. The medicard program will support access for the poor to health services during the financial crisis. It will use the health insurance system's existing institutional arrangements to reimburse participating facilities. Although 75% of the population has health insurance, and 50% of health insurance premiums are subsidized, the subsidies are poorly targeted, failing to

capture unregistered households and many poor households. In addition, health insurance covers only a limited set of essential health services and products. The lack of subsidy targeting and the limited benefit package make it difficult for the poor to access health services.

16. The medicard program is conceived as a temporary program to cover the deficiencies of the current health insurance system, especially during the financial crisis. As financial protection from health insurance improves in the future,¹⁰ the medicard program will be absorbed by the health insurance system. If health insurance reforms are delayed, MOH's regular budget is expected to fund the targeted medicard program.

17. Externalities linked to micronutrient deficiencies justify government funding of targeted micronutrient distribution, especially to the poor and during the crisis. With future increases in Government revenues, essentially from mining, the Government will likely find it easier to earmark funds for nutrition. Even in the event of a decline in mineral prices, the development of world-class mines in Mongolia is expected to boost the real economy. As a result, Mongolia's economy should sustain high growth over the next decade. The extent to which mining revenues translate into developmental outcomes will depend on how well finances are managed and spent in the medium term.¹¹

6. Participatory Approach

18. The Project was designed through a participatory process involving key stakeholders, who invariably expressed their agreement with the proposed project objectives, components, and implementation approach. The Project will continue to involve key stakeholders in (i) introducing targeting for the medicard and nutritional supplement programs; (ii) generating, delivering, and testing approaches; and (iii) assessing current practices, as well as the needs and priorities of disadvantaged communities and families. Many activities stimulated by the Project will require the active participation of communities and beneficiaries, including the distribution of nutritional supplements, qualitative satisfaction surveys, and focus group discussions of medicard beneficiaries. Stakeholders will take part in project monitoring and evaluation, as well as in advising on policy. Local governments will be closely involved throughout the Project, mainly through their support to local FGPs, SHCs, and social welfare systems and their involvement in monitoring and evaluation. Where relevant, ethnic minorities will be targeted and involved in consultations, and they will not be adversely affected by the Project.

19. A major underlying project objective is to make assistance to the poor more efficient by targeting those most in need and thereby enhancing the responsiveness of governments, society, FGPs, social welfare offices, and community activists to the food, health, and nutrition needs of disadvantaged groups, especially women, infants, and children. Community organizations, private businesses, activists, and community leaders will be mobilized to play key roles in advocacy; needs assessment; and the identification of approaches to improve the selection of poor beneficiaries and their access to health services and, for mothers and children, adequate nutrition.

¹⁰ Health insurance reforms are part of the Government's action plan during the present Government's term.

¹¹ World Bank. 2009. *Mongolia: Consolidating the Gains, Managing the Booms and Busts, and Moving to Better Service Delivery*. A public expenditure and financial management review. Washington, DC.

20. This participatory approach will be extended to stakeholders at all levels, encouraging their contribution through collaboration, information sharing, and monitoring. Stakeholders will thereby contribute to the Project's general objective.¹²

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
<p>At least 50% of eligible poor households will benefit from the medicard program's providing them with important access to basic health services.</p> <p>At least 15,000 children under 3 years old in project aimags will receive micronutrients during the prescribed period.</p>	<p>MOH, the Executing Agency of the Project, will benefit from the introduction of targeting methodologies that can be integrated into a wider range of programs that particularly seek to direct access to health services to the poor.</p> <p>MSWL and MOH will benefit from coordinating means testing across sectors, thereby improving efficiency and the outreach of government assistance and building local capacity.</p> <p>Aimag and soum authorities will receive technical assistance in assessing ways to target assistance and address health access and nutrition issues in disadvantaged communities and families.</p> <p>MOH will benefit by being able to provide micronutrient assistance nationwide and by exploring targeting as a way of improving efficiency and promoting the sustainability of their programs.</p>

7. Coordination

21. The Project was designed with inputs from MOH, MSWL, MOF, representatives of United Nations agencies, and nongovernment organizations working in health and nutrition.

22. Component A of the Project will liaise, cooperate, and harmonize processes with an ongoing JFPR project,¹³ as will component B.¹⁴ The Project will coordinate with the FNSWPP under MSWL to ensure the sharing of the database of beneficiaries determined by means testing. For component B, the Project will cooperate with the United Nations Children's Fund project to improve maternal and child nutrition in aimags in western Mongolia and with the World Vision Mongolia area-development program in aimags in central Mongolia, with both organizations providing micronutrients.

23. The PIU will work closely with MOH, MSWL, and MOF in implementing the policy measures under the health and social welfare sectors. The expansion of the drug-discount system and the reform of eligibility for health insurance subsidies directly affect the access of the poor to health services and products.

24. The Embassy of Japan was briefed about the proposed JFPR Project in March 2009.

¹² Appropriate measures in line with ADB's *Policy on Indigenous Peoples* (1998) will be taken, should the risk of negative impact on ethnic minorities be identified during JFPR Project implementation.

¹³ ADB. 2007. *JFPR 9115-MON: Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila.

¹⁴ ADB. 2009. *JFPR 9131-MON: Reducing Persistent Chronic Malnutrition in Children in Mongolia*. Manila.

8. Detailed Cost Table

25. Please refer to Appendix 2 for the summary of costs, Appendix 3 for the detailed cost estimates, and Appendix 4 for fund flow arrangements.

C. Linkage to ADB Strategy and ADB-Financed Operations

1. Linkage to ADB Strategy

26. The proposed assistance is in line with the development agenda for inclusive economic growth of ADB's Long-Term Strategic Framework 2008–2020 (Strategy 2020)¹⁵ and supports the Mongolia Country Partnership Strategy pillar of inclusive social development. The proposed Project is consistent with the health, nutrition, and social protection priority sectors of the Country Operations Business Plan 2008–2010.¹⁶ Health is a focus of ADB assistance to Mongolia, and ADB is the main funding agency in the sector. The Health Sector Master Plan stresses the need to provide essential health services to the people of Mongolia, with emphasis on vulnerable groups such as the poor and remote. The recently approved FNSWPP under MSWL is reintroducing targeting in the social welfare sector to directly benefit those who are most in need of government assistance. Approaches to malnutrition deserve a special focus in view of the intergenerational perpetuation of low education and productivity. Both the FNSWPP and the Health Sector Master Plan call for the full participation of communities and other stakeholders.

27. In addition to meeting Government and ADB sector goals, the expected outcome of the Project will satisfy several poverty-reduction objectives of the Government's economic growth and poverty reduction strategy for the long term.¹⁷ The Project directly addresses MDGs 1 on poverty and hunger, 2 on child health, and 3 on maternal health.

Document	Document Number	Date of Last Discussion	Objective
Mongolia Country Operations Business Plan 2008–2010	IN315-07		The JFPR Project supports the Government's explicit commitment to achieving the Millennium Development Goals.

2. Linkage to Specific ADB-Financed Operation

Project Name	MON: Social Sectors Support Program
Project Number	43096
Date of Board Approval	24 June 2009
Loan / Grant Amount (\$)	43.1 million/16.9 million

¹⁵ ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*. Manila.

¹⁶ ADB. 2007. *Country Operations Business Plan: Mongolia 2008–2010*. Manila.

¹⁷ Government of Mongolia. 2003. *Economic Growth Support and Poverty Reduction Strategy*. Ulaanbaatar.

3. Development Objective of the Associated ADB-Financed Operation

28. The SSSP will help guarantee continued consumption and access to basic health and education services for the poor during the financial crisis. This will be achieved by strategically increasing the efficiency of programs in health, education, and social welfare with the introduction of targeting the poor through means testing. These measures will create a database of poor households that can be shared across sectors and better focused poverty reduction efforts on those most in need.

4. Main Components of the Associated ADB-Financed Operation

29. The Project will assist in implementing two policy measures under the SSSP. The policy measures included in the program loan refer to (i) protecting children from malnutrition by expanding the coverage of household micronutrient fortification for children aged 6–23 months and (ii) reducing out-of-pocket expenditures for the poor through the introduction of the medicard program for PHCs and hospitals, conditional on proper referral procedures.

30. The SSSP includes additional policy measures to ensure access to services under MSWL, MOH, and the Ministry of Education, Culture and Sciences (MOECS).

5. Rationale for Grant Funding versus ADB Lending

31. The Project's poverty focus and its innovative character make it eligible for JFPR grant funding. The associated SSSP is meant to protect social sector expenditures by supporting the economic program of the Government to effectively address the financial crisis. The accompanying policy measures to protect the poor are meant to be cost neutral to assist the Government in meeting its fiscal deficit target included in its agreement with the International Monetary Fund. The Project will help the Government maintain the cost neutrality of policy measures during the 2009 and 2010 budget cycles.

D. Implementation of the Proposed Grant

1. Implementing Agency	Ministry of Health
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32. The Third Health Sector Development Project (THSDP) project steering committee will perform the same role for the Project, providing strategic orientation and overall guidance on implementation. The Project will be implemented by a PIU established in the THSDP PIU, which will be responsible for recruiting (i) the project PIU staff, (ii) two national consultants, and (iii) two international consultants.¹⁸ Recruitment will be conducted in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). Summary terms of reference for consulting services are in Supplementary Appendix A.

33. The Project will recruit two international consultants for 4 person-months each by individual recruitment: (i) a public health expert with expertise in health service organization, health financing, and policy; and (ii) a nutritionist with expertise in implementing public nutrition programs. The two experts will have three field assignments in Mongolia at project inception, midterm, and completion. Their main roles will be to help the PIU (i) design the implementation mechanisms of the two components; (ii) prepare and validate the monitoring and evaluation system; (iii) draft the policy for submission to the Government; and (iv) conduct the evaluation of

¹⁸ The PIU of the THSDP is experienced in hiring consultants using ADB procedures. It has recruited international and national individual consultants and entities under the THSDP. The same PIU is in charge of hiring consultants for JFPR 9115-MON: Access to Health Services for Disadvantaged Groups in Ulaanbaatar.

the Project, including the preparation of the knowledge product. The two international experts will each prepare three reports: inception, midterm, and final.

34. The Project will recruit two national consultants for 16 person months each by individual recruitment: (i) a health economist with expertise in health financing and policy and (ii) a nutritionist with expertise in implementing public nutrition programs in Mongolia. The two experts will help the PIU implement the technical aspects of the Project and assist the international consultants during their field assignments. The Project will recruit a national monitoring-and-evaluation specialist for component A with a lump sum contract.

35. Procurement related to the Project's management will be conducted by the PIU of THSDP in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). The procurement plan is in Supplementary Appendix B. Implementation arrangements are detailed in Appendix 5.

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Deepening Macroeconomic Instability	The worsening of the macroeconomic situation and its implications for social sectors could further harm public finances and reduce social expenditures, compromising the implementation of the medicard program and the sustainability of micronutrient distribution.	The International Monetary Fund, World Bank, ADB, and other donors actively support the Government of Mongolia in stabilizing the economy.
Reluctance of the Government and Parliament to shift to targeted safety net programs	The Government and Parliament could be reluctant to implement social targeting because of political sensitivities and resistance from consumer groups.	ADB has reached a first agreement with the Government in targeting the poor through means testing for the food stamp program, which is a new social welfare mechanism introduced in 2009. This initiative will develop a means test and establish a national database of poor and near poor, which will be used to introduce targeting in other social assistance programs.
Design flaws in the medicard program	The design of the medicard program needs to remain manageable in line with the institutional capacity and must propose the right incentives for health care providers to support its proper functioning.	The medicard program will be designed to fit within the existing institutional arrangements of the health insurance system and closely involve health providers.
Governance	Problems of corruption or nepotism may affect the distribution of micronutrients.	Strict financial control, strong management mechanisms, transparent appointment procedures, clear and agreed beneficiary selection, and annual audits.

3. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for Monitoring and Evaluation
A sex-disaggregated database of means-tested poor eligible for benefits under the medicard program is available.	Database in MSWL	Database available in September 2009
Qualitative, sex-disaggregated information on poor households covered by the medicard program show an improvement in their satisfaction regarding access to health services.	Focus group discussion results	Baseline August 2009 Follow-up discussions in June and November 2010
About 50% of eligible poor households benefited from the medicard program, with results disaggregated for rural and urban areas	MOH statistics	Quarterly monitoring and data collection
At least 15,000 children under 3 years old in project aimags received micronutrients during the prescribed period, with results disaggregated for sex and rural and urban areas	MOH statistics	Quarterly monitoring and data collection
The Project submitted draft policy reforms to the Government to lower financial barriers to the poor accessing health services	Evaluation and report on policy implications submitted to Government Project completion report	Final evaluation December 2010

4. Estimated Disbursement Schedule

Fiscal Year	Amount (\$)
2009	900,000
2010	2,100,000
Total Disbursements	3,000,000

Appendixes

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

Supplementary Appendixes

- A. Summary Terms of Reference for Consulting Services
- B. Procurement Plan
- C. Implementation Schedule

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact The health of the poor in Mongolia is protected during the financial crisis</p>	Government spending on primary health care services remains steady in 2009 and 2010	MOH, MOECS, and MSWL 2009 and 2010 budgets	<p>Risk</p> <ul style="list-style-type: none"> Deepening macroeconomic instability
<p>Outcome The poor are assured access to health services and basic nutritional services during the financial crisis (2009–2010)</p>	<p>Vaccination coverage and accessibility to health services for the poor remained stable during the financial crisis, with results disaggregated by sex.</p> <p>Increased consumption of micronutrient sprinkles among children 0–24 months old by 2013, with results disaggregated by sex and urban and rural area</p>	<p>National Center for Health Development statistics</p> <p>Pre- and post-project survey results</p>	<p>Risks</p> <ul style="list-style-type: none"> Reluctance of the Government and Parliament to shift to targeted safety net programs Demand for micronutrients does not increase because of competing household issues (e.g., food insecurity and spending for education).
<p>Outputs Component A: The poor are assured access to health services during the financial crisis until December 2010</p> <p>Component B: Malnutrition in poor households is prevented during the financial crisis until December 2010</p>	<p>Database of means-tested poor eligible for medicard benefits, disaggregated by sex and available by September 2009</p> <p>List of participating health facilities and pharmacies by September 2009</p> <p>Medicard design approved by joint ministerial order of MOH and MSWL by October 2009</p> <p>About 50% of eligible poor households have benefited from the medicard program by end-2010, with results disaggregated by rural and urban area.</p> <p>Improved community awareness, skills, and behavior for preventing malnutrition by December 2010</p> <p>At least 15,000 children under 3 years old in project aimags received micronutrients during the</p>	<p>Database in MOH and MSWL</p> <p>List of MOH</p> <p>Joint ministerial order</p> <p>SSIGO statistics; qualitative satisfaction surveys</p> <p>Pre- and post-project survey results</p> <p>Quarterly project reports and MOH statistics</p>	<p>Assumption</p> <ul style="list-style-type: none"> Support and commitment of central authorities, especially MOH and SSIGO <p>Risk</p> <ul style="list-style-type: none"> Medicard design does not include the right incentives for health care providers or health insurance to implement the system properly

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Component C: Project management and policy development are ensured up to December 2010</p>	<p>prescribed period by December 2010, with results disaggregated by sex.</p> <p>Grant implementation manual prepared by August 2009</p> <p>Monitoring and evaluation system is designed and in place within the first 6 months of implementation</p> <p>Final dissemination workshops organized and implemented by November 2010)</p> <p>Draft policy recommendations submitted to the Government by October 2010</p> <p>Knowledge product produced before closure of Project by October 2010</p> <p>Final evaluation report, including implementation completion memorandum, delivered by February 2011</p>	<p>Project documentation</p> <p>Project documentation</p> <p>Project documentation</p> <p>Project documentation</p> <p>Knowledge product</p> <p>Project documentation</p>	
<p>Activities:</p> <p>Component A: Ensuring the Poor's Access to Health Services during the Financial Crisis (by December 2010)</p> <ol style="list-style-type: none"> 1. Fine-tune the proxy means test (July 2009). 2. Develop a database of eligible households (September 2009). 3. Design, in coordination with the SSIGO, procedures for the medicard program (August 2009). 4. Train the actors involved in implementing the medicard program (September 2009). 5. Implement medicard program (continuous). 6. Design and organize the data collection for proper monitoring and evaluation (continuous). <p>Component B: Preventing Malnutrition in Poor Households during the Financial Crisis (by December 2010)</p> <ol style="list-style-type: none"> 1. Test and deliver on-the-job training to FGPs and SHCs in community IMCI, with special focus on improved counseling skills regarding exclusive breastfeeding and the appropriate timing, frequency, adequacy, and composition of complementary feeding of infants and young children (August 2009–June 2010). 2. Provide support to technical improvements and increased coverage of monitoring and promoting growth in children under 2 years old managed by FGPs and SHCs. 3. Procure, deliver, and promote the use of MOH-agreed micronutrients in the form of sprinkles^a among children 6–24 months old and PLWs (November 2009–October 2010). 			<p>Inputs (\$)</p> <p>ADB: \$3,000,000 financed by the Japan Fund for Poverty Reduction</p> <p>Government: \$78,350 equivalent as in-kind contribution</p>

<p>Activities</p> <p>4. Treat low-birth-weight and malnourished infants and children under 3 and PLWs with supplemental iron and vitamin D to treat anemia and rickets (continuous).</p> <p>Component C: Project management and Health Policy Development (by December 2010)</p> <ol style="list-style-type: none"> 1. Establish the PIU (July 2009). 2. Prepare the grant implementation manual (August 2009). 3. Perform annual audits. 4. Conduct experience-sharing workshops during implementation (quarterly). 5. Monitor and evaluate the medicard program and malnutrition prevention in the project areas (continuous). 6. Conduct a final dissemination workshop with broad and senior participation (November 2010). 7. Use the project data to produce a knowledge product on the medicard experience (October 2010). 8. Submit draft policies to the Government on how to ensure the poor access to health services (October 2010). 9. Prepare the draft implementation completion memorandum (December 2010). 	
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ADB = Asian Development Bank, FGP = family group practice, IMCI = integrated management of child illness, JFPR = Japan Fund for Poverty Reduction, MOECS = Ministry of Education, Culture, and Sciences, MOH = Ministry of Health, MSWL = Ministry of Social Welfare and labor, PIU = project implementation unit, PLW = pregnant and lactating women, SHC = soum health center, SSIGO = State Social Insurance General Office.

^a Sprinkles is an innovative powder of multiple micronutrients that is sprinkled once daily into the staple food.

SUMMARY COSTS TABLE

(\$)

<div style="display: flex; align-items: center;"> <div style="text-align: right; margin-right: 10px;"> ↓ Inputs/ Expenditure category </div> <div style="text-align: left;"> → Grant Components </div> </div>	Component A: Ensuring the Poor's Access to Health Services during the Financial Crisis	Component B: Preventing Malnutrition in Poor Households during the Financial Crisis	Component C: Project Management and Policy Development	Total (input)	Percent
1. Civil Works	0	0	0	0	0.0
2. Equipment and Supplies	0	315,200	0	315,200	10.5
3. Training, Workshops, Seminars, and Public Campaigns	25,500	63,100	21,000	109,600	3.7
4. Consulting Services	15,000	0	365,600	380,600	12.7
5. Grant Management	0	0	119,600	119,600	4.0
6. Other Inputs	1,920,000	0	5,000	1,925,000	64.2
7. Contingencies	103,185	19,910	26,905	150,000	5.0
Subtotal JFPR Grant Financed	2,063,685	398,210	538,105	3,000,000	100.0
Central Government Contribution	0	39,350	29,000	68,350	
Local Government Contribution	0	10,000	0	10,000	
Communities' Contributions (mostly in-kind)	0	0	0	0	
Total Estimated Cost	2,063,685	447,560	567,105	3,078,350	

JFPR = Japan Fund for Poverty Reduction.

Source: Asian Development Bank estimates.

DETAILED COST ESTIMATES
(\$)

Supplies and Services Rendered	Unit	Costs			Contributions				
		Quantity	Cost per Unit	Total	JFPR Amount	Method of Procurement ^a	Central Government	Local Government	Communities
Component A: Ensuring the Poor's Access to Health Services during the Financial Crisis			Subtotal	1,960,500	1,960,500		0	0	0
1.1 Civil Works									
1.2 Equipment and Supplies									
1.3 Training, Workshops, and Seminars									
1.3.1 Technical workshop for fine-tuning the proxy means test	person-day	40	50	2,000	2,000				
1.3.2 Technical workshop for establishing the database of poor households	person-day	50	50	2,500	2,500				
1.3.3 Workshop for finalizing the design of the medicard program	expert person-day	120	50	6,000	6,000				
1.3.4 Training of SSIGO, MOH, and health care providers to run the medicard program	person-day	300	50	15,000	15,000				
1.4 Consulting Services									
National monitoring and evaluation specialist	lump-sum	1	15,000	15,000	15,000	individual recruitment			
1.5 Management and Coordination of Component A									
1.6 Other Project Inputs									
Funds for providing health services to poor households ^b	lump-sum	12	160,000	1,920,000	1,920,000				
Component B: Preventing Malnutrition in Poor Households during the Financial Crisis			Subtotal	427,650	378,300		39,350	10,000	0
2.1 Civil Works									
2.2 Equipment and Supplies									
2.2.1 Procurement of micronutrient sprinkles agreed with MOH	package	3	86,517	259,550	239,550	international shopping	20,000		
2.2.2 Procurement of iron and vitamin D supplements ^b	package	3	20,000	60,000	49,650	international shopping	10,350		

Supplies and Services Rendered	Unit	Costs			Contributions				
		Quantity	Cost per Unit	Total	JFPR	Central Government	Local Government	Communities	
					Amount	Method of Procurement ^a			
2.2.3 IEC/BCC materials on improving mother and child nutrition for mothers, families, and communities	package	3	10,000	30,000	26,000	shopping	4,000		
2.3 Training, Workshops, and Seminars									
2.3.1 In-service and on-the-job training of FGPs in community IMCI (counseling, growth monitoring, use of sprinkles, and proper feeding during child illness)	person-contact	12,600	6	75,600	60,600		5,000	10,000	
2.3.2 Workshop to select targeting methodology for micronutrient distribution	person-day	50	50	2,500	2,500				
2.4 Consulting Services									
2.5 Management and Coordination of Component B									
2.6 Other Project Inputs									
Component C: Project Management and Policy Development			Subtotal	540,200	511,200		29,000	0	0
3.1 Civil Works									
3.2 Equipment and Supplies									
3.3 Training, Workshops, and Seminars									
3.3.1 Disseminating workshop findings, experience-sharing, and planning	person-day	300	50	15,000	13,000		2,000		
3.3.2 Final dissemination workshop	person-day	240	50	12,000	8,000		4,000		
3.4 Consulting Services									
3.4.1 International public health expert and international nutritionist	person-month	8	26,000	208,000	208,000	individual recruitment			
3.4.2 Travel cost for international public health and nutrition experts	trip	6	6,000	36,000	36,000				
3.4.3 National public health expert and nutritionist	person-month	32	3,000	96,000	96,000	individual recruitment			
3.4.4 Domestic travel for national public health expert and international nutritionist	trip	32	300	9,600	9,600				

Supplies and Services Rendered	Unit	Costs			Contributions				
		Quantity	Cost per Unit	Total	JFPR Amount	Method of Procurement ^a	Central Government	Local Government	Communities
3.4.5 External audit	contract	2	8,000	16,000	16,000				
3.5 Management and Coordination of Component C									
3.5.1 Project coordinator	person-month	18	1,700	30,600	30,600	individual recruitment			
3.5.2 Financial and administrative assistant	person-month	18	1,200	21,600	21,600	individual recruitment			
3.5.3 Secretary	person-month	18	800	14,400	14,400	individual recruitment			
3.5.4 Office space	lump-sum	1	15,000	15,000			15,000		
3.5.5 Office furniture	lump-sum	1	7,000	7,000	4,000	shopping	3,000		
3.5.6 Office equipment	lump-sum	1	12,000	12,000	9,000	shopping	3,000		
3.5.7 Travel and per diem for PIU staff	lump-sum	30	500	15,000	13,000		2,000		
3.5.8 Operational costs	monthly	18	1,500	27,000	27,000				
3.6 Other Project Inputs									
Printing and distribution of knowledge product on medicard program	lump-sum	1	5,000	5,000	5,000	shopping			
Components A–C Subtotal			Subtotal	2,928,350	2,850,000		68,350	10,000	0
Contingency (maximum 10% of total JFPR contribution)				150,000	150,000				
Total Grant Cost			Total	3,078,350	3,000,000		68,350	10,000	0

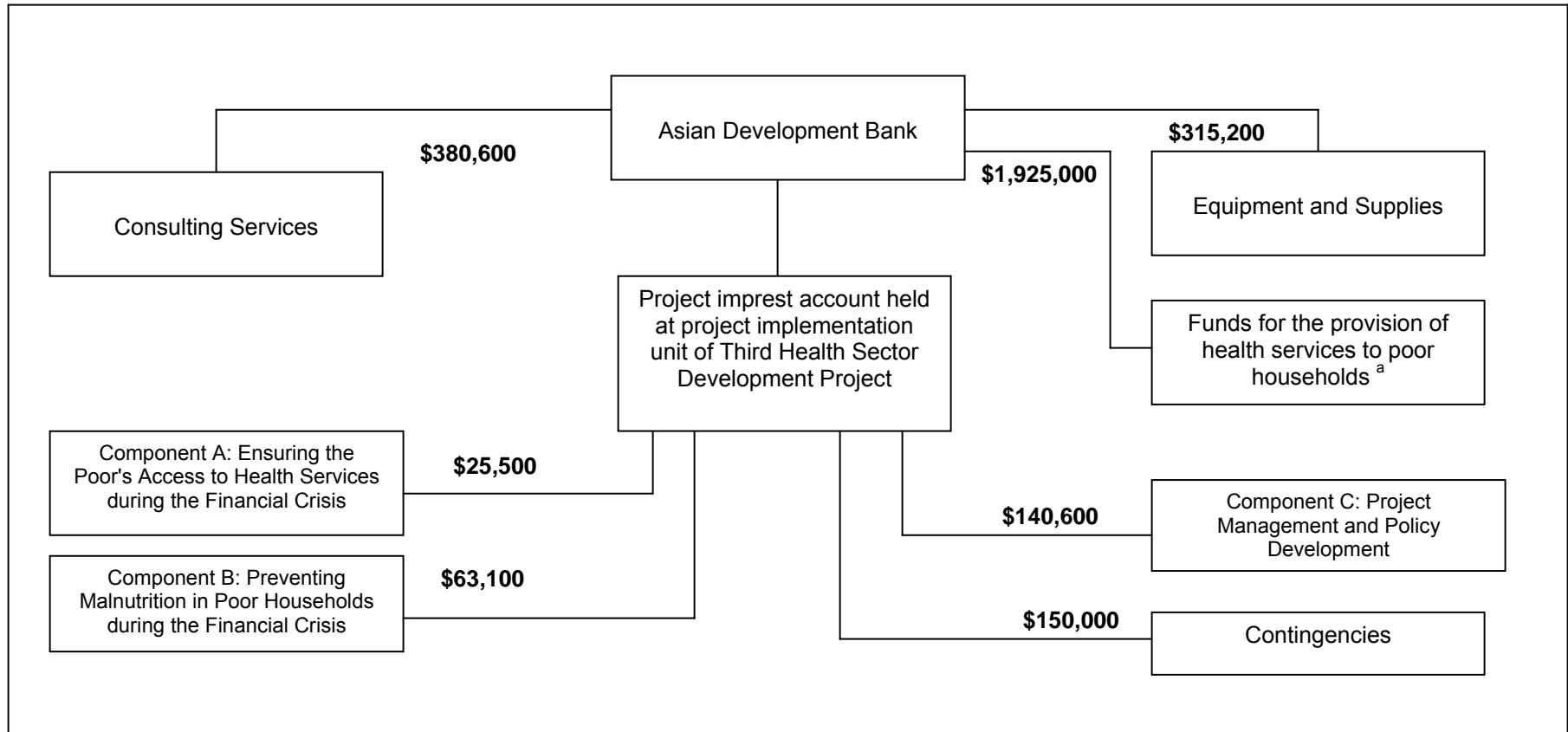
FGP = family group practice, IEC/BCC = information and education communication and/or behavior change communication, IMCI = integrated management of child illness, JFPR = Japan Fund for Poverty Reduction, MOH = Ministry of Health, PIU = project implementation unit, SSIGO = Social State Insurance General Office.

^a Procurement under the Project will be conducted in accordance with the *Procurement Guidelines* (2007, as amended from time to time) and the *Guidelines on the Use of Consultants* (2007, as amended from time to time) of the Asian Development Bank (ADB). Goods, services, and works estimated to cost \$50,000 or less will be procured using ADB's shopping procedure. Goods with a higher estimated value but less than \$500,000 will be procured using national competitive bidding. The PIU of the Third Health Sector Development Project will be responsible for procurement, with technical inputs from the implementation unit of the JFPR Project. To procure items below \$10,000, the PIU of THSDP may purchase the items directly from the supplier.

^b The cost of health services provided to the poor is estimated through a model that includes the following parameters: population of lowest quintile, utilization rate of primary health and hospital care, percentage of poor insured and uninsured, and estimated cost of services and products provided at pharmacies and health facilities. The total cost estimate of \$1,920,000 includes \$262,500 for PHC services to the insured, \$393,750 for hospital services to the insured, \$225,000 for PHC services to the uninsured, and \$1,038,750 for hospital services to the uninsured.

Source: Asian Development Bank.

FUND FLOW ARRANGEMENTS



^a Fund flow and payment mechanisms to reimburse participating health facilities for services provided to the poor, as currently discussed with the Government, will be approved by ADB prior to their implementation and in line with the *Loan Disbursement Handbook* (2007 as amended from time to time).

Source: Asian Development Bank.

IMPLEMENTATION ARRANGEMENTS

A. Project Management

1. Executing Agency

1. The Ministry of Health (MOH) will be the Executing Agency (EA) for the proposed Japan Fund for Poverty Reduction (JFPR) grant to Mongolia for Protecting the Health Status of the Poor during the Financial Crisis (the Project).

2. Project Steering Committee

2. The project steering committee (PSC) of the Third Health Sector Development Project (THSDP) will act as the PSC for the Project, providing strategic orientation and guidance on project implementation. The PSC will be chaired by the state secretary of MOH and composed of senior officials from the Public Health Institute at MOH, Ministry of Finance (MOF), and nongovernment organizations.

3. Implementing Agency

3. The project implementation unit (PIU) will be established in the PIU of THSDP. The PIU will be headed by a project coordinator with management and public health skills who will be assisted by (i) a financial and administrative assistant and (ii) a secretary. The PIU members will be recruited by MOH and approved by the Asian Development Bank (ADB). The project coordinator will guide implementation and administer the Project, reporting to ADB and the Government of Mongolia. The PIU will prepare a grant implementation manual, for ADB approval, during the first quarter of implementation. The project coordinator will work under the supervision of the project manager of the PIU of THSDP for disbursement; procurement; financial management; monitoring and evaluation; and preparing detailed project implementation plans and budgets, annual reports, and quarterly progress reports. The financial and administrative assistant, under the supervision of the project coordinator, will work closely with the finance officer of the PIU of THSDP. The PIU of THSDP will be in charge of procurement.

4. Disbursement Arrangements

4. JFPR grant proceeds will be disbursed in line with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time). To facilitate project implementation and fund flow, the imprest account will be set up and managed by the PIU of the THSDP and be used exclusively to finance expenditures eligible under the Project, except those for consulting services, equipment, and supplies. Fund flow and payment mechanisms to reimburse participating health facilities for services provided to the poor, as currently discussed with the Government, will be approved by ADB prior to their implementation and in line with the *Loan Disbursement Handbook* (2007, as amended from time to time). The imprest account will be opened at a commercial bank acceptable to the EA and ADB. The initial advance to be deposited to an imprest account will not exceed either 6 months of estimated expenditures to be financed from the imprest account or \$200,000 of the grant amount, whichever is less. To expedite fund flow and simplify documentation, the statement of expenditures (SOE) procedure will be used for the reimbursement, liquidation, and replenishment of imprest account for expenditures not exceeding \$10,000 per individual payment. Payments in excess of the SOE ceiling will be liquidated or replenished after full supporting documentation. Withdrawal applications and the

SOE will be signed by the authorized representative of the EA. Direct payment and reimbursement procedures will be used for project expenditures related to consulting services, equipment, and supplies. The interest earned on the JFPR imprest accounts, net of bank charges, can be used for the Project, subject to ADB's prior approval and within the approved total amount of JFPR. Upon completing the JFPR Project and before closing the imprest account, any unutilized interest should be returned to the JFPR fund account maintained at ADB.

5. Detailed implementation arrangements, including disbursement procedures, will be detailed in the Grant Implementation Manual and established between ADB and the Government through the JFPR letter of agreement. ADB has verified that the EA has sufficient financial management capability to establish adequate accounting procedures and control to administer the imprest fund efficiently. The schematic fund flow for the Project is shown in Appendix 4.

5. Procurement

6. Procurement under the Project will be conducted in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). Goods and services estimated to cost less than \$50,000 will be procured using ADB's shopping procedure. Goods with a higher estimated value but less than \$500,000 will be procured using national competitive bidding. The PIU of the THSDP will be responsible for procurement, with technical inputs from the project coordinator. To procure items below \$10,000, the PIU of the THSDP may purchase the items directly from the supplier. In such cases, ADB should be satisfied that the price is reasonable. International competitive bidding is not envisaged under this Project. The procurement plan is in Supplementary Appendix B.

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

6. Consulting Services

8. The Project will recruit two international consultants for 4 person months each through individual recruitment: (i) a public health expert with expertise in health services organization, health financing, and policy; and (ii) a nutritionist with expertise in implementing public nutrition programs. The two experts will have three field assignments in Mongolia at project inception, mid-term, and completion. The main roles of the two experts will be to assist the PIU in (i) designing the implementation mechanisms of the two components; (ii) preparing and validating the monitoring and evaluation system; (iii) drafting the policy for submission to the Government; and (iv) evaluating the Project, including the preparation of the knowledge product. The two international experts will each prepare three reports; inception, midterm, and final.

9. The Project will recruit two national consultants for 16 person-months each through individual recruitment: (i) a health economist with expertise in health financing and policy and (ii) a nutritionist with expertise in implementing public nutrition programs in Mongolia. The two experts will help the PIU implement the technical aspects of the Project and assist the international consultants during their field assignments. The Project will recruit a national monitoring and evaluation specialist through a lump sum contract.

10. The consultants will be recruited by the PIU of the THSDP with technical input from the project coordinator and in accordance with ADB's *Guidelines on the Use of Consultants* (2007,

as amended from time to time). The terms of reference for consulting services are in Supplementary Appendix A.

7. Reporting

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

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

8. Monitoring and Evaluation

13. The framework for monitoring and evaluation is described in Appendix 1. At the beginning of implementation, the PIU will, with input of the consultants, consolidate existing baseline information to refine the monitoring and evaluation framework, as well as to monitor and evaluate the implementation of the components of the Project. The final evaluation of the JFPR will include a report on the Project's policy implications and lessons, including the preparation of the knowledge product.

9. Project Review

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

B. Implementation Schedule

15. The Project will be implemented over 18 months, tentatively from July 2009 to December 2010. Project preparation is expected to start in July 2009 with establishing the PIU and hiring consultants. The detailed implementation schedule is in Supplementary Appendix C.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country/Project Title: Mongolia/Protecting the Health Status of the Poor during the Financial Crisis

Lending/Financing
Modality: Grant

Japan Fund for Poverty Reduction (JFPR)

Department/
Division:

EARD/EASS

I. POVERTY ANALYSIS AND STRATEGY

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

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

The current global financial crisis has put the Government budget in Mongolia under enormous pressure, with spending for the social sectors particularly at risk of reduction. Recent estimates by the United Kingdom's Department for International Development state that progress toward the Millennium Development Goals (MDGs) worldwide will be pushed back by at least 3 years by the "financial tsunami" sweeping across the world, and another 90 million people will be pushed into poverty by the end of next year.

Despite gains in Mongolia's gross domestic product, the proportion of people below the poverty threshold was estimated at 29% nationwide in late 2008. The current financial crisis, which follows a year of high inflation provoked by the food crisis, is adding to the burden for the poor. The participatory poverty assessment carried out for the CPS demonstrates that the poor have made significant cuts in health care and consumption. Even during more normal times, the links between pervasive poverty and under-nutrition are reflected in the persistence of chronic child malnutrition and stunting (low height for age) today, especially in rural areas. Child under-nutrition is an underlying determinant of permanent physical and mental disability and sometimes child mortality.

The proposed JFPR grant for Protecting the Health Status of the Poor during the Financial Crisis (the Project) aims to protect the poor during the financial crisis by ensuring access to health care and expanding the distribution of micronutrients. Both programs rely on improved targeting and, as such, will address issues of efficiency and sustainability in the health sector. The targeting methodology is based on that being developed under the Food and Nutrition Social Welfare Program and Project (FNSWPP) with the Ministry of Social Welfare and Labor and will promote the adoption of national strategies and methods for targeting programs to those most in need, thereby building efficiency in programs with limited funds. Improved health care access and nutrition contribute directly to six of the eight MDGs and are key factors in addressing poverty. The CPS update for Mongolia (2007–2009) confirmed a priority focus on poverty reduction and the MDGs. The health road map of the CPS (2009–2013, in preparation) identifies barriers in coverage of health insurance for the poor, persistent chronic child malnutrition and stunting, and disparities in nutritional status between urban and rural areas as important issues in Mongolia. The Health Sector Master Plan (2006–2015) identifies nutrition as a priority issue and makes improving nutrition, particularly of micronutrients among children and women, one of the outcomes to be attained until 2015. The social protection road map of the CPS (2009–2013, in preparation) identifies the targeting of benefits as one of the most essential shifts needed in the sector to improve efficiency and provide sufficient assistance to really help the poor. The project directly supports Mongolia's efforts to achieve the MDGs and creates an enabling environment for poverty reduction directly and indirectly by promoting

- access to health services for the poor by implementing the targeted medicard program;
- improved nutrition in targeted beneficiaries in selected aimags by providing micronutrients;
- extensive outreach and information and education communication (IEC) to mothers and communities on nutrition and basic health; and
- capacity building of local government health care and social welfare workers in identifying the poor, providing services, and conducting appropriate outreach and support for communities.

B. Poverty Analysis

Targeting Classification: MDG-TI

1. Key Issues

The Project is classified as MDG-TI because of its focus on targeting the poor and alleviating maternal and child malnutrition, which are all MDG targets. It directly addresses Mongolia's priority focus on the MDGs in its poverty reduction strategy and directly addresses the priorities of the health sector strategy. The main beneficiaries of the program will be the poor, women, and children.

Limited access to health services and the burden of caring for ill family members are two of the major issues raised by the poor as reasons for chronic poverty in assessment consultations. When children are undernourished before their second birthday, they can suffer irreversible cognitive and physical damage that affects their future health, economic well-being, and welfare. The consequences continue into adulthood, limit social development, lower economic productivity in affected

communities, and are passed on to the next generation, as undernourished girls and women have children of their own. The multiple indicator cluster survey carried out by the National Statistical Office with United Nations Children's Fund (UNICEF) support in 2005 showed that one quarter of each new generation of infants in Mongolia becomes seriously growth retarded during the first 2 years of life. Growth retardation or stunting indicators are higher in soum centers and the countryside, remote aimags, families with more than two children under 5 years old, and families with a mother with little or no formal education, affecting 60% of the poorest households. The project strategies of (i) targeting the poor for health care access by distributing a medicard providing free access; (ii) targeted distribution of micronutrient supplements; and (iii) efforts at IEC to raise awareness, knowledge, and skills in the population about good nutritional habits for mothers directly address MDGs 1 on eradicating extreme poverty and hunger, 4 on reducing child mortality, and 5 on improving maternal health.

2. Design Features. The Project aims to protect the poor from the effects of the financial crisis. Innovative design features include the (i) adoption of targeting methodologies for both programs, (ii) inclusion of qualitative satisfaction assessments of beneficiaries of the medicard program, and (iii) identification of relevant triggers to shut down the medicard program once more sustainable health care approaches have been identified and implemented. Communities will help distribute micronutrients, and local nongovernment organizations will be used for IEC outreach in communities.

II. SOCIAL ANALYSIS AND STRATEGY

A. Findings of Social Analysis

Mongolia spends more on health care than any other country in transition, but health outcomes for the poor and those in rural areas appear to be declining. Inequality is prominent in the health sector, where the better off have access to extensive health services and often bypass family group practices (FGPs) and soum health centers. The affordability of health needs such as pharmaceuticals and the lack of participation in the health insurance program limit the access of the poor and contribute to perpetuating chronic poverty in the country.

Child and maternal mortality is directly linked to poverty. Infants and undernourished pregnant women from poor families are much more likely to die or suffer complications than well-nourished mothers and their offspring. Currently, one in 20 children in Mongolia does not live to the age of 5. Child mortality is high in rural areas and is particularly low in the capital city. The maternal mortality rate is still high at 93 per 100,000 live births, with a substantial rural–urban gap, as the rural figure is 105.7 and the urban figure 73.3. Low birth weight is another poverty-related health indicator that shows the mother's health and nutrition status. According to the latest survey carried out by the National Statistical Office in partnership with UNICEF, the proportion of babies who weigh less than 2,500 grams at birth is 5.5%. The risk of being born underweight varies from 4.9% in urban areas to 6.1% in rural areas and is the highest by far among children born to mothers with no education, at 10%.

Key social issues related to health care access and improved nutrition outcomes identified in the social analysis include the need

- for methodologies to directly target those most in need of assistance;
- to address gaps in the health insurance system that deny the poor or unregistered with access to the health services that are available and make them unaffordable;
- for extensive public information campaigns to modify the belief that primary health services are low quality and intended only for the poor and to counter the perception that good services are provided only by specialists in hospitals; and
- for public health and health education programs to improve community and local government involvement..

FGPs must provide preventive services in addition to curative services, including health promotion and protection. Clients expressed greater need for preventive health services. They agree that receiving preventive services will prevent serious illness and thus contribute to stopping the cycle of chronic poverty.

B. Consultation and Participation

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

The Project was designed with inputs from the Ministry of Health, Ministry of Social Welfare and Labor, and representatives of United Nations agencies and nongovernment organizations working on access to health and nutrition. Specific social analyses and perspectives of communities were generated during the comprehensive social assessments carried out for the JFPR project 9115-MON: Access to Health Services for Disadvantaged Groups In Ulaanbaatar, the Third Health Sector Development Project, and the Participatory Poverty Assessment carried out December 2008 to February 2009 for the CPS.

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

- Information sharing Consultation Collaborative decision making Empowerment

Qualitative monitoring of beneficiary satisfaction with the medicard program will be implemented.

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

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

C. Gender and Development

1. Key Issues. Limited access to, and high costs for, health care are two of the primary factors participants cited in participatory poverty assessments in 2005 and 2009, which plunge families into poverty in Mongolia or perpetuate it. Child and maternal mortality is directly linked to poverty. Infants and undernourished pregnant women from poor families are much more likely to die or suffer complications than well-nourished mothers and their offspring. The Project directly focuses on addressing health care access for the poor through targeting and providing assistance through the medicard program that will bridge the gap of access until the health sector can identify and implement adequate changes in policies and programs. In addition, it will address the immediate micronutrient needs of children in project areas and, ultimately, the long-term education of mothers, communities, and health workers regarding nutrition and health.

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

Gender plan Other actions/measures No action/measure

This Project is linked to the planned Social Sectors Support Program (SSSP), in which effort is being made to ensure that gender issues are adequately identified and addressed. The most important aspect for both the medicard program and micronutrient distribution will be the design and implementation of the means test. The FNSWPP gender plan ensures that this tool, which will be used in the Project, will be gender sensitive and pay particular attention to identifying households at risk, such as those headed by women. Micronutrient distribution primarily focuses on mothers and children.

III. SOCIAL SAFEGUARD ISSUES AND OTHER SOCIAL RISKS

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

IV. MONITORING AND EVALUATION

Are social indicators included in the design and monitoring framework to facilitate monitoring of social development activities and/or social impacts during project implementation? Yes No These include sex and rural/urban disaggregation of data on beneficiaries and qualitative monitoring on beneficiary satisfaction with the medicard program.

^a National Statistics Office, ADB, World Bank, 2006. Participatory Poverty Assessment Mongolia. Ulaanbaatar. p. 80.