Validation Report

Reference Number: PVR-438
Project Number: 41119-012
Grant Number: 0086
December 2015

Mongolia: Third Health Sector Development Project

Independent Evaluation Department

Asian Development Bank

ABBREVIATIONS

AGH	–	*aimag* (province) general hospital
CME	–	continuing medical education
DGH	–	*dureeg* (district) general hospital
DMF	–	design and monitoring framework
EIRR		economic internal rate of return
FGP	–	family group practice
FHC	–	family health center
HSDP	–	health sector development project
HSMP	–	Health Sector Master Plan
JFPR	–	Japan Fund for Poverty Reduction
MNUMS	–	Mongolian National University of Medical Sciences
MOH	–	Ministry of Health
NCD	–	chronic, non-communicable disease
NCHD	–	National Center for Health Development
PHC	–	primary health care
PIU	–	project implementation unit
RRP	–	report and recommendation of the President
SHC	–	*soum* health centers
TA	–	technical assistance

NOTE

In this report, "$" refers to US dollars.

Key Words

adb, agh, *aimag*, asian development bank, dgh, health care financing, health insurance, health sector, mongolia, phc, primary health care, *soum*, validation

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PROJECT BASIC DATA

Project Number:	41119-012	**PCR Circulation Date:**	Jun 2015	
Grant Number:	0086	**PCR Validation Date:**	Dec 2015	
Project Name:	**Third Health Sector Development Project**			
Country:	Mongolia		**Approved** ($ million)	**Actual** ($ million)
Sector:	Health	**Total Project Costs:**	17.6	16.2
ADB Financing: ($ million)	**ADF:**14.0	**Loan:**	14.0	12.8
		Borrower:	3.6	3.4
	OCR:0.00	**Beneficiaries:**	0.0	0.0
		Others:	0.0	0.0
Cofinancier:		**Total Cofinancing:**	0.0	0.0
Approval Date:	19 Nov 2007	**Effectiveness Date:**	12 Mar 2008	27 Mar 2008
Signing Date:	13 Dec 2007	**Closing Date:**	31 Dec 2013	30 Jun 2014
Project Officers:	C. Bodart C. Bodart A. Jigjidsuren	**Location:** ADB headquarters Mongolia Resident Mission Mongolia Resident Mission	**From:** Nov 2007 Jan 2010 Jan 2013	**To:** Dec 2010 Jan 2013 Jun 2014
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ADB = Asian Development Bank; ADF = Asian Development Fund; IED1 = Independent Evaluation Department, Division 1; OCR = ordinary capital resources; PCR = project completion report.

I. PROJECT DESCRIPTION

A. Rationale

1. The Asian Development Bank (ADB) approved the Third Health Sector Development Project (Third HSDP) in October 2007. The project aimed to build on previous health sector development initiatives [1] by providing further assistance needed to address the issues confronting the Mongolian health system—such as (i) poor quality of health services; (ii) wide disparity in access to health services and health outcomes, particularly between urban and rural areas; (iii) inefficient hospital sector; (iv) poorly developed health care financing and health insurance; (v) weak human resources development; (vi) weak monitoring and evaluation; and (vi) weak regulation and governance capacities.[2]

[1] These included the Health Sector Development Program that was completed in 2003 and the Second Health Sector Development Project (Second HSDP), which was completed in 2008 and was ongoing at the time of grant negotiations for the Third HSDP. These previous initiatives helped implement initial sector reforms, develop primary health care (PHC), and improve infrastructure and service delivery.

[2] ADB 2007.*Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Mongolia: Third Health Sector Development Project*. Manila.

B. Expected Impact

2. The project aimed to improve the health status and quality of life for the Mongolian population by (i) reducing the incidence of tuberculosis from 175 per 100,000 people in 2005 to 72 by 2015, and (ii) reducing maternal mortality from 93 per 100,000 live births in 2005 to 50 in 2015. Through the various health sector interventions, the project was expected to contribute to reducing poverty from 36% in 2002–2003 to 7% by 2015 (report and recommendation of the President [RRP], Appendix 1).

3. The project was to directly benefit 700,000 people in five *aimags* and two *duuregs* [3] of Ulaanbaatar or 26.8% of the country's total population (RRP, para. 58).

C. Expected Outcomes

4. The targeted outcomes of the project were effective primary health care (PHC) and improved financial protection through health insurance. Indicators and targets to measure the above were established as (i) an increase in early antenatal coverage from 80% in 2005 to 95% in 2013; (ii) vaccination rates for children under-5 years maintained above 90% in the project areas; (iii) an increase in the annual national per capita expenditure on PHC (in real terms) from $11 in 2006 to $17 in 2013;(iv) an increase in health insurance coverage from 73% in 2007 to 85% by 2013, primarily through informal sector enrollment; and (v) an increase in the share of government health expenditures funded by the Health Insurance Fund from 19% in 2007 to 35% in 2013.

D. Outputs

5. The project had four expected outputs: (i) strengthened health services, (ii) improved health care financing and health insurance, (iii) improved human resources development, and (iv) sector capacity development and management. These four outputs were to be operationalized through 12 initiatives—three for strengthening health services, three for improved health care financing and health insurance, two for improved human resources development, and four for health sector capacity development and management (RRP, paras. 26–44). More specific details are presented below:

(i) **Output 1: Strengthened health services.** This was to be delivered through (a) improved family group practices or FGPs (renamed as family health centers or FHCs), *soum* [4] health centers (SHCs), and *aimag* (province) general hospitals (AGHs); (b) improved clinical competencies, referral systems, and infrastructure and equipment in selected SHCs in project *aimags*; and (c) enhanced capacity of AGHs and *duureg* (district) general hospitals (DGHs) in Ulaanbaatar to support FGPs and SHCs.

(ii) **Output 2: Improved health financing policies.** This was to be delivered through (a) improved health resource allocations and purchasing based on best practice and rational methods, (b) strengthened health insurance to improve financial protection and expand coverage and optimize the benefit package, and (c) improved hospital efficiency by introducing appropriate health financing management measures and incentives.

[3] A *duureg* is a district in Ulaanbaatar.
[4] A *soum* is an administrative subunit (district or sub-province) of an aimag.

(iii) **Output 3.** Strengthened human resource management. This was to be delivered through (a) improved human resource planning and processes, and (b) enhanced incentive and motivation schemes to encourage key health staff to areas where there is a critical shortage of health professionals.

(iv) **Output 4. Improved capacity and governance in the health sector.** This was to be delivered through (a) increased capacity of the Ministry of Health (MOH), the National Center for Health Development (NCHD), an agency of MOH, and other health agencies to implement and monitor the Health Sector Master Plan (HSMP); (b) improved governance in the health sector; (c) establishment of an operational policy and guidelines on private sector development and regulation in health; and (d) enhanced project management capacity.

6. Output 1 focused on five *aimags* (Arkhangai, Dundogov, Gobi Altai, Sukhbaatar, and Tuv) that have been selected based on poverty levels, health status, and levels of development investment; and on two *duuregs* (Chingeltei and Songinokhairkan) having significant populations of poor and disadvantaged people living in *ger* (traditional tent) areas. Outputs 2, 3, and 4 focused on policy change and reform of the health sector system nationwide, including health financing and insurance, human resources development, and regulation and governance (RRP, Grant and Project Summary, p. i).

E. Provision of Inputs

7. Strengthening of health services involved civil works, equipment, training, policy support, and environmental safeguards. For improved health care financing and health insurance, planned inputs included policy concepts and recommendations on health insurance, hospital autonomy and hospital management incentive scheme, and the corresponding decisions by government. For improved human resource management and capacity, the planned inputs were workforce planning model development, human resource training, recommendations for career pathways for rural health workers, institutionalization of training, and guidance on incentives to encourage staff transfer to rural areas. For health sector capacity development and stronger management, planned inputs included the conduct of annual sector-wide reviews, assistance for institutionalizing sector-wide management mechanisms, client satisfaction monitoring, installing procedures for patient rights and complaints, a regulatory framework for private sector operations, and monitoring of private hospitals.

8. During appraisal, the total project cost was estimated at $17.6 million, distributed as follows: (i) $11.3 million for strengthening health services, (ii) $0.7 million for improving health care financing and health insurance, (iii) $0.8 million for improving human resources development, (iv) $2.8 million for sector capacity development and management, and (v) $2.0 million for physical and price contingencies. Of the total amount, $14.0 million (80%) was grant financing from the ADB Special Funds resources, and the remaining $3.6 million (20%) was provided by the Government of Mongolia (RRP, para. 46). The project ended up costing $1.39 million less ($1.24 million undisbursed from the ADB grant, and $0.15 million on the government side) due to underspending, mainly in the categories of “other investment support” (accounting for more than 50% of the total underspent amount) and “equipment” (accounting for 26% of the total underspent amount). Lack of government contribution resulted in underspending for Outputs 2 and 3. However, for Output 1, the actual expenditure exceeded the appraisal estimate by $2.01 million ($0.38 million from the government, and $1.63 million

from ADB) because of changes, which were agreed and endorsed by the government and ADB (para. 15).

9. The project required 369 person-months of consulting services (57 international and 312 domestic). However, 365.50 person-months were recruited, individually or through a firm, under the cost category "consultants," and an additional 56.25 person-months in eight subprojects under the cost category "other investment support." A firm supplied a package of consulting services, comprising a team leader and PHC specialist, human resource management and organizational development specialists, sector capacity development and management specialist, and health care financing and modeling specialists.

10. Assistance from the Japan Fund for Poverty Reduction (JFPR) was sought to improve access to health services for disadvantaged groups in Ulaanbaatar through a separate grant project,[5] with a total of $2 million implemented from April 2008 to August 2013.[6] This project was to support the Third HSDP by demonstrating improved health service models to increase access for urban disadvantaged groups, particularly the poor, unregistered, and uninsured citizens, which will feed into the broader policy objectives of the Third HSDP (RRP, para. 26 and footnote 8).

F. Implementation Arrangements

11. The implementation arrangements were executed as planned. MOH was the executing agency for the project and was responsible for its overall implementation. A project steering committee was established to provide strategic orientation and overall guidance on project implementation, chaired by the vice minister of health (in lieu of the secretary of MOH, as embodied in a ministerial order) and composed of senior officials from MOH, Ministry of Social Welfare and Labor, Ministry of Finance, State Social Insurance General Office, and Health Sciences University of Mongolia in Ulaanbaatar City; and of representatives from project *aimags* and *duuregs* and from the Mongolian Association of Family Doctors. A project implementation unit (PIU) was set up in MOH, headed by a project manager, for the day-to-day implementation and coordination of all project activities. The PIU oversaw construction, procurement, selection of consultants, and project performance and progress reporting through quarterly and annual reports. For each project *aimag,* a project coordinator was designated to oversee its day-to-day project activities under the supervision of *aimag* supervisory groups and the PIU.

12. The five project *aimags* established supervisory groups, chaired by the *aimag* governors' offices and composed of representatives from the health departments, AGHs, and SHCs and were already operating well at midterm. As planned, the supervisory groups met quarterly. Supervisory groups were also to be established at the district level, but this was not pursued due to the resistance of the districts arising from foreseen additional workload vis-à-vis the presence of already numerous working groups. Instead, a district coordinator was appointed.

[5] ADB. 2007. *Grant Assistance to Mongolia for Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila (Grant 9115-MON).

[6] ADB. Project information on Access to Health Services for Disadvantaged Groups in Ulaanbaatar. Grant 9115-MON. www.adb.org

13. For the JFPR grant on improved access for disadvantaged groups in Ulaanbaatar, the plan was for its project management structure to be integrated with that of the Third HSDP to greatly facilitate the process.[7] There was no mention in the project completion report (PCR) if this was done.

14. **Compliance with covenants.** Of the 30 covenants, 27 were complied with, and three were partially complied with. The covenants that were partially complied with were on the timely allocation of the required counterpart funds, piloting of hospital or health boards, and public reporting mechanisms for expressing complaint or satisfaction with FGPs and hospital services. Some of the covenants, especially those in relation to policy reforms, have deadlines that may, on hindsight, be considered as too ambitious in the light of risks that were identified at appraisal in relation to stakeholder buy-ins and the political environment (PCR, paras. 37–38).

15. **Changes in scope.** Changes were made to the technical assistance (TA) during implementation. At the request of the Government of Mongolia, ADB agreed to reallocate $860,000 to the Civil Works subcategory from the Unallocated category to meet the share of ADB in the cost associated with works contracts that the executing agency awarded in 2010 and plans to award these in the remaining period of the project. At midterm, minor changes in scope, including an extension,[8] were proposed and subsequently approved. The executing agency and ADB agreed on value-adding changes, consisting of eight subprojects that required additional expertise and other inputs on information and communication technology and health, laboratory strengthening, hospital efficiency and autonomy, hospital governance, health economics, health statistics, advocacy, and national health accounts (PCR, paras. 39 and 47 and Appendix 4).

II. EVALUATION OF PERFORMANCE AND RATINGS

A. Relevance of Design and Formulation

16. The PCR rated the project *highly relevant.* The project was designed to build on the policy platform established by previous projects and continue the reform agenda in line with the government's HSMP, which was later superseded by the Health Sector Strategic Plan (2006–2015). The efforts to improve the quality of health services, broaden access to PHC, improve health care financing, and improve the capacity for health systems governance were crucial to reducing poverty; accelerating economic growth; and reducing development disparities, particularly between rural and urban areas, as espoused by the National Development Strategy, 2006–2020 (PCR, paras.5 and 9).The project was consistent with the ADB country strategy and program update, 2007–2009 for Mongolia, which emphasized human development and the importance of program actions in the health sector, including those for governance and public–private partnerships.[9]The project was also consistent with the country partnership strategy, 2012–2016, which speaks of building on the positive momentum for health sector reform and meeting health-related Millennium Development Goals through involvement in health insurance reform, PHC strengthening, and efficient and quality hospital services.[10] Key lessons from previous assistance were also incorporated in the project design (PCR, para. 8).

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[7] ADB. 2007. *Grant Assistance to Mongolia for Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila.

[8] An extension of the project was agreed on at the midterm review to support the development of national health accounts, and telemedicine equipment and remote diagnostic capacity; and the establishment of an economic unit in the National Center for Health Development (NCHD). (PCR, para. 9)

[9] ADB. 2006. *Mongolia: Country Strategy and Program Update, 2007–2009.* Manila.

[10] ADB. 2012. *Mongolia: Country Strategy and Program Update, 2012–2016*. Manila.

17. At midterm, minor changes in the design and monitoring framework (DMF) were made, primarily in the timing of attaining certain targets that were affected by delays in implementation.[11] An extension of the project to support the development of national health accounts, purchase and install telemedicine equipment and remote diagnostic capacity, and establish an economic unit in the NCHD was appropriate. The installation of 37 deep wells in SHCs also promoted sanitation in the project areas.

18. Nevertheless, given the detailed analysis of the rise of chronic, non-communicable diseases (NCDs), the relevance of the project design and implementation could have been strengthened with the addition of further output level indicators related to reducing the incidence of NCDs. Although the latter was not part of the outcome of the program, the RRP did highlight that the increase of NCDs was also impacting on the overall health of the community and so training initiatives targeting the reduction of NCDs could have complemented the other training activities without diluting key outcomes of the program. The scourge of NCDs, particularly lifestyle diseases (e.g., cardiovascular diseases, diabetes, and cancer) especially among the male population, was strongly articulated prior to inception (RRP, para. 11 and 60). Including a requisite indicator (e.g., design and production of evidence-based and culturally appropriate information, education, and communication advocacy materials or peer training modules on smoking to be used in the health promotion campaign) or a reinforcing indicator (policy recommendation on strengthening health promotion for NCD prevention and control) could not have distracted the project from its core focal areas and would have resonated well with PHC strengthening. From the standpoint of health financing, reduced incidence of lifestyle-related illnesses can contribute to lesser spending for chronic care.

19. Given the identified challenges, the project design should have also included capacity building to strengthen the regulatory capacities of the MOH to monitor private sector hospitals. This would have entailed an additional project performance indicator on operationalizing a regulatory framework and mechanism to govern private sector health operations. Moreover, it would have been useful to introduce a deliberate strategy on advocacy and social marketing to generate buy-ins to ensure the approval and implementation of key policy measures. On the basis of the above, this validation assesses the project *relevant*.

B. Effectiveness in Achieving Project Outcomes and Outputs

20. The PCR rated the project *effective* in achieving its outcome indicators and described the project as having achieved all the service delivery targets specified at appraisal. Nonetheless, the PCR points out that the project had mixed success in achieving the various policy targets.

21. **Outcomes.** The first outcome—a more effective PHC service—was measured through antenatal coverage, under-5 vaccination rates, increase per capita expenditure on PHC, and share of government expenditure financed by health insurance financing. Except for one indicator, the project reached its targets or was trending toward the achievement of targets. There were variations in the antenatal coverage, which were attributed to the significant rural–urban migration and increasing local poverty levels, especially in the western parts of Mongolia, resulting in barriers and interruptions to service access (PCR, Appendix 1, p. 16).[12] As a consequence, while other project areas exceeded targets for early antenatal coverage, one

[11] Delays in implementation were cited as the reason for moving four indicator timelines. Nine indicator timelines were approved to be moved to a later date

[12] ADB. 2015. *Completion Report: Third Health Sector Development Project (Mongolia).* Manila.

project area (Gobi-Altai) was below target. The performance of Gobi-Altai merits some further explanation as the 20% decrease could be indicative of not just the effects of socioeconomic determinants of health, but also the failure of health systems, or a part thereof, during a period when an HSDP is supposed to be strengthening PHC services. The target for children under-5 vaccination (maintained above 90%) was achieved nationally and in project areas. The target per capita expenditure for PHC of $17 by 2013 was overachieved, at $22. As to national health insurance coverage, it increased nationally to 97.7% in 2013 from the target of 85%.

22. On the second outcome, the share of government expenditure funded from health insurance reached 26% in 2013 compared to the target of 35%. However, with the passage of the revised Health Insurance Law (2015), it is expected that the share of health insurance funding in government health expenditure will increase markedly as health insurance coverage, benefit packages, and government subsidies for vulnerable people increase.

23. **Outputs.** The project was particularly effective in strengthening FHCs as the first level of Output 1. The PCR cited follow-up surveys that showed increased community satisfaction and 12%–15% reduction in the patient flow to DGHs for laboratory tests and rehabilitation services. With these results, MOH decided in 2015 to adopt the expanded services of FHCs nationwide. This initiative was reinforced by the strengthening of SHCs with the view of aligning them with PHC objectives. To rationalize health facilities—with PHC strengthening as an overriding consideration—a national strategic plan for reforming *soum* hospitals into SHCs was recommended by the project and approved by MOH.

24. Overall, the project achieved 20 of the 28 output indicators, but had difficulty in the following: (i) FHC gatekeeping function regulated and promoted through a public information campaign by 2012; (ii) 30% of hospitals with budget autonomy by 2012; (iii) 50% of hospital managers under performance-based contracts, coupled with incentive schemes by 2012; (iv) sector-wide management mechanisms for planning, supervision, monitoring, and reporting established by 2012; (v) MOH plans and budgets according to HSMP and implementation framework; (vi) annual public reporting mechanism on community satisfaction with FHCs and hospitals developed (by 2010) and operational (by 2012); (vii) patient rights and complaints procedures institutionalized by 2012; and (viii) monitoring of private sector hospitals effective by 2013 (PCR, Appendix 1).Of the eight output indicators that were not achieved as of project completion, four were due to unforeseen circumstances (e.g., changes in national and agency leaderships, and staff turnover), while three could have been pushed toward implementation with well-planned advocacies or social marketing. This validation rates the achievement of project outputs *effective* as most of the significant targets were reached.

C. Efficiency of Resource Use in Achieving Outcomes and Outputs

25. The PCR rated the project *efficient* in achieving its outcomes and outputs. The RRP estimated an economic internal rate of return (EIRR) of 22.8% and a net present value of MNT11.3 billion (at a discount rate of 12%), based on calculated resource cost savings and productivity gains (RRP, para. 68). However, the PCR did not provide an EIRR at completion. This may have been due to the fact that a number of output indicators in the policy arena, with far-reaching impact on health financing, were yet to be or just about to be realized as of project completion. Nevertheless, a qualitative assessment of the parameters utilized in the RRP's EIRR could have been undertaken to see if the potential EIRR as estimated would have been less or more than what was assessed during project appraisal.

26. The efficiency assessment is thus primarily based on a shorter time frame of process efficiency. Based on the measures cited by the PCR, this validation noted the (i) consistency between project expenditures with planned disbursements;[13] (ii) full utilization of planned consulting inputs; (iii) PIU accounting for only 6.8% of total project costs; (iv) introduction of additional value-adding activities without any increase in costs—e.g., establishment of two model FHCs with laboratory diagnostic facilities, development of electronic health information system or *H-Info*, development of national health accounts, and strengthening the capacity of NCHD for preparing it, and PHC costing studies; and (v) the use of local contractors for civil works in *aimags*, rather than larger companies from Ulaanbaatar, which reduced logistical and travel costs while still maintaining construction standards under the close supervision of a project consultant,[14] not to mention that it also created local jobs and ensured that construction workers were available for follow-ups and repairs. These dimensions of process efficiency would also impact positively on an EIRR calculation. This validation, thus, assesses the project *efficient*.

D. Preliminary Assessment of Sustainability

27. The PCR rated the project *likely sustainable.* This validation notes several factors leading to this rating. Among these are the institutionalization of the training of trainers approach that put in place trained trainers for the training programs developed by the project, which in turn can be regularly updated as needed;[15] and the training structures set up by the projects, which have been embedded in *aimag* and district operations. The key to such arrangement has been to incorporate such trainings into annual budget plans and allocations, with *aimag* and district managers committed to the funding and to operating the training programs. The other factors were the (i) establishment of the family medicine curriculum at the Mongolian National University of Medical Sciences (MNUMS) and making it a compulsory module in undergraduate medical education;[16] (ii) establishment of a well-equipped skills laboratory at MNUMS, which is now widely used by medical students; (iii) establishment of a unit at the *aimag* and district hospitals to maintain civil works and equipment procured, guided by maintenance manuals and schedules;(iv) strengthening of the referral links between family doctors and hospital specialists; (v) better infrastructure and operational standards for FHCs and SHCs; (vi) shared guidelines and protocols, and ongoing training and professional development programs; and (vii) production of concept and policy papers in the areas of health insurance, health financing, public–private partnerships, and workforce planning, thus, consolidating the thinking of policy makers (PCR, paras. 52–56).

28. Moreover, as observed by this validation, sustainability was also served by the following capacity-building interventions: (i) setting up of an undergraduate student scholarship program to the support training of health professionals from remote, rural health centers; (ii) establishment of a clinical rotation system, where 1,203 SHC and FHC doctors and nurses undertook in-service training in AGHs and DGHs, enabling them to extend the skills acquired to

[13] The ADB grant, however, was underspent by $1.23 million mainly because of mis-procurement of medical equipment and the lack of counterpart financing during the extension period (PCR, para. 50).

[14] The clause referring to maintenance of construction standards (PCR, para. 51) needs to be verified vis-à-vis another para. in the PCR that speaks of varying quality occurring in civil works especially for the more remote SHCs (PCR, para. 42).

[15] A total of 219 health professionals from AGHs and DGHs were trained as trainers, and they conducted continuing medical education (CME) clinical training for 2,757 health staff, including 363 *feldshers* or community-based rural health workers from 305 *baghs* (subunits of *soums*) in project *aimags*. These trainers are still in place and able to conduct further training as project-promoted CME becomes institutionalized.

[16] An internationally recognized family medicine textbook was translated into Mongolian to serve as the core teaching reference for trainee doctors.

their colleagues in the workplace; and (iii) provision of support to the NCHD in establishing a health professionals' postgraduate training e-database for monitoring continuing medical education (CME) and in-service training of medical staff. Project *aimags* have institutionalized clinical rotation training among *soum* health staff by providing financial and nonfinancial incentives for trainers and trainees from local budgets.

29. Substantiating its conclusion that FHCs are now well established in Mongolia and are increasingly used as the first point of contact for health care, the PCR cited a survey of FHCs conducted during the project completion review mission that indicated that the poor and the vulnerable, including older people and children, are major users of FHC services and that the model is stable in terms of financing (PCR, para. 55). Moreover, in 2015, after follow-up survey results showed increased community satisfaction and reduction in the patient flow to the DGHs, MOH adopted the expanded services of FHCs nationwide.

30. At the realm of policy reform, the revision of the Health Law and the Health Insurance Law of 2015, based on project recommendations, provided the government a strong legislative and policy base for further advancing health reforms and system improvements. Based on these observations, this validation assesses the project *likely sustainable*.

D. Impact

31. The PCR noted that poverty levels are steadily decreasing (from 38.7% in 2010 to 27.4% in 2013, as targeted) and this is corroborated, though not with exactly the same data, by other sources.[17] While it would be difficult to establish the project's impact in this regard, the interventions that were introduced or implemented are likely to contribute to poverty reduction especially among vulnerable segments of the population. Among others, the new Health Law ensures free access to medical services for the poor, and under the Health Insurance Law, health insurance has been expanded to vulnerable groups.

32. Project inputs that strengthened PHC delivery and the referral system (evidence-based clinical guidelines, teleconsultations, clinical training, expanded services, and upgraded infrastructure and equipment, among others) were seen to contribute to the reduction in maternal mortality rate,[18] especially if there are continuing follow-through efforts to build on what the project started.

33. Project interventions for equipping FGPs and SHCs are likely to have strengthened the laboratory and diagnostic capacities of these health care facilities. Complemented by the training provided by the project on strengthening the outreach function of SHC staff, tuberculosis case detection can be expected to have improved and led to a reduction in transmission and incidence.[19]

34. The project contributed significantly to gender health and development by prioritizing female health professionals in the continuing medical education program; fostering gender awareness in health development through information, education and communication;

[17] Ministry of Economic Development and United Nations Development Programme (UNDP). 2013. *Fifth National Progress Report on Achieving the MDGs.* Ulaanbaatar.

[18] The PCR cited MOH data showing that maternal mortality decreased nationally from 93/100,000 in 2005 to 42.6/100,000 in 2013, surpassing the target of 50/100,000.

[19] The PCR cited MOH data showing that tuberculosis decreased nationally from175/100,000 in 2005 to 142/100,000 in 2013, versus a target of 72/100,000. It is noted that two project sites (Ulaanbaatar City and Sukhbataar *aimag*) were among those with TB incidence that were higher than the national average in 2012, based on a UNDP report.

mainstreaming gender in all family medicine training programs of MNUMS; facilitating cooperation for the passage of the Gender Equality Law in 2011; gender sensitization of health sector planning and programming through advocacy and concrete recommendations for gender-disaggregated health statistics; and a more gender-inclusive health insurance program (PCR, Appendix 6).

35. No major negative environmental impacts were expected from the project, which was classified as environmental Category B. Environment performance of the project was reported in all annual progress reports and adequate environmental provisions were made in contracts for works. Changes made in project design, such as the shift from waste incineration to local segregation, sterilization and land filling, and training in hospital waste management contributed to good environmental safeguards. An energy-efficient design and execution was applied to both new and renovated buildings. Negative impacts on the environment were mitigated through adequate environmental management that included community consultations and regular monitoring of mitigation measures during civil works. At project closing, field visits were undertaken to assess waste management, water supply, and overall quality of works and ongoing maintenance. Deep wells were operating efficiently; however, in a few health centers, the septic tanks were not regularly and sufficiently emptied because of budget constraints and some autoclaves to treat medical waste were not operational. The project caused no involuntary land acquisition and resettlement issues, and had no adverse impact on indigenous peoples (PCR, para. 60 and Appendix 7).Overall, the project impact is assessed *moderate*.

III. OTHER PERFORMANCE ASSESSMENTS

A. Performance of the Borrower and Executing Agency

36. The PCR rated the performance of the executing agency *less than satisfactory*. This validation agrees with this rating. The change of government in 2012 resulted in the dilution of the ownership of the HSMP and reduced the sector-wide focus. In moving away from the HSMP, to which project components are linked, the government sent conflicting signals vis-a-vis health sector reforms. The lack of counterpart funding in 2013–2014 resulted in underspending in components 2 and 3, specifically on materials, training, and advocacy activities. The mis-procurement case in 2014 also casted a shadow on an otherwise successful project.[20] In addition, there were the (i) non-implementation of the hospital efficiency pilot plan, as of project completion; (ii) very little progress in sector-wide approaches and cooperative mechanisms due to high staff turnover in MOH; (iii) delay in installing the complaints mechanism for hospital services developed by the project; and (iv) non-implementation of the hospital board concept.

37. However, the PCR acknowledged that MOH handled the project successfully on a managerial level, along with the active support of ADB Mongolia Resident Mission. This validation agrees with this observation on the good working relationship between project staff and the health departments in the project sites, which served to maximize project achievements. This validation also notes the readiness of MOH to push for important, although relationally-sensitive project recommendations (e.g., hospital rationalization, incremental implementation of single purchasing), shepherd the institutionalization of training initiatives through budget allocation, and build on project success (e.g., MOH's initiation of a cost study for secondary and tertiary hospital services financed from the state budget, after the project-supported cost study

[20] In 2014, during a procurement process for the provision of equipment, potential alteration of tender documents was identified and one lot of the tender was declared as a mis-procurement by ADB. The amount involved was $250,780 (PCR, para. 32).

for PHC services was completed).[21] This validation assesses the performance of the government *satisfactory*.

B. Performance of the Asian Development Bank

38. The PCR rated ADB performance *satisfactory*, and this validation agrees with this rating. ADB demonstrated readiness to make the project as responsive as possible, showing flexibility and maximizing project gains as the opportunities emerged. ADB made optimal use of the 11 review missions that were conducted during the life of the project. The conduct of review missions by ADB, as reflected in the loan review mission reports and ADB's persistence when following up on actions that needed to be made helped the project stay on course. ADB sought solutions to identified issues through discussion and building consensus with the agencies concerned. ADB also demonstrated flexibility in responding to the needs of the project by approving the use of resources to support value-adding subprojects and by approving the government's request to extend the project. After the midterm review in 2011, the PIU, which is also responsible for the fourth and fifth HSDPs, was expanded, which improved project management.

C. Others

39. The JFPR project on *Access to Health Services for Disadvantaged Groups in Ulaanbaatar* was designed to support the government's HSMP—by identifying issues and barriers facing the disadvantaged in accessing health services. It supported the Third HSDP by demonstrating improved health service models to increase access for urban disadvantaged groups, particularly the poor, unregistered, and uninsured citizens.As a result of the TA project, several pro-poor policies were developed and presented to the government in 2012, covering programs to increase health insurance coverage for internal migrants, community volunteers in deprived areas, and welfare social workers attached to FHCs; and to have easier and speedier registration and enrollment processes. The TA project also provided significant support for the revision of the Health Insurance Law (passed in 2015), which mandates full health insurance coverage of the poor and disabled (PCR, para. 6).

IV. OVERALL ASSESSMENT, LESSONS, AND RECOMMENDATIONS

A. Overall Assessment and Ratings

40. The PCR rated the project *successful* since it is rated *highly relevant*, *effective*, *efficient,* and *likely sustainable.* This validation is of the view that the project was particularly effective in strengthening health service delivery, especially at the PHC level.The inclusion of value-adding subprojects after the mid-term review enhanced relevance but there were also missed opportunities in design and implementation planning. Despite some slight delays in civil works and equipment procurement in the first 2 years of implementation, physical progress (including civil works, equipment procurement, and training) was largely in step with the elapsed grant period. Having implemented two HSDPs before, the project design included policy reforms. However, the frequent changes in government and agency leadership, and the high staff turnover at MOH limited the implementation of reform initiatives. The project strengthened capacities for PHC and advanced the agenda for policy reforms toward improved financial protection through health insurance, improved private sector regulation, and better management

[21] ADB. 2015. *Completion Report: Third Health Sector Development Project (Mongolia).* Manila.

and utilization of curative resources by introducing concepts that can be implemented at a later stage. Overall, this validation assesses the project *successful*.

Overall Ratings

Criteria	PCR	IED Review	Reason for Disagreement and/or Comments
Relevance	Highly relevant	Relevant	Project design and implementation could have been more relevant if (i) one or two indicators complementing and reinforcing the output indicator on health promotion training were included, thus, making the design more purposive without being distracted from its core focal areas; and (ii) if the weak capacity of MOH for monitoring private sector hospitals were considered (paras.18–19).
Effectiveness in achieving outcome	Effective	Effective	.
Efficiency in achieving outcome and outputs	Efficient	Efficient	
Preliminary assessment of sustainability	Likely sustainable	Likely sustainable	
Overall assessment	**Successful**	**Successful**	
Impact	Not rated	Moderate	Refer to paras. 31–35.
Borrower and executing agency	Less than satisfactory	Satisfactory	Refer to para. 37.
Performance of ADB	Satisfactory	Satisfactory	
Quality of PCR		Satisfactory	Refer to paras.46–47.

ADB = Asian Development Bank, IED = Independent Evaluation Department, MOH = Ministry of Health, PCR = project completion report.
Source: ADB Independent Evaluation Department.

B. Lessons

41. This validation agrees with the lessons enumerated in the PCR, especially on (i) the need to match reform ambitions with actual capacity of government agencies, and factoring in staff turnovers; and (ii) the need to minimize the eroding impact of high staff turnover and leadership changes in the executing agency by improving counterpart competence, both individual and organizational, through training or skills in development in policy analysis and through regular briefing, dialogues, and information sharing with MOH staff. In addition, there should be continuing advocacy and social marketing of the reform ideals, given frequent changes in leadership. Hence, it is important to keep the rhetoric up and alive to create and maintain the groundswell of support from everyone.

42. This validation supports the longer-term recommendation of the PCR for ADB to consider engaging the ministry staff in project administration, instead of establishing a parallel PIU. This can be supported, but not led, by an external consulting service. While this may have challenges due to staff capacity, it is ideal from the standpoint of ownership and may perhaps discourage the high staff turnover experienced in the past. Staff accountability can be strengthened through closer monitoring of its performance and the provision of staff development inputs based on needs.

C. Recommendations for Follow-Up

43. This validation agrees with all PCR recommendations. In addition, ADB should promote advocacy and wider discussion of health sector reforms among parliamentarians, civil society, and other government departments, e.g., Ministry of Finance. This would help to ensure wider ownership of the reform agenda and help to create sustainability in the event of changes in the government.

V. OTHER CONSIDERATIONS AND FOLLOW-UP

A. Monitoring and Evaluation Design, Implementation, and Utilization

44. The monitoring of performance, as presented in the DMF and in the grant covenant, covers all possible information available to determine if the project is on track, on time, and doing things right. The project performance monitoring system was also approved by ADB and MOH in 2008. The system is comprehensive and spells out all aspects of the project, including DMF indicators, environment and gender plan monitoring, planned surveys and studies, and monitoring of risks and assumptions (PCR, Appendix 3, p. 31).

45. Of the review missions, 11 were fielded from November 2008 (7 months after actual grant effectivity) to January 2014 (5 months before closing). These missions were useful in collecting information on implementation status, identifying bottlenecks, pinpointing areas for fine-tuning as well as additional TA needs, and recommending necessary actions. A survey of FHCs in Ulaanbaatar was conducted during project completion, and the PCR also mentioned a follow-up survey. Findings from these surveys informed MOH decision regarding the nationwide application of the expanded services of FHC.

B. Comments on Project Completion Report Quality

46. This validation could have been strengthened with more analytic discussion that highlighted (i) the inconsistencies in PCR judgments—where one section speaks of compliance with or maintenance of standards in the quality of civil works (PCR, para. 51) while another section talks of varying quality occurring in civil works especially for the more remote SHCs (PCR, para. 42); (ii) how health insurance coverage for the informal sector was to be achieved; and (ii) the inadequate information on how the JFPR grant for improving health access of disadvantaged groups in Ulaanbaatar interfaced with the project. The lack of discussion on the EIRR, even at a qualitative level, was also an omission as it represents the most comprehensive picture of efficiency.

47. Notwithstanding these inconsistencies, the PCR captured significant highlights of the project cycle, surfaced the strengths, identified the enabling factors, and was candid in describing the constraints and weaknesses in the project. A survey was also conducted during the project completion review mission to verify the sustainability of outputs undertaken to strengthen PHCs. The results of the survey helped inform findings in the PCR. Overall, this validation finds the quality of the PCR *satisfactory.*

C. Data Sources for Validation

48. Data sources used in this validation include the following: RRP, PCR, loan review mission reports, project information document, Grant Assistance Report on an associated TA project, and published literature on desired project impact and outcomes.

D. Recommendation for Independent Evaluation Department Follow-Up

49. The conduct of a project performance evaluation report 3 years after project completion would be very helpful in (i) tracking the progress made by the government in pursuing the unaccomplished output indicators (unless their accomplishment was made part of a follow-on project that is currently being implemented); (ii) gaining a better understanding of how health service delivery interventions were and should be implemented in areas that seem to have perennially low performance indices (e.g., maternal care services coverage in Gobi-Altai); and (iii) ascertaining the accuracy of data in impact indicators on maternal mortality rate and incidence of tuberculosis, since data from the United Nations Development Programme, World Health Organization, United Nations Children's Fund, and the World Bank are showing a marked difference from the data shown in the PCR.