SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Mongolia	Project Title:	Fifth Health Sector Development Project
Lending/Financing Modality:	Project	Department/ Division:	East Asia Department Urban and Social Sectors Division

I. POVERTY ANALYSIS AND STRATEGY

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

The project will improve patients' and health workers' safety in hospitals in Mongolia. It will (i) improve the safety of blood transfusions, (ii) strengthen medical waste management, and (iii) prevent and control hospital-acquired infections. The component on improving the safety of blood transfusions will be applied nationwide reaching 2,780,000 beneficiaries. The components on improving medical waste management and prevention and control of hospital-acquired infections will be conducted in nine *aimags* (provinces) and three urban centers (Ulaanbaatar, Darkhan, Erdenet) reaching about 1,800,000 beneficiaries. About 29,400 health workers (82% women) will also benefit directly, especially those with professions that put them at occupational risk because of insufficient and unsecure blood products and processes.

The project will deliver benefits to both staff and patients by ensuring higher safety standards and protection against hospital-acquired infections, transfusion transmitted infections, and occupational safety risks. The project builds on previous Asian Development Bank (ADB) health sector development initiatives to continue reforming the Mongolian health sector in line with (i) the National Development Strategy in achieving the Millennium Development Goals (MDGs), especially MDG 4 (child health) and MDG 5 (maternal health); and (ii) the government's Health Sector Master Plan, 2006–2015 in improving hospital services. The project is included in the country operations business plan, 2012–2014[a] and is consistent with the current country partnership strategy, 2012–2016,[b] which emphasizes social development through efficient delivery of health services. The project is in line with the Operational Plan for Health in addressing sector governance issues and promoting more efficient allocation of health resources.

B. Poverty Analysis — Targeting Classification: MDG-TI (M4, M5, M6, M7)

1. Key issues. The National Statistical Office of Mongolia and the World Bank have estimated the national poverty headcount at 29.8% (26.6% in urban areas and 33.3% in rural areas) in 2011.[c] This represents an overall decrease since 2003, but the trend is also marked by a growing concern regarding increases in income inequality. Rising inflation is creating a greater burden for the poor to access basic commodities and services, including health. While key health indicators in Mongolia (nutrition and child mortality) have improved (2005–2012),[d] illnesses related to standard of living deprivation indicators now rank among the most prevalent, according to Ministry of Health 2010 indicators (cardiovascular disease, high blood pressure, liver disease). Clients who are least able to afford care pay a higher percentage of their income. Limited budgets in hospitals and health services often result in insufficient expenditures on basic infrastructure and supplies such as personal protective equipment. Health care workers sometimes have to purchase their own items to ensure personal safety and patients frequently must purchase personal protective equipment for health care workers who provide care for them.

The project will support MDG 4 (child health), MDG 5 (maternal mortality), MDG 6 (HIV/AIDS and tuberculosis), and MDG 7 (environmental health and sanitation) through enhancing blood safety, improving awareness on hygiene and safety, and strengthening medical waste management. Improvements in the quality of health care will restore the population's trust in the system, which has eroded significantly, as people resort to expensive (but not necessarily better) private care, self-diagnosis and medication, traditional remedies, and neglect. Greater trust results in more use of services and better health, which is closely linked to an improved standard of living overall.

2. Design features. Civil works and equipment components will bring the National Transfusiology Center, other blood banks, waste management, and infection prevention and control (IPC) equipment and supplies up to international standards, including for occupational safety. Training and capacity building programs will improve health care worker practices on blood safety, medical waste management, and infection prevention. The information, education, and communication (IEC) campaign on voluntary blood donation will be applied nationwide and will help to ensure an adequate and safe supply of blood for the country.

II. SOCIAL ANALYSIS AND STRATEGY

A. Findings of Social Analysis

The poverty and social assessment found that the project outputs meet urgent needs of the population. The main issues raised by health workers, patients, the public, and other stakeholders revealed the following:

(i) **Insufficient voluntary blood donation.** According to World Health Organization standards, at least 1% of the total population should donate blood per year to reach and maintain minimum requirements for an adequate blood supply for the population. Mongolia has achieved only 80% of the required minimum demand. No voluntary donor database exists to facilitate emergency donations. The results of a 2010 survey by the National Transfusiology Center in Ulaanbaatar revealed that the main obstacles to blood donation were (i) lack of time, (ii) fear of infection, and (iii) the belief that giving blood is bad for one's health. Effective (including gender and culturally sensitive) IEC for the public is required on this issue.

(ii) **Distribution and use of personal protective equipment.** Some health care facilities have insufficient supply, distribution, and use of personal protective equipment. Where facilities do not have enough to distribute to staff, a high percentage of health care workers are aware of their risks but often end up having to purchase materials themselves. Patients also reported having to purchase personal protective equipment for health care workers. Monitoring data on behavior and use is too limited to be able to target awareness raising and ensure behavior change.

(iii) **Nonmedical workers' contact with medical waste.** Focus group discussion revealed that nonmedical workers (such as those working in kitchens, as janitors, etc.) often come into contact with or are required to dispose of medical waste, without proper protection or knowledge on how to do so safely. These workers must be trained in appropriate procedures.

(iv) **Need for updated infection prevention and control information, education, and communication.** Health care workers and patients noted that IPC procedures are often not fully followed, leading to risks of hospital-acquired infections and transfusion transmitted infections.

B. Consultation and Participation

1. Provide a summary of the consultation and participation (C&P) process during project preparation.

Three workshops were held with related government departments, beneficiaries, environment protection bureau, local governments, etc., to inform the project design. The poverty and social analysis involved focus group and key informant interviews with health care workers, patients, and the public. Development of the environmental impact assessments and environmental management plan (EMP) involved two rounds of public consultations. The gender action plan (GAP) has been prepared and discussed with the Ministry of Health. The GAP and EMP set out detailed ongoing public participation plans.

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

☒ Information sharing ☒ Consultation ☐ Collaborative decision making ☐ Empowerment

3. Was a C&P plan prepared for project implementation? ☒ Yes ☐ No

Public disclosure of all project documents was made at the project management office and on the ADB website, including the project information document, design and monitoring framework, consolidated environmental impact assessment, report and recommendation of the President, public sector legal agreement, project administration memorandum, and environmental monitoring reports. The GAP and EMP indicate how consultation will continue throughout implementation.

C. Gender and Development — Gender Mainstreaming Category: EGM

1. **Key issues:**

(i) **Leadership.** Women make up 82.3% of the health care workforce.[e]

(ii) **Safety.** Women conduct most common blood processing, IPC, waste management and handling, cleaning, disinfection, etc., and are most exposed to hospital-acquired infections. Women and lower tier workers perpetuate non-reporting of risk situations because of a punitive institutional culture.

(iii) **Gendered use of health facilities.** Women use health facilities more and make up about 80% of patients while men only constitute about 20% of clients at facilities.

(iv) **Gender dimensions of need for blood transfusion.** Men represent nearly 70% of trauma inpatients while women usually need blood transfusions during complications from childbirth and other reproductive health procedures.

2. **Key actions.** Key actions in the GAP address (i) the issues of women as staff predominantly at risk in handling blood products by targeting training at mid-level staff (predominantly women) and monitoring behavior change; (ii) increasing knowledge and addressing behavior differences between men and women regarding voluntary blood donation and hospital-acquired infections in the knowledge, attitude, and practice survey and IEC; (iii) paying special attention to high-risk groups such as women in labor to ensure that these areas, which most affect women, are prioritized for promoting behavior change; and (iv) the opportunity to have the project GAP help ensure, through effective monitoring, that Ministry of Health human resource policies on gender equity is achieved in the selection of participants for training events and promotion of career development. This will help pave the way for helping women enter higher levels and management positions.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

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. No involuntary resettlement effects are foreseen and the project is classified a category C project. The National Transfusiology Center will be established on existing government land and will not affect local residents or residential buildings.		☒ No action
Indigenous Peoples	No impact. The geographical focus of the project will include hospitals in Ulaanbaatar, *aimags* (provinces) and *soum* (administrative subdivision of the *aimag*) centers. During the PPTA,[f] it was determined that in Bayan-Ulgii, which is primarily Kazakh, the population is not socially or economically vulnerable, but everyday communication among the public is normally conducted in Kazakh. The IEC outreach activities on voluntary non-remunerated blood donation for beneficiaries in Bayan-Ulgii will be conducted in two languages (Mongolian and Kazakh).	The project will be conducted nationwide. Improvements to blood safety, medical waste treatment, and prevention of hospital-acquired infections will benefit all citizens equally. The IEC campaign will be conducted in a culturally sensitive manner.	☒ Other action
Labor ☒ Employment opportunities ☐ Labor retrenchment ☒ Core labor standards	Limited. The project will build the National Transfusiology Center.	Project assurances ensure core labor standards compliance.	☒ Other action
Affordability	No impact		☒ No action
Other Risks and/or Vulnerabilities ☐HIV/AIDS ☐Human trafficking ☐Others (conflict, political instability, etc.)	No impact		☒ No action
IV. MONITORING AND EVALUATION			
Are social indicators included in the design and monitoring framework to facilitate monitoring of gender and social development activities and/or social impacts during project implementation? ☒ Yes ☐ No Indicators include the percentage of health care workers trained in blood safety, report on risk factors for hospital-acquired infections with disaggregated analysis; sex and job data are used for planning, performance monitoring, and staffing decisions.			

[a] ADB. 2009. *Country Operations Business Plan: Mongolia, 2012–2014.* Manila.
[b] ADB. 2012. *Country Partnership Strategy: Mongolia, 2012–2016.* Manila.
[c] National Statistical Office of Mongolia and the World Bank. 2012. National Poverty Headcount at 29.8% (26.6% in urban areas and 33.3% in rural areas) in 2011, Says Study. News Release 17 April. http://www.worldbank.org/en/news/2012/04/17/poverty-level-estimated-at-nearly-30-percent-in-mongolia
[d] National Statistical Office. 2012. *5-month report*. Ulaanbaatar.
[e] Ministry of Health. 2011. *Health Sector Human Resource Development Policy 2010–2014*. Ulaanbaatar.
[f] ADB. 2011. *Technical Assistance to Mongolia for Preparing the Fifth Health Sector Development Project*. Manila.
Source: Asian Development Bank.