ADB

Grant Assistance Report

Project Number: 41119
November 2007

Proposed Grant Assistance
Mongolia: Access to Health Services for Disadvantaged Groups in Ulaanbaatar
(Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 16 November 2007)

Currency Unit	–	togrog (MNT)
MNT1.00	=	$0.00085
$1.00	=	MNT1,173

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
DSW	–	development social worker
FGP	–	family group practice
IEC	–	information and education communication
JFPR	–	Japan Fund for Poverty Reduction
MOH	–	Ministry of Health
MSWL	–	Ministry of Social Welfare and Labor
NCB	–	national competitive bidding
NGO	–	nongovernment organization
PIU	–	project implementation unit
PSC	–	project steering committee
THSDP	–	Third Health Sector Development Project
TWC	–	technical working committee
UNFPA	–	United Nations Population Fund

GLOSSARY

aimag	–	administrative unit (province)
duureg	–	administrative subunit of Ulaanbaatar City (district)
ger	–	traditional tent
khoroo	–	administrative subunit of duureg (subdistrict)
ward	–	administrative subunit of khoroo
soum	–	administrative subunit of aimag (district)

NOTES

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

Vice President	C. Lawrence Greenwood, Jr., Operations 2
Director General	H. Satish Rao, East Asia Department (EARD)
Director	R. Wihtol, Social Sectors Division, EARD
Team leader	C. Bodart, Health Specialist, EARD
Team members	S. W. Handayani, Senior Social Development Specialist, Regional and Sustainable Development Department
	Bayasgalan Bavuusuren, Social Sector Officer, EARD


MONGOLIA
ACCESS TO HEALTH SERVICES FOR DISADVANTAGED GROUPS IN ULAANBAATAR
RUSSIAN FEDERATION
PEOPLE'S REPUBLIC OF CHINA
96°00'E
111°00'E
50°00'N
42°00'N
Ulaanbayshint
Ulaangom
UVS
Tsengel
Nogoonnuur
Naranbulag
Dayan
Olgiy
BAYAN-OLGIY
Tes
Tsagaan-Uul
Hanh
Hatgal
HOVSGOL
Moron
Altanbulag
Suhbaatar
BULGAN
SELENGE
Sukhbaatar
Selenge
Darhan
DARHAN-UUL
Hutag-Ondor
Erdenet
Ereentsav
Bayan-Uul
DORNOD
Havirga
Choybalsan
Tudevtey
ZAVHAN
Hovd
Bulgan
ORHON
Sumber
ARHANGAY
Hishig Ondor
Battsengel
Tsahir
Uliastay
Manhan
Dariv
HOVD
Yarant
Uyench
Tayshir
Altay
Togrog
Buutsagaan
Bayanhongor
Tsetserleg
Harhorin
Arvayheer
Nariynteel
OVORHANGAY
GOVI-ALTAY
BAYANHONGOR
Burgastay
ULAANBAATAR
Lun
ULAANBAATAR
Baganuur
Batnorov
HENTIY
Nalayh
Maanit
TOV
Zuunmod
Ondorhaan
Monhhaan
Matad
Tamsagbulag
GOVISUMBER
Baruun-Urt
Choyr
Erdenetsagaan
Bichigt
SUHBAATAR
Mandalgovi
DUNDGOVI
Saynshand
Tsogt-Ovoo
DORNOGOVI
Zamyn-Uud
Dalanzadgad
OMNOGOVI
Bayan-Ovoo
Gashuun Suhayt
N
0 50 100 150 200 250
Kilometers
Project Duureg (Chingeltei, Songinokhairkan, Bayanzurkh)
National Capital
Provincial Capital
City/Town
Main Road
Provincial Road
Railway
River
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
07-2504 HR

JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR Grant Proposal

I. Basic Data

Name of Proposed Activity	Access to Health Services for Disadvantaged Groups in Ulaanbaatar
Country	Mongolia
Grant Amount Requested	$2,000,000
Project Duration	4 years
Regional Grant	No
Grant Type	Project

II. Grant Development Objectives and Expected Key Performance Indicators

Grant Development Objectives:

The general objective is to improve access to health services for disadvantaged groups in Ulaanbaatar. The specific objectives are to:

(i) analyze the constraints that prevent the disadvantaged from accessing health services, using participatory survey methods that include stakeholders;
(ii) identify and test demand-driven schemes to improve the access to health services of disadvantaged groups living in the poorest *duuregs* (districts) of Ulaanbaatar; and
(iii) analyze the policy implications of successful schemes, and submit draft policy amendments to the Government.

Expected Key Performance Indicators

(i) At least 30,000 disadvantaged people living in the project duuregs have improved access to health services, particularly at the primary level.
(ii) The development social worker (DSW) program is established and rated successful in all three project duuregs.
(iii) At least 10 innovative pilot schemes are demonstrated to improve access and health services to disadvantaged citizens.
(iv) The Project submits policies to the Government that will improve access and services for disadvantaged groups.

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

Category	Amount of Grant Allocated in $	Percentage of Expenditures
1. Civil works	0	0.0
2. Equipment and supplies	150,000	7.5
3. Training, workshops, seminars, public campaigns	178,750	8.9
4. Consulting services	624,000	31.2
5. Grant management	221,100	11.1
6. Other inputs	626,150	31.3
7. Contingencies	200,000	10.0
Total	**2,000,000**	**100.0**

JAPAN FUND FOR POVERTY REDUCTION

JFPR Grant Proposal
Background Information

A. Other Data

Date of Submission of Application	
Project Officer	Claude Bodart, Health Specialist
Project Officer's Division, E-mail, phone	East Asia Department, Social Sectors Division (EASS) cbodart@adb.org, +632 632-5616
Other Staff Who Will Need Access to Review the Report	Sri Wening Handayani Senior Social Development Specialist, Gender, Social Development and Civil Society Division, swhandayani@adb.org, +632 632-6926 Bayasgalan Bavuusuren, Social Sector Officer, MNRM bbavuusuren@adb.org
Sector	Health, nutrition and social protection
Subsector	Health programs
Theme	Inclusive social development
Subtheme	Human development
Targeting Classification	Targeted intervention—non-income MDGs (TI-M)
Was JFPR Seed Money used to prepare this grant proposal?	Yes
Have SRC comments been reflected in the proposal?	Yes
Name of Associated ADB Financed Operation	Third Health Sector Development Project (THSDP)
Executing Agency	Ministry of Health (MOH)
Grant Implementing Agency	Ministry of Health B. Batsereedene. State Secretary 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	Assessment of access to health services and capacity development to strengthen formal and informal institutions
Cost	$161,111
Component Description	Component A has two subcomponents. Subcomponent A.1 will produce a situation analysis of constraints on access to health services, and an institutional analysis of issues affecting the delivery of health service to the disadvantaged.[1] The analyses will

[1] The use of the term "vulnerable" has been avoided since, according to the Government's current policy, "vulnerability" is a classification used for state benefits that is not necessarily linked to poverty criteria. The classification includes all citizens regardless of socioeconomic status who are under 16 years of age, all mothers of newborn infants, all elderly people, all unemployed people, and all single parents. It excludes unregistered urban residents, students (about two thirds of whom come from outside Ulaanbaatar), and herders. Disadvantaged people include overlapping groups such as the poor, unregistered migrants, the uninsured, informal sector community members, and individuals with special needs, including the disabled, single-parent families, elderly people without pensions, the homeless, and street children.

	provide the basis for service providers, local government, nongovernment organizations (NGOs), and communities to test solutions through pilot schemes that are part of Component B. Core activities under subcomponent A.1 include (i) conducting a situation analysis and household survey, (ii) carrying out an institutional assessment of health services at the primary level, and (iii) conducting a workshop to disseminate results and formulate selection criteria for pilot schemes. The expected outcomes of subcomponent A.1 include: (i) identification and characterization of constraints on access by disadvantaged households to health services, and proposed solutions involving stakeholder participation; (ii) description of weaknesses and strengths of family group practices (FGPs), and referral hospitals, and proposed solutions to reach the disadvantaged; and (iii) formulation of selection criteria for pilot schemes involving stakeholder participation (subcomponent B.2). Subcomponent A.2 will provide capacity development to the community, the local government's service providers, and the central level to participate actively in the design and implementation of the JFPR and the pilot schemes to improve access to health services in particular. Core activities under subcomponent A.2 include (i) mobilizing communities to participate in the Project through the provision of technical assistance by facilitators and an NGO; (ii) orienting a technical working committee (TWC), a project steering committee (PSC), local governments, and health providers; and (iii) training local government and health service providers to implement JFPR pilot schemes. The expected outcomes of subcomponent A.2 include: (i) community mobilization for involvement in JFPR activities; (ii) orientation of TWC and steering committee, local government, and health service providers for the Project; (iii) provision of technical assistance and training in participatory planning, project design, and implementation, and of monitoring to participating local government and health providers; (iv) adoption of screening and selection criteria for pilot schemes; (v) preparation of the TWC on screening and selection of pilot schemes; (vi) identification of sustainability issues of pilot schemes, and formulation of solutions with stakeholders from central, local, and community levels; and (vii) analysis of results of implementation of pilot schemes with community, health providers, local and central government representatives.
Monitorable Deliverables/Outputs	(i) Assessment results on disadvantaged groups, and institutional assessment of FGPs, including detailed

	recommendations on how to improve access to disadvantaged groups. (ii) Dissemination workshops of assessment results in each project *duureg* (district). (iii) Training of 10 participating local governments and health providers in participatory planning, project design, and monitoring and evaluation, in preparation of pilot schemes implementation. (iv) Identification and selection of criteria for FGP–local government pilot schemes. (v) Establishment of TWC through Ministry of Health (MOH) order.
Implementation of Major Activities: Number of months for grant activities	48 months

Component B	
Component Name	Pilot schemes: Improving access of urban disadvantaged to health services
Cost	$1,113,222
Component Description	Component B will implement 16 pilot schemes to demonstrate improved health service models to increase the access by urban disadvantaged groups to health services. Subcomponent B.1 will test a model of development social workers (DSWs) to serve as community-level health service facilitators, and will be implemented in all 10 project sites. Subcomponent B.2 will test 15 pilot schemes formulated by participating *khoroos* (subunits of duuregs). Core activities under subcomponent B.1 include: (i) hiring a national training institute; (ii) recruiting and designating and training DSWs; (iii) signing a memorandum of understanding with local governments on further use of DSW; and (iv) designing and producing information, education, and behavior change communication (IEC/BCC) material. The expected outcomes of Subcomponent B.1 include: (i) the selection and hiring of 10 DSWs in participating khoroos; (ii) preparation of DSWs through regular and on-the-job training, provided by a national training institute; (iii) increasing awareness of the public through the production and distribution of IEC/BCC material on FGP, and hospital services and eligibility; procedures of civil registration, health insurance enrolment and entitlement to the insurance book; advice services in case of domestic violence; and DSW services, generally; and (iv) monitoring of disadvantaged persons, and of the assistance provided by DSWs in facilitating their registration, and securing their entitlement to social benefits. Subcomponent B.2 will establish a fund to award 15 grants of about $40,000 each in response to applications submitted jointly by duureg governments and FGPs of participating khoroos to the TWC.[2] Priority will be given to innovative and quality proposals that will improve access to health services for disadvantaged groups.

[2] Based on preliminary consultations with stakeholders, several innovative schemes are being considered, including (i) improvement of targeting for entitlement to social services; (ii) assisted civil registration; (iii) a database of unregistered persons, linking FGPs and local governments; (iv) an assisted gatekeeping function for FGPs; and (iv) identification of entitlement through a bar code system.

	Core activities under subcomponent B.2 include (i) providing support to local governments and FGPs during the preparation of proposals for pilot schemes, (ii) submitting pilot schemes to TWC, (iii) screening and selecting pilot schemes for implementation, and (iv) providing continuous support during pilot scheme implementation. The expected outcomes of Component B.2 include: (i) joint preparation and submission to the TWC of pilot schemes by duureg governments and FGPs, with the support of local NGOs involved at primary health care level;[3] (ii) evaluation of the pilot schemes by the TWC, and selection of pilot schemes based on previously developed principles and criteria; and (iii) provision of grants to FGPs–local governments based on signed agreements.
Monitorable Deliverables/Outputs	(i) Five DSWs appointed and designated to five project khoroo governments and trained, five DSWs appointed and designated to five khoroo FGPs, and trained (ii) Information materials based on the needs assessment are produced and distributed by DSW to at least 5,000 households. (iii) 15 pilot schemes are awarded and implemented as models of FGP–local government partnerships.
Implementation of Major Activities: Number of months for grant activities	38 months

Component C	
Component Name	Project management and health policy development
Cost	$725,667
Component Description	The component will monitor and support the effective implementation of the pilot schemes, facilitate interagency coordination, and support policy analysis and development, based on the results of the pilot schemes. Core activities under Component C include (i) establishing the project implementation unit (PIU), (ii) preparing the grant implementation manual, (iii) performing annual audits, (iv) reviewing the social welfare system, (v) conducting follow-up surveys and workshops during pilot schemes implementation, (vi) monitoring and evaluating pilot projects, (vii) conducting policy seminars, and (viii) submitting draft policies to Government. The expected outcomes of Component C include: (i) provision of managerial support in the implementation of the pilot schemes by the project coordinator and consultants hired under the Project; (ii) interagency coordination provided by the project coordinator, with particular attention to the implementation of other projects in the three project duuregs; (iii) documentation of the processes in implementing the pilot schemes, and dissemination of results of progress to

[3] Infrastructure work for pilot schemes will be limited to minor rehabilitation and involve no land acquisition or displacement of people.

	communities, central and local government, and health service providers; (iv) quarterly monitoring reports to the PSC of implementation of pilot schemes, in coordination with stakeholders; (v) final evaluation of pilot schemes, and a review of policy implications, drawing on project outputs, and consultations with the project coordinator, the PIUs, and project steering committee (PSC) of the Third Health Sector Development Project (THSDP), DSWs, FGPs and hospitals, duureg and khoroo governments, ward representatives, community groups, and other participating stakeholder agencies.
Monitorable Deliverables/Outputs	(i) The PIU and the TWC of the PSC are established. (ii) A grant implementation manual is prepared. (iii) Newsletters on project progress are distributed twice a year to other funding agencies, NGOs, and concerned local governments. (iv) Two policy seminars are held with key agencies, including Ministry of Social Welfare and Labor (MSWL), MOH, city and duureg governors, and at least five high-level international participants from areas facing similar problems with urban migrants. (v) Workshops are organized at the end of years 2 and 3 on follow-up surveys, and progress made in implementing the pilot schemes (Component B), with the participation of stakeholders and community members. (vi) A policy analysis and development report on access to health services for disadvantaged groups is submitted and discussed with key agencies and institutions involved in providing health services to disadvantaged groups. (vii) Summary documentation of each of the pilot schemes is prepared for policymakers, and at the operational level. (viii) Quarterly monitoring reports are completed on pilot schemes. (ix) The final evaluation report is delivered. (x) Four audit reports are completed.
Implementation of Major Activities: Number of months for grant activities	48 months

FGP = family group practice, MOH = Ministry of Health, MSWL = Ministry of Social Welfare and Labor, NGO = nongovernment organization, PIU = project implementation unit, PSC = project steering committee, THSDP = Third Health Sector Development Project, TWC = technical working committee.

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

Funding Source	Amount ($)
JFPR	2,000,000
Government	61,500 (in kind)
Other Sources	
Local Government Contributions	37,600 (in kind)
Community Contributions	28,000 (in kind)
Total	**2,127,100**

3. Background

1. The Government of Mongolia (Government) and administrations at the municipal, district and subdistrict levels need help to cope with massive migration by the rural poor, which is

overwhelming social, hospital and primary health services in many urban areas. The poor make up 27% of the population of Ulaanbaatar estimated at approximately 1 million, and are concentrated in areas surrounding the city where rural migrants have chosen to live. Most of the new arrivals are not only unemployed but cannot avail of free state social and health services because they have not met residential registration requirements. This transfer of population in search of economic opportunities has accelerated rapidly since the mid-1990s, resulting in a demographic transformation of Ulaanbaatar and some smaller provincial cities. In 2005 and 2006 alone, according to the Ulaanbaatar municipal government, 30,000 to 40,000 rural people arrived in the city each year—the equivalent of the population of an entire *aimag* (province). State health and social services cannot deal with these numbers. In order to improve access to health care in particular, the Project will target overlapping groups of the disadvantaged, including poor unregistered migrants, the uninsured, members of the informal sector community, and individuals with special needs—the disabled, single-parent families, elderly people without pensions, the homeless, and street children.

2. Precise statistics are not available but the majority of the poor are ineligible for health insurance, free access to primary health care facilities, and other state social services, because they have not legally registered in their new places of residence. Neither can they afford to pay for health care services, such as diagnostic tests and medicine. In many cases, these are lacking at the primary health care level.

3. Government registration procedures are intended, in part, to slow the flow of rural people to urban areas. If migrants do not deregister in the districts they leave, moreover, and do not later reregister in their new districts, government funds for social programs cannot be allocated in the geographically correct amounts. Mongolians have the constitutional right to live wherever they choose, but to move, and still maintain full social and health service benefits in a new district, they must also fulfill extensive, time-consuming bureaucratic requirements. Would-be migrants must by law obtain a permit to leave their district of residence. To get this permit, they must hold (i) a current identification card, which is legally required of all adult citizens; (ii) a police clearance certificate to show they face no outstanding charges; (iii) a bank clearance certificate, to show they have no outstanding debt; and (iv) a social insurance certificate, to show they are no longer registered in the district for benefits or entitlements such as health insurance and pensions. On relocation, they must reregister at the city, duureg, and khoroo level, before they are entitled to apply for state welfare benefits, health insurance, or residential and land rights.

4. The reasons poor rural migrants do not meet these requirements vary. Some do not know about the regulations. Others think their move will be temporary and decide to make it permanent only at a later stage. This group can include those now in an urban area who lack the means to return to their old rural districts and complete deregistration. Some people do not have the documents they need to deregister or register; they have lost their identification cards or their birth certificates have been destroyed.

5. The Asian Development Bank (ADB) has supported health sector reform in Mongolia since mid-1990s. By demonstrating improved health service models to increase the access to health care of disadvantaged urban groups—poor unregistered citizens, in particular—the Project feeds into the broader objectives of the planned Third Health Sector Development Project (THSDP), which will provide grant funding to address policy and financial issues in the sector. The Project has also been designed to support the Government's Health Sector Master Plan, which calls for the "provision of essential health services to the people of Mongolia with emphasis on the elderly, adolescents, and vulnerable groups such as the poor, with the full participation of the community and other stakeholders."

6. The project duuregs, or districts, and khoroos, which are administrative subunits of the duuregs, were selected after extensive consultation with Ministry of Health (MOH), the Ministry of Social Welfare and Labor (MSWL), local government officials at city, duureg and khoroo level, and health service providers. Of the 83,290 residents of the 10 khoroos selected, 40% are poor or disadvantaged. These khoroos are newly established or rapidly expanding, and have very poor infrastructure, a lack of skilled human resources, and insufficient local government capacity. Further demographic and socioeconomic details on the project duuregs and khoroos are in Supplementary Appendix A.

7. The maternal mortality reduction project[4] funded by the Japan Fund for Poverty Reduction (JFPR) showed a need for greater participation by khoroo governments in health-related issues, greater teamwork between service providers at the khoroo level, and more support for disadvantaged client groups. Employees designated as social workers by khoroo governments have full-time clerical responsibilities for birth registration and managing the Government's baby bonus[5] program. Most are not trained in community social work and lack time to work at the community level. Primary health clinic services in poor periurban areas were also found to be overstretched and to provide generally inadequate health services. Major problems include (i) overcrowded and deteriorating buildings; (ii) lack of diagnostic equipment, clinical knowledge, and transport for home visits; (iii) poor communication between health providers and local government; and (iv) staff attitudes that were not conducive to encouraging attendance by the poor.

4. Innovation

8. The Project will implement a number of innovative, demand-driven pilot measures to improve access to health services for the disadvantaged in the 10 project khoroos. By conducting focused policy-oriented surveys that include the participation of the stakeholders, it will identify specific obstacles to giving the disadvantaged greater access to health services, and propose policy measures that will be submitted to the Government through THSDP.

9. The piloting of a development social worker (DSW) program in the selected khoroos will be a major innovation. The MSWL, the Ulaanbaatar municipal government, and duureg governors have been considering ways to establish local development social work programs that would encourage community participation and self-help,[6] but these ideas have not been implemented. The training of community social workers started only recently in Mongolia, and few employees with that designation at the duureg and khoroo local governments have been educated in modern social work methods. Most are office-based and handle clerical responsibilities.

10. In the poor periurban areas, family clinics (or family group practices [FGPs]), need health and social workers to help unregistered and uninsured clients establish legal status to access unrestricted free FGP services, and selected hospital services. By training and supporting DSWs to work with FGPs in these locations, the Project will test the benefits to the disadvantaged of adding a DSW to the FGPs' basic package of services.

11. The assessment of needs in the targeted khoroos is innovative because it will enable FGPs to participate in identifying their local priorities, in consultation with local government and their client communities. In partnership with nongovernment organizations (NGOs) and the

[4] ADB. 2005. *Grant Assistance to Mongolia for the Maternal Mortality Reduction Project.* Manila (*JFPR-9063).*
[5] The Government provides a lump-sum for every newborn to encourage a higher birthrate.
[6] Ministry of Social Welfare and Labor. 2003. *Social Security Sector Strategy Paper*. Ulaanbaatar.

duureg government, FGPs will plan action to tackle specific community health issues, including family violence, malnutrition, alcoholism, disabilities and particular diseases.

12. Finally, the design and demonstration of successful, innovative models will provide MOH and MSWL with tested examples they can use in planning and carrying out reforms and rationalization in the urban health services. The Project's outputs will also contribute to the reform efforts of THSDP, and of other international partners active in the country's social sectors.

5. Sustainability

13. Sustainability will be a key indicator of success in the Project. Successful civil society initiatives and programs directed at disadvantaged groups in periurban areas tend to be discontinued when funding ends.

14. The Project will develop sustainable models and approaches involving key stakeholders in every stage of their development, implementation, and evaluation. Institutional sustainability will be addressed through capacity-building activities and systems strengthening. The Project will pay particular attention to developing models that are financially sustainable, by monitoring investment and recurrent costs, and identifying potential sources of funding at various levels of government and the community. Local governments will commit to absorbing the budget for operations and maintenance of successful FGP and DSW schemes.

15. A thorough analysis of the policy implications of the pilot schemes, and the submission of policy amendments to the Government, will pave the way for sustaining the Project's outputs. Successful pilot schemes could be replicated in FGPs throughout in the country, especially in rapidly urbanizing aimag centers such as Dharkhan and Erdenet, which are experiencing problems from internal migration.

16. The policies generated by the Project will also enhance sustainability by contributing to the reform of health sector financing that is being supported by THSDP. For instance, the Project will ensure that resource allocation mechanisms—e.g., local capitation rates for primary health care—take into account such issues as the proportion of migrants, the unregistered population, and the special needs in communities.

6. Participatory Approach

17. The Project was designed through a participatory process and will involve key stakeholders in (i) the selection of project location, (ii) the pilot schemes, and (iii) the assessment of the needs and priorities of disadvantaged groups. Stakeholders will also take part in project monitoring and evaluation.

18. A major project objective is to increase the responsiveness of governments, FGPs, and hospital services to the specific needs of the disadvantaged. Community organizations and community leaders, such as the heads of wards, which are administrative subunits of the khoroos, will play a central role in assessing needs and identifying health promotion priorities.

19. Since they were established 10 years ago, assistance to FGPs has tended to take a cookie cutter approach. All FGPs are provided—or are supposed to be provided—with the means to supply a set predetermined package of services, irrespective of the specific needs of their clients and the local priorities. While this approach was necessary to build basic primary level services, the Project's pilot scheme approach will provide each FGP and local government with the opportunity and means to plan projects in a consultative manner. They can improve their facilities, equipment, and services in ways tailored to what they have identified as their

poor clients' particular needs. This will increase the effectiveness of FGPs, increase the trust and confidence of FGP clients, and improve the morale of FGP staff.

20. This participatory approach will be extended to all relevant stakeholders at national, city, duureg, and khoroo level, encouraging their contribution through collaboration, information sharing, and annual workshops that will assess findings and outcomes. Stakeholders will thereby contribute to the Project's general objective. [7]

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
• Bayanzurkh, Chingeltai, and Songinokhairkhan urban duureg governments, which will participate in project implementation. • 10 periurban khoroo governments that will participate in project implementation. • The 10 FGPs that will submit successful proposals and implement pilot schemes. • About 20,000 unregistered residents in 10 khoroos, who will be helped to register. • About 30,000 residents in 10 khoroos, who will receive help in qualifying for health insurance previously unavailable to them. • 10,000 households whose poverty impedes access to health services, and whose situation will be documented for policy improvement through the Project. • Disadvantaged households with special needs assessed in surveys, including single-parent households, male and female, whose situation will be documented for policy improvement. • The elderly, homeless, disabled, unemployed, street children, and the mobile poor, or urban nomads, whose health access situations will be documented for policy improvement through the Project.	• MOH, the Executing Agency of the Project, which will benefit from the FGP-based activities, and support for policy development. • MSWL, which will benefit from the pilot-testing of the DSW concept that is included in its strategic plan for development of community-based social welfare support services. • City and duureg civil registration authorities, which will receive help to increase rates of registration among poor migrants, making them eligible for state health services. • State health insurance authorities, which get help to raise the number of health insurance beneficiaries in poor periurban areas and will benefit from data collected and policy development activities. • The family empowerment program of the United Nations Children's Fund (UNICEF), and convergent social services programs working in project duuregs, and their associated NGOs, with which the Project will cooperate in Bayanzurkh and Songinokhairkhan duuregs. • World Bank-assisted household livelihood capacity support councils, with which the Project will cooperate in Bayanzurkh, Chingeltai, and Songinokhairkhan duuregs. • The maternal mortality reduction project of JFPR, which works with FGPs in periurban areas, and with which the Project will cooperate in Bayanzurkh, Chingeltai and Songinokhairkhan duuregs. • United Nations Population Fund (UNFPA), supported by the United Nations Trust Fund for Human Security,[8] whose project, Reducing Socio-Economic Vulnerabilities in Selected Peri-Urban and Informal Mining Communities in Mongolia, provides mobile health services to the unregistered and

[7] Appropriate measures in line with ADB *Policy on Indigenous Peoples* (1998) will be taken should negative impact on ethnic minorities be identified during JFPR implementation.

[8] The Trust Fund for Human Security was established in the United Nations Secretariat in March 1999 at the initiative of the Government of Japan.

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
	uninsured poor, and whose subprojects the Project will cooperate with in Bayanzurkh and Songinokhairkhan duuregs, in activities such as training and IEC/BCC. • NGOs working in periurban khoroos, with which the Project will cooperate in Bayanzurkh, Chingeltai, and Songinokhairkhan duuregs. The NGOs include World Vision Mongolia, National Centre Against Violence, National Federation of Disabled Peoples Organization, Elderly Peoples Association, Gender Studies Council, Center for Adolescents and Children, and Mongolian Youth Development Center.

7. Coordination

21. The Project was designed with inputs from MOH, MSWL, the Mongolian Association of Family Doctors, and selected directors of FGPs, Ulaanbaatar city mayor's office, and Ulaanbaatar city health office, duureg government representatives and health officers, and representatives of United Nations (UN) agencies and NGOs working on social issues in periurban areas.

22. The project management structure will be integrated with that of the THSDP, greatly facilitating the processes. The Project will also benefit from THSDP experience with policy reforms and development in the sector, and the PIU of THSDP will facilitate access to decision makers of MOH, MSWL, and the Ministry of Finance. In turn, the Project will act as a laboratory for testing innovative community-based schemes that will contribute to the THSDP's broad goal of strengthening primary health care in Mongolia.

23. The Project will work closely with the JFPR project for maternal mortality reduction, and will communicate with the JFPR project for community-driven development for urban poor in ger areas.[9] Lessons will be exchanged, given the similarity of development issues in the respective target communities. To coordinate khoroo-level health, social registration, and state health insurance coverage activities, the Project will liaise, cooperate and assist with the UNFPA project for reducing socioeconomic vulnerabilities in periurban communities in Songinokhairkhan and Bayanzurkh duuregs, which is supported by the United Nations Trust Fund for Human Security. This UNFPA project will target unregistered migrants in *ger* (traditional tent) areas.

24. The Project will encourage cooperation between NGOs and FGPs. Collaborating NGOs will include (i) World Vision Mongolia, for community mobilization and support in maternal and child health and nutrition, and fighting infectious diseases, in partnership with FGPs and hospitals; (ii) the National Centre Against Violence, supporting health and other social services with special programs; (iii) the National Federation of Disabled People's Organizations; (iv) the Elderly People's Association; (v) the Gender Studies Council, working to overcome gender inequity; (vi) the Center for Adolescents and Children, which provides research and training services on prevention of injury and rehabilitation of the injured; and (vii) the Mongolian Youth

[9] See footnote 4; and ADB. 2007. *Grant Assistance to Mongolia on Community-Driven Development for Urban Poor in Ger Areas.* Manila (*JFPR 9106).*

Development Center, which implements programs to prevent the sexual abuse of children and youths, and to provide rehabilitation to those affected.

25. The Embassy of Japan was briefed about the proposed JFPR project in May 2007 and indicated its support for the initiative. Consultations with the resident representative of Japan International Cooperation Agency in Mongolia in July 2007 indicated the agency's support for the proposed project objectives.

8. Detailed Cost Table

26. Please refer to Appendix 1 for the summary of costs, Appendix 2 for the detailed cost estimates, and Appendix 3 for the Fund Flow Arrangement.

C. Linkage to ADB Strategy and ADB-Financed Operations

1. Linkage to ADB Strategy

27. The health sector is a key focus of ADB assistance to Mongolia and ADB is the main funding agency in the sector. The Health Sector Master Plan[10] stresses the need to provide essential health services to the people of Mongolia, with emphasis on the elderly, adolescents, and vulnerable groups such as the poor. It also calls for the full participation of the community and other stakeholders. In addition to meeting sector goals of the Government and ADB, the expected outcome of the Project will also satisfy several poverty reduction objectives of the Government's economic growth and poverty reduction strategy[11] by increasing the quality of public services and their accessibility to the poor.

Document	Document Number	Date of Last Discussion	Objective(s)
Mongolia Country Strategy and Program Update 2007–2009	Sec.M78-06	14 Aug 2006	In relation to the JFPR: • Supporting the Government's explicit commitment to achieving the Millennium Development Goals. • Improving governance focus.

2. Linkage to Specific ADB-Financed Operation

Project Name	Mongolia Third Health Sector Development Project
Project Number	41119
Date of Board Approval	October 2007
Grant Amount ($ million)	14.0

3. Development Objective of the Associated ADB-Financed Operation

28. The THSDP will improve health infrastructure and service delivery in aimags that were not covered by previous ADB support, and build on and refine the policy reforms initiated with ADB support in the past. These include expanding and improving primary health care, improving financial expenditure for increased system efficiency, improving development and management of human resources, and strengthening sector capacity. Health policy reform in Mongolia requires continued support to maintain momentum, in line with the Government's Health Sector

[10] Government of Mongolia. 2005. *Health Sector Master Plan.* Government of Mongolia Resolution of April 2005.
[11] Government of Mongolia. 2003. *Economic and Growth Support and Poverty Reduction Strategy.* Ulaanbaatar.

Master Plan and in coordination with recently established intersectoral coordinating mechanisms.

4. Main Components of the Associated ADB-Financed Operation

No.	Component Name	Brief Description
1.	Strengthen health services.	1.1 Improve urban and rural FGPs, *soum* (district) health centers, and aimag general hospitals through infrastructure upgrades, equipment, and training. 1.2 Strengthen aimag general hospitals, and duureg hospitals in Ulaanbaatar.
2.	Improved health care financing and health insurance.	2.1 Improve health-resource allocation, essentially by pooling funding for the health sector, and establishing a single purchaser of health services with strong fiscal leverage to reform health care and promote quality. 2.2 Improve financial protection by expanding health insurance coverage and benefits. 2.3 Improve hospital financial efficiency by introducing market elements in hospital service provision.
3.	Improved human resources development.	3.1 Strengthen health human resources management by developing work force models, assisting in career development, and providing training in human resource development. 3.2 Develop incentive systems to increase key health staff in areas of critical shortage, especially rural areas.
4.	Sector capacity development and management.	4.1 Improve capacity and governance in the health sector through increased capabilities in planning, monitoring, and evaluation. 4.2 Strengthen the regulation of the private health sector. 4.3 Improve the capacity of the MOH to implement the health sector master plan, and engage in intersectoral dialogue.

5. Rationale for Grant Funding versus ADB Lending

29. THSDP is strongly focused on policy reforms, and pays less attention to community and local government inputs in policy and program making. The Project will complement the THSDP approach with a bottom-up planning and implementation process.

30. The Project will be implemented in the poorest khoroos of the poorest duuregs in Ulaanbaatar, whose governments face enormous difficulties providing social services to their residents. Through pilot projects, it provides an opportunity to test schemes for improving accessibility to health services for disadvantaged groups—mainly unregistered migrants—and to bring these citizens into the mainstream of the health system. Close coordination between the Project and THSDP will ensure that the issues affecting the disadvantaged are not neglected in the policy dialogues and activities of THSDP.

31. The Project will also address a relative weakness in government planning—insufficient intersectoral dialogue. The MOH has a tendency to plan and implement programs in isolation, missing the benefits of interaction with key partners in solving the problems of socially disadvantaged groups. The Project will bring together stakeholders from different ministries, different levels of government, and a range of NGOs to discuss access to health services for disadvantaged groups.

D. Implementation of the Proposed Grant

1. Implementing Agency	Ministry of Health

32. The project steering committee (PSC) of the THSDP will act as the PSC for the Project, providing strategic orientation and overall guidance on implementation. The Project will be implemented by a PIU established within the PIU of THSDP. The PIU of the THSDP will be responsible for recruiting (i) the project PIU staff; (ii) the national consultants; (iii) a national NGO in charge of community mobilization; (iv) a national organization in charge of assessment, monitoring, and evaluation; and (v) a national training institute. 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 B.

33. A legally registered national NGO will be recruited to develop a community mobilization and communication strategy, and to organize community mobilization on project activities in all 10 project khoroos. A national organization, NGO or research institute, will be contracted to (i) design, implement, and report on a survey of households that face problems in accessing health services, (ii) carry out an institutional analysis of 10 selected FGPs, (iii) organize workshops to disseminate findings, (iv) monitor and evaluate the implementation of the pilot schemes, and (v) carry out annual follow-up workshops, including reports on the implementation of the pilot schemes. A national training institute will be selected to provide the initial training to the DSWs, and 3 months of on-the-job training.

34. Proposals for pilot schemes will be reviewed and selected by the technical working committee to be established by MOH. Once the proposal is approved, an agreement will be signed with the parties involved in the implementation of the pilot schemes.

35. Procurement related to project management of the Project 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 C. Implementation arrangements are detailed in Appendix 4.

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Governance	Problems of corruption or nepotism may affect distribution of assistance funds or appointments.	Strict financial control. Strong management mechanisms. Transparent appointment procedures. Transparent proposal appraisal and selection processes for grants. Clear and agreed beneficiary selection. Annual audits.

Type of Risk	Brief Description	Measure to Mitigate the Risk
Policy	Government policy may affect proposed activities to support client registration and health insurance.	Annual assessments to review government policy, and, if necessary, changes in the focus of planned communication and support activities.
Infrastructure	Bad road conditions, transport difficulties, or extreme weather conditions may impede surveys, and regular household and follow-up visits by project personnel and FGPs.	Funding for public transportation to the PIU, and for selected implementers of pilot schemes.

3. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for Monitoring and Evaluation
At least 30,000 disadvantaged people living in the project duuregs have improved access to health services, particularly at primary level.	Survey results.[12]	Situation analysis in year 1. Repeat surveys in years 2 and 3.
DSW program is established and rated successful in all three project duuregs.	Quarterly project reports. External validation study. Final evaluation report.	Situation analysis of disadvantaged groups and constraints in year 1. Monitoring of DSW program in years 2 and 3. Independent assessment of DSW program and policy recommendations in year 4.
At least 10 innovative pilot schemes are demonstrated to improve access and health services to disadvantaged citizens.	Quarterly project reports. FGPs and khoroos government reporting on pilot schemes. Final evaluation report.	Independent annual follow-up and evaluation of pilot schemes by end of year 3. Review of policy implications of pilot schemes in year 4.
The PIU submits policies for improving access and services to disadvantaged groups to Government.	Evaluation and report on policy implications. Minutes of high-level seminars on policy implications of the Project. Policy papers submitted to cabinet. Project completion report.	Independent evaluation and policy review in year 4.

[12] The survey will include the questions of whether households have been unable to access health care, because of either a lack of funds or inadequate services at the primary level, or whether they have discontinued treatment. If so, they will be asked why.

4. Estimated Disbursement Schedule

Fiscal Year (FY)	Amount ($)
FY2008	200,000
FY2009	450,000
FY2010	600,000
FY2011	550,000
FY2012	200,000
Total Disbursements	**2,000,000**

Appendixes

1. Summary Cost Table
2. Detailed Cost Estimates
3. Fund Flow Arrangement
4. Implementation Arrangements

Supplementary Appendixes

A. Preliminary Needs Assessment and Selection of Project Sites
B. TOR for Consulting Services
C. Procurement Plan
D. Design and Monitoring Framework
E. Implementation Schedule

SUMMARY COST TABLE
($)

Grant Components / Inputs/ Expenditure category	Component A: Assessment and Institutional Development	Component B: Pilot Schemes—Improving Access of Urban Disadvantaged to Health Services	Component C: Project Management and Health Policy Development	Total Input	Percentage of Total (%)
1. Civil Works	0	0	0	0	0.0
2. Equipment and Supplies	0	150,000	0	150,000	7.5
3. Training, Workshops, Seminars, and Public Campaigns	100,000	18,750	60,000	178,750	8.9
4. Consulting Services	45,000	207,000	372,000	624,000	31.2
5. Grant Management	0	0	221,100	221,100	11.1
6. Other Inputs	0	626,150	0	626,150	31.3
7. Contingencies (0–10% of total estimated grant fund)	16,111	111,322	72,567	200,000	10.0
Subtotal JFPR Grant Financed	**161,111**	**1,113,222**	**725,667**	**2,000,000**	**100.0**
Central Government Contribution	0	16,000	45,500	61,500	
Local Government Contributions	0	37,600	0	37,600	
Community's Contributions (mostly in kind)	12,000	16,000	0	28,000	
Total Estimated Cost	**173,111**	**1,182,822**	**771,167**	**2,127,100**	

Source: Asian Development Bank estimates.

DETAILED COST ESTIMATES
($)

Supplies and Services Rendered	Costs						Contributions		
	Unit	Quantity Units	Cost Per Unit	Total	JFPR		Central Government	Local govern-ment	Communities
					Amount	Method of Procurement [a]			
Component A: Assessment and Institutional Development			**Subtotal**	**157,000**	**145,000**		**0**	**0**	**12,000**
1.1 Civil Works									
1.2 Equipment and Supplies									
1.3 Training, Workshops, and Seminars									
1.3.1 Orientation TWC, PSC, local governments, and health service providers	person-day	150	20	3,000	3,000				
1.3.2 Community mobilizer (NGO)	lump-sum	1	60,000	60,000	60,000				
1.3.3 Community mobilization and dissemination meetings	person-day	12,000	3	36,000	24,000				12,000
1.3.4 Dissemination workshop of results of situation analysis and institutional assessment	person-day	150	20	3,000	3,000				
1.3.5 Training in participatory planning, design and implementation to local government and providers	person-day	250	20	5,000	5,000				
1.3.6 Participatory analysis of results of implementation of pilot schemes	person-day	250	20	5,000	5,000				
1.4 Consulting Services									
1.4.1 Situation analysis (survey of disadvantaged and non-disadvantaged)	lump-sum	1	30,000	30,000	30,000				
1.4.2 Institutional assessment of FGPs	lump-sum	1	15,000	15,000	15,000				
1.5 Management and Coordination of Component A									

Supplies and Services Rendered	Costs				Contributions				
	Unit	Quantity Units	Cost Per Unit	Total	JFPR		Central Government	Local govern-ment	Communities
					Amount	Method of Procurement [a]			
1.6 Other Project Inputs									
Component B: Pilot Schemes: Improving Access of Urban Disadvantaged to Health Services			**Subtotal**	**1,071,500**	**1,001,900**		**16,000**	**37,600**	**16,000**
2.1 Civil Works									
2.2 Equipment and Supplies									
2.2.1 IEC/BCC material on social security procedures, health information, civil registration, etc.	IEC package	5	30,000	150,000	150,000				
2.3 Training, Workshops, and Seminars									
2.3.1 Initial training of DSWs	person-day	450	25	11,250	11,250				
2.3.2 On-the-job training for DSWs (10 days/month for 3 months)	person-day	300	25	7,500	7,500				
2.4 Consulting Services									
2.4.1 Development of IEC/BCC materials	lump-sum	1	15,000	15,000	15,000				
2.4.2 Quarterly monitoring and assistance of 16 pilot projects (including DSW program)	lump-sum	16	12,000	192,000	192,000				
2.5 Management and Coordination of Component B									
2.6 Other Project Inputs									
2.6.1 DSW remuneration	person-month	360	150	54,000	54,000				
2.6.2 Performance bonus for DSW	bonus	20	200	4,000	4,000				
2.6.3 Installation DSW	lump-sum	10	2,000	20,000	18,000			2,000	
2.6.4 Operational costs for DSW	monthly	360	100	36,000	32,400			3,600	
2.6.5 Grants for pilot schemes	lump-sum	15	38,783	581,750	517,750		16,000	32,000	16,000

Supplies and Services Rendered	Costs				Contributions			
	Unit	Quantity Units	Cost Per Unit	Total	JFPR		Central Government	Local govern-ment	Communities
					Amount	Method of Procurement [a]			
Component C: Project Management			**Subtotal**	**698,600**	**653,100**		**45,500**	**0**	**0**
3.1 Civil Works									
3.2 Equipment and Supplies									
3.3 Training, Workshops, and Seminars									
3.3.1 Public information campaign (leaflet, billboards, radio, and TV broadcastings)	lump-sum	1	70,000	70,000	50,000		20,000		
3.3.1 Annual workshop (year 2–3)	person-day	400	20	8,000	6,000		2,000		
3.3.2 Policy development seminars	person-day	400	20	8,000	4,000		4,000		
3.4 Consulting Services									
3.4.1 International policy development and evaluation specialist	person-month	8	17,000	136,000	136,000				
3.4.2 Travel costs for policy development and evaluation specialist	trips	4	6,000	24,000	24,000				
3.4.3 National policy development and evaluation specialist	person-month	12	2,000	24,000	24,000				
3.4.4 Quarterly monitoring of the implementation of pilot schemes and the DSW program	lump-sum	10	8,000	80,000	80,000				
3.4.5 Follow-up surveys (years 2–3)	lump-sum	2	30,000	60,000	60,000				
3.4.6 Final evaluation of 16 pilot projects	lump-sum	16	1,000	16,000	16,000				
3.4.7 External audit	contract	4	8,000	32,000	32,000				
3.5 Management and Coordination of Component C									
3.5.1 Project manager	person-month	48	1,500	72,000	72,000				
3.5.2 Financial assistant	person-month	48	1,000	48,000	48,000				
3.5.3 Administrative assistant	person-month	48	700	33,600	33,600				
3.5.4 Office space	lump-sum	1	12,000	12,000			12,000		
3.5.5 Office furniture	lump-sum	1	7,000	7,000	2,500		4,500		
3.5.6 Office equipment	lump-sum	1	12,000	12,000	9,000		3,000		
3.5.7 Travel and per diem (for PIU staff)	lump-sum	20	400	8,000	8,000				
3.5.8 Operational costs	monthly	48	1,000	48,000	48,000				

Supplies and Services Rendered	Costs				Contributions			
	Unit	Quantity Units	Cost Per Unit	Total	JFPR		Central Government	Local govern-ment	Communities
					Amount	Method of Procurement [a]			
3.6 Other Project Inputs									
Components A to C = Subtotal			**Subtotal**	**1,927,100**	**1,800,000**		**61,500**	**37,600**	**28,000**
Contingency (Maximum 10% of total JFPR contribution)				**200,000**	**200,000**				
Total Grant Cost			**Total**	**2,127,100**	**2,000,000**		**61,500**	**37,600**	**28,000**

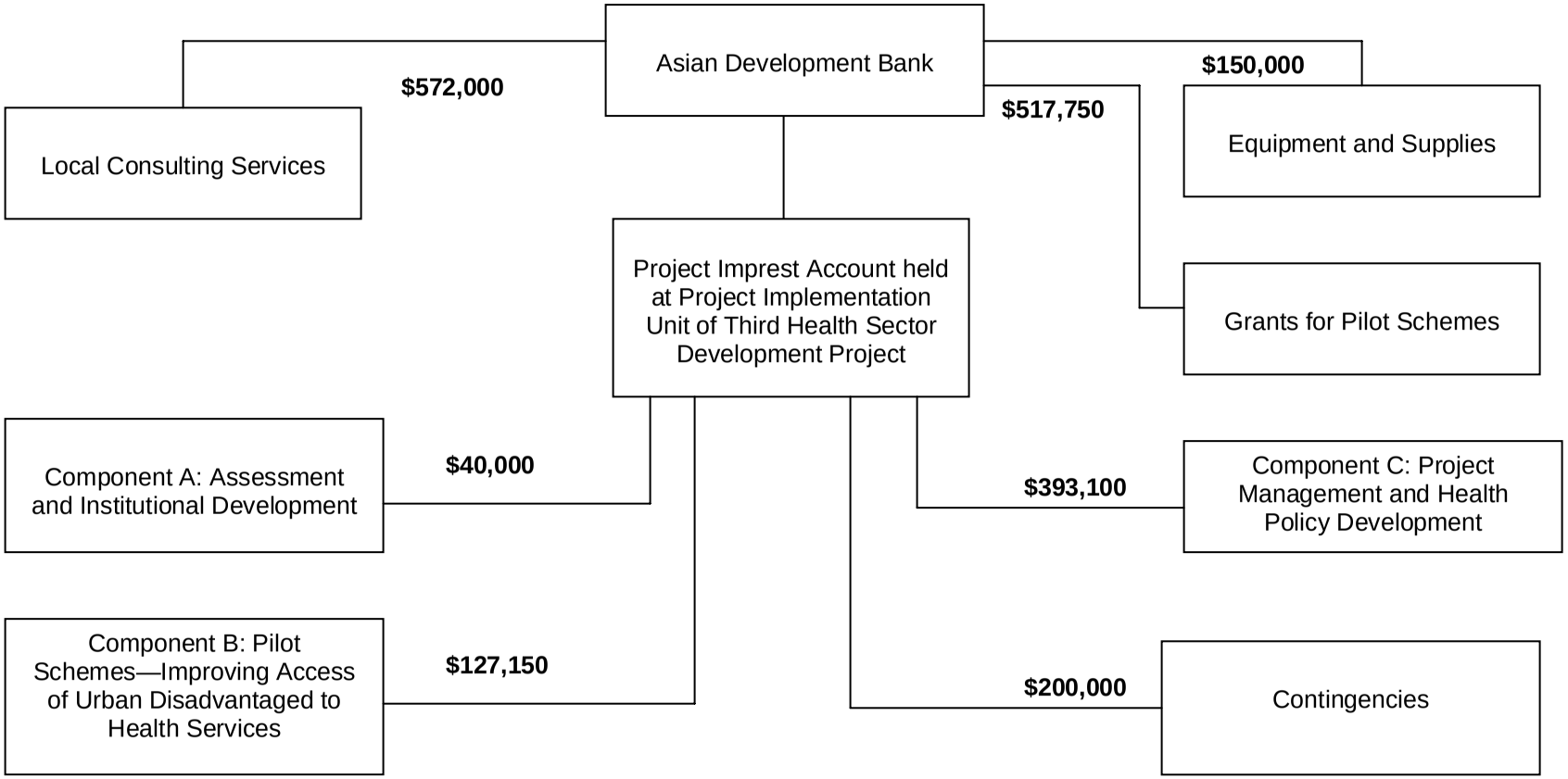
DSW = development social; worker, FGP = family group practice, IEC/BCC = Information, Education, and Behavior Change Communication, JFPR = Japan Fund for Poverty Reduction, PIU = project implementation unit, PSC = project steering committee, TWC = technical working committee.

[a] Procurement under the Project will be conducted in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time) and ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). Goods and services estimated to cost the equivalent of $10,000 or less will be procured using ADB's direct purchase procedure. Goods and services estimated to cost more than $10,000 and less than $100,000 will be procured using ADB's shopping procedure. The project implementation unit of the Third Health Sector Development Project will be responsible for procurement, with technical inputs from the implementation unit of the Japan Fund for Poverty Reduction Project.

FUND FLOW ARRANGEMENTS

ADB will channel the JFPR funds directly to the JFPR imprest account, which will be opened and maintained by the PIU of THSDP at a commercial bank in Ulaanbaatar acceptable to ADB. Disbursement from the imprest account will be supported by an appropriate withdrawal application and related documentation. Such documentation will demonstrate that the goods and/or services are (i) produced and procured from ADB's member countries, and (ii) eligible for JFPR financing. The initial amount to be deposited in the account will not exceed $100,000. Total advances to be financed through the imprest account are not to exceed $200,000, or the estimated average expenditures for a 6-month period, whichever is less. The statement of expenditures (SOE) procedure will be used for reimbursing, replenishing and liquidating eligible expenditures; and individual payment to be reimbursed, replenished, or liquidated under the SOE procedure will not exceed $10,000. The establishment and liquidation of the imprest account and the use of SOE procedures will be in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time). The schematic fund flow for the Project is shown in Figure 1.

Figure 1. Fund Flow Arrangements



IMPLEMENTATION ARRANGEMENTS

A. Project Management

1. Executing Agency

1. The Ministry of Health (MOH) will be the Executing Agency for the Japan Fund for Poverty Reduction (JFPR) Project.

2. Project Steering Committee

2. The project steering committee (PSC) of the Third Health Sector Development Program (THSDP) will act as the PSC for the Project, providing strategic orientation and overall guidance on project implementation. The PSC will be chaired by the state secretary of MOH and composed of senior officials from MOH, Ministry of Social Welfare and Labor (MSWL), Ministry of Finance (MOF), State Social Insurance General Office, Health Sciences University of Mongolia, and of the Ulaanbaatar city government.

3. Implementing Agency

3. The project implementation unit (PIU) for the Project will be established within the PIU of THSDP. The PIU will be headed by a project coordinator and will comprise a financial assistant and an administrative assistant. The PIU members will be recruited by the PIU of THSDP and approved by the Asian Development Bank (ADB). The project coordinator will guide implementation and administer the Project, and report to ADB and the Government of Mongolia. The PIU will prepare a grant implementation manual, for ADB approval, during the first quarter of implementation, including grant disbursement methods for pilot schemes (Component B). 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 assistant, under the supervision of the project coordinator, will work closely with the finance officer of the PIU of THSDP. Procurement of medical equipment will be handled by the PIU of THSDP.

4. Flow of funds

4. Disbursement of the imprest fund will be made by the project manager of the PIU of THSDP. The imprest account will be replenished by ADB based on budget requests prepared by the project coordinator and endorsed by the project manager of the PIU of THSDP. The withdrawal applications will be signed by the THSDP project manager.

5. Procurement

5. Procurement under the Project will be conducted in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). Goods, services, and works estimated to cost the equivalent of $100,000 or less will be procured using ADB's shopping procedure. Goods, services, and works with estimated value of $500,000 or less will be procured using national competitive bidding (NCB) procedure. The PIU of THSDP will be responsible for procurement, with technical inputs from the project coordinator. To procure items costing $10,000 or below, the PIU of THSDP may purchase the items directly from the supplier. In such cases, ADB

should be satisfied that the price paid is reasonable. International competitive bidding is not envisaged under this Project. The procurement plan is in Supplementary Appendix C.

6. NCB procurement will be done on the basis of NCB procedures, in accordance with the Mongolian Procurement Law, subject to modifications agreed with ADB.

6. Consulting Services

7. The Project will require 8 person-months of international and 12 person-months of national consulting services. The Project will also recruit (i) a national nongovernment organization (NGO) for community mobilization; (ii) a national organization for assessment, monitoring and evaluation; and (iii) a national training institute for the development social worker (DSW) program. The national consultants and the organizations will be recruited by the PIU of THSDP, with technical input from the project coordinator, in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). The national consultants will be recruited based on no-objection from ADB. ADB will be in charge of recruiting international consultants. For quality- and cost-based selection, the quality–cost ratio is 80:20. The terms of reference for consulting services are in Supplementary Appendix B.

7. Reporting

8. The PIU will prepare quarterly and annual reports on project implementation, the form and content of which will be agreed upon 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 the JFPR and by the Government, and 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 the timely submission of audited project accounts and financial statements, including the suspension of disbursements in case of noncompliance. ADB will also finance, through the Project, annual audits by an independent audit company acceptable to ADB.

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

8. Monitoring and Evaluation

10. The framework for monitoring and evaluation is described in Supplementary Appendix D. At the beginning of implementation, a national organization, NGO or research institute, will be recruited to collect baseline information on beneficiaries, carryout an institutional assessment, and monitor and evaluate the implementation of the pilot schemes. These data will be used to refine the monitoring and evaluation framework, and to monitor and evaluate the implementation of the pilot schemes. The final evaluation of the JFPR will include a report on the Project's policy implications and lessons.

9. Project Review

11. 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 towards the end of the second year of implementation. It will (i) review the scope, design, and implementation arrangements, and identify adjustments required; (ii) assess progress of the project implementation against performance indicators; and (iii) recommend changes in the design or implementation arrangements, if necessary.

B. Implementation of Component B

12. **Component B1.** The Project will fund *duureg* (district) governments of participating khoroos to employ or designate 10 DSW. Five DSWs will be based in khoroo governments and five in family group practices (FGPs) to test the most effective service focal point. DSWs will be proposed by participating local governments, selected by the technical working committee (TWC), and hired or designated by the local government on 12-month contracts renewable over 36 months. Bonuses will be paid to DSWs based on performance. Memorandums of understanding will be signed by duureg and khoroo governments, and by FGPs, stating that DSWs will be employed exclusively in activities specific to the objectives of the Project.

1. Selection Criteria

13. **Component B2.** Selection criteria for the pilot schemes will be formulated in a manner involving stakeholders during the workshop planned towards the end of year 1 to disseminate the results of the situation analysis. The criteria will include consideration and assessment of the following factors in pilot proposals: (i) relevance to findings of the baseline studies; (ii) local government contribution, in cash and kind; (iii) the existence of a clear implementation plan, and budgeting, (iv) the quality of the monitoring and evaluation system, (v) the need for capacity development defined and guaranteed, (vi) whether sustainability concerns are addressed, and (vi) the level of community beneficiary participation in preparation and implementation.

14. The pilot schemes will be implemented by the duureg governments of Songinokhairkhan in four khoroos, the duureg government of Chingeltai in two khoroos, and the Duureg government of Bayanzurkh in four khoroos. The khoroos were selected during project preparation in consultation with the city and duureg governments, MOH, and MSWL.

2. Proposal Submission

15. The duureg governments and FGPs participating in the Project will be invited to jointly submit proposals for pilot schemes to improve access to health services for disadvantaged groups. The PIU and the national organization for assessment, monitoring, and evaluation will provide technical support during the preparation of the proposals for the pilot schemes. It is expected that the proposals will be submitted by the end of year 1.

3. Screening and Selection of Proposals

16. An appointed technical working committee of the PSC will screen and select proposals for implementation based on the selection criteria previously formulated, and then report to the PSC. It will comprise representatives of the MOH, MSWL, the Ulaanbaatar city health department, Health Sciences University of Mongolia, the project coordinator, and external

members, such as selected representatives of other projects implementing similar activities in favor of disadvantaged. The results will be announced within 4 weeks of proposal submission. The successful proposals will be submitted to PIU and ADB's Mongolia resident mission for approval. ADB's assessment will be announced within 3 working days, otherwise the pilot scheme is considered approved. Results of the screening and awarding of grants for pilot schemes will be advertised in at least two local newspapers by the PIU.

4. Approval and Implementation

17. Once a pilot schemes has been approved for testing, the PIU will prepare, in conformity with the grant implementation manual: (i) an approval letter detailing the steps the beneficiary local government must take prior to implementing the pilot schemes, and (ii) an agreement, to be signed by all parties, detailing the obligations and responsibilities of each party—local government, FGP, PIU, and the organization responsible for monitoring and evaluation.

18. The responsible officer and the implementation team for each pilot scheme will be clearly identified and should represent the local parties involved in reaching disadvantaged groups—for example, local governments, FGPs, and social welfare offices.

5. Technical Assistance and Monitoring During Implementation

19. The project coordinator and a national organization recruited at the beginning of the project implementation will be responsible for technical assistance and monitoring of the pilot schemes.

C. Implementation Schedule

20. The Project will be implemented over a period of 4 years, tentatively from June 2008 to May 2012. Project preparation is expected to start in June 2008, with the establishment of the PIU and hiring of the national organization, and international and national evaluation and policy experts. The situation analysis and the institutional assessment are expected to be completed by March 2009, and the first pilot schemes to start by July 2009. The detailed implementation schedule is in Supplementary Appendix E.