GENDER EQUALITY
RESULTS IN
ADB PROJECTS

Mongolia Country Report

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Juliet Hunt
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Asian Development Bank
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Asian Development Bank
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables and Boxes</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>vi</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>vii</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>viii</td>
</tr>
<tr>
<td><strong>Rapid Gender Assessments</strong></td>
<td>viii</td>
</tr>
<tr>
<td><strong>Findings for Mongolia</strong></td>
<td>viii</td>
</tr>
<tr>
<td><strong>Other Contextual and Institutional Factors</strong></td>
<td>xii</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>xiii</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Background of the RGA-II</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Methodology and Scope</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Fieldwork for the Mongolia RGA-II</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Background on Mongolia</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Second Health Sector Development Project</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Project Description</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Gender Analysis and Gender Action Plan in the Loan Design</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Implementation of the Gender Action Plan</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Gender Equality Results</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Contribution of Gender Equality Results to Overall Loan Outcomes</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td>13</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>Factors Influencing the Achievement of Gender Equality Results</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>Technical Assistance in the Regional Road Development Project:</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Awareness and Prevention of HIV/AIDS and Human Trafficking</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Project Description</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Gender Analysis and Provisions in the Technical Assistance Design</strong></td>
<td>18</td>
</tr>
<tr>
<td><strong>Gender Mainstreaming during Implementation</strong></td>
<td>18</td>
</tr>
<tr>
<td><strong>Gender Equality Results</strong></td>
<td>19</td>
</tr>
<tr>
<td><strong>Contribution of Gender Equality Results to Overall Project Outcomes</strong></td>
<td>23</td>
</tr>
</tbody>
</table>
List of Tables and Boxes

Tables
1. Project Profiles 4
2. Second Health Sector Development Project Summary of Gender Equality Results 9
3. Summary of Gender Equality Results from the Technical Assistance on Awareness and Prevention of HIV/AIDS and Human Trafficking 19
4. Social Security Sector Development Program Summary of Gender Entry Points 31

Boxes
1. Job Challenges of a Community-Based Nurse 10
2. Attitude Change among Police Officers in Choyr 23
Acknowledgments

This report is one of a series of four country reports and one synthesis report presenting findings of rapid gender assessments (RGAs) of selected ADB-financed loan projects in four developing member countries: Indonesia, Mongolia, Sri Lanka, and Viet Nam. The series follows an earlier round of RGAs that were carried out in Bangladesh, Cambodia, Nepal, and Pakistan in 2004 and 2005. This report was prepared under the overall guidance of Shireen Lateef, director, Social Sectors, Southeast Asia Department, and chair, Gender Equity Community of Practice, Asian Development Bank (ADB); and Sonomi Tanaka, principal social development specialist (Gender and Development), ADB. The RGA team leader and editor of the country reports was Juliet Hunt.

The authors acknowledge the assistance provided by staff and consultants working on the projects included in this assessment, including those from the Ministry of Health, Department of Roads, and Ministry of Social Welfare and Labor of Mongolia. ADB project officers also provided much assistance, including Claude Bodart and Wendy Walker. The authors also thank all ADB staff who provided valuable feedback and comments on the RGA report during its development. Aldrin Roco assisted in production.

The authors hope that the report will be useful to governments, nongovernment organizations, development practitioners, researchers, and other individuals working in the field of gender and development.
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>BCC</td>
<td>behavior change communication</td>
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<td>DMF</td>
<td>design and monitoring framework</td>
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<td>FGP</td>
<td>family group practice</td>
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<td>GAD</td>
<td>gender and development</td>
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<td>GAP</td>
<td>gender action plan</td>
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<td>HSDP2</td>
<td>Second Health Sector Development Project</td>
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<tr>
<td>IEC</td>
<td>information, education, and communication</td>
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<tr>
<td>JFPR</td>
<td>Japan Fund for Poverty Reduction</td>
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<tr>
<td>MCH</td>
<td>maternal and child health</td>
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<td>MIS</td>
<td>management information system</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSWL</td>
<td>Ministry of Social Welfare and Labor</td>
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<tr>
<td>NCRD</td>
<td>National Center for the Rehabilitation of the Disabled</td>
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<tr>
<td>NGO</td>
<td>nongovernment organization</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>PRC</td>
<td>People’s Republic of China</td>
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<td>RGA-I</td>
<td>rapid gender assessment—phase 1</td>
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<td>RGA-II</td>
<td>rapid gender assessment—phase 2</td>
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<td>RRDP</td>
<td>Regional Road Development Project</td>
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<td>RRP</td>
<td>report and recommendation of the President (loan document)</td>
</tr>
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<td>SSSDP</td>
<td>Social Security Sector Development Program</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>VCT</td>
<td>voluntary counseling and testing</td>
</tr>
</tbody>
</table>
Executive Summary

Rapid Gender Assessments

Rapid gender assessments (RGAs) of 12 loans in four countries (Indonesia, Mongolia, Sri Lanka, and Viet Nam) were undertaken as part of the ongoing commitment of the Asian Development Bank (ADB) to aid effectiveness and the assessment of gender equality results. With three loans selected from various sectors in each country, the RGAs were not designed to meet the broad range of criteria for an evaluation. The aims were to assess the extent to which project-specific gender action plans (GAPs), gender strategies, or gender provisions in ADB loans contributed to gender equality results and overall project outcomes, and to share knowledge on the key features of GAPs and gender provisions that contributed to these results.

The three loan projects assessed in Mongolia were

(i) Second Health Sector Development Project, loan 1998, approved June 2003 for $14 million, with an accompanying Japan Fund for Poverty Reduction grant of $1 million, scheduled for completion in June 2009;

(ii) Awareness and Prevention of HIV/AIDS and Human Trafficking, technical assistance 4364, part of Regional Road Development Project, loan 2087, approved June 2004 for $350,000 for the technical assistance grant and $37.1 million for the loan, scheduled for completion in January 2010; and

(iii) Social Security Sector Development Program, loan 1836/1837, approved August 2001 for an $8 million program loan and a $4 million investment loan, scheduled for completion in June 2009.

This report is one of a series of four country reports that assess gender equality results in the following areas: participation in project activities; access to resources; practical benefits delivered to women; and changes in gender relations among individuals and in households, communities, and institutions. A synthesis report compares results and summarizes lessons across all four countries and provides recommendations to assist ADB in meeting its commitments to gender equality as outlined in Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank, 2008–2020 (2008a) and Gender and Development Plan of Action (2008–2010) (2007a). This is the second round of RGAs (RGA-II) carried out by ADB. The first series (RGA-I) was undertaken in 2004 and 2005 and reviewed 12 loans in Bangladesh, Cambodia, Nepal, and Pakistan.

Findings for Mongolia

Gender Equality Results

The Second Health Sector Development Project (HSDP2) and the technical assistance (TA) component of the Regional Road Development Project (RRDP) achieved very positive gender equality results. In HSDP2, a major benefit was improvement in the quality of health care services for women and children, including strengthened capacity to respond to their health needs. Many of the 7,850 rural health workers trained were women, including community-based nurses, doctors, and medical and administrative staff at provincial health centers. Training primary health care (PHC) workers, improvements to health infrastructure and equipment, and new patient-focused approaches to delivering services improved key maternal and child health (MCH) indicators in project areas. Access to antenatal care...
is now equal to or above the national average, and the proportion of women experiencing pregnancy-related complications decreased from 50.0% to 34.5%. A Japan Fund for Poverty Reduction (JFPR) grant addressed nonmedical barriers to women’s access to improved health services in HSDP2 areas by providing subsidies to cover transport costs to clinics and assistance with the citizen registration needed to obtain government services. Upgrades to civil works took women’s needs into account in the height of showerheads for new mothers and the provision of cooking facilities. Home visits reduced the opportunity cost of accessing health care and encouraged a more holistic consideration of factors influencing women’s health. In addition to these practical benefits, progress was also made toward strategic changes in gender relations and institutional changes. The patient-focused approach that treats women as partners in improving MCH was institutionalized in HSDP2 areas, and training for PHC workers empowered them to become more confident agents of change with more respect from other health professionals.

The TA on HIV/AIDS and human trafficking increased awareness of the health and security risks associated with the development of the regional road. Information, education, and communication (IEC) materials were provided to a wide cross-section of male and female groups. Peer educators and vulnerable groups gained knowledge of high-risk behavior and took steps to reduce risks. The TA provided voluntary counseling and testing (VCT) services for all sexually transmitted infections (STIs), bringing much-needed attention to reproductive health issues in areas with the highest rates of STIs in the country. Also, mobile clinics offering these services were taken to construction and mining sites. Another practical benefit was the provision of condoms in communities affected by the road corridor. Although the TA was not designed to influence gender relations or promote institutional changes, there were positive signs in these areas. Discussions with men and women about high-risk sexual behavior and STIs and advocacy to increase men’s attendance at VCT clinics have the potential to improve women’s reproductive health in the long term. Training for police and border officials raised their awareness of human trafficking and increased their efforts to support and protect vulnerable women. This could contribute to broader institutional changes if the approaches taken in the TA are reinforced and supported in other ADB-financed projects. The involvement of local government decision makers in the TA encouraged community leaders to be more aware of the social and economic impacts of development along the road corridor and of the needs of vulnerable groups. Staff from the Department of Roads gained understanding of nonengineering issues, such as the social impacts to consider as projects are planned and implemented.

The Social Security Sector Development Program (SSSDP) had no gender design features, and there was no evidence from interviews or project reports that the project explicitly sought the participation of women in the development or implementation of project activities or that gender equality results were achieved. However, with high numbers of women employed in the social security sector, it is likely that they participated in several training activities, although no sex-disaggregated data were available to verify this.

**Gender Equality Results Contributed to Overall Project Outcomes**

Attention to gender issues and the achievement of gender equality results directly contributed to overall project outcomes and effectiveness. In HSDP2, a combination of gender-responsive strategies helped to address some of the constraints faced by women when accessing health services, and this was a key factor in improving MCH indicators. These strategies included the promotion of patient-focused approaches that treated women as partners, increasing outreach services, subsidizing transport, and other activities provided under the JFPR grant that addressed nonmedical barriers to women using health services.

The aim of the TA was to reduce the risk of the spread of HIV/AIDS and human trafficking associated with the construction and operation of the regional road. This was achieved because a comprehensive gender-inclusive approach was taken during implementation, with groups of men and women vulnerable to negative impacts involved in project activities. The TA also helped road project staff and local community leaders identify vulnerable groups and social impact issues that would otherwise have remained hidden. The road project team intends to encourage a similar socially inclusive approach...
when developing economic activities along the corridor. The TA was effective at increasing the capacity of local decision makers to promote sustainable growth, which was the goal of the regional road project.

The purpose of the SSSDP was to strengthen the capacity of the social security system to deliver essential welfare, insurance, and employment services to those most in need. The limited capacity of the Ministry of Social Welfare and Labor to target social security programming was acknowledged in the project design, but gender differences were not addressed during implementation. Loan outcomes and effectiveness could have been enhanced and more effectively monitored if the project had strengthened gender and social analysis capacity and introduced a sex-disaggregated management information system (MIS) for the sector.

The Quality of Gender Mainstreaming During Design and Implementation

HSDP2 was the only project that included a GAP in the project design. Although the HSDP2 GAP was not used as an implementation tool, most GAP strategies were implemented because they were fully integrated into the project design. The TA had no gender provisions in its design, but attention to gender issues was mainstreamed during implementation. Loan outcomes and effectiveness could have been enhanced and more effectively monitored if the project had strengthened gender and social analysis capacity and introduced a sex-disaggregated management information system (MIS) for the sector.

Comparing the gender mainstreaming approaches of the three projects and the gender equality results achieved demonstrates that paying attention to gender differences and issues during design and implementation produced better results for women and enhanced the quality of project implementation. HSDP2’s GAP focused on improving MCH, training women PHC workers, and improving the quality of health services and their capacity to respond to women’s and children’s needs. Significant practical benefits accrued to women; progress was made toward changes in gender relations and there were important institutional changes that will help to sustain the benefits achieved. These results were enhanced by the JFPR grant, which focused on addressing key gender issues that had not been addressed in the HSDP2 design. The TA also achieved important practical benefits for vulnerable groups of women and men, building their awareness of HIV/AIDS and human trafficking risks and increasing their access to services. Promising steps were taken to change the way local institutions respond to vulnerable groups. Some progress was also made on changing gender relations with more men attending VCT clinics. In contrast, it was not possible to verify any gender equality results in SSSDP.

Factors that influenced the achievement of gender equality results included the following:

(i) The quality of gender analysis and its application to design and implementation. All three projects included some gender analysis in the report and recommendation of the President (RRP) but the comprehensiveness of the gender analysis and its application to project design and implementation differed. Where gender analysis was translated into practical strategies to involve and benefit women and men, good gender equality results were achieved. In HSDP2, gender analysis was used to develop a GAP and the JFPR grant provided an important opportunity to apply further gender analysis during implementation (to address barriers to women using health services). In the TA, the gender analysis undertaken during inception was applied systematically during implementation, ensuring that at-risk groups were identified and IEC materials and outreach activities adapted to meet their needs. In SSSDP, the gender analysis included in the RRP was not used to develop a GAP or gender provisions and no additional gender analysis was undertaken during implementation to address this weakness. Furthermore, the quality of gender analysis could have been improved in each of the three projects and this would have enhanced the achievement of gender equality results. HSDP2 overlooked gender differences related to infectious disease control (a secondary focus of the project), women’s underrepresentation in decision making in the health sector, the impact of staff rationalization
and changes in service delivery on female health workers, and the impact of alcohol abuse and violence against women on women’s health status. In the TA, the impact of gender power relations on women’s vulnerability to HIV infection and human trafficking were not considered. In SSSDP, fundamental differences in women’s and men’s work patterns and social welfare and insurance needs were overlooked, as were the effects of gender stereotyping on employment opportunities.

(ii) Quality of the GAP. Positive features of the HSDP2 GAP were that its strategies were integrated into the project design and it identified anticipated benefits for women. However, the GAP did not include step-by-step guidelines or interim targets to ensure that the anticipated benefits were achieved. The GAP was not reviewed during implementation, so the project team was unaware of it. The anticipated benefits were not integrated into the HSDP2 design and monitoring framework (DMF) and the GAP was not included in the loan covenants. Therefore, GAP implementation and the achievement of gender equality results were not monitored by the executing agency or ADB. Consequently, some key gender issues were overlooked and sex-disaggregated data were not systematically collected or reported, despite this being a GAP requirement. A more detailed GAP in the project design and a loan covenant requiring it to be revised at inception and monitored during implementation would have identified these shortfalls.

(iii) Targets and special measures to ensure the participation of women. Experience in other countries with ADB projects demonstrates that targets focus attention on women’s participation and significantly increase the likelihood that sex-disaggregated data will be collected to monitor achievements, particularly where targets are included in DMFs. None of the Mongolian projects identified adequate targets. Although the HSDP2 GAP provided notional estimates of the number of women likely to benefit, these were not incorporated into the DMF or regular project reporting, which limited their usefulness for ensuring women’s participation and benefits. A lack of targets and special measures also meant that women’s participation was low in some HSDP2 project training. The TA did not include targets for women’s participation, but the TA team was conscious of the need to achieve a gender balance in the training of peer educators. TA activities reached vulnerable groups of both men and women, which in some cases required special measures. However, without clear targets, sex-disaggregated data were not collected to verify women’s participation across all TA activities. The SSSDP did not include any targets to ensure that women participated and benefited equally.

(iv) Gender capacity building of executing agencies and implementers. No provisions were made for gender capacity building in HSDP2. However, the JFPR grant provided training on the nonmedical factors influencing the ability of marginalized women to access improved health services, and this enhanced results. The TA project coordinator participated in national HIV/AIDS networks and collaborated with other development partners supporting similar awareness-raising activities in Mongolia. This provided important opportunities for the TA team to discuss lessons and programming challenges despite the lack of provision for formal gender capacity building. The SSSDP had no gender capacity building despite acknowledgment in the RRP of capacity deficiencies within the executing agency to target programming to those most in need. Gender capacity building could have improved targeting and the more efficient use of social security resources—key objectives of this project.

(v) Leadership and collaboration with stakeholders. Two additional factors contributed to the achievement of gender equality results in the TA. One was the collaborative approach to working with a range of local government stakeholders, which secured their support and understanding. The other was the leadership
shown by the TA project coordinator, who encouraged project partners to seek out both male and female at-risk groups and ensure that their needs were addressed.

Institutionalization of Gender Mainstreaming in Project Design, Implementation, and Monitoring

More effort is needed to ensure that GAPs and other gender mainstreaming features are institutionalized into the Mongolia program. None of the projects systematically collected sex-disaggregated baseline or monitoring data. This was a significant weakness compared with other countries included in the RGA-II study. HSDP2 included several MCH indicators in its DMF. While this was positive, no other gender-related targets or indicators were included in the DMFs for the HSDP2, the TA, or SSSDP. Consequently, there was no regular monitoring or reporting on gender-related results by either executing agencies or ADB. Systematic collection of sex-disaggregated data is a key action included in ADB’s GAD Plan of Action (2007a), along with the incorporation of gender targets and indicators in the DMFs of all projects. These features are widely accepted internationally as standard good practice for project design and implementation. They are essential to identify differences in participation, access to resources, and benefits for women and men, and to share knowledge about effective strategies for capitalizing on gender equity as a driver of change for sustainable and inclusive growth and poverty reduction. Furthermore, the RRDP was the only project that included a gender-related loan covenant. If HSDP2’s GAP had been included in the loan covenants, this would have focused the attention of the executing agency and ADB on gender issues during loan review missions and could have helped address implementation challenges.

The Role of Local Gender Specialists

None of the project teams included gender advisers to guide implementation. However, HSDP2 and the TA had access to gender expertise from other sources, which contributed to achieving gender equality results. Nevertheless, in all three projects, a gender adviser on the project team could have helped to address implementation challenges, enhanced the achievement of gender equality results, and improved monitoring by ensuring that sex-disaggregated data were systematically collected, analyzed, and reported.

No ADB resident mission gender specialist was available during the design or implementation of the three projects. An ADB gender specialist is now on contract at the Mongolia Resident Mission. The findings underline the need for technical support from the gender specialist to address the shortfalls identified by the RGA, including in applying quality gender analysis to design and implementation, collecting and analyzing sex-disaggregated baseline and monitoring data, monitoring the implementation of GAPs and gender provisions, and capacity building with executing agencies and implementers.

Other Contextual and Institutional Factors

Findings from the RGA-II in Mongolia highlight the need to raise awareness of gender issues and the rationale for taking special measures to benefit women with policy makers and development partners. In general, there was little understanding of the need to identify and respond to gender differences. Strengthening the capacity for comprehensive social and gender analysis needs to be a high priority to increase the return on loan investments. The lack of reliable sex-disaggregated data, particularly in the area of social security and protection, has been a major bottleneck in preparing gender-inclusive social protection policy and programs. ADB assistance in developing a comprehensive sex-disaggregated MIS would be a good step in this direction in the social security sector. Gender analysis and sex-disaggregated data are also required to demonstrate the rationale for adopting gender-inclusive approaches in loan operations in other sectors. Without such analytical capacity, quality GAPs cannot be developed, the different results for women and men cannot be identified, the costs of not taking gender differences into account cannot be demonstrated, and the positive impacts of achieving good results for women on overall development outcomes cannot be discerned.

ADB can address these challenges by encouraging the use of gender and social analysis across the portfolio and adopting a consistent approach to integrating and monitoring gender and development issues in its
operations in Mongolia. Where good gender equality results and institutional changes have been achieved, such as in the TA on HIV/AIDS and human trafficking, high priority should be given to sharing knowledge on effective approaches and replicating them in current and future projects in the sector. Lessons from the TA, including the collaborative approach with local stakeholders and the targeting of a broad range of vulnerable groups, should be applied to the ADB-financed Mongolia Western Regional Road Corridor Development Project–Phase I, approved in 2008, which appears to have downgraded attention to mitigating the potential negative impacts of road construction and operation.

Recommendations

ADB’s Strategy 2020 highlights gender equity as one of five drivers of change and commits the organization to designing gender-inclusive projects and paying careful attention to gender issues across the full range of its operations. In addition to specific recommendations on each project, the following are recommended to achieve these aims for the Mongolia country program:

(i) Comprehensive gender analysis should be undertaken during loan preparation for all sectors of ADB operations to understand the factors that influence development outcomes for women and men and to develop a detailed GAP with step-by-step guidance on how to achieve and monitor gender-related targets. Where it is not appropriate to develop a GAP, such as for TA projects, gender provisions should be incorporated into the design to ensure that a gender-inclusive approach is followed.

(ii) The GAP should include strategies and targets for each loan component, project gender advisers throughout implementation, and gender capacity building with executing and implementing agencies and other stakeholders to ensure that gender equality results are sustained. GAP targets and gender-related indicators should be incorporated into the DMF, and the review and implementation of the GAP should be included in the loan covenants to ensure regular monitoring.

(iii) Projects should systematically collect, analyze, and report on sex-disaggregated data. Reporting on the GAP and on gender equality results should be integrated into core project documents, such as annual reports, midterm review, impact assessment, and project completion reports. They should assess gender differences in participation, access to project resources, and benefits.

(iv) The ADB resident mission gender specialist should be involved in loan design, implementation, and monitoring, including in loan review missions for projects in high-priority sectors where it is possible to demonstrate the impact of a gender-inclusive approach and where there are opportunities for lesson learning, replication to other projects, and capacity building of partners.

(v) Current and future social protection projects should give high priority to strengthening social and gender analysis capacity and assisting with a comprehensive sex-disaggregated MIS.

(vi) Future road corridor projects should include HIV/AIDS and human trafficking awareness and mitigation as a standard component and where necessary this should be included in the core project budget. Consideration should be given to documenting the effective collaborative, gender mainstreaming, and capacity-building approaches and outcomes from the TA as a good practice case study, to share knowledge and encourage replication. These lessons should be applied to upcoming regional corridor projects in Mongolia.
Introduction

Background of the RGA-II

The Policy on Gender and Development of the Asian Development Bank (ADB) identified gender mainstreaming as a key strategy for addressing gender equality and the empowerment of women in all ADB-financed activities (ADB 1998, 41). Several institutional mechanisms have been adopted since then to ensure policy implementation, including the appointment of local gender specialists in ADB resident missions and the development of gender action plans (GAPs) for loan projects (ADB 2006a).

The first series of rapid gender assessments (RGA-I) was undertaken in 2004–2005 as part of ADB’s review of the implementation of the gender and development (GAD) policy (ADB 2006b, vii–viii). RGA-I assessed 12 loans in four countries (Bangladesh, Cambodia, Nepal, and Pakistan) and found that GAPs were an effective gender mainstreaming tool because they provided a road map for implementing the project’s gender design features (ADB 2006b; Hunt, Lateef, and Thomas 2007, xiii–xiv).1

Strengthening the implementation of gender-related loan design features is a central aspect of ADB’s GAD Plan of Action (ADB 2007a). The plan identifies several actions to achieve this purpose, including institutionalizing the development and use of project-specific GAPs, incorporating gender-related targets and indicators in the design and monitoring frameworks (DMFs) of all projects, and promoting stricter compliance with gender-related loan assurances and covenants (ADB 2007a, 7).

Gender equity was highlighted in ADB’s Strategy 2020 as one of five drivers of change essential for achieving inclusive and sustainable growth, reducing poverty, and improving living standards.2 Under Strategy 2020, ADB will promote gender equity by designing gender-inclusive projects and paying careful attention to gender issues across the full range of its operations. This commitment is reinforced in ADB’s results framework (designed to monitor implementation of Strategy 2020), which includes a gender mainstreaming indicator (ADB 2007b, 4–13).

As part of its commitment to aid effectiveness, ADB is a partner to the 2005 Paris Declaration on Aid Effectiveness (Organisation for Economic Co-operation and Development 2005). To achieve greater development effectiveness in meeting the Millennium Development Goals by 2015, developed and developing member countries and multilateral and bilateral development institutions committed themselves to five principles: ownership, harmonization, alignment, results, and mutual accountability. With gender equality and women’s empowerment as one of the Millennium Development Goals, aid effectiveness in gender equality has become an important part of the global development agenda. How to manage, achieve, and measure gender equality and women’s empowerment results is a topic of concern among donors and development partners. Managing for development results is also part of a broader commitment by ADB to demonstrate and increase aid effectiveness (ADB 2007c).

In order to monitor these commitments, the GAD Plan of Action scheduled rapid gender assessments (RGA-II) to assess the results and impacts of GAD-relevant projects (ADB 2007a, 11). RGA-II includes assessments of 12 loans in Indonesia, Mongolia, Sri Lanka, and Viet Nam. This report on the Mongolia RGAs is part of a series of four country reports and a

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1 The results from RGA-I were published in four country-specific reports and one synthesis report: www.adb.org/Documents/Books/Gender-Equality-Results/

2 The other drivers of change are good governance, capacity development, knowledge solutions, and partnerships. See ADB 2008a, 1, 15.
synthesis report that consolidates findings from across the four countries.

Objectives

The objective of RGA-II was to assess the extent to which project-specific GAPs, gender strategies, or gender provisions in ADB loans achieved gender equality results and contributed to projects’ overall outcomes and outputs. Findings were to be used as follows:

(i) Assess the quality and implementation of GAPs, including compliance with gender-related loan assurances and covenants, and the incorporation of GAP elements into design and monitoring and evaluation frameworks and performance-monitoring systems.

(ii) Assess how the achievement of gender equality results contributed to overall development outcomes, effectiveness, and sustainability, and to demonstrate these links, if they were found.

(iii) Share knowledge on the core elements of quality GAPs and gender strategies that are critical for the achievement of gender equality results and overall development outcomes.

Methodology and Scope

The following criteria were used to select the loan projects for RGA-II:

(i) Projects were categorized with a gender and development theme or effective gender mainstreaming, preferably having gender targets in the framework or a project-specific GAP; in a country where a limited number of such loan projects existed, such as Mongolia, projects with some gender provisions were included.

(ii) Projects were at an advanced stage of implementation of gender-related activities and outputs and preliminary outcomes could be assessed.

(iii) Projects covered a mix of rural and urban locations and a variety of sectors, including the priority sectors highlighted in ADB’s Strategy 2020.

(iv) Projects included some components that addressed the constraints and needs of marginalized people (for example, indigenous peoples and ethnic minorities).

(v) The developing member country showed a willingness to participate.

A common methodological framework was developed to guide the assessments in each country. It included overarching questions, process and outcome indicators, and an exploration of negative and positive changes and intended and unintended results. Key gender-related results investigated were

(i) participation in project activities and access to project resources;

(ii) practical benefits achieved;

(iii) progress toward strategic changes in gender relations, including at the individual, household, community, societal, or national level; and

(iv) other results such as institutional changes within executing agencies, implementing agencies, or other government agencies or programs.

The questions and indicators were modified as needed for each project. The overarching questions for assessment were as follows:

(i) What gender equality results were achieved?

(ii) Where gender equality results were demonstrated, how did these contribute to the achievement of overall loan objectives or outcomes, and the effectiveness and sustainability of the loan investment?

(iii) Where gender equality results were demonstrated, what caused or contributed to these results?
(iv) What were the key features of GAPs, gender strategies, and gender provisions that contributed to the achievement of positive gender equality results and overall development outcomes, effectiveness, and sustainability? To what extent were GAPs, gender strategies, and gender provisions implemented?

(v) To what extent were GAPs, gender strategies, and gender provisions institutionalized into project management and monitoring systems and processes by ADB and executing agencies?

(vi) What are the implications of findings in all the above areas for improving the focus on gender equality in ADB loan preparation, design, implementation, and monitoring?

An international gender specialist and ADB’s resident mission gender specialist carried out the field assessments. They visited project sites and interviewed project beneficiaries (women and men), staff, and local stakeholders individually and in groups (Appendix) using questions from the methodological framework. Each RGA reviewed project documents, including the report and recommendation of the President (RRP), GAPs, project administration memoranda where available, back-to-office reports from review missions, progress reports, ADB case studies, and other relevant documents at the resident missions.

The RGAs were systematic assessments that adhered to quality standards for data collection, analysis, and validation (ADB n.d.). However, the focus was on gender equality results and the causes of those results; with three loans from various sectors in each country, the RGAs were not designed to meet the broad range of criteria usually specified for an evaluation. Very few projects had adequate baseline or sex-disaggregated quantitative data for assessing results for women compared with those for men. RGAs were based on both qualitative and quantitative information. Qualitative assessments were cross-checked with a range of in-country stakeholders and relevant ADB headquarters staff. Details of the three projects included in the Mongolia RGA-II are set out in Table 1.

Fieldwork for the Mongolia RGA-II

The RGA-II international consultant spent 13 working days in Mongolia, conducting 57 interviews in Ulaanbaatar and at field sites with executing agency staff and beneficiaries, and interviewed staff at ADB headquarters in Manila. The international consultant and the ADB resident mission gender specialist worked with the Social Security Sector Development Program (SSSSDP) project manager for 2 days. They also worked with implementing staff from several project components including a technical college (under the employment component), the National Center for the Rehabilitation of the Disabled, the Labor and Social Welfare Services Office (where they worked with the vice-chairperson), and the Project Monitoring and Evaluation Office. An interview was also conducted with the ADB project team leader at ADB headquarters.

After meeting the project implementation unit director for the Second Health Sector Development Project (HSDP2), the RGA-II team traveled to a project site in Hentiy District for 2 days, where project beneficiaries and stakeholders at the district hospital were interviewed, including the province project coordinator, medical staff who had received training, four community-based nurses, and patients. The team also visited a village health center, a family group practice (FGP) team, and a nongovernment organization (NGO) director implementing the Japan Fund for Poverty Reduction (JFPR) grant activities. An additional day was spent interviewing the project implementation unit director and visiting an FGP at a herder community on the outskirts of Ulaanbaatar where staff and patients were interviewed. A telephone interview was later conducted with the ADB team leader.

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3 The RGA consultants requested project administration memoranda but they were not always made available.

4 Evaluations are defined as comprehensive assessments of the design, implementation, and results of all aspects of a project, including the relevance and fulfillment of objectives, efficiency, effectiveness, impact, and sustainability (Development Assistance Committee 2002, 21–22).
<table>
<thead>
<tr>
<th>Loan or TA No.</th>
<th>Loan or TA Name</th>
<th>Gender Category&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Thematic Classification&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Sector</th>
<th>Loan Approval (A) E: Loan completion (C)&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Loan Amount ($ million)</th>
<th>Executing Agency</th>
<th>ADB Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>Second Health Sector Development Project</td>
<td>GD</td>
<td>Social development/core poverty intervention</td>
<td>Health, nutrition, and social protection</td>
<td>A: Jun 2003 E: Nov 2003 C: Jun 2009</td>
<td>Loan – ADF: $14.0 JFPR grant: $1.0</td>
<td>Ministry of Health</td>
<td>East Asia Department, Urban and Social Sectors Division</td>
</tr>
<tr>
<td>TA:4364 Loan: 2087</td>
<td>Technical Assistance: Awareness and Prevention of HIV/AIDS and Human Trafficking (part of Regional Road Development Project)</td>
<td>SGB</td>
<td>Social development</td>
<td>Loan: Transport and communication</td>
<td>A: Jun 2004 E: Jul 2005 C: Jan 2010</td>
<td>TA grant: $0.35 Loan – ADF: $37.1</td>
<td>TA: Ministry of Health Loan: Department of Roads</td>
<td>East Asia Department, Urban and Social Sectors Division</td>
</tr>
</tbody>
</table>


<sup>a</sup> ADB classifies loans according to these gender categories (ADB 2008b): GD theme, EGM, and SGB. Loans are assigned a GD theme if they directly promote gender equity by attempting to narrow gender disparities or if they integrate a gender perspective to achieve equal participation, benefits, and rights. (Since RGA-II was conducted, the GD theme has been updated to GEN.) A loan is classified as SGB when it has the potential to provide some gender benefits because it identifies gender issues during project preparation and provides some minor design elements or small components to benefit women.

<sup>b</sup> Thematic classification tracks how projects support the strategic goals of ADB.

<sup>c</sup> Loan effectivity refers to the date at which the loan becomes effective and can be drawn down.


Three days were spent on the assessment of the technical assistance (TA) grant that was part of the RRDP. The international consultant traveled to the Govisumber district center, Choyr, located along the upgraded regional road, for interviews with TA stakeholders including school peer educators, staff at the district hospital, the TA district coordinator, staff at a voluntary counseling and testing (VCT) center, and the district governor. Discussions were also held with law enforcement officers and government lawyers who attended TA training. Subsequently, in Ulaanbaatar, the team met with a range of TA stakeholders, including implementing NGOs, the National Committee on AIDS Prevention, the National Center for Health Development, the United Nations Population Fund (UNFPA), and the Mongolian Employers’ Federation,
and had several interviews with the coordinator-manager of the TA. The remaining time was spent in Ulaanbaatar interviewing other stakeholders to assess recent developments in Mongolia regarding gender equality, reviewing files, and discussing findings with the resident mission staff including the resident mission gender specialist.

Background on Mongolia

Basic human development indicators are almost equal for men and women, suggesting relative gender equality. However, evidence from recent studies and gender analysis of national statistics show that the period of transition to a market economy and more recent global economic shocks have had different impacts on women than on men. Many families were plunged into poverty during the transition period, as previously protected jobs disappeared. At the same time, social services were drastically reduced so there remained little to cushion the effects of unemployment. Women have had to carry new burdens within the household to absorb reductions in previously free government services, such as early childhood education and health care. The emerging labor market is increasingly distorted by limitations on women’s opportunities for employment compared to men’s, such as employers’ preference for hiring men based on the assumption that they are the main family earners, and for hiring young, “attractive” women. This period of change is creating gender gaps in many areas of economic and social development that are new to Mongolia.

Enrollment and attendance rates for boys in secondary education are persistently lower than those for girls as boys are required to earn cash or to labor in subsistence herding operations for family survival. However, the additional investment in girls’ education is not reflected in the labor market, where women remain in lower-paid positions and are excluded from many sectors considered inappropriate for them. Growth sectors in the formal economy tend to have a predominantly male workforce in jobs with the highest wages, for example, transport and extraction industries. Women are principally employed in service sectors, such as health and education, which are contracting sharply, and tourism and agro-processing, which mainly offer seasonal employment. Despite the shift to a free market economy with labor legislation based on equity principles, gender distortions in the labor market remain, leading to discrimination against women and a persistent wage gap between average earnings for men and for women across all sectors.

The poverty data currently available in Mongolia do not give a clear picture of differences in the experience of poverty for women and men. There is evidence from census and Participatory Living Standards Assessments that a disproportionate number of households headed by women are in poverty, and that this proportion is growing. The sharp rise in food prices over 2007–2008 brought a crisis to all poor families, and nutritional levels are falling. There is little data or analysis of gender differences within households under these conditions.

Maternal mortality rates have declined more slowly than other health indicators. Although maternal, infant, and child mortality rates have begun to improve recently, women’s and children’s health remains a concern, particularly in remote areas, where there are significantly higher mortality rates. The need to improve maternal mortality rates is widely recognized, but other issues, such as the effects of domestic violence, deteriorating caloric intake, and high levels of anemia among women are not well understood from a gender perspective. There is evidence that poor families are having difficulty accessing health services despite reforms to the health insurance scheme, with a disproportionate effect on women as primary caregivers in the family. There are also emerging health problems for men, such as hypertension and stroke, that are related to poor diet, alcohol consumption, and extremely high levels of smoking.

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5 From 1921 to 1990, Mongolia was under a socialist regime with a centrally planned economy and extensive support from the Soviet Union. The transition to a market economy started in 1990 with a series of economic shocks that placed enormous pressure on all aspects of daily life. The information in this section, “Background on Mongolia,” was drawn from ADB and World Bank 2005.
Second Health Sector Development Project

Project Description

The goal of the Second Health Sector Development Project (HSDP2) is to improve the health of the people of Mongolia, especially the poor and vulnerable, including women and children, in targeted rural areas (ADB 2003a). The project associated its performance targets with Millennium Development Goal targets for maternal, infant, and under-5 child mortality rates.

Unequal access to quality health services and inferior health status in rural areas as compared to urban areas are serious challenges in the health sector in Mongolia. Health resources are concentrated in urban areas, particularly in Ulaanbaatar, while rural areas have a shortage of physicians and other qualified health workers, have deteriorated buildings, and a lack of basic equipment and supplies. Reflecting the low population density and low service quality, district health centers have only 2–5 outpatients a day and 5–10 births per year. Mortality rates are consistently higher in rural than urban areas, indicating that rural Mongolians have not benefited equitably from health service improvements in recent years.

In this context, HSDP2 had two objectives: (i) improve the quality and utilization of health services in rural areas, especially for the poor and vulnerable; and (ii) build the capacity of the health sector, extending the reforms in sector efficiency, effectiveness and sustainability, and institutional development initiated by the first phase of the HSDP. The second phase had three components, listed here with their outputs:

(i) Integrated improvement of rural health services

(a) District health development: Utilization of basic health services, service quality, and effectiveness at district health centers improved; community and family health and nutrition practices improved.

(b) Provincial hospitals: Hospitals and environmental management upgraded by improving working conditions through rehabilitating facilities and providing equipment; enhancing knowledge and skills of staff; providing incentives to staff to work in rural areas and meet the needs of the poor and vulnerable; and providing participatory and informative public health campaigns that created demand for quality primary health care (PHC) services and improved community and family health and nutrition practices. The PHC services targeted for strengthening included maternal and child health (MCH) services and infectious disease control.

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6 The total cost of the project was estimated to be $17.5 million including $14.0 million from ADB, approved in June 2003 for loan 1998, and $3.5 million from the Government of Mongolia (ADB 2003a, IV).

7 Mongolia is divided into 21 provinces (aimags), 315 districts (soums), and many villages (baghs). This administrative structure was established during the centrally planned economic period and provided for government services, including health care, in each province and district center.

8 FGPs are private teams of doctors and nurses funded through performance-based contracts with the Ministry of Health.
(ii) Institutional capacity development

(a) Consolidation of reforms: Family group practice (FGP) service quality and utilization improved, national treatment-quality improvement program developed, accreditation system and licensing made more effective, rationalization of hospitals and staff supported, and career development services provided to encourage rationalization.

(b) Capacity building: Training capacity of Directorate of Medical Services strengthened; staff of directorate, Ministry of Health (MOH), and Health Insurance Fund trained in planning, budgeting, and management; staff of local governments at all levels trained to improve service delivery, quality, and efficiency; human resource action plan produced; and external assistance coordination improved.

(iii) Project management

(a) Project implementation unit, local coordinators, steering committee, and province supervisory groups established.

(b) Project management capacities enhanced.

(c) Project performance monitoring and evaluation system set up.

Component (i) was implemented in five rural provinces (Bayanhongor, Dornod, Dzavhan, Ovorhangay, and Hentiy), which were selected for their rate and severity of poverty, levels of infant and maternal mortality, and incidence of infectious diseases. Components (ii) and (iii) were nationwide. HSDP2 invested in areas that would have the greatest impact on the poor and vulnerable.

HSDP2 was classified as a core poverty intervention with a thematic focus on human development and secondary focus on gender and development. The executing agency for this project was the MOH. The project was originally scheduled to be completed in June 2008 and this was revised to June 2009. Overall, the project was rated as satisfactory by ADB with the majority of funds disbursed at the time of the RGA and most physical activities completed (ADB 2009a).

Gender Analysis and Gender Action Plan in the Loan Design

The RRP included a GAP that stated how the project would benefit women and identified broad project strategies for each component to achieve these benefits. For the rural health component, these strategies included focusing on PHC by strengthening community-based nurses, strengthening province hospitals so they can provide quality services for pregnant women and children, training rural health workers to provide efficient outreach services, and improving rural health facilities and equipment. For the institutional development component, GAP strategies included basic and refresher training for FGPs, strengthening FGP monitoring systems to assess satisfaction with health services on the part of the poor and women, and improving the capacity of the health system to respond to the diverse needs of client groups. The project management component required that data for performance monitoring and evaluation be sex-disaggregated, and progress of the GAP was to be included in quarterly progress reports (ADB 2003a, 52). Due to the focus on MCH and infectious disease control, with most services for reproductive health provided to women by female health workers, it was assumed that the project would benefit women by providing improved health services and human resources development, civil works, and equipment provision. However, the GAP did not include a step-by-step plan for activities to ensure that these benefits would be achieved.

The HSDP2 GAP anticipated the following benefits:

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9 Most community-based nurses (or bagh feldshers) in Mongolia are employed at the village level. They receive basic health training and refer cases to a health clinic or hospital if necessary. They are primarily responsible for reproductive health and maintain close contact with all pregnant women in their communities, which can cover several hundred square kilometers in rural areas.
(i) Approximately 120,000 women of reproductive age living in five HSDP2 rural provinces will have improved access to quality reproductive health services.

(ii) Approximately 200,000 women living in five HSDP2 rural provinces will be encouraged to promote their health and adopt health-seeking behavior for themselves and their families.

(iii) More than 7,000 urban and rural women PHC workers will be trained.

(iv) Working conditions will improve in rural facilities in five HSDP2 provinces where most health workers are women.

The HSDP2 DMF included outcome indicators for improvements in maternal, infant, and child mortality, contraceptive use, antenatal coverage, and knowledge and practices on family planning and nutrition. There was no covenant in the loan agreement associated with the implementation of the GAP (ADB 2003b). Nor were there provisions in the project budget for gender specialist inputs to guide implementation of the GAP or for capacity building to ensure monitoring of anticipated gender equality results.

The discussion of gender issues in the RRP highlighted the unacceptably high maternal mortality rate in Mongolia, which could be prevented through the application of basic medical knowledge and technologies. Poor reproductive health was acknowledged as "the cumulative result of poverty; educational, social, and cultural behavior; and health care factors" (ADB 2003a, 50–51). The RRP social and gender analysis identified two key factors restricting access to MCH services by poor and remote women: (i) often-prohibitive travel costs precluded regular attendance at antenatal clinics, and (ii) the complexities of citizen registration for highly mobile and poor women prevented them from claiming maternity benefits (ADB 2003a, 47–52). It is necessary to produce a citizen registration card to obtain government services, and in rural areas, many herder families are not registered as they move frequently between government districts and many do not understand the benefits of registration. The RRP social analysis also indicated that high maternal mortality rates were linked to the lack of citizen registration of some mothers.

There was no discussion of any gender-based differences in medical or social factors contributing to the control of infectious diseases. It is well recognized in Mongolia, for example, that men are considerably less likely than women to seek health services until they are seriously ill—a gender-based difference influencing the control of infectious disease. Men are also considered to be hard to reach with reproductive health messages concerning issues such as contraceptive use or high-risk behavior associated with exposure to sexually transmitted infections (STIs).

A Japan Fund for Poverty Reduction (JFPR) grant for $1 million, the Maternal Mortality Reduction Project, was linked to HSDP2 (ADB 2005). One component of this grant was designed to address some of the non-medical factors associated with high maternal mortality rates, by ensuring that socially disadvantaged pregnant women could access the improved HSDP2 health services and providing additional training to rural PHC workers to encourage adoption of new techniques.

Implementation of the Gender Action Plan

The GAP was not revised during inception and staff were unaware of the GAP and its elements. No explicit attention was paid to its implementation. Nevertheless, most GAP strategies were implemented because they were a core part of the project design, although sex-disaggregated data were not collected and no mechanisms were put in place to validate the assumption that women would benefit, or ensure that activities were implemented in a gender-responsive manner. However, following a request from the RGA-II team, some sex-disaggregated data were provided by the project team.

Gender Equality Results

Despite the lack of explicit attention to GAP implementation, many benefits for women were achieved. Table 2 provides a summary of gender equality results. An analysis of achievements, challenges, and the potential for sustainability is provided in this table.
Table 2  Second Health Sector Development Project Summary of Gender Equality Results

<table>
<thead>
<tr>
<th>Loan Components</th>
<th>Gender Equality Results</th>
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</table>
| Project goal: Improve the health of people, especially the poor and vulnerable, including women and children in rural areas | • Improved reproductive health in project provinces: Complications during pregnancy, delivery, and post-delivery reduced from 50% (project baseline) to 34.5% in 2007.  
• Increased access to reproductive health services by pregnant women: 84%–94% attendance at antenatal services in project provinces compared with national average of 84%. |

1. Integrated improvement of rural health services
   • District health development: Utilization of basic health services, service quality, and effectiveness at district health centers improved; community and family health and nutrition practices improved  
   • Province hospitals and environmental management upgraded: Facilities and equipment rehabilitated; knowledge and skills of staff improved  
   Improved MCH and PHC skills and services available to rural poor women:  
   • Women were the majority of patients and health workers who benefited from 35 civil works projects at rural hospitals and medical equipment provided to 78 district health centers and 5 provinces.  
   • Differences in needs of male and female workers and patients were taken into account in the design of civil works, e.g., height of showerheads lowered for new mothers and cooking facilities provided.  
   • The majority of the 7,850 health workers trained were women, including 84% of 241 community-based nurses; community-based nurses received their first training in over 10 years.  
   More holistic and patient-focused approach and better understanding of nonmedical barriers to women using health services:  
   • Home visits by health professionals; better understanding of the impact of nutrition and domestic violence on women’s health.  
   • Transport subsidies for poor women to attend antenatal clinics and assistance to pregnant women with citizen registration through JFPR grant project. |

2. Institutional capacity building
   • Consolidation of sector reforms: Improved FGP; improved treatment quality at national level, rationalization of hospitals; and career development for staff  
   • Capacity building: Staff trained in planning, budgeting, and management; staff of local governments trained to improve service delivery, quality, and efficiency; and human resource action plan produced  
   Improved technical skills and working conditions for PHC and other medical staff, the majority of whom are women:  
   • 50% of family doctors trained were women and 70% of medical and administrative staff at province centers.  
   • 36 family doctors’ kits and medical equipment provided to newly established FGP, including at least 50% women.  
   • Patient satisfaction survey showed 79% of patients in project sites were satisfied compared with 52% in non-project sites; 69% of patients surveyed were women.  
   • Health planning training for local government officials: 9% of the 57 district governors, 40% of 283 village governors, and 30% of 77 administration directors were women; local government officials also received training on domestic violence.  
   • Increased understanding of the role of social workers in improving health-seeking behaviors due to JFPR activities. |

3. Project management
   • Project performance monitoring and evaluation system set up  
   Sex-disaggregated data not routinely collected or included in quarterly progress reports. |

FGP = family group practice, JFPR = Japan Fund for Poverty Reduction, MCH = maternal and child health, PHC = primary health care.  
Participation, Access to Project Resources, and Practical Benefits

The project resulted in significant practical benefits for women, including increased access to health services and improvements in MCH indicators in all project provinces. For example, women’s use of antenatal services in project areas is now equal to or above the national average of 84%, with 87% in Bayanhongor province, 94% in Dzavhan province, and 84% in Hentiy province. In addition, the proportion of women experiencing complications during pregnancy, delivery, or post-delivery decreased from approximately 50.0% (the project baseline) to 34.5% in 2007.

The majority of the 7,850 rural health workers trained through the project were women, including 84% of the community-based nurses, 50% of family doctors from FGPs, and 70% of the medical and administrative staff at province centers (Second Health Sector Development Project 2008). These workers benefited considerably from improvements in their physical working conditions due to the upgrading of health facilities and equipment. Both their training and the civil works component significantly strengthened the capacity of health service workers to respond to the needs of women patients. In the Ondorkhaan provincial hospital, for example, the height of showerheads was changed to accommodate new mothers who prefer to sit while bathing and the ward to which at-risk women come for the final weeks before delivery was renovated to meet their needs, with cooking equipment conveniently placed for their use.

Community-based nurses interviewed by the RGA-II team received their first training in more than 10 years from HSDP2. The community-based nurses play a vital role in rural areas. They link remote communities with the health system by referring high-risk patients, encouraging health-seeking behavior, and communicating important public health messages. The community-based nurses interviewed were all recruited and initially trained prior to 1990, when the economic transition began to bring foreign assistance, including new health care practices, to Mongolia. Therefore, this was their first exposure to new diagnostic techniques and some now-standard technologies. Their work in rural areas is very demanding with long hours, requiring travel of up to 200 kilometers in all seasons to find patients from nomadic herding families.

Their training was critical to HSDP2’s effectiveness in promoting a more patient-focused approach.

Box 1 Job Challenges of a Community-Based Nurse

Several community-based nurses talked to the RGA-II team about the challenges of their job and the impact of the training they received from HSDP2. One nurse described a typical working week, during which she traveled by horse for more than 150 kilometers in bitter winter weather to visit a pregnant woman, encouraged her to attend antenatal clinics, and discussed the health of her older children and other concerns in the family. She again traveled to another herder campsite to provide palliative care to a man dying from cancer. She remained there for several days helping the family care for this man, returning home after spending more than a week away. This community-based nurse laughed when asked if her children or other young people want to enter her profession. She replied that they all know she has to spend as many as three weeks per month away from home, under difficult travel and weather conditions, and asked, “Who wants to do that?” She also remarked in an amused way that her children ask why other people receive more attention from her than they do.

The nurses talked expansively about how useful the project training was for their work. They had been trained before the transition period, and over the past 10 years had not received any upgrading or new skills. One commented, “Before this training, we were wild women! We knew nothing and had to cope on our own. Now the family group practice doctor or nurse may come with us so we are not alone. We also know new things which make our work easier.”

The community-based nurses now feel that they are part of the primary health care team and are more confident in their work. They appreciated the regular home visits by doctors that were initiated by HSDP2, and the patient-focused approach to care promoted by the project. They feel they now have respect from the other medical professionals who attended the same training; they have become empowered to be agents of change in their communities and are more effective in their work.

Source: Interviews with beneficiaries conducted during fieldwork.
The holistic, patient-focused approach to health care promoted by this project is new to rural Mongolian health services. This approach helped to identify the nonmedical barriers to accessing health services that are different for men and women and encouraged a more gender-responsive approach to ensuring women’s access. It also provided very practical benefits to women, with doctors and nurses now making regular home visits. Several community-based nurses and other female health staff noted improved relationships with patients due to all these factors.

One illustration of the patient-focused approach is that training for medical professionals included new skills for assessing all factors contributing to the symptoms presented by a patient—for example, nutrition and general living conditions—and for helping patients identify when they should seek medical services. Basic training was also offered regarding the impact of domestic violence on the health status of women and children, a priority concern for women. Those who attended sessions on domestic violence noted in interviews that they now realize they should not blame women and need to create a secure environment in which to discuss these issues. Medical professionals are taking a patient-focused approach by making time for patients to discuss all problems affecting their health and for building trust.

Informants among health professionals noted that health education is reaching women and girls more effectively following the revision of public health messages and information, education, and communication (IEC) materials concerning MCH. Health workers believed that this had a positive impact on health-seeking behavior. For example, once young pregnant women attended antenatal clinics, they were more likely to continue to seek medical attention for their children.

Many pregnant women in remote areas fail to claim government maternity benefits due to cumbersome bureaucratic procedures or long distances to district administration centers. Local NGOs in each of the HSDP2 project provinces were contracted under the JFPR grant to assist district health centers and community-based nurses to provide social as well as health support to pregnant women to encourage them to apply for government MCH services. These JFPR-funded activities addressed some of the nonmedical factors that discouraged poor women in remote areas from going to health centers. Training funded by the JFPR grant focused on social services offered by the welfare system and legal supports for marginalized women. The PHC providers were encouraged to extend more holistic support to vulnerable mothers by bringing social and health workers together and consolidating the services and benefits offered to pregnant women by different government agencies.

The JFPR grant also provided subsidies for the cost of transport to antenatal clinics and assistance with citizen registration to enable more disadvantaged women to claim government services during pregnancy. This was of enormous practical benefit. The JFPR activities significantly increased the impact of HSDP2 by maximizing the use of improved services. They also increased understanding among health workers of the potential for social workers (attached to the Ministry of Social Welfare and Labor at province and district centers) to become more active partners in improving health-seeking behavior in remote and poor communities.

Progress toward Strategic Changes in Gender Relations

A patient-focused approach to health care delivery meant that women were treated as partners in improving MCH. Booklets developed by the United Nations Children’s Fund (UNICEF) were distributed to pregnant women and updated in antenatal and postnatal visits by PHC workers to encourage mothers to monitor their own pregnancy and infant care in partnership with the medical professionals. These booklets are used to track weight and other infant developmental indicators. Both community-based nurses and other PHC workers noted that this had the positive impact of improving health-seeking behavior among women. According to PHC workers, this partnership approach coupled with the other HSDP2 improvements and IEC activities resulted in women becoming more confident in the quality of

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10 It is argued by some analysts in Mongolia that there is higher mortality among women associated with domestic violence than with childbearing.
health services; the benefits of attending local health centers for antenatal and postnatal services are now much better understood by women in project areas.

Medical professionals from PHC centers and FGP are now traveling on a regular basis to homes of high-risk pregnant patients, even to the mobile dwellings of nomadic herders. This assisted the community-based nurses who can now consult with the PHC team on individual cases before referral to a health center. These visits also helped all PHC workers to understand the living conditions affecting the health of many rural women. Furthermore, these visits eliminated transport costs and absences from home for the patients. The labor of all family members is vital to subsistence herding operations and women bear additional responsibilities, such as caring for children or elderly family members, so their absence when seeking health care is keenly felt by other family members who have to take on extra work.

PHC workers who received training through HSDP2 remarked that taking a patient-focused approach helps them to understand the complete picture behind women’s reproductive health. Many community-based nurses also said that they were more confident now; they work more fully as PHC team members through home visits and are now brought into discussions of the general living conditions of particular patients. Training for community-based nurses increased their status and empowered them to become more active agents of change within the health system, by enabling them to address some of the broader and often nonmedical issues faced by women.

Institutional Changes

The patient-focused approach to health care delivery—which takes into account a range of gender and social factors that affect reproductive and general health—has been institutionalized in HSDP2 project areas. JFPR-funded NGO activities strengthened the adoption of a more patient-focused approach to health care and public health education by facilitating additional training and consultation with PHC workers that was much appreciated by all involved. This component improved understanding by health professionals of the different types of barriers women face when accessing health services, especially those associated with distance, registration of citizens, and other nonmedical factors. The NGO director implementing the JFPR grant at Ondorkhaan in Hentiy province has recommended the establishment of a task force with a group of agencies at the provincial center to work in a more coordinated manner to overcome barriers faced by the most vulnerable to accessing government services; this was to include social workers responsible for citizen registration from the Ministry of Social Welfare and Labor and PHC workers from the MOH. Although this was not implemented at the time of RGA-II, it points to the potential for consolidating and extending institutional changes that would benefit both patients and health workers.

Over 400 local government decision makers received training on the importance of women accessing improved MCH services and other public health messages including the impact of domestic violence on women’s health. Although there were no demonstrated changes in approaches by local government officials at the time of the RGA, there was increased awareness of the impact of domestic violence and the need to provide a secure environment for women to discuss these issues.

Contribution of Gender Equality Results to Overall Loan Outcomes

HSDP2’s goal was to improve the health status of the poor and vulnerable (primarily marginalized women) by improving the quality and utilization of rural health services. There was little project-wide sex-disaggregated data available on improvements in health status or access to health services; however where data were available—on attendance at antenatal clinics and pregnancy-related complications—it showed significant improvements in both areas.

Several HSDP2 GAP strategies contributed to improving the quality of health services and their capacity to respond to women’s needs, including the rehabilitation of health centers, training PHC workers and other medical professionals such as the community-based nurses, and improving the quality of IEC materials. Most important were the efforts to promote a patient-focused approach and the JFPR grant that allowed some of the barriers to the utilization of these improved services to be addressed. Although there was no HSDP2 reporting on the impact of subsidized travel
costs or closer collaboration between social workers and health professionals to overcome barriers to citizen registration, it is reasonable to conclude that these contributed to improved health-seeking behavior by at-risk pregnant women.

Challenges

Despite the achievement of important gender equality results from improvements in the quality of MCH services, there were several challenges and missed opportunities. These could have been addressed if HSDP2 had contracted a gender specialist to review the GAP and provide step-by-step guidance during project implementation. The GAP design could have been improved if it had been reviewed during project inception. The sustainability of gender equality results could have been secured if consideration had been given to intermediate steps and targets required to achieve all the anticipated benefits. A more detailed gender analysis during the design phase of a project can identify where such challenges to implementing a GAP might lie and point to where additional technical expertise is required to ensure its implementation. Given that the GAP was laid to one side during implementation, a loan covenant covering GAP implementation and monitoring would have increased the likelihood of GAP implementation. Similarly, the inclusion in the DMF of the benefits anticipated by the GAP would have encouraged sex-disaggregation of data and better monitoring of gender equality results.

The lack of regular collection, analysis, and reporting of sex-disaggregated data was a major challenge despite this being a requirement of the GAP. No sex-disaggregated data were reported on the use of health services; consequently, changes in the proportions of women and men using health services could not be verified, particularly concerning infectious disease control. Although contraceptive usage rates were reported to have increased and were above the national average in one HSDP2 province, it was unclear whether this increase related to men’s or women’s use. The need for technical support to ensure sex-disaggregation of all data could have been anticipated and a budget allocated for contracting a gender specialist.

The GAP also required that a strengthened monitoring system be established to assess the satisfaction of the poor and women with HSDP2 health services. Customer satisfaction rates were high at 79% in project sites compared to 52% in non-project sites, and 69% of patients surveyed were women (Second Health Sector Development Project 2008). This is a very positive result. However without sex-disaggregation of the survey responses it was not possible to assess whether the services met women’s specific needs, or to gain a deeper understanding of the different needs of women and men when accessing health services. Furthermore, it was unclear whether the patient satisfaction rates referred to MCH services or those associated with the control of infectious diseases, the other focus of the project. Sex-disaggregated patient survey data could have provided a comprehensive picture of the weaknesses and strengths of services from the perspectives of female and male patients. They also could have been fed into decision making regarding health planning and budgeting to improve service delivery. Gender specialist expertise could have improved the design of the patient satisfaction surveys by requiring sex-disaggregated data and considering whether different questions were needed to understand the needs of women and men regarding reproductive health and infectious disease control. It could also have contributed to analysis of differences in women’s and men’s responses.

Two issues identified as significant MCH challenges by health professionals during the RGA were the impacts of alcohol abuse and violence against women. No counseling or other training was provided to address the problem of alcohol abuse. Several informants noted that frontline medical professionals need more training in counseling women subjected to violence.¹¹ FGP and PHC centers do not have protocols in place for reporting suspected cases of violence against women to the police under the newly

¹¹ For example, one informant noted she did not know how to respond when it became clear that a teenage girl had been sexually abused by a relative, resulting in her pregnancy. It is generally extremely difficult to discuss such cases openly in Mongolia, as in most countries. The informant was concerned about what actions she could take to protect this patient in the future.
adopted domestic violence legislation and none of the health centers visited had a rape kit for the collection of evidence should a woman decide to proceed with criminal prosecution. More training addressing these kinds of issues would have assisted the MOH to promote enforcement of the new domestic violence legislation and provided health workers with the skills to help women address these very serious problems.

While a high proportion of women participated in project training activities because of the concentration of women employed in the health system, only 34% of those participating in health planning, budgeting, and management training activities were women. This gender imbalance reflects the low proportion of women holding decision-making positions in local government—for example only 9% of the district governors participating were women. No efforts were taken to ensure more women participated in these training sessions. The gender imbalance among participants from local government in health planning and management training also could have been anticipated and addressed if each component of the DMF had been monitored from a gender perspective. Strategies to address this challenge could have been identified if the GAP had been reviewed with targets for women’s participation set and monitored. Possible strategies for increasing women’s participation include establishing female health-service-user committees (which could have been mobilized by the JFPR partner NGOs) and inviting committee members to participate in the training, or identifying other women within the community to participate in training. It is important that health planners and managers are encouraged to understand the needs of poor women and address the constraints they face in accessing all health services. The inclusion of women in health planning and management training and the establishment of community-based health-user committees could have assisted with this and enhanced outreach efforts to poor and marginalized women.

One of the anticipated benefits from the GAP was an improvement in the working conditions of female health workers in rural areas. However, the gender analysis in the RRP did not consider major issues that affect female MOH staff and PHC workers. Some of the difficulties faced by women employed in the health sector in rural areas include long working hours (which create difficulties in balancing work and family responsibilities, especially given extra pressure on women’s work time with the new patient-focused approach to service delivery), relatively low pay, job insecurity due to the current rationalization of staffing within MOH, and women’s limited role in senior decision making within the MOH. Due to a lack of project reporting on the anticipated benefits set out in the GAP, it was not possible to track whether these concerns were addressed by the project.

Other challenges were raised during RGA interviews that could be considered by the HSDP2 team when assessing project impacts or planning a new phase of assistance. Some women patients had insufficient literacy skills to fully understand the UNICEF’s mother and child health tracking booklets, despite what are considered to be high functional literacy levels among women in Mongolia. For example, one woman noted she had to ask assistance from a neighbor to read the text of the booklet, although she found the charts tracking her infant’s weight and other health statistics easier to understand than the wordier public health messages. Health workers also noted that there were still considerable problems in reaching men and boys with IEC in order to increase their use of health services. Men’s reluctance to seek health care even in cases of serious illness is an important gender issue that needs to be addressed to more effectively control infectious diseases.

Sustainability

Strengthening the institutional capacity of the MOH to sustain improvements in the quality of health services was an important component of the project. Training effectively promoted a patient-focused approach and RGA interviews indicated that the benefits of this approach were appreciated by the health workers trained. It is reasonable to assume that, given adequate human resources, this approach will continue to be applied. However, community-based nurses and other health staff also noted the increased pressure on their time. The new approach requires longer consultations and more visits to patient homes and on-the-job learning. Furthermore, many community-based nurse positions are vacant, so existing nurses cover larger areas with higher numbers of patients. These factors have the potential to limit access to health services in
the future and to undermine the ongoing application of patient-focused approaches and the benefits that have been gained to date.

Support from local government decision makers will be essential if there is to be greater consolidation of social and health services to overcome the combination of constraints that poor women in remote areas face in accessing MCH services, as local government takes on greater responsibility for delivering services. Factors influencing the utilization of services by poor and vulnerable women in rural areas (such as transport costs and citizen registration) were brought into focus through the support from the JFPR grant, but it is unclear whether the need to address these factors was included in the health planning and management training provided to local government staff. Continued support will be needed for programs to overcome these constraints if MCH gains are to be sustained. The NGO in Hentiy implementing the JFPR grant suggested mechanisms for closer collaboration between social workers and health professionals, such as the formation of district and province subcommittees to discuss cases and consolidate welfare services available to at-risk pregnant women. If these ideas are taken up, benefits are more likely to be sustained and extended.

Factors Influencing the Achievement of Gender Equality Results

GAP strategies incorporated into the project design. The GAP lacked sufficient detail to be used as an implementation tool and most staff were unaware of it. Nevertheless, the GAP highlighted the ways that women could benefit from most project components, and identified project strategies to achieve these benefits that were fully integrated into the project design. This was a key factor contributing to the results that were achieved.

Gender analysis and capacity during implementation. Key HSDP2 staff were aware of both the social and the medical factors contributing to high maternal mortality in rural areas, due to project training. The JFPR grant provided opportunities to consult women regarding the constraints they face in accessing health services and encouraged health workers to take these factors into account in their efforts to promote health-seeking behavior. The JFPR grant enabled nonmedical issues to be raised in training for PHC workers, encouraged collaboration between social and PHC workers, and raised awareness of the significance of nonmedical factors among local government decision makers. JFPR activities contributed considerably to bringing a gender focus to HSDP2 by ensuring utilization of improved services, and highlighted the need to consider such factors in ongoing programming by MOH to sustain improvements in health outcomes across Mongolia.

Institutional and other factors. There was no gender specialist at the ADB resident mission to provide inputs to either the design or the implementation of this project. However, one resident mission staff member (the gender focal point) provided a gender perspective to the social analysis during design.

Recommendations

The current ADB resident mission gender specialist was included in the project team to review gender issues and develop a fully operational GAP for the next phase of HSDP. As the project is close to completion and a third phase of the project under preparation, the following recommendations are made to enhance the sustainability of project outcomes, and to share knowledge on effective strategies for achieving gender equality results:

(i) Sex-disaggregated data should be collected and analyzed to verify whether assumptions made at the start of HSDP2 regarding benefits to women have been realized. Additional analysis of HSDP2 patient satisfaction surveys should be considered to identify any concerns raised by women regarding the delivery of MCH services.

(ii) The HSDP2 project completion report and impact assessment should analyze the gender equality results achieved and how the JFPR grant contributed to these results.

(iii) Consideration should be given to how social and health care workers can collaborate more effectively to ensure that the most vulnerable citizens—such as at-risk pregnant women living...
in remote areas—can access the government services to which they are entitled. Institutional changes and budget allocations will be required to capitalize on the lessons from the JFPR grant project.

(iv) Representation of women patients on health planning committees should be encouraged. One option is to establish women’s community health planning committees or task forces with mobilization support from local NGOs and representation from health service providers. Opportunities should be provided for female committee members to be trained on health planning functions, how to solicit input from their community, how to organize consultation meetings, and how to develop evidence-based advocacy messages.

The following key lessons from HSDP2 should also be applied to the design and implementation of the next phase:

(i) Detailed gender analysis should be undertaken of medical and nonmedical factors influencing health service utilization and delivery. The gender analysis should be applied to all health services and not just those related to reproductive health, because women have health concerns beyond their childbearing functions. Gender analysis should also be used to anticipate where challenges in meeting gender-related targets might lie and what technical expertise would be required to address these challenges.

(ii) A detailed GAP with step-by-step guidance on how to achieve and monitor gender-related targets should be developed and reviewed during implementation. GAP targets should be included in the DMF to ensure regular monitoring, and implementation of the GAP should be included in the loan covenants.

(iii) The project budget should include provision for technical gender expertise to resolve challenges in meeting gender-related targets during implementation.

(iv) The capacity of the executing agency and other partners, such as local government decision makers, should be strengthened during implementation to ensure that gender equality results are sustained.

(v) Gender equality results, the achievement of gender-related targets, and the effectiveness of GAP strategies should be regularly reviewed and included in project reports, including the project impact assessment.
Technical Assistance in the Regional Road Development Project: Awareness and Prevention of HIV/AIDS and Human Trafficking

Project Description

Technical assistance (TA) for awareness and prevention of HIV/AIDS and human trafficking was one of five components of the Regional Road Development Project (RRDP) loan to construct a connecting road on the north–south corridor between Choijr and the People’s Republic of China (PRC) at Zamyn-Uud. The goal of the TA was to reduce the risks of HIV/AIDS and human trafficking associated with construction of the road and operation of the road corridor after project completion. The purposes of the TA were to (i) raise public awareness of HIV/AIDS and human trafficking; (ii) address the risk of HIV/AIDS transmission among construction workers, sex workers, local communities, truck drivers, and other road users; and (iii) strengthen border control capacity against human trafficking.

The objectives of the TA were to be achieved through five outputs:

(i) **Advocacy workshops.** Target groups included local governments and communities, owners of hotels and entertainment establishments, relevant nongovernment organizations (NGOs), transport operators, business communities, media, local police, road construction companies and contractors, the provincial branches of the Department of Roads along the road, and border and customs offices.

(ii) **Support for in-depth behavior change.** Intensive health education campaigns and peer education were to be undertaken to promote behavior change among construction workers, sex workers, and local people in the project area, with support from the National AIDS Foundation. Condoms were to be made available free of charge or at low prices during the first 2 years of construction of the road.

(iii) **Comprehensive medical package.** The TA was to supervise sexually transmitted infection (STI) treatments at construction camps, conduct training for health workers on STI management and voluntary counseling and testing (VCT) services, and provide STI drugs to cover excess needs that might arise during the period of road construction. HIV testing kits were to be provided to construction areas.

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12 The total cost of TA 4364 was $420,000 including $350,000 from ADB, approved in June 2004 as part of loan 2087 (ADB 2004). The road would complete the link between Mongolia, the PRC, and the Russian Federation.
(iv) Border control and cross-border cooperation to prevent HIV/AIDS and human trafficking. This included (a) training to strengthen the capacity of border officers regarding risks related to HIV/AIDS and human trafficking; (b) capacity building of national stakeholders; (c) workshops organized for participants from Mongolia and the PRC to discuss the possibility of establishing cross-border cooperation mechanisms and exchange information on HIV/AIDS and human trafficking; and (d) basic equipment provided to help border offices identify and register human trafficking suspects.

(v) Benefit monitoring and evaluation system in construction areas. This was to strengthen the existing surveillance systems and provide data for performance monitoring including on sexual and treatment-seeking behavior and STIs.

The executing agency was the Ministry of Health (MOH) in coordination with the Department of Roads (which was the executing agency for the RRDP). The implementing agency for the TA was the project implementation unit for the ADB-assisted HSDP2. The TA was the first of its kind in Mongolia, integrating HIV/AIDS mitigation and anti-trafficking efforts, and local governments demonstrated strong commitment and support for TA activities. The TA was not completed at the time of the RGA due to delays in road construction and had been extended to October 2009, with 47% of allocated funds disbursed (ADB 2009b).

Gender Analysis and Provisions in the Technical Assistance Design

The RRDP RRP noted that women are disproportionately vulnerable to poverty and exposure to HIV/AIDS and human trafficking risks. No gender analysis was presented in the TA component of the RRP and no gender provisions with associated targets or strategies were incorporated into the TA during the design phase. The DMF for the RRDP included targets and indicators on HIV/AIDS and trafficking prevention, but these did not include any gender-related provisions. Loan covenants supported implementation of the TA by requiring the government to disseminate information on HIV/AIDS and human trafficking. There was also a separate covenant relating to labor and contracting that required women and other vulnerable groups to participate in the design and implementation of the road project. The terms of reference for the TA team, including health and trafficking prevention specialists, did not require gender expertise. 13

Gender Mainstreaming during Implementation

During project inception, a situation analysis was prepared to guide the development of human trafficking aspects of the TA work plan (ADB 2006c). The situation analysis identified a range of male and female vulnerable groups and facilitated consideration of the different approaches that would be needed to ensure that benefits reached all these groups. Thus gender concerns were mainstreamed into the situation analysis, and consideration was given to gender aspects for all TA work plan components. Care was taken to ensure a gender balance in training activities and in the recruitment of peer educators. Hard-to-reach stakeholders—for example, both men and women from highly mobile families, and unemployed youth—were consulted as activities were planned, to ensure their participation.

As implementation was under way, the TA team gained a deeper understanding of the situation on the ground regarding high-risk behavior leading to vulnerability to HIV/AIDS and human trafficking. The project coordinator participated in donor coordination meetings in Ulaanbaatar and collaborated in other activities associated with HIV and human trafficking prevention that took a gender-responsive approach, offering an excellent learning opportunity for the

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13 The RRDP included some gender design provisions, such as assurances regarding pay equity and equal opportunities for female construction workers (ADB 2004). These were not assessed during RGA-II.
TA team. The TA team also showed leadership in reaching the most vulnerable groups by encouraging all partners to ensure that all those identified in the situation analysis could become involved in activities. For example, police involved in human trafficking training realized during implementation that private van drivers taking paying customers (a recent phenomenon in Mongolia) were bartering sexual services from poor women trying to visit family members in a nearby prison. The police sought out the drivers as an additional target group and ensured they received awareness messages and IEC materials. Also, peer educators had difficulties contacting out-of-school youth from poor families, particularly boys, who are likely to drop out of school to return to a highly mobile life tending family herds. These male youths therefore cannot be reached through employment, school, or vocational training centers. Peer educators identified where these youths might spend time while at the provincial center for other business, or discussed with relatives how to contact a particular youth. More was also learned about poor women engaging in casual or transactional sexual relationships with mine workers and construction laborers and special efforts were made to reach this vulnerable group.14

Leading gender-focused NGOs from Ulaanbaatar were contracted to develop IEC and training materials and consequently key gender issues were incorporated. Similarly, staff at the National Center for Health Development, which assisted in IEC material development and peer educator training, were aware of key gender issues concerning HIV/AIDS and human trafficking and integrated these perspectives into their work for the TA.

Gender Equality Results

Table 3 summarizes the gender equality results achieved for each output of the TA. An analysis of achievements, challenges, and the potential for sustainability follows. No sex-disaggregated data were available for most of the activities undertaken. Such data might have covered participants involved in consultations on the TA, stakeholders who participated in the development of IEC and behavior change communication (BCC) materials, the recipients of IEC/BCC materials, training of stakeholders, or the beneficiaries who used VCT clinics and other reproductive health and counseling services.

Table 3 Summary of Gender Equality Results from the Technical Assistance on Awareness and Prevention of HIV/AIDS and Human Trafficking

<table>
<thead>
<tr>
<th>Technical Assistance Outputs</th>
<th>Gender Equality Results</th>
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<tbody>
<tr>
<td><strong>Technical Assistance goal:</strong> Reduce the risks of HIV/AIDS and human trafficking associated with the construction and operation of the north–south road corridor</td>
<td>Men and women from vulnerable groups, health staff, and key stakeholders in government and the private sector have increased awareness of the risks of HIV/AIDS and human trafficking and have taken effective steps to reduce these risks.</td>
</tr>
<tr>
<td><strong>1. Advocacy</strong></td>
<td><strong>•</strong> Comprehensive awareness outreach to a wide range of male and female vulnerable groups including mobile women engaging in transactional sex, miners, van drivers, contracted laborers, school-age boys and girls, male and female vocational students living in dormitories, and unemployed youth.</td>
</tr>
<tr>
<td><strong>•</strong> Information sheets on HIV/AIDS and human trafficking</td>
<td><strong>•</strong> Greater awareness among private resource companies and contractors regarding HIV/AIDS and human trafficking.</td>
</tr>
<tr>
<td><strong>•</strong> Advocacy meetings in provinces involving local government, media, business communities, contractors, and transport companies</td>
<td><strong>•</strong> Recognition by province governor and project team of the importance of addressing social and economic impacts of the road development on the community.</td>
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14 Transactional sexual relationships involve the giving of gifts or services in return for sex. Unlike prostitution, transactional sex provides only a portion of the income of the person providing sex.
### Technical Assistance Outputs

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<tr>
<th>2. In-depth behavior change support</th>
<th>Gender Equality Results</th>
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<tr>
<td>• IEC materials on safe migration, STIs, and HIV/AIDS—posters, leaflets, information boards, and CD/VCDs—disseminated to construction sites, restaurants, bars, hotels, and public areas</td>
<td>• Increased knowledge by vulnerable groups of medical consequences of high-risk behavior and where to obtain related health services.</td>
</tr>
<tr>
<td>• Peer educators trained annually: 60 construction workers, 10 drivers, 5 CSWs, 60 local youth at risk, and 30 trainers among teachers and school social workers</td>
<td>• 1,005 peer educators trained including 583 (58%) female and 422 (42%) male.</td>
</tr>
<tr>
<td>• 25% of target workers, 10% of CSWs, and 5% of local population, school teachers, and social workers contacted by peer educators each year</td>
<td>• School-age peer educators (female and male) reported increased self-confidence and motivation for community action to combat the potential negative social impacts of road development.</td>
</tr>
<tr>
<td>• Increased use of condoms by 20% among the populations at risk by the end of the project</td>
<td>• Highly vulnerable groups identified who were previously marginalized from government services, such as poor and mobile women engaging in casual sex with transient workers.</td>
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<tr>
<th>3. Comprehensive medical package and VCT</th>
<th>Gender Equality Results</th>
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</thead>
<tbody>
<tr>
<td>• 20 health workers trained in STI management and HIV VCT</td>
<td>• Increased access to STI diagnosis and care under confidential conditions.</td>
</tr>
<tr>
<td>• 500 people reached by mobile STI/VCT team</td>
<td>• Counseling available on reproductive health issues, improving health-seeking behavior of women and particularly men who are reluctant to attend clinics.</td>
</tr>
<tr>
<td>• STI diagnostic kits and treatment provided to clinics and medical centers; all clinics along the road use guideline to prevent accidental HIV transmission</td>
<td>• Health professionals trained in techniques to avoid accidental HIV transmission.</td>
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<tr>
<th>4. Police and cross-border cooperation</th>
<th>Gender Equality Results</th>
</tr>
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<tbody>
<tr>
<td>• Curriculum and training for 30 police</td>
<td>• Police and border control officers have increased awareness of human trafficking risks and strengthened ability to identify vulnerable populations, such as poor and mobile women.</td>
</tr>
<tr>
<td>• Curriculum and training for 30 border control officers</td>
<td>• Police have increased understanding of the links between trafficking and other forms of VAW; potential to reduce discrimination against survivors of human trafficking and VAW.</td>
</tr>
<tr>
<td>• Initial meeting to increase cooperation with the People’s Republic of China regarding human trafficking</td>
<td>• Safe area set up in one project provincial police office for VAW and human trafficking survivors.</td>
</tr>
<tr>
<td>• Equipment provided for border officials; border officials demonstrate ability to operate new computerized system to identify missing persons</td>
<td>• Police officers at the border more cooperative in rescuing stranded Mongolian CSWs from the People’s Republic of China.</td>
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<tr>
<th>5. Monitoring and evaluation system</th>
<th>Gender Equality Results</th>
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<tr>
<td>• Data for monitoring indicators sent quarterly to TA office in Ulaanbaatar</td>
<td>• Sex-disaggregated data not reported or available for most outputs and activities.</td>
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</tbody>
</table>

CD/VCDs = audio and video compact discs; CSW = commercial sex worker; IEC = information, education, and communication; MOH = Ministry of Health; STI = sexually transmitted infection; VAW = violence against women; VCT = voluntary counseling and testing.

Participation, Access to Project Resources, and Practical Benefits

There was increased awareness among the males and females targeted for IEC materials and training of high-risk behaviors that increase vulnerability to HIV/AIDS infection and human trafficking. BCC and IEC materials were designed to be readily accessible to the young and less literate. Awareness messages were printed on playing cards, notebooks, and other attractive and useful objects that should remain in the possession of the target groups for some time. A broad range of stakeholders were involved in the development of these materials, including leading NGOs that promote women’s rights and combat violence against women and human trafficking. BCC and IEC materials were widely distributed to all target groups, and special efforts were made to contact groups that are more difficult to reach, such as out-of-school male youth (school dropout rates are much higher for boys than for girls) and “ninja” miners.

Another hard-to-reach target group was the poor, mobile women who engage in occasional casual sex with transient workers, such as truck drivers and those at mining or construction camps. The TA staff stressed that these women are not commercial sex workers as they do not necessarily obtain money from these encounters. These women were noted as being “very shy” and peer educators and other project implementers found it very hard to discuss their high-risk behavior directly. Very little seems to be known about this target group, who come from poor herder families with limited education, few prospects for employment, and often very limited exposure to the outside world. They succumb to the temptations of food, alcohol, and a warm place to spend a few hours, with no understanding of the consequences of high-risk sexual behavior. The TA identified these marginalized women as a target group for reproductive health services and support, and developed IEC and BCC materials that might appeal to them directly. The staff at health clinics and social workers now can build on this initial experience to develop further outreach. Health staff noted that these women are generally not registered with local government, but as a result of the TA are now more willing to come to the provincial center for health services.

Most social workers and health professionals in Mongolia are female, so a challenge for the TA was to involve a good balance of men as peer educators. Recruiting 58% females and 42% males among trained peer educators was a success. Efforts such as a request to the secondary school in Choyr for gender balance among those students selected to be involved in the program contributed to this success.

Both male and female students were able to explain the importance of reaching out to a comprehensive group of peers that included out-of-school children, vocational students living in dormitories, and poor herder communities in the area around the provincial center. Some recounted that when they casually encounter peers not attending school, they find ways to discuss high-risk behavior that might lead to STIs and the dangers of human trafficking. IEC materials were revised by students to ensure they were accessible to their peers. Both male and female students reported that training increased their self-confidence. They were motivated to continue community action to combat the negative social impacts of road development. For example, they spoke of wanting to prepare additional video compact disc materials using their own ideas to reach more youth in the community.

An important component in building awareness of HIV/AIDS is the provision of appropriate follow-up testing, counseling, and health services for all STIs to both men and women at risk. The TA provided training for local health workers along the road corridor in VCT, and mobile clinics were provided to construction and mining sites. These services are a particularly important practical benefit as one project province has the highest incidence of STIs in the country.

Another practical benefit was the supply of condoms available for purchase by target groups and in high-risk target communities. Men in Mongolia

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15 Evidence for this increased awareness is drawn from TA progress reports and interviews conducted by the RGA-II team.

16 “Ninja” miners operate unauthorized mines or pan dirt for gold. Their permanent residence is unknown. They are so named because of the green bowls they use for panning; when carried on their backs, these supposedly resemble the shells of the Teenage Mutant Ninja Turtles cartoon characters.
are hard to reach with public health messages. Peer education efforts helped to increase understanding of male as well as female reproductive health issues along the road corridor. Outreach to construction laborers was effective; they now visit VCT clinics for STI testing. At Choyr, VCT clinic staff noted that some of the women having casual sex at a Chinese mining camp came for testing because they “saw the sign board” and were experiencing STI symptoms. Staff at the VCT clinic noted these women would not otherwise have sought testing.

A comprehensive range of stakeholders were involved in planning the police and cross-border activities of the TA, including NGOs that promote women’s rights and address violence against women. Training in the provinces included police as well as government prosecution officers and lawyers, ensuring that all those who might be involved in preparing a human trafficking case received information on current laws and the benefits of a woman-centered approach to case preparation and court proceedings. Those who attended the training reported that their attitudes to survivors of trafficking had changed. Previously, they had tended to blame the victims and they had not understood the impact of these crimes on survivors.

Progress toward Strategic Changes in Gender Relations

Through advocacy, awareness-raising activities, and supplying condoms along the road corridor, men were encouraged to attend VCT clinics offering services for STIs and HIV/AIDS testing and counseling. Poor health-seeking behavior among men has been identified as a stumbling block to improving women’s reproductive health in Mongolia. Although most women are tested when attending antenatal clinics, it has been challenging to encourage their partners to attend for STI testing. Discussions with both women and men on the links between high-risk sexual behavior and STIs have the potential to improve women’s reproductive health over the longer term.

Progress toward Institutional Changes

There were several signs that the TA could contribute to institutional changes, particularly if the approaches taken are consolidated by local decision makers and reinforced in future ADB-funded projects. For example, key stakeholders and community leaders in local government in Govisumber province indicated that they now recognize the significant social as well as economic impacts of the new road. It is estimated traffic will increase from 100 vehicles per day to between 3,000 and 5,000 vehicles per day, bringing new and transient people to communities, challenging existing social norms, and changing behavior, in addition to economic benefits that may come. The TA encouraged local decision makers to consider a range of concerns affecting women as well as men as the road corridor is developed.

Community leaders and staff from the Department of Roads are now more aware of vulnerable populations and the high-risk behavior associated with exposure to HIV/AIDS and human trafficking. During RGA interviews with local government staff, they identified different social groups, the various types of risks they face, and how their concerns might be met as the impact of the new road takes effect. They also identified other issues to consider, such as skills training for male youth. They recognized that the provinces will have to address these kinds of issues systematically in the future, during the rapid social and economic change that will follow road construction. As one local governor noted, financial and human resources will have to be identified to address the needs of all community members in these changing social and economic circumstances. This type of social and gender analysis is an important change that has been promoted and reinforced by the consultative approach taken by the TA.

One very important result is that the TA broadened the range of stakeholders involved in protecting a woman’s right to live free from violence. For example, police officers who attended the training on human trafficking have increased understanding of the links between trafficking and other forms of violence against women, such as domestic violence, and some police and border officers appear to be changing their behavior toward commercial sex workers (Box 2).

Increased awareness of human trafficking risks and the ability to identify vulnerable populations has the potential to reduce the marginalization of these groups, particularly poor, mobile, unemployed
women who have very little contact with government or law enforcement officers. Police officers at the border were reported as being more cooperative and proactive in rescuing stranded Mongolian commercial sex workers from the Chinese side of the border. For example, one Mongolian police officer was reported to frequently travel to the brothels on the Chinese side to assist Mongolian women who are facing exploitation or violence and want to return home. There was optimism among the TA team and partner NGOs that the attitude of border officers toward stranded Mongolian commercial sex workers is improving.

The changes above point to the potential to reduce blame and discrimination against survivors of human trafficking and other forms of violence against women. Women are frequently blamed for causing domestic violence in Mongolia and there are few protocols in place to guide police officers developing cases against perpetrators. The links between alcohol abuse and increases in domestic violence are well known in these communities, and the police have been trained on the new Domestic Violence Law, but the situation on the ground has yet to change. The TA has increased police knowledge of how to deal with these cases.

**Box 2 Attitude Change among Police Officers in Choyr**

A police officer who received training regarding human trafficking in Choyr noted that one of his colleagues had also attended training in Ulaanbaatar regarding the new Domestic Violence Law. When they were arranging new office space, they decided to set aside one room in which to interview women more privately regarding complaints about gender-based violence, including human trafficking, to help them build a trusting relationship with survivors as they explore the evidence presented. Their view of the women has changed: “We now realize that women are not at fault in these cases, but are rather the victim.” These police officers also noted they are more likely to encounter women reporting domestic violence than human trafficking. They took ideas from both training sessions for actions to take in their own offices. The change in their attitude toward women survivors of violence has the potential to increase attention and effort by law enforcement officers to reduce these serious crimes.

Source: Interviews with beneficiaries conducted during fieldwork.

Contribution of Gender Equality Results to Overall Project Outcomes

This TA identified the groups most vulnerable to negative impacts from the road construction, focusing on HIV/AIDS and human trafficking; it then aimed to change high-risk behavior among these groups, provided appropriate comprehensive medical services during construction, and built the capacity of law enforcement agencies to address human trafficking. The TA was effective at achieving its aims because a gender mainstreaming approach was taken during project implementation that gave careful consideration to the different vulnerabilities of women, men, girls, and boys. Much work in the past concerning HIV/AIDS has failed to take measures to ensure that gender-based differences in high-risk behavior are taken into account. Similarly, indirect impacts of high-risk behaviors on sexual partners have not been well understood or addressed among hard-to-reach groups, such as poor women. In contrast, this TA ensured that some of the key causes of vulnerability among men and women were better understood. Consequently, special materials and approaches were adopted to ensure effective outreach to the different male and female groups at risk.

One aim of the RRDP was to promote sustainable economic growth. The TA was of limited scope in the context of the whole loan. Nevertheless, the TA and its results contributed to minimizing the potential negative impacts of the road on the most vulnerable groups. Although the focus of the TA was on HIV/AIDS and human trafficking, key project staff noted how useful the TA was in identifying social impact issues that would otherwise have remained hidden. This has resulted in a broader recognition of nonengineering issues among project staff and local government decision makers, and a commitment among project staff to encourage a similar approach when developing economic activities along the corridor. By encouraging a collaborative approach among various stakeholders...
and considering broader social and gender impacts, the TA increased the potential for decision makers to prioritize sustainable growth along the road corridor following project completion.

Challenges

No sex-disaggregated baseline data were collected during design or implementation. Although the situation analysis provided a comprehensive assessment of male and female vulnerable groups, without the collection and analysis of sex-disaggregated data it was not possible to validate the effectiveness of TA activities, such as the targeting of IEC materials for specific groups, training, or awareness raising. At the time of the RGA, sex-disaggregated data on the use of VCT clinics and other medical and counseling services were not available, despite the fact that this information is included in patient records. Collection and analysis of sex-disaggregated data in quarterly reports would have enhanced the analysis of results and enabled strategies to be refined. For example, during the RGA-II interviews, project partners noted that male student-peer educators were more interested in human trafficking aspects of TA activities, whereas female students were more interested in HIV/AIDS issues. Analysis of this kind of information could add to knowledge regarding the types of IEC and BCC materials appropriate for different students. Similarly, tracking the sex of those attending VCT clinics could have indicated where to focus future public health education activities regarding STIs. Contracting gender specialist expertise could have helped identify these challenges during implementation and analyze sex-disaggregated data.

To optimize learning from the TA, an assessment of gender differences in all these areas would be useful at project completion. It is not clear whether the final TA or RRDP completion reports will include or analyze sex-disaggregated data. In addition to providing more detailed information on gender equality results, this would supply important information that local decision makers, including provincial staff, could use to respond to any gender-based differences in the follow-up to the project.

Power relations between men and women—which have a significant impact on women’s and girls’ vulnerability to HIV/AIDS and human trafficking—were not explicitly examined in the situation analysis for the TA, nor addressed during implementation. It is not expected that a TA of this size and scope can promote significant changes in gender relations. Nevertheless, overlooking the complex interplay between gender-based discrimination, violence against women, poverty, and vulnerability to HIV/AIDS and trafficking was a missed opportunity to address the root causes of these vulnerabilities, promote gender equality, and increase the effectiveness of TA activities, particularly among male and female youth. Consequently, the low status of women and their inability to influence male decision making was not acknowledged or addressed. Women have difficulty negotiating safe sex, especially during casual or commercial encounters. The extremely limited options for poor and marginalized women from nomadic families mean they resort to high-risk sexual behavior to meet very immediate needs. Women’s low status, especially when they step outside social norms as commercial sex workers, means they receive very little protection from police or border officials. Given the openness of local decision makers to considering the social and gender impacts of development during implementation of the TA, a focus on gender relations could have assisted with reducing discrimination against commercial sex workers and trafficking victims, and promoted a broader consideration of factors needed to ensure equitable development for both women and men impacted by the road corridor. Contracting gender specialist expertise could have assisted with addressing these issues.

Due to delays in the construction of the road corridor, TA activities were completed even though construction labor had not yet arrived in the northern section of Govisumber province. The TA worked with construction laborers further south along the corridor as construction took place, and the principles of how to approach these activities have been brought to the Govisumber province decision makers in health, social work, and law enforcement. It is to be hoped that the training and availability of appropriate health services will be sustained through the construction period as the final section of road is completed.

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17 See, for example, ADB 2003c and Rothschild, C., M.A. Reilly, and S.A. Nordstrom 2006.
Sustainability

One factor likely to contribute to sustainability of results was the involvement of a wide range of stakeholders within local government on TA implementation committees and task forces and the involvement of senior decision makers in national HIV/AIDS coordination committees. This engendered strong local commitment and support for the TA activities. As noted above, good progress was made toward institutional changes among local government and community leaders, project staff from the Department of Roads, police, and border officials. Nevertheless, in all cases, further inputs will be needed to consolidate and sustain these results.

The TA demonstrated the benefits of social and gender analysis to improve understanding of both the social and economic impacts of development. Provincial governors noted during RGA-II interviews that the TA helped them understand the needs of different at-risk groups within their community. In Mongolia, most decision makers have not been required to carry out such analysis and many do not have the necessary skills. Involvement in this TA may encourage officials to continue to take a wider view of the potential social and economic impacts of development activities, such as road construction. However, for this to become institutionalized, additional measures will be needed, such as capacity building for local officials in how to carry out social and gender impact assessments, and how government services may best be used to mitigate potential negative impacts.

Project staff from the Department of Roads noted that they better understood the need to take non-engineering factors into account in road development. It is not clear, however, whether links with health and social service agencies have been established to support this kind of impact assessment on a regular basis by the Department of Roads. The TA has also brought new insights to the civil society organizations working regularly on HIV/AIDS and human trafficking issues regarding the impact of large infrastructure projects on social and economic vulnerabilities. However, it is unclear whether these organizations will be able to sustain links with the Department of Roads to continue combating HIV/AIDS and human trafficking along the north–south road and other transport corridors.

Police and border officials will require continued support to consolidate attitudinal and institutional changes toward commercial sex workers and survivors of domestic violence and trafficking. The initiative of the police officers in Choyr to create a safe room where survivors can be interviewed is a good example of a practical and concrete action that could contribute to more effective implementation of the human trafficking provisions in the criminal code and the new Domestic Violence Law. Sustainability of institutional changes would be enhanced if this example were shared more widely as a case study, and if the police officers trained through the TA were equipped and supported to provide awareness training outside the road corridor or in other areas where there are transport infrastructure projects. The incidence of violence against women is growing and a national network on domestic violence has been established, involving local women’s groups. There is a women’s shelter close to Choyr, and links between this organization and the police in Govisumber province could also help to sustain progress made to date.

ADB reports indicate that cooperation with government officials of the People’s Republic of China (PRC) was disappointing (ADB 2009b). Nevertheless TA activities have started to raise cross-border concerns beyond trade and other economic issues. Experience in other countries has demonstrated that it can take some time for national governments to address the concerns of commercial sex workers and other highly vulnerable citizens living outside their borders. The status of these vulnerable groups is very low and shaped by stereotypes about women who step outside the norms of behavior, intensifying their marginalization. It is challenging in all countries to promote and protect the individual human rights of commercial sex workers and other transients; this TA has raised awareness of their needs in both Mongolia and the northern PRC.

Police interviewed during the RGA noted that over 600 female students from Ulaanbaatar travel to the Chinese border area to earn income as commercial sex workers during their summer break, increasing the number of commercial sex workers there to about 1,000. This is because there are very few other temporary employment opportunities in Mongolia for these young women and they need to finance their education.
IEC materials on HIV/AIDS and STIs developed by the TA will be used in the next ADB-supported road project, the Western Regional Road Corridor Development Project–Phase I, approved in 2008. While this is positive, overall the new project design downgrades attention to mitigating the potential negative impacts associated with road construction, compared with the TA for the north–south RRDP. There is no separate TA for the new western corridor project; the IEC materials will be distributed only to construction workers (rather than to a range of vulnerable groups in the community or truck drivers); there is no separate budget allocation to raise awareness more broadly among key stakeholders such as police, border officials, and local government decision makers of the potential negative social impacts of the road corridor; and there is no component focused on human trafficking despite the fact that the western corridor will complete a key transport link between Mongolia, the PRC, and the Russian Federation (ADB 2008c). The new project has no design features to ensure a participatory and consultative approach to identifying vulnerable groups. This is a missed opportunity to reinforce the learning and consolidate the results from the TA, which was a first initiative with the Department of Roads to consider broader social impacts of road construction.

Factors Influencing the Achievement of Gender Equality Results

Gender mainstreaming during implementation. Even though the TA design lacked gender provisions, important results were achieved for at-risk men and women. This was due to the gender-inclusive approach taken during inception in the situation analysis, which identified male and female vulnerable groups and carefully considered activities to ensure that benefits reached both. This gender mainstreaming approach was continued throughout implementation with special efforts made to reach poor women engaged in high-risk transactional sexual relations with transient laborers and out-of-school male youth. Consequently, government officials and decision makers are now aware of the different kinds of vulnerabilities of these groups and the special efforts needed to reach them.

Gender capacity building and access to gender expertise during implementation. The TA project coordinator participated in national networks of development partners and government agencies involved in HIV/AIDS and human trafficking activities. This provided exposure to technical gender expertise, and provided opportunities for on-the-job learning and capacity building on gender mainstreaming within the MOH TA team. It was also a forum in which to discuss challenges in the work of the TA team. The project team partnered with leading women-focused NGOs and the National Center for Health Development. These organizations have solid experience with addressing gender considerations in their work and they complemented the experience of the international consultant, who had previous experience in the region and shared gender-sensitive approaches implemented elsewhere.

Leadership within the TA team. The TA team and the project coordinator demonstrated leadership by encouraging partners and local officials to seek out at-risk groups within their communities and to ensure their needs were better understood and addressed. Most of these groups have low status within communities and require special consideration when planning appropriate activities if they are to participate, factors the project coordinator stressed in her work with TA partners.

Institutional factors including collaboration with key stakeholders. The TA team sought out a broad range of government officials and representatives as stakeholders, including the police, prosecutors, health and social workers, education officials, and provincial governors. Engaging the governors from all provinces in national committees associated with countering HIV/AIDS gave additional prestige to the TA work. This collaborative approach was effective in securing support and a major contributing factor to the institutional results achieved.

Recommendations

The TA identified vulnerable groups within communities including poor women, the unemployed, and out-of-school male youth. These groups had little prospect of benefiting from economic growth and were most likely to be affected by negative social changes due to
increased commercial and human traffic through previously isolated communities. Local governors and senior staff from the RRDP noted that without the TA, these vulnerable groups would not have been identified and their needs would not have been met. The TA achieved significant results and yielded good returns on investment, given its small scale. Considering that the TA was the first in Mongolia to combine HIV/AIDS and human trafficking awareness, the following recommendations are made to share knowledge on effective mitigation strategies, and to increase the likelihood that positive institutional changes will be sustained:

(i) **Sex-disaggregated data and gender equality results for all TA outputs and activities should be included in the TA project completion report and the completion report for the RRDP to ensure that lessons are learned on the positive impacts of the TA and the effectiveness of strategies used to achieve those results. Consideration should be given to documenting the good practices drawn from this TA in a case study.**

(ii) **Consideration should be given at project completion and during impact assessment to follow-up activities needed to sustain the institutional results achieved with all stakeholders.**

(iii) **Further consideration should be given on to how to institutionalize within the police service gender-responsive approaches to addressing human trafficking and violence against women, and applying these approaches more broadly along the road corridor.**

(iv) **ADB road and transport infrastructure projects should include a comprehensive social and gender impact assessment at the design stage to identify male and female vulnerable groups, and gender provisions to address the risks associated with both HIV/AIDS and human trafficking. Sex-disaggregated social and gender impact data should be collected and analyzed during design and implementation.**

(v) **Lessons from the TA regarding the positive contribution of gender mainstreaming during implementation, collaboration with local stakeholders, gender capacity building, and targeting a broad range of vulnerable groups should be applied to upcoming regional corridor projects, including the implementation of the Mongolia Western Regional Road Corridor Development Project–Phase I. Given that a TA was not included in the design of this project, core project funds should be used to ensure that a comprehensive and consultative approach is taken to raising awareness of and preventing the spread of HIV/AIDS and human trafficking during and following road construction.**
Social Security Sector Development Program

Project Description

The objective of the Social Security Sector Development Program (SSSDP) was to reduce poverty among the most vulnerable groups of society by strengthening the social security system and its ability to deliver essential welfare insurance and employment services to the ultra poor, the very poor, and those close to the poverty line. The SSSDP included a program loan and an investment project loan with the following components:

Policy Reform

The SSSDP supported the development of comprehensive poverty reduction policies that focus on employment promotion and the provision of essential social welfare and insurance services to the most vulnerable, who are unable to work. The program loan supported:

(i) improving the quality and coverage of social welfare services and benefits,
(ii) developing pro-poor labor market policies,
(iii) strengthening participation in social insurance (unemployment and occupational injury and disease insurance), and
(iv) developing a social security master plan.

Investment Project

The investment project had four components with the following outputs:

(i) Social welfare. This aimed to achieve qualitative and quantitative improvements in social welfare services for up to 230,000 people, of whom 70% are poor, by (a) developing and upgrading social welfare service facilities including nursing homes, the National Center for the Rehabilitation of the Disabled (NCRD), and three pilot social security centers with improved services; (b) improving community-based social welfare services; and (c) strengthening social welfare management, for example by establishing a new management information system (MIS).

(ii) Employment promotion. This aimed to achieve qualitative and quantitative improvements in employment services for up to 143,000 people, of whom 43% are poor, through (a) skills training for the unemployed and poor, (b) entrepreneurship development programs for the unemployed and poor, and (c) capacity building for employment services and improvement of working conditions.

(iii) Social insurance. This aimed to achieve qualitative and quantitative improvements in social

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19 ADB 2001. SSSDP is supported by loan 1836/1837, comprised of an $8 million program loan and a $4 million investment loan, approved by ADB on August 28, 2001, with a revised loan closing date of June 30, 2009.
insurance services for up to 330,000 people through (a) strengthening social insurance management capacity and (b) training social insurance inspectors.

(iv) **Support for project management.** This aimed to establish an effective project management unit.

The executing agency for the program loan was the Ministry of Finance and the executing agency for the investment loan was the Ministry of Social Welfare and Labor (MSWL). The Ministry of Education, Culture, and Science was the implementing agency for two of the employment subcomponents, skills training for the unemployed and entrepreneurship development.

At the time of RGA-II fieldwork in September 2008, overall progress on both the program and project investment loans was assessed as satisfactory by ADB with the project loan due to be completed by June 2009. The development of Mongolia’s social security sector strategy was the major outcome from the program loan. For the project loan, several nursing homes had been rehabilitated and equipped and training had been provided to nursing home staff. Two pilot social security centers had been built and equipped with 48 employees trained, and training had been provided to 621 social workers in five provinces and six districts. Employment promotion services had been improved with 71 training centers equipped and several buildings upgraded, and training provided to senior officials and teachers at employment education centers. A social welfare MIS had been set up. A campaign had been undertaken through a range of media to raise awareness of social security sector reforms and to encourage herders and informal sector workers to subscribe to social insurance (ADB 2009c).

**Gender Analysis and Provisions in the Loan Design**

The RRP included a brief overview of some gender issues and differences relevant to the loan design. It acknowledged that women’s economic and social independence was undermined during the transition from a planned economy, with women having less job security and access to information and credit than men and higher unemployment rates. More women than men with disabilities were living in poverty, and households with female heads and single pensioners (who tend to be women due to differences in life expectancy) were identified as being particularly vulnerable to poverty. It was noted that women were more likely to be forced into early retirement than men, particularly those with four or more children, and that women’s choice of jobs was limited. Reductions in health and social services due to the transition resulted in women having to spend more time caring for the young, sick, and elderly. Finally, it was acknowledged that attention would need to be paid to women’s unique problems and life patterns—the competing demands from their household responsibilities, longer lives, and less stable earning patterns—when reforming social welfare services, benefits, and social insurance (ADB 2001, 4–5, 54).

Although the RRP identified some gender differences that increase women’s vulnerability to poverty and the need to tailor social security reforms to meet women’s particular needs, no GAP or gender provisions were included in the design of either the program or investment loan to address potential gender differences in impacts. There was discussion of the need to improve the targeting of social services to those most in need, but no elaboration of how different project components would reach the poorest or most marginalized, who are often women. There were no gender-related targets or indicators in the DMF, and no requirement to collect sex-disaggregated data or report on gender differences in outputs. Nor was any provision made for gender expertise to provide guidance on how to address the gender issues identified in the RRP.

**Attention to Gender Equality in Implementation**

Interviews with project team members highlighted that with no gender provisions in the project design

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20 Population Reference Bureau 2006 and data provided by the Mongolia Resident Mission’s gender specialist indicate that women lived on average 4 years longer than men in 1992, 5.68 years in 2002, and 7.1 years in 2007.
and thus no expectations to take gender issues into account, no consideration was given to addressing gender issues during implementation and reporting. It was assumed that improved targeting of social services would ensure that women and men would have better access to the social safety nets each required, without building in special measures to ensure these outcomes. No sex-disaggregated data were collected or available for the RGA-II team to review; consequently it was not possible to identify gender equality results.

Entry Points for Integrating Gender Dimensions and Addressing Gender Inequalities

In the absence of demonstrated gender equality results, this section provides additional gender analysis and outlines possible entry points for addressing significant gender issues in each loan component. These could have been considered in the development of a GAP during design or implementation. Table 4 summarizes these entry points.

Policy Reforms

ADB reports identified progress on the implementation of key policy reforms as satisfactory, although project team members and other informants interviewed during the RGA indicated that gender considerations had not been taken into account. A social security strategy paper prepared in 2003 was the major product of the program loan; although the strategy was not formally adopted by the Government of Mongolia, it guided the delivery of social security services over the duration of the project. The strategy confirms the government’s commitment to mainstream gender issues in poverty reduction efforts and undertakes to design all employment promotion programs in a gender-sensitive manner, although it does not identify any interventions to achieve these aims. It also commits to gradually equalize the retirement age for men and women by increasing women’s retirement age from 55 to 60 by 2010. However, there was no analysis of gender differences or issues in the strategy, no information on women’s and men’s particular vulnerabilities and needs for social security services, and no consideration of potential gender-differentiated impacts of proposed policy reforms. The commitment to equalize the retirement age has not been implemented to date (Government of Mongolia 2003, 5, 23, 35).

Several gender issues could have been considered. For example, the strategy notes that 66% of retirees in 2002 were under the age of 55 and that 72% of these were women (Government of Mongolia 2003, 23). Even if the retirement age were equalized, because women live longer they require pension payments over a longer period than men. Reform of social insurance schemes needs to take this into account and the fact that women tend to have a disrupted working life because of childbearing and child-rearing responsibilities. Consequently, compulsory contributions to social insurance will be lower than those for men, in most circumstances. But women may need to draw against this insurance more frequently than men as women of childbearing age tend to be laid off earlier than men, precisely because of concerns about their interrupted labor patterns. In addition, those identified as the poorest and most vulnerable in Mongolia include informal sector workers, who are ineligible for formal social insurance schemes. Although valid data regarding the proportion of the workforce engaged in informal sector activities is hard to obtain, it is estimated that more women than men work in the informal sector. Vertical segregation of the labor force also results in fewer women in management positions in formal sector employment, resulting in overall lower wages and consequently much lower pensions. All these factors need to be taken into account when strengthening social insurance schemes.

One issue raised by several informants during the assessment of other Mongolian projects was the unintended impact of universal child support benefits paid in cash to mothers, particularly when these benefits are the only source of family income. It was argued

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21 The International Labour Organization estimated that 70% of those in the informal economy are women who are mainly engaged in trade, services, manufacturing, and financial services, whereas men are mainly involved in transport (estimate given at the 2002 National Conference on the Informal Economy in Mongolia and Small and Medium Enterprise Development). Data gathered by ADB for an update of the Mongolia country gender assessment indicate that women make up between 54% and 69% of the informal sector workforce.
Goal: Reduce poverty among the most vulnerable groups of society by strengthening the social security system’s ability to deliver essential welfare, insurance, and employment services to the ultra poor, the very poor, and those close to the poverty line.

### Key loan components

<table>
<thead>
<tr>
<th>Loan Components</th>
<th>Potential Gender Equality Entry Points</th>
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<tbody>
<tr>
<td><strong>1. Policy reform component</strong></td>
<td>Consider gender dimensions and impacts of the full range of social security policies such as:</td>
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<tr>
<td>Improved social security policies and institutional reforms in social security agencies by</td>
<td>• Growing proportion of women drawing pensions but with lower contributions due to vertical labor segregation and fewer years worked means their incomes are lower than men’s or falling.</td>
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<tr>
<td>• improving the quality and coverage of social welfare services and benefits</td>
<td>• The promotion of community-based care for the elderly and persons with disabilities brings greater reliance on women within families to care for these groups, putting increased pressure on their already scarce time and resources.</td>
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<td>• developing pro-poor labor market policies</td>
<td>• Women face different barriers to finding employment than men, which needs to be reflected in employment promotion policies and programming.</td>
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<td>• strengthening social insurance operations to increase compliance</td>
<td>• Some programs are more obviously targeting women, e.g., child support, but impacts of programs are not analyzed from a gender perspective.</td>
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<td>• development of social security master plan</td>
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<td><strong>2. Social welfare</strong></td>
<td>Most staff in government facilities are female and have potential to improve status and training.</td>
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<td>Social welfare services developed and upgraded including nursing homes; the NCRD and 3 pilot social security centers established</td>
<td>• Gender analysis needed on barriers to women and men accessing social welfare services, and strategies could be developed to address these, e.g., lack of civil registration.</td>
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<td>Community-based social welfare services improved, including community-based projects in support of PWD, the elderly, children, and single-parent families; and a national awareness-raising campaign undertaken</td>
<td>• Consideration needs to be given to the impact of returning patients to their families, communities, and on the women who will care for them; gender capacity building could be provided to NGOs contracted to provide care; and on the risks of violence for PWDs and protocols to address this.</td>
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<td>Social welfare management: New MIS established within MSWL</td>
<td>• The majority of target groups for community-based projects are women and children and special measures may be necessary to ensure their needs and interests are taken into account as new programs are designed.</td>
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<td></td>
<td>• The potential impact of policies promoting increased community-based programming on female household members needs to be taken into account.</td>
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<td></td>
<td>• Woman may require different approaches to public awareness campaigns to ensure they understand new benefits and programs; involvement of women-led NGOs could be considered; sex-disaggregated data are required to understand possible gender differences in response to public awareness campaigns.</td>
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<td></td>
<td>• Ensure women participate equitably in social welfare management training; establish targets for women’s participation in social welfare training in proportion to their employment in the subsector including for higher-level training.</td>
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<td></td>
<td>• MIS data needs to be sex-disaggregated throughout the system to improve targeting and management of social welfare programs.</td>
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Table 4 Social Security Sector Development Program Summary of Gender Entry Points
3. Employment promotion

- Skills training for the unemployed and poor including employment training centers, employment education centers, regional resource centers, and national curriculum and methodological center
- Entrepreneurship development programs for the unemployed and poor
- Capacity building for employment services, improvement of working conditions, central MIS and labor market analysis system, and a public awareness campaign

- Need to explore different employment patterns of men and women to understand different training needed to address unemployment for both women and men.
- Consider training in nontraditional areas for women and men and provide follow-up support for transition to the workforce.
- Set targets for women’s and men’s participation in different types of skill training and collect sex-disaggregated data on women’s and men’s participation by type of training.
- Sex-disaggregated data and consultation with women are required to understand the needs of women seeking available income-generating activities and establishing small enterprises in the informal sector, for example differences in accessing capital and skills; more women than men are working and seeking employment in the informal sector.
- Set targets for women’s participation in entrepreneurship training and other business support services and collect sex-disaggregated data on their participation in these activities.
- Gender capacity building of employment service providers to address the above issues; set targets for women’s participation in training in proportion to their workforce participation in the provision of employment services.
- Ensure MIS is sex-disaggregated.
- Target public awareness campaign specifically to women and men.

4. Social insurance

- Social insurance management: New participants registered, offices upgraded, and systems for including self-employed designed
- Training of social insurance inspectors conducted

- At the lowest level all data collected are sex disaggregated, e.g., sex of pensioners; however, data are aggregated at national level and therefore gender difference across the entire population receiving different social insurance programs is not available to contribute to understanding policy impacts.
- Gender-based barriers to accessing social insurance programs or complexities of gender-based impacts of policies and/or programs need to be taken into account to maximize efficiency and effectiveness of social insurance programs.
- Capacity building needs to focus on increasing understanding of the gender-based differences in accessing social insurance; set targets for women’s participation in training of social insurance inspectors in proportion to the percentage of women employed in the subsector.

MIS = management information system, MSWL = Ministry of Social Welfare and Labor, NCRD = National Center for the Rehabilitation of the Disabled, PWDs = persons with disabilities.
Source: Interviews with beneficiaries and from experiences and gender analysis by the authors.
that this has encouraged some poor families to have more children to supplement family income, increasing their dependence on government handouts. Policy and program reforms to support mothers to remain in or return to the workforce, such as the reinstatement of affordable child care facilities, could be considered. At the time of the RGA, only 11% of poor families have children in preschool and mothers are forced to leave children in unsafe care situations or stop looking for work. Informants also noted that many women work in the informal sector so they can keep their children with them, despite the low return on their labor from this type of work. This issue also highlights the need to target employment training programs specifically to women’s needs. Women face different barriers to finding and retaining employment than men do in a labor market characterized by long-standing gender stereotypes, and this should be reflected in reforms to employment policy and promotion and training services.

To improve targeting for all types of social security services, the potential impacts of legislation and programming on different groups within society need to be understood. The rationale for targeting is not well accepted among government officials in Mongolia. Comprehensive social and gender analysis of proposed reforms and sex-disaggregated monitoring of outcomes has enormous potential to increase the efficiency and effectiveness of social security services. Programming that builds self-reliance, particularly for women, and provides opportunities to apply investments in girls’ education, need to be considered for different target groups. There is growing evidence of increased efficiency through careful targeting of both women and men from other countries facing similar shifts in approaches to social security programming.  

Social Welfare

Social Welfare and Community-Based Services

The development and upgrading of nursing homes and the NCRD had the potential to benefit women by improving their working environment, given that staff in government facilities are primarily female. There was also potential to improve women’s status and capacity through training for nursing home staff.

A gender analysis of the barriers that prevent women from accessing various social welfare services could have increased the effectiveness and quality of social welfare and community-based services. For example, concerns have been expressed by NGOs working on women’s health issues about the need to link social workers more closely with health service providers to ensure that barriers to women accessing such services, such as those associated with the civil registration process, are understood and addressed. Poor rural women in particular are fearful of seeking MCH services when they are not registered, and cannot understand the complex registration process. Health workers could refer such women to social workers for assistance if they were working closely together. The establishment of three pilot social security centers with improved services including staff training had the potential to address these and other barriers to poor women and men accessing their entitlements and to explore new methods of service delivery.

While moving the elderly and those with disabilities out of institutions can have a positive impact on their well-being, increased care responsibilities within families and the community will generally lie with women. No consideration was given either in nursing home upgrading or in NCRD activities to the impact on other family members of increasing care within the community. Associations representing the interests of the disabled already exist, with programs to support parents of children with disabilities. Gender aspects could be introduced to the activities of the associations by NCRD, for example, to encourage them to work with all family members to share equally the extra care responsibilities incurred when those with disabilities return home. Where the community-based care was subcontracted to NGOs, gender capacity building with NGO subcontractors and disabled people’s associations could also raise awareness of the increased risk of physical and sexual violence against women and girls living with disabilities (UN General Assembly 2006, 13, 16, 24 and Disabled Women’s Network Ontario n.d.), the Domestic Violence Law, and the use of appropriate

protocols to protect disabled people from violence. The MSWL could also consider monetary and other kinds of support for care providers, such as respite services, or additional financial support for professional care givers, allowing women to continue to earn income.

Target groups identified for pilot community-based projects included the elderly, people with disabilities, children, and single-parent families. Activities were to focus on day care, preschool, recreation, education, catering, counseling, accommodation, and skills training. Consultation with women would have helped identify any special measures needed to ensure that their needs and interests were met in these new activities, and the monitoring and reporting of gender equality results would have enabled lessons to be learned regarding the most effective forms of service delivery to reach the poorest and most marginalized women and men. The involvement of NGOs led by women could have been explicitly encouraged, and gender-sensitive selection criteria could have been developed for subcontractors. These provisions, particularly women’s involvement in decision making for the development of innovative community-based services, could have promoted gender equality in social welfare service delivery.

There was no evidence that efforts were made to ensure that women-led NGOs with expertise in reaching out to marginalized women participated in national awareness-raising campaigns; however, the RGA-II team did not have access to information, education, and communication (IEC) materials developed by the project. No sex-disaggregated data were available regarding those participating or targeted through the awareness campaigns. Such information could improve the effectiveness of campaigns and highlight how IEC materials may need to be revised to appeal to both men and women, if gender-based differences were observed.

Social Welfare Management Information System
No sex-disaggregated data were incorporated into the social welfare MIS developed under the project. MSWL staff interviewed by the RGA team did not have a clear understanding of how collecting and analyzing such data could be used to improve social welfare planning and targeting and monitoring functions. This was a missed opportunity to improve the gender capacity of MSWL and improve the quality of long-term planning in the sector.

The collection of sex-disaggregated baseline data on women’s employment across the subsector and the establishment of training targets, particularly at decision-making levels, would have focused efforts on improving women’s status, addressing any barriers to their participation in advanced training, and ensured the collection of sex-disaggregated monitoring data on training activities.

Employment Promotion

Skills Training for the Unemployed and Poor

Gender differences in the labor market need to be taken into account when reforming, designing, and monitoring social security and employment promotion programs. For example, there was no mention in the project design of the gender-based vertical and horizontal segregation in the workforce, and how employment promotion activities might need to be tailored to address current gender inequalities. During the era of the centrally planned economy, gender stereotypes regarding careers deemed suitable for men and women were widespread. Despite changes in economic structures, these stereotypes remain, closing off new employment opportunities for women in emerging sectors, such as mining and mechanical engineering. Women are concentrated in social service sectors, such as health and education, where they make up 83% (health) and 77% (education) of the total workforce. These sectors are contracting, leaving more women unemployed than men. In contrast, men are concentrated in expanding sectors with higher wages, such as mining, where they make up 81% of the workforce, and construction, where they are 79% of workers. 23

A pattern has been established over many years of more women than men seeking additional training after leaving school, an extension of the general trend in Mongolia for families to invest more in girls’ education

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23 Unemployment data differ greatly depending on the source. According to official data from October 2008, the number of unemployed people increased to 6,861, of whom almost 60% were women (ADB 2008d).
than boys'. Educational attainment tends to be lower among male youth, and consequently vocational training in recent years focused on encouraging young men to improve their skills. For example, the director of one technical college (an SSSDP partner agency) visited by the RGA team noted that his concern had been to increase the number of men attending training. When he started as director in 1996, only 10% of students were male. This was partly because the training offered by the college at that time was mostly associated with light manufacturing and social service sectors where female workers predominated. At the time of the RGA, the proportion of male students had risen to 60% because courses are now offered in sectors such as motor mechanics that interest male students. This focus on addressing unemployment among men was positive. However, special efforts were also needed to explore women’s training needs to address their rising unemployment. The collection of sex-disaggregated data in this component on training participants by type of course would have enabled an assessment of women’s and men’s access to important capacity-building resources and an analysis of the extent to which these focused on gender stereotyped roles. Analysis of the causes of lower educational attainment among males will also be necessary if training programs are to be designed to encourage skills training for both men and women.

Staff at one vocational training college visited by the RGA team were well aware of gender-based differences in women’s and men’s access to skills training, but lacked the capacity to address any barriers to employment in nontraditional areas faced by women or men. Labor market reforms and employment promotion programs need to help women access training for employment opportunities in growth sectors of the economy that are usually open only to men. In general, there is a reluctance to admit that women face discrimination in hiring practices, despite evidence to the contrary from women seeking employment in nontraditional sectors. Experience from other countries has demonstrated that encouraging women to train in nontraditional skills starts a process of broader change in attitudes among employers and other workers, particularly when this is followed up by support, mentoring, and networking in the workplace. The government needs to take a lead in encouraging such change. The RGA found that there was interest in addressing the barriers faced by men and women in finding employment among the management of employment training centers and employment education centers, but the skills to carry out comprehensive analysis and to provide the necessary support needed to be strengthened.

Entrepreneurship Development and Capacity Building for Employment Services

As with other aspects of the SSSDP, no sex-disaggregated data were available to compare women’s and men’s access to entrepreneurship training or other services provided under this component, such as management, production, and marketing support. Women are the majority of informal sector workers (ADB and World Bank 2005, 25) but they earn only half as much as men who are engaged in the informal sector. RGA informants indicated that more women than men are seeking to establish income-generating activities and small enterprises, but gender-based differences in accessing capital and skills are not well documented or reflected in public policy. In-depth gender analysis of poor women’s and men’s access to these resources would have provided guidance for targeting training, financial, and marketing services in this component, and for capacity building of employment service providers. The establishment of targets for women’s participation in training and business support services would have ensured that poor women had equal access to these important resources.

This component also included the development of an MIS to manage, monitor, and evaluate employment services, and a public awareness campaign to encourage unemployed people to use these services. As with the social welfare component, there was no evidence that sex-disaggregation of data was built into the MIS or that consideration was given to ensuring that the public awareness campaign was effective at reaching both women and men. Having sex-disaggregated data is a prerequisite for understanding the different needs of women and men seeking to engage in income generation and small business enterprises in the informal sector.

Social Insurance

Differences in life expectancy and work patterns and their influence on the social security needs of women and men (discussed on page 30, on policy reforms)
were not addressed in the project design. RGA interviews and document review indicated that gender-based barriers to accessing social insurance programs and the complexities of gender-based impacts of policies and programs were not well understood or taken into account. At the lowest local government level, all data collected are sex-disaggregated. However, at the national level, data are aggregated so it is not possible to analyze gender differences across the entire population receiving social insurance pensions and benefits.

Training for social insurance inspectors around the country was a key focus for this component, which aimed to improve the management of social insurance programs. As noted above, the setting of targets for women’s participation in training would have been a good first step for ensuring that women had equal access to capacity-building opportunities.

Factors Influencing Gender Equality Results and the Achievement of Loan Outcomes

Social and gender analysis capacity and sex-disaggregated data. The purpose of SSSDP was to strengthen the capacity of the social security system to deliver essential welfare, insurance, and employment services to the ultra poor, the very poor, and those close to the poverty line. The RRP noted that there was limited capacity in the MSWL to effectively target social security programs to these groups and highlighted the need to strengthen information collection, analysis, and dissemination, which are essential for effective targeting. During implementation, the government continued to introduce universal social welfare programs that undermined loan objectives to target support for the poor in a manner that is fiscally sustainable. Strengthening skills and mechanisms to carry out comprehensive gender and social impact assessment could have enhanced understanding of the rationale for targeting and how it might be undertaken. Gender-based difference is one of several key axes of analysis required to fully understand the impact of social security policies and programs along with employment status, income levels, age, and rural versus urban location. The development of the sector-wide MIS offered an excellent opportunity to ensure that all data were sex-disaggregated at collection point and for national analysis across all related agencies, and to build capacities to take gender considerations into account when analyzing such data along with the other factors mentioned above. These omissions were a missed opportunity to increase the effectiveness of the loan investment and the achievement of outcomes.

Developing and implementing a GAP. Although the RRP identified several important gender issues and acknowledged the need to pay attention to them, these concerns were not translated into a GAP nor integrated into the DMF in any way. A GAP would have provided guidance to project implementers on how to take gender issues into account in each component. Including gender-related targets and indicators in the DMF would have ensured the collection of sex-disaggregated data. Including a GAP or some key gender provisions in the loan covenants would have increased the likelihood of explicit attention being paid to gender considerations and women’s equal access to project resources. Without a GAP or explicit gender provisions, a series of opportunities were missed to address gender inequalities in the activities supported by ADB. It may have been assumed that the gender-specific concerns of poor and vulnerable women in Mongolia would be automatically taken into account. However, experience with ADB and other donor-funded projects internationally demonstrates that explicit provisions are needed to ensure that both poor women’s and men’s needs and interests are met. Further, the lack of sex-disaggregated baseline or monitoring data made it impossible to verify whether women’s needs were considered, or to assess the different results achieved for poor women and men—including their participation in project activities, access to project resources, practical benefits, and whether policy reforms in fact increased their access to social security services.

Gender specialist expertise on the project team. A more in-depth social and gender analysis during design and implementation would have helped to identify potential entry points for addressing gender issues and for promoting gender equality, such as those discussed above. Gender specialist expertise on the project team would have assisted with this analysis and with the identification of achievable targets and relevant strategies for each component, including the collection and analysis of sex-disaggregated monitoring data. Gender specialist expertise could also have been used
to strengthen capacity and commitment to a gender-inclusive approach to social security planning and targeting with executing and implementing agencies.

Recommendations

With the project nearing completion, it cannot address the issues discussed above. A project was under preparation by ADB at the time of the RGA-II fieldwork that will provide food stamps and similar safety net supports for the poor, needed because of the spiraling cost of food basics and the current difficult economic climate. The project team carried out a gender analysis to better understand the implications of the specific needs of women and the potential impacts of proposed programming on women compared to their effects on men. With little sex-disaggregated data available, this analysis was limited, affecting the design of the project GAP. The following recommendations should be considered to ensure that a gender-inclusive approach is applied to the design and implementation of future projects in the sector:

(i) Gender capacity building should be incorporated into the design and implementation of future projects with MSWL. This should include the relevance of taking a gender perspective in policy and programming, efficiency gains from improved targeting, and developing a comprehensive sex-disaggregated MIS to strengthen sex-disaggregated data collection and gender analysis skills for policy and program planning and impact assessment.

(ii) All programs and projects in the sector should include gender-related targets and indicators in DMFs and systematically collect and analyze sex-disaggregated baseline and monitoring data to improve the quality of social and gender analysis, the targeting of services, and the assessment of outcomes.

(iii) Future and current projects within the sector should include a GAP and gender expertise on the project team to assist with the collection and analysis of sex-disaggregated data, the development and review of strategies to address gender issues, and gender capacity building with executing and implementing agencies.

(iv) A TA should be considered to assist with understanding how existing and planned social services affect women and men differently, improving data collection and analysis, and identifying priority areas for policy and program change to address gender issues in social security service delivery.
Findings, Issues, and Conclusions

Summary of Gender Equality Results and Links to Loan Outcomes

Participation in Project Activities

Both the Second Health Sector Development Project (HSDP2) and the technical assistance (TA) on HIV/AIDS and human trafficking achieved good results in the area of women’s participation. In HSDP2, the predominantly female workforce benefited from training although fewer women participated in courses on health planning and management. The TA conducted a social and gender analysis during implementation and consequently a comprehensive range of at-risk groups participated in TA activities, including poor women involved in casual sex and unemployed young men, both of whom were hard to reach. Key stakeholders including women’s nongovernment organizations (NGOs) were involved in the development of IEC materials, which were tailored to meet the needs of both male and female vulnerable groups, and IEC materials were widely distributed to both women and men. There was also good participation by females and males in training for peer educators.

The Social Security Sector Development Program (SSSDP) had no gender design provisions, and there was no evidence from interviews or project reports that women’s participation was sought in the development or implementation of project activities. Given the high proportion of women employed in the social security sector including in nursing home facilities, it is likely that women did participate in several project training activities. However, no sex-disaggregated data were available to verify this.

Access to Project Resources and Practical Benefits

HSDP2 and the TA were effective at delivering resources to women as well as men and a range of practical benefits were achieved in both projects. Although SSSDP had great potential to increase access to much-needed social welfare, insurance, and employment resources, the lack of sex-disaggregated data made it impossible to identify gender equality results for either the program or project investment loan.

HSDP2 achieved significant improvements to the quality of health services and their capacity to respond to women’s and children’s health needs, by training primary health care (PHC) workers, improving health infrastructure and equipment that took women’s special needs into account, and implementing new patient-focused approaches to service delivery. These strategies contributed to significant improvements in key maternal and child health (MCH) indicators, including increases in antenatal care in remote project areas and reductions in pregnancy-related complications.

An associated Japan Fund for Poverty Reduction (JFPR) grant enabled PHC workers to complement improvements in the quality of MCH services by addressing nonmedical barriers to women accessing the improved health services provided by HSDP2. Subsidies to cover transport costs for poor women to attend antenatal clinics and assistance with civil registration so women could access government health and other services were also very important practical benefits. Home visits were introduced, reducing the opportunity cost for women to attend clinics, particularly high-risk pregnant women. This ensured that a more holistic approach to factors influencing women’s health—including nutrition, general living conditions, and domestic violence—was considered.
The TA increased awareness among communities of the new risks brought by the development of the north–south regional road. Male and female peer educators and vulnerable groups provided with information, education, and communication (IEC) materials had increased knowledge of high-risk behavior associated with HIV/AIDS, sexually transmitted infections (STIs), and human trafficking. The TA provided voluntary counseling and testing (VCT) and health services for all STIs by taking mobile clinics to construction and mine sites. This has the potential to bring benefits beyond the control of HIV/AIDS infection, as one project province had the highest incidence of STIs in the country. Although there were no sex-disaggregated data on the use of VCT services, anecdotal information indicated that both women and men from vulnerable groups benefited from this service. Poor women engaging in casual sex with transient men started to attend these clinics due to effective IEC and outreach activities. A supply of condoms was available for purchase by target groups and in high-risk target communities. These efforts were also effective at encouraging men to attend VCT clinics. As men in Mongolia are hard to reach with public health messages, these initiatives increased understanding of both male and female reproductive health issues along the road corridor.

Progress toward Strategic Changes in Gender Relations

HSDP2 introduced a patient-focused approach to health care delivery that resulted in women being treated as partners in improving MCH. The training offered to PHC workers through HSDP2 empowered many to become more confident agents of change within the community. Community-based nurses, most of whom are women, have increased status and respect from other health professionals because they received training together and now work together during home visits.

The TA did not address the contribution of gender power relations to women’s vulnerability to HIV/AIDS and human trafficking. However, the good results achieved in encouraging men to be tested for STIs has the potential to improve reproductive health for both women and men in project areas.

Progress toward Institutional Changes That Promote Gender Equality

An important institutional change from HSDP2 was the introduction of a patient-focused approach to health care delivery. Additional training under the JFPR grant also focused on how social, legal, and other nonmedical concerns could be addressed and encouraged collaboration across ministries. If this approach is sustained, it will significantly increase the quality of health service delivery and its effectiveness at meeting women’s health needs. Training with local government decision makers and health workers on domestic violence and its impact on women’s health was successful at raising awareness of this critical issue. This is an essential step toward institutional change in the way health and other services interact with survivors.

The involvement of local government decision makers in the TA encouraged community leaders to be more aware of the social impacts of development along the road corridor, including the situation of vulnerable populations and the risks they face. Police officers who received training in human trafficking prevention identified at-risk groups beyond those identified by the TA team, an encouraging sign that these government officials were considering a range of social impacts from the new traffic patterns along the highway. There were also promising signs that training for police and other law enforcement officers may reduce the marginalization and blame experienced by women who have been trafficked or subjected to other forms of violence. These officers are now aware of the risks commercial sex workers face of being coerced and forcibly moved while working in brothels along the Chinese border area, the vulnerability of women bartering sex for transport from van drivers, and the links between trafficking and other forms of violence against women. Two police officers in Choyr set aside a safe room for interviewing survivors of trafficking and domestic violence as a result of their increased understanding of the issues involved. The attitudes and behavior of individual officers changed as a result of their involvement in this TA. This could have far-reaching positive effects if future support from ADB helps to consolidate and extend these changes, such
as by supporting these officers to influence others to protect women’s rights irrespective of their status, and by continuing to focus on HIV/AIDS and human trafficking awareness with a range of local stakeholders in other ADB-funded transport projects.

SSSDP also had the potential to promote institutional changes to address gender inequalities and promote effective targeting of social security and employment promotion services to poor women and men. However, opportunities were missed to strengthen institutional capacity for the collection and analysis of sex-disaggregated data, and to apply quality social and gender analysis to social security planning, programming, and monitoring.

Contribution of Gender Equality Results to Loan Outcomes and Effectiveness

The gender equality results achieved by HSDP2 and the TA contributed significantly to the achievement of overall loan outcomes. While HSDP2’s GAP and most project activities were concentrated on improving the quality of health services to respond to women’s health needs, the promotion of a patient-focused approach in service delivery including increased outreach visits, IEC materials that treated women as partners, and the JFPR grant allowed some of the barriers to the use of these improved services by marginalized women to be addressed. This combination of strategies resulted in improvements to women’s health and particularly MCH indicators, which was the aim of the project.

Commitments from ADB to minimize negative impacts of transport loans on HIV/AIDS and human trafficking were addressed in a comprehensive and gender-inclusive manner under the TA. Groups of men and women vulnerable to negative impacts were identified and involved in project activities, and local community leaders now have a better understanding of how to identify such groups and respond to their needs. Key team members from the Regional Road Development Project (RRDP) noted how useful the TA was in identifying social impact issues that would otherwise have remained hidden, and intend to encourage this approach when developing economic activities. The gender mainstreaming approach taken during implementation and collaboration with a broad range of stakeholders enhanced the capacity of local decision makers to ensure sustainable growth along the road corridor, which was one aim of the RRDP.

The purpose of SSSDP was to strengthen the capacity of the social security system to deliver essential welfare, insurance, and employment services to those most in need, including women. The limited capacity of the MSWL to target social security programming was noted in the project design, but an opportunity to build those skills through the use of gender and social analysis was missed in this project. Loan outcomes and effectiveness could have been enhanced considerably if the collection and analysis of sex-disaggregated data had been integrated into the new sector-wide MIS and if gender and social analysis capacity had been strengthened.

The Quality and Effectiveness of Gender Action Plans and Gender Mainstreaming

Of the three projects assessed during the RGA in Mongolia, only HSDP2 had a GAP included in the project design. The TA had no specific gender provisions included in its design, but gender perspectives were mainstreamed during implementation based on a situation analysis that took most social and gender considerations into account. No gender provisions were included in the design of SSSDP and no attention was paid to addressing gender issues during implementation.

Comparing the approaches and gender equality results achieved by the three projects demonstrates clearly that paying attention to gender differences and issues during design and implementation produced better results for women and enhanced the achievement of loan outcomes. Although the HSDP2 GAP was not used as an implementation tool by the project team, its strategies were fully integrated into the project design, which focused on MCH, training for PHC workers (mostly women), and improving the quality of health services and their capacity to respond to women’s and children’s needs. Significant practical benefits accrued to women, some progress was made toward changes in gender relations, and there were some important institutional changes that will help to sustain the benefits achieved. The TA implemented as part of the RRDP also achieved important practical
benefits for both female and male vulnerable groups, building their awareness of HIV/AIDS and human trafficking risks, and increasing their access to services. Promising steps were taken to change the way local institutions respond to vulnerable groups. Some progress was also made on changing gender relations with more men attending VCT clinics. In contrast, it was not possible to verify any gender equality results in SSSDP. Factors that influenced the achievement of gender equality results are discussed below.

**The quality of gender analysis and its application to design and implementation.** All three projects included some gender analysis in the report and recommendation of the President (RRP) and identified several differences in men’s and women’s experience of poverty and their access to government services. However, the quality and comprehensiveness of this gender analysis and its application to project design and implementation differed markedly for each project. This played a major role in the achievement of gender equality results; wherever gender analysis was translated into practical strategies to involve and benefit both women and men, good results were achieved. In HSDP2, broad strategies were identified in the GAP to achieve benefits for women and these were implemented because they were an integral feature of the project design. Although the GAP did not provide implementers with a step-by-step guide to addressing the key barriers to women accessing improved health services, the JFPR grant provided an opportunity during implementation to apply further gender analysis to address these barriers; this was a major factor contributing to the good results achieved. The TA had very little gender analysis included in the RRP, but the situation analysis conducted during project inception incorporated several gender-related factors influencing different vulnerable groups. This gender analysis was applied systematically to the implementation of the TA, ensuring that some particularly at-risk groups of women and men were reached through peer educators with IEC materials specifically adapted to meet their needs. In contrast, in SSSDP the gender analysis in the RRP was not applied to the development of a GAP or gender provisions during the project design phase; no further gender analysis was undertaken during implementation and no gender equality results were demonstrated.

Although many positive gender equality results were achieved, the quality of the gender analysis could have been improved in all three projects. In HSDP2, there was no analysis of gender-based differences in infectious disease control, a secondary focus of the project. HSDP2’s GAP identified improved working conditions for female health staff as an anticipated benefit, but no consideration was given to women’s underrepresentation in senior decision-making positions in MOH, nor to the impacts of staff rationalization and health service delivery changes on female health workers. The impact of alcohol abuse and violence against women on women’s health could have been given more attention. A more in-depth analysis and the identification of strategies to address these issues would have enhanced gender equality results in HSDP2. The situation analysis for the TA did not identify gender power relations as an underlying cause of women’s vulnerability to HIV/AIDS and human trafficking, although women’s low status undermines their ability to negotiate safe sex, for example by limiting their access to information regarding high-risk behavior by their regular sexual partners, and this is particularly true for marginalized women. If these factors had been included in the analysis, some key local stakeholders could have developed a better understanding of the underlying reasons why women are more vulnerable than men to human trafficking and HIV/AIDS and enabled these factors to be addressed in both the TA and future programming. In SSSDP, a range of critical differences in women’s and men’s work patterns, employment opportunities, and social welfare and insurance needs were overlooked and this undermined efforts to improve targeting in the social security system and increase its efficiency.

**Quality of the GAP.** The HSDP2 GAP set out the scope of benefits that the project aimed to deliver to women and GAP strategies were integrated into the project design. While these elements were positive, the GAP did not provide guidelines for special measures to ensure that the benefits were achieved and the project team was unaware of the GAP and its requirements. The anticipated benefits were not integrated into the design and monitoring framework (DMF) as targets so neither the GAP nor the achievement of these anticipated benefits was regularly monitored. The GAP was not included in the loan covenants, so its implementation was not a focus of attention by either the executing agency or ADB, and there was no requirement for the GAP to be updated or reviewed during inception to ensure that it was known and used, or to update
the gender analysis, improve strategies, or ensure their relevance. Consequently, some key gender issues were not addressed, such as the gender imbalance in training for local government officials and health planning and management, and attention to gender issues in infectious disease control. Patient satisfaction surveys did not disaggregate findings by sex, and sex-disaggregated data were not collected or analyzed to assess the achievement of benefits and overall gender equality results. A more detailed GAP during the design phase and a covenanted requirement for it to be reviewed during inception, implemented, and monitored could have brought these concerns to light and ensured that shortfalls were met.

**Targets and special measures for the participation of women.** The HSDP2 GAP provided notional estimates of the number of women likely to benefit from the project, both as patients accessing improved MCH and as PHC workers and professionals. As noted above, these anticipated benefits were not known by project staff or incorporated into the design and monitoring framework (DMF) or regular project reporting, which limited their usefulness as a tool for ensuring women’s participation. However, special measures were identified during implementation by the JFPR implementers to ensure that women could access services. The TA did not include targets for women’s participation, but the TA team was conscious of the need to achieve a gender balance in some areas, such as the proportion of male and female peer educators. TA activities did reach both male and female vulnerable groups, which in some cases required special measures. The SSSDP did not include any targets for women’s participation, either as staff of the executing agency or for new social security programs, such as employment training. There were also several public awareness campaigns regarding new social security programs, but no reporting of how activities targeted different stakeholders, including women. Experience in other countries demonstrates that targets and special measures bring attention to women’s participation and significantly increase the likelihood that sex-disaggregated data will be collected to monitor the achievement of targets, particularly where the targets are included in DMFs. This was a challenge in all three projects.

**Gender capacity building of implementers.** No provisions were made for gender capacity building in HSDP2, but the JFPR grant provided opportunities for further training on the nonmedical factors influencing women’s utilization of improved health services, and this contributed to the achievement of improved MCH indicators. Additional training with Ministry of Health (MOH) staff, especially in health planning, will also enhance the achievement of MCH Millennium Development Goals over the longer term. The TA included a provision for the project coordinator to participate in national HIV/AIDS networks with other development partners such as the United Nations Population Fund (UNFPA). This provided important opportunities for learning as gender issues were frequently discussed and lessons and challenges from current programming were explored. Local government decision makers were also exposed to discussion regarding underlying gender issues influencing vulnerable groups within their communities. Additional capacity building could have consolidated this awareness and provided some tools to cope with the rapid social change these communities are facing with the road corridor development. SSSDP had no gender capacity building despite acknowledgement of deficiencies in executing agency capacity to target programming to those most in need. Gender capacity building could have improved targeting and the more efficient use of social security resources, which are key objectives of this project.

**Institutionalization of GAPs and Gender Mainstreaming in Project Design, Implementation, and Monitoring**

Far more effort is needed to ensure that GAPs and gender mainstreaming approaches are institutionalized by both executing agencies and ADB in Mongolia. None of the three projects systematically collected sex-disaggregated data. HSDP2 included several MCH indicators in its DMF. While this was positive, no other gender-related targets or indicators were included in the DMFs for the HSDP2, the TA, or SSSDP. Consequently, there was no regular monitoring or reporting on gender-related results by either executing agencies or ADB. Systematic collection of sex-disaggregated data and gender-specific information is a key action included in ADB’s Gender and Development (GAD) Plan of Action (2007a), along with the incorporation of gender targets and indicators in the DMFs of all projects. These are
Findings, Issues, and Conclusions

now widely accepted internationally as standard good practice for project design and implementation. They are essential to identify differences in participation, access to resources, and benefits for women and men, and to share knowledge about effective strategies for capitalizing on gender equity as a driver of change for sustainable and inclusive growth and poverty reduction.

Of the three projects assessed, the RRDP was the only one that included a gender-related loan covenant requiring the executing agency to ensure that women and vulnerable groups participated in project design and implementation. Implementation of the TA was also covenanted. Even though HSDP2’s project design included a GAP, there was no loan covenant concerning review, implementation, or reporting on the GAP. The RRP noted that progress on GAP implementation should be included in quarterly reports, but this did not occur. If HSDP2’s GAP had been included in the loan covenants, the project team would have been aware of it. A loan covenant would also have focused the attention of the executing agency and ADB on gender issues during loan review missions and this could have helped with addressing some of the challenges discussed above.

The Role of Local Gender Specialists

None of the projects included gender advisers on the project teams to guide implementation, although both HSDP2 and the TA had access to gender expertise from other sources, which improved the quality of implementation. In HSDP2, the JFPR grant contracted women-led local NGOs to address nonmedical barriers to women’s use of improved MCH services, bringing gender expertise to these components. The TA accessed gender specialist advice informally from national HIV/AIDS networks and UNFPA, and NGOs contracted to develop IEC materials and to deliver training to police and border officials had expertise on gender issues for HIV/AIDS and human trafficking. The international consultant for the TA also shared gender-inclusive approaches from other countries, even though the TOR for the consultant did not require gender expertise.

Nevertheless, in all three projects, having a gender adviser on the project team would have enhanced the achievement and monitoring of gender equality results by ensuring that sex-disaggregated data were collected and analyzed. In HSDP2, several challenges could have been addressed if a gender adviser had been contracted. The GAP could have been revised at inception to include detailed step-by-step guidance and a gender adviser could have ensured that it was implemented and monitored; shortcomings in the patient satisfaction survey could have been avoided if a gender specialist had provided inputs to the design and analysis of the survey; gender issues in the control of infectious diseases could have been addressed; the working conditions of female staff might have received more attention; and gender imbalances in health management training could have been addressed.

In both projects, the links between violence against women, vulnerability to HIV/AIDS infection, and women’s reproductive health could also have been highlighted. In SSSDP, a gender advisor could have improved the targeting and effectiveness of social security programming in policy development, social welfare, social insurance, and employment promotion.

No ADB resident mission gender specialist input was available for the design or implementation of the three projects assessed in RGA-II. An ADB gender specialist is now on contract at the Mongolia Resident Mission providing technical support as projects are designed and implemented. The findings from RGA-II underline the need for technical support from the resident mission gender specialist to address the type of shortfalls identified during the RGA, particularly for the collection and analysis of sex-disaggregated data, monitoring the implementation of GAPs and gender provisions, and capacity building with executing agencies. It may also be necessary to contract more specialized technical expertise or to provide mentoring to the resident mission gender specialist from colleagues with previous experience in some highly technical sectors, such as social security. Government partner agencies require gender capacity building in many areas, especially concerning gender impact assessment of policies to ensure inclusiveness and focused training regarding targeting and monitoring of government programming. The resident mission gender specialist can
provide support and develop opportunities for such gender capacity development during loan implementation, building on lessons learned in other countries. She can also play a key role in sharing knowledge on good practices between projects and sectors within Mongolia, such as the effective strategies used for involving and benefiting women and men in HSDP2 and the TA.

### Other Contextual and Institutional Factors

Two additional factors contributed to the achievement of gender equality results in the TA. These were the collaborative approach taken to working with a range of local government stakeholders, which secured their support and understanding and were key to the institutional changes achieved. The leadership shown by the TA team and project coordinator in seeking out both male and female at-risk groups and encouraging partners to do likewise was also very important.

Many policy makers in Mongolia have assumed that because women outperform men in education and have longer life expectancy, greater emphasis on men is needed in public policy and programming; little attention has been paid to other gender differences and there is little understanding of the need to identify and respond to gender issues. Where women make up the majority of workers in a sector, such as in health or social welfare, it has been assumed that there are no gender issues needing to be addressed in the workplace. Despite their educational achievement, women have higher unemployment, lower wages, and lower representation in decision-making positions than men, and greater pressure on their time because of caring responsibilities for the family that were previously provided by government services, for example preschool child care. Even where the government seeks to target men, such as in employment support and training, doing this effectively would require a comprehensive gender analysis to understand why men participate less than women in secondary education and why they do not seek vocational training. The lack of reliable sex-disaggregated data, particularly in the areas of social security and social protection, has been a major bottleneck in preparing gender-inclusive social protection policy and programs. The capacity for comprehensive social and gender analysis needs to be strengthened as a high priority to increase the return on loan investments. ADB assistance to develop a comprehensive sex-disaggregated MIS would be a good step in this direction in the social security sector.

In addition, gender analysis that includes the collection of sex-disaggregated data is required to demonstrate the rationale for adopting gender-inclusive approaches in loan operations in other sectors. Without such analytical capacity, the different results for women and men cannot be identified; the costs of not taking gender differences into account cannot be demonstrated; and the positive impacts of achieving good results for women on the achievement of loan outcomes cannot be discerned. ADB can help to address these challenges by encouraging the use of gender and social impact analysis across the portfolio, and adopting a consistent approach to integrating and monitoring gender and development issues in its operations in Mongolia. Where good gender equality results and institutional changes have been achieved, such as in the TA on HIV/AIDS and human trafficking, knowledge about effective approaches should be shared and best practices replicated. Lessons from the TA, including the collaborative approach with local stakeholders and the targeting of a broad range of vulnerable groups, should be applied to the ADB-financed Western Regional Road Corridor Development Project–Phase I as a matter of urgency, since this project appears to have downgraded attention to mitigating the potential negative impacts of the road construction and operation.

### Overarching Recommendations for Mongolia

In addition to the recommendations for each project, the following suggestions are made to enhance progress toward ADB’s Strategy 2020 commitments, the achievement of gender equality results, and overall loan quality in Mongolia:

1. Comprehensive gender analysis should be undertaken during loan preparation for all sectors of ADB operations in order to understand the factors that influence development outcomes for women and men and to develop
Findings, Issues, and Conclusions

(i) The GAP should include strategies and targets for each loan component, project gender advisers throughout implementation, and gender capacity building with executing and implementing agencies and other stakeholders to ensure that gender equality results are sustained. GAP targets and gender-related indicators should be incorporated into the DMF, and the review and implementation of the GAP should be included in the loan covenants to ensure regular monitoring.

(ii) Projects should systematically collect, analyze, and report on sex-disaggregated data. Reporting on the GAP and on gender equality results should be integrated into core project documents, such as annual reports, midterm reviews, impact assessments, and project completion reports. They should assess gender differences in participation and access to project resources and benefits.

(iii) The ADB resident mission gender specialist should be involved in loan design, implementation, and monitoring, including in loan review missions for projects in high-priority sectors where it is possible to demonstrate the impact of a gender-inclusive approach and where there are opportunities for learning, replication to other projects, and capacity building of partners.

(iv) Current and future social protection projects should give high priority to strengthening social and gender analysis capacity and assisting with a comprehensive sex-disaggregated MIS.

(v) Future road corridor projects should include HIV/AIDS and human trafficking awareness and mitigation as a standard component and where necessary this should be included in the core project budget. Consideration should be given to documenting the effective collaborative, gender mainstreaming, and capacity-building approaches and outcomes from the TA as a good practice case study, to share knowledge and encourage replication. These lessons should be applied to upcoming or ongoing regional corridor projects in Mongolia including the Western Regional Road Corridor Development Project–Phase I.

Conclusions and Findings from All Four Rapid Gender Assessments

Lessons and findings from the Mongolia RGA are confirmed and reinforced by the RGAs in Indonesia, Sri Lanka, and Viet Nam, which also validated the findings from RGA-I: projects with detailed GAPs had the most comprehensive gender equality results, including participation in project activities, access to project resources, practical benefits, and progress toward equal gender relations. In some cases in the other countries, the implementation of GAPs and the achievement of gender equality results also promoted or reinforced institutional changes within executing agencies that are expected to support future gender mainstreaming efforts.

Findings from the RGAs also demonstrated that where comprehensive gender equality results were achieved, these directly contributed to overall loan effectiveness and the achievement of loan outcomes. The following design and implementation features were critical for achieving comprehensive gender equality results:

(i) GAPs should be prepared during loan preparation and incorporated into loan designs to provide a road map for executing and implementing agencies to ensure equal participation and benefits. The projects that achieved the most comprehensive results had loan designs that were informed by good quality and integrated gender and social analysis.

(ii) GAPs should have realistic and achievable targets and strategies for each component that are clearly relevant to the loan components and outcomes.
Projects with the most comprehensive results had achievable targets and inclusive community participation and mobilization strategies. (iii) GAP implementation and gender equality results should be systematically monitored. Consistent monitoring by executing agencies on gender issues was a strong feature for those projects that achieved the most comprehensive results.

(iv) GAPs need to be owned and understood by executing and implementing agencies. The most comprehensive results were achieved where key stakeholders understood the rationale for ensuring that women participated and benefited, and how this contributed to the achievement of loan outcomes and/or the implementation of government policy.

(v) Gender capacity building and gender and social development expertise during implementation are needed to enhance understanding and ownership of GAPs and to ensure that they are fully implemented and regularly reviewed. These were also key features of the projects that achieved the most comprehensive results.

(vi) ADB needs to continue to invest in lateral learning through peer exchanges on effective strategies for achieving gender equality results. Some of the projects with the most comprehensive results had project directors who had participated in ADB lateral learning events on gender mainstreaming.

There were also some common challenges evident across all four countries. The findings highlight the importance of developing and implementing quality GAPs. In addition to the features listed above, GAPs need to be effective communication tools. Many of the GAPs included in RGA-II focused on women’s participation in project activities. While this was essential, more attention is also needed on higher-level results, such as benefits and outcomes, including clear strategies for how to achieve these.

The monitoring of GAP implementation by ADB and the collection and analysis of sex-disaggregated data by executing agencies and ADB need to be improved. Even where gender-related loan covenants were in place, reporting on compliance was often cursory and sometimes inaccurate. In some projects, particularly those with poor-quality GAPs or no GAPs, collection and reporting of sex-disaggregated data were inadequate.

Monitoring needs to be supported by integrating key gender-related outputs and gender-sensitive indicators for each component into DMFs and ADB project performance reporting. The institutionalization of GAPs into ADB DMFs and project performance reports was weak across all four countries. This needs to be considerably improved if ADB is to demonstrate its Strategy 2020 commitments to promoting gender equity as a driver of change and to increasing aid effectiveness by managing for development results.

The findings from RGA-I demonstrated that the involvement of the ADB resident mission gender specialists was critical for improving the quality of loan design and implementation. These findings were reinforced in RGA-II, which also points to the need for resident mission gender specialists to be used as strategically as possible throughout the project cycle to ensure that quality GAPs are designed, implemented, and monitored. For this to occur systematically and consistently, ADB project team leaders need to be open to the involvement and inputs of resident mission gender specialists. This requires ADB country directors and headquarters staff to actively promote the inclusion of gender considerations in all loans, and to support the role of resident mission gender specialists, particularly during project preparation, design, and loan review missions.
Appendix
List of Persons Visited and Interviewed

Regional Road Development Project, HIV/AIDS and Human Trafficking TA

Ms. Bolorchimeg, project coordinator of the HIV/AIDS prevention technical assistance (TA)
Mr. Gombo, project implementation unit director, Department of Roads
Mr. Kh. Ganbaatar, vice president, executive director, Mongolian Employers’ Federation
Ms. Dulamsuren, deputy director, National Center for Health Development
Ms. Ganbayasgakh G., head, Mongolian Gender Equality Center
Ms. Erdenechimeg U., international relations and information officer, Mongolian Gender Equality Center

Field Visit to Govisumber Province

Mrs. L. Tuvshinzaya, head of Province Health Department, team leader of the province’s TA team
Mr. J. Bayanmunkh, Province Governor
Mrs. D. Zandarya, head of Justice Department, Province Governor’s Office, person in charge of human trafficking prevention for the TA
Mrs. A. Undarmaa, person in charge of the HIV/AIDS activities for the TA
Mr. Erdenedalai, head, Shiveegovi District Police Division
Mr. Altangartaam, police officer, Province Police Department
Ms. Tanderia, head of Legal Department of Governor’s Office
Mrs. Khorloo, health teacher, secondary school no. 2
Peer educators from school no. 2—four boys and three girls
Mrs. Boldmaa, patient aide health worker and herder

Social Security Sector Development Project

Ms. A. Nyamaamaa, project manager, SSSDP
Ms. Batmunh, deputy chair, Labor and Social Service Office
Mr. D. Lkhagya, director, Mongolian-Korean Technical College, Regional Methodological Center
Ms. Bolor B, head, Department of Rehabilitation Medicine and Prosthetic/Orthopedic Workshop, National Center for the Rehabilitation of the Disabled
Mr. Nyamdavaa B, deputy chair, Government Implementation Agency, Labor and Social Welfare Service Office
Mr. Choijilsuren, Labor and Social Welfare Service Office
Mr. Purevtseren Yo, State Social Insurance General Office, Monitoring and Evaluation Department

Second Health Sector Development Project

Ms. Jargalsaihan Dondog, project manager

Field Visit to Hentiy Province

Province hospital:
Ms. Orkhonchimeg, deputy head of health center
Ms. Uranchimeg, head of training at general hospital

Staff:
One nurse from the health care center
Ms. D. Oyungerel, pediatrician
Ms. Dolgormaa, surgical assistant
Ms. N. Ariunaa, reproductive health officer, also in charge of the maternal mortality and reproductive health projects
Ms. Oyunchuluun, specialist in nursing at health center
Mr. T. Erdenebaatar, doctor at health center, trainer of trainers in nursing, nursing methodologist
Ms. D. Naranmichid, statistics officer at the health center
Ms. B. Tsegmid, head of the infectious diseases department at the health center

Family group practice close to the hospital at province center:
Ms. G. Tsend, head doctor
D. Tsegmid, doctor
One nurse

Community-based nurses:
Ms. L. Enhtsetseg
Ms. Altanchimeg
Ms. J. Enhtsetseg, Tsenhermandal District
Ms. Bebish, Jargalthaan District
Ms. B. Tsegmid, doctor and head of the province branch of the Social Democratic Women’s Association, implementing NGO for the Japan Fund for Poverty Reduction grant

Jargalthaan district center hospital:
Mr. Tserengombo, statistics officer
Female patient at the hospital

“Tegsh Ulzii” family group practice at the outskirts of Ulaanbaatar, herder community in Khailaast:
Mr. Gansukh, doctor
Ms. Enhtuya, doctor
Two patients

Experts
Ms. T. Undarya, coordinator, MonFemNet (a network of women’s NGOs)
Ms. Solongoo, researcher, and Ms. Bolormaa Ts, director, Population Teaching and Research Center, School of Economic Studies, National University of Mongolia
Ms. Delia Barcelona, country coordinator, United Nations Population Fund (UNFPA)
Ms. Sandra Nicole Rotzinger, program officer (Human Trafficking), UNFPA
Mr. Michele Savel, country representative, Action Contre La Faim

ADB Mongolia Resident Mission
Itgel Lonjid, social sector officer
Oyunbileg Baasanjav, gender specialist

ADB Headquarters
Wendy Walker, social development specialist, Urban and Social Sectors Division, East Asia Department
Sarath Lakshman Athukorala, senior financial analysis specialist, Transport Division, East Asia Department
Claude Bodart, health specialist, Social Sectors Division, East Asia Department (interviewed via telephone)
<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
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<tr>
<td>Gender action plan (GAP) and/or gender strategies</td>
<td>A comprehensive framework for addressing gender issues in the design and implementation of an ADB loan project or program based on the social and gender analyses undertaken during project preparation. A GAP identifies strategies, activities, resources, gender capacity-building initiatives, targets, and indicators for ensuring that both women and men participate in and benefit from all components of the project or program.</td>
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<td>Gender analysis</td>
<td>A form of social analysis that requires the collection, analysis, and application of sex-disaggregated information, including on women’s and men’s participation and benefits; the process of considering the different impacts of a development project or program on women and men, and on the economic and social relations between them.</td>
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<tr>
<td>Gender equality and equity</td>
<td>Gender equality refers to equal opportunities and outcomes for women and men. This involves the removal of discrimination and structural inequalities in access to resources, opportunities, and services. It also encompasses the promotion of equal rights between men and women. Gender equity refers to fairness in access to resources and in the distribution of benefits from development.</td>
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<td>Gender equality results</td>
<td>Results achieved for women compared with men, including participation in project activities, access to project and other resources, practical benefits, and strategic changes in gender relations (see next page). For the purposes of RGA-II, gender equality results may be immediate or process-type results, intermediate results or outputs, or long-term results or outcomes.</td>
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<tr>
<td>Gender mainstreaming</td>
<td>A strategy to achieve the goal of gender equality by ensuring that gender issues and women’s needs and perspectives are explicitly considered in all ADB operations, so that both women and men participate as decision makers and beneficiaries in all activities, and so that their needs and interests are addressed in all project components and activities.</td>
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<tr>
<td>Gender provisions</td>
<td>Specific requirements included in the project design to address women’s needs or ensure that women participate in a project, such as targets for women’s participation in training. In the RGAs, this refers to design features that are not integrated into an overarching GAP or gender strategy.</td>
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Gender-sensitive, gender-responsive, gender-inclusive – Women’s different needs and priorities have been considered, and efforts have been made to ensure that they participate in and benefit equally from development activities. For example, a gender-sensitive indicator is one that disaggregates information by sex and enables monitoring of any differences in participation, benefits, and impacts between women and men; or that assesses changes in gender relations between women and men.

Outcome – The likely or achieved effects from a development intervention; may refer to short-term effects but usually refers to medium-term effects.

Output – The products, capital goods, and services that result from a development intervention; changes resulting from the intervention that contribute to the achievement of outcomes.

Practical benefits – Benefits that meet the practical needs women have for survival and livelihood. They do not challenge existing gender relations of culture or tradition, the gender division of labor, legal inequalities, or any other aspects of women’s status or power.

Result – The output, outcome, or impact (intended or unintended, positive or negative) of a development intervention.

Strategic changes in gender relations – Progress toward equality between women and men by transforming social or economic power relations between them.

Sustainability – The continuation of benefits after the development project or program has been completed. Given that all the loans included in the RGAs were either under implementation or recently completed, in this report, sustainability refers to a reasonable likelihood that benefits will continue to be enjoyed beyond the life of the project.

Sources: Development Assistance Committee 2002; ADB 2006a; and Hunt, J., S. Lateef, and H. T. Thomas 2007.
References


———. 2004. Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to Mongolia for the Regional Road Development Project. Manila.


———. 2008c. Report and Recommendation of the President to the Board of Directors, Proposed Grant Mongolia: Western Regional Road Corridor Development Project—Phase I. Manila.


Gender Equality Results in ADB Projects: Mongolia Country Report

Rapid gender assessments of 12 projects in four countries were undertaken as part of the Asian Development Bank’s commitment to improving aid effectiveness. The assessment of three loans in Mongolia found that positive gender equality results were achieved due to the implementation of a gender action plan in one project and a gender mainstreaming approach in another. Comparing approaches between the three projects demonstrated that paying attention to gender differences during design and implementation produced better results for women, enhanced the quality of project implementation, and contributed directly to achieving loan outcomes and improved project effectiveness.

This report discusses the gender equality results achieved for each project, summarizes factors that enhanced the quality of project design and implementation, and makes recommendations to maximize gender equity as a driver of change.

About the Asian Development Bank

ADB’s vision is an Asia and Pacific region free of poverty. Its mission is to help its developing member countries substantially reduce poverty and improve the quality of life of their people. Despite the region’s many successes, it remains home to two-thirds of the world’s poor: 1.8 billion people who live on less than $2 a day, with 903 million struggling on less than $1.25 a day. ADB is committed to reducing poverty through inclusive economic growth, environmentally sustainable growth, and regional integration.

Based in Manila, ADB is owned by 67 members, including 48 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance.