Evaluation Study

Rapid Sector Assessment
October 2008

Mongolia: Health and Social Protection

Operations Evaluation Department

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ABBREVIATIONS

ADB	–	Asian Development Bank
CAPE	–	country assistance program evaluation
CERO	–	Central Employment Regulation Office
CSP	–	country strategy and program
EA	–	executing agency
EGSPRS	–	Economic Growth Support and Poverty Reduction Strategy
ERO	–	employment regulation office
FGP	–	family group practice
GDP	–	gross domestic product
GTZ	–	German Technical Cooperation Agency
HIF	–	Health Insurance Fund
HSDP	–	Health Sector Development Program
HSMP	–	Health Sector Strategic Master Plan
ICT	–	information and communication technology
JICA	–	Japan International Cooperation Agency
JFPR	–	Japan Fund for Poverty Reduction
MDG	–	Millennium Development Goal
MMR	–	maternal mortality rate
MOH	–	Ministry of Health
MPRP	–	Mongolian People's Revolutionary Party
MSWL	–	Ministry of Social Welfare and Labor
NDF	–	Nordic Development Fund
PHC	–	primary health care
PIU	–	Project Implementation Unit
PPA	–	poverty partnership agreement
PPR	–	project performance report
PPTA	–	project preparatory technical assistance
PwD	–	persons with disabilities
RSA	–	rapid sector assessment
SAF	–	Social Assistance Fund
SDP	–	sector development program
SHSDP	–	Second Health Sector Development Project
SIF	–	Social Insurance Fund
SSIGO	–	State Social Insurance General Office
SSMP	–	Social Security Master Plan
SSSDP	–	Social Security Sector Development Program
TA	–	technical assistance
THSDP	–	Third Health Sector Development Project
UNDP	–	United Nations Development Programme
UNICEF	–	United Nations Children's Fund
USAID	–	United States Agency for International Development

NOTE

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

KEYWORDS

mongolian family group practice, mongolian health care systems, mongolian primary health care, mongolian social protection, millennium development goals, transitional economy, adb, evaluation, asian development bank, health policy reform, mongolian projects programs evaluations

Officer-in-Charge	R.B. Adhikari, Operations Evaluation Department (OED)
Team leader	J. Tubadeza, Senior Evaluation Officer, Office of the Director General, OED
Team member	R. Perez, Senior Operations Evaluation Assistant, Operations Evaluation Division 2, OED
	Operations Evaluation Department, SA-3

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In accordance with the guidelines formally adopted by the Operations Evaluation Department (OED) on avoiding conflict of interest in its independent evaluations, the Director General of OED did not review this report and delegated approval of this evaluation to the Director of Operations Evaluation Division 2. Penelope Schoeffel (social sector specialist) and Patricia Lim served as consultants. To the knowledge of the management of OED, there were no conflicts of interest of the persons preparing, reviewing, or approving this report.

EXECUTIVE SUMMARY

This rapid sector assessment (RSA) aims to provide an independent assessment of Asian Development Bank (ADB) assistance to the health and social protection sectors in Mongolia and to identify lessons and areas to further improve the effectiveness of its future interventions. The results of the RSA also provided feedback for the preparation of the Mongolia Country Assistance Program Evaluation.

Under the command economy in Mongolia before 1990, the social sectors—i.e., education, health, and social protection—were generously financed by the state. Health services were widespread and accessible due to the high priority placed on human development by the Government. Access to employment was nearly universally guaranteed, and there was essentially no open unemployment. All sectors of society were covered by the pension system; and the state also provided a comprehensive range of benefits to families, children, and vulnerable groups.

Mongolia's transition to a market-oriented economy adversely affected the Government's ability to finance and deliver health services and to provide social security services to cushion the social impacts of the transition. With the cessation of Soviet financial assistance, drastic cuts had to be made in the Government's health expenditures and in subsidies for social welfare programs. Following the transition, the Government initiated steps to change the social welfare system from provision of universal access to more targeted assistance.

The transition created unique and specific challenges to the health sector including (i) improving efficiency in the hospital system; (ii) providing adequate support for primary health care (PHC); (iii) strengthening governance, monitoring, and regulation; and (iv) addressing urban health service issues.

The Government's development strategies for health (comprising its Poverty Reduction Strategy, National Development Strategy 2021, National Action Plan, Health Sector Master Plan, and Millennium Development Goals) have identified improved access to and quality of health care, particularly maternal and child health services and PHC, as immediate targets. The Government considers improving the quality of the health care system, ensuring access to and quality of PHC, and reforming health care financing to be key instruments to reduce poverty; accelerate economic growth; and reduce disparities in the development process, particularly between rural and urban areas.

ADB's health sector strategies have been based on the Government's stated priorities, ADB's country strategies, sector studies, and policy dialogue with the Government and other development partners. However, there has only been "modest" progress in replacing a health system dominated by high-cost, urban-based hospitals with a system that relies more on PHC and preventive services. Key sector goals such as the rationalization of hospitals and personnel have also faced stiff political opposition, and have not yet been achieved. Consequently, the RSA finds ADB's strategic performance in the health sector to be "partly successful" based on the three parameters of sector positioning, contribution to development results, and ADB's performance in the sector.

ADB has been a major partner in the Government's efforts to reform the health sector since the early 1990s, providing three loans for two projects totaling $29.9 million, grant financing of $14 million for one project, eight technical assistance (TA) operations amounting to about $3.5 million, and three grant projects for $4 million for the sector. Although

implementation of ADB projects, TAs, and grants has generally proceeded satisfactorily, the achievement of sector results has been affected by political instability, inconsistent policy approaches, and political resistance to sector reforms.

ADB's sector assistance has been consistent with its sector strategies, responsive to the critical needs in the sector, and in line with the Government's priorities. ADB interventions have supported efforts to attain health-related Millennium Development Goals (MDG). ADB introduced significant and necessary changes in the health system, notably family group practices (FGPs) to provide PHC in urban areas. However, FGPs continue to face significant challenges of inadequate funding, ambiguous legal status, and unsatisfactory quality of services. State policies on civil registration have also prevented many migrant poor from accessing essential health services. Moreover, implementation of reforms in the health sector including rationalization of hospitals and health personnel, and improving allocation of resources between hospital (curative) and PHC (preventive) services, remains a largely unfinished process. For these reasons, ADB's sector assistance in health is assessed "partly successful" using the evaluation criteria of relevance, effectiveness, efficiency, sustainability, and impact. Combining the strategy and program assessments, overall performance in the health sector to date is rated "partly successful."

In the social protection subsector, ADB interventions have intended to address the following key issues: (i) improving the targeting of social welfare beneficiaries, (ii) providing more equitable access to social assistance benefits, (iii) addressing unemployment and related concerns, (iv) tackling social insurance issues, (v) strengthening institutional capacity of the Ministry of Social Welfare and Labor (MSWL) and attached agencies, (vi) assisting the unregistered poor, and (vii) adopting a coherent and consistent sector policy.

The Government's main goals for the social protection subsector are to reduce unemployment and poverty, improve living standards (particularly for the poor), ensure social guarantees, and improve the quality of and access to care services. ADB's sector strategies have been consistent with the Government's poverty reduction strategy, which recognizes the importance of social protection to increase security among vulnerable groups and to prevent more people from falling below the poverty line. Sector strategies have been based on the Government's priorities, the country's development needs, and dialogue with other development partners. However, contribution to development results is assessed as "modest," because a key objective of sector assistance—to focus public resources more on the poorest to allow for increased levels of assistance per beneficiary—has not been attained after the Government adopted a social welfare package in 2006 that increased benefits to all newborns, schoolchildren, newlyweds, pregnant mothers, and mothers with five or more children. ADB's performance is also assessed as "modest" due to lack of selectivity and focus, insufficient diagnostic work on the Government's capacity to actually implement a social welfare system involving narrow targeting, and failure to convince Parliament of the necessity to focus assistance on the poorest. As a result, ADB's strategic performance for the subsector is found to be "partly successful."

ADB has approved two loans amounting to $12 million for the Social Security Sector Development Program (SSSDP), five TA operations totaling $3.6 million, and one grant project for $1 million for the sector. Weak capacity of the project management unit, staff turnover, and policy vacillation have affected implementation of the SSSDP. Weak institutional capacity and lack of political will to implement reforms aimed at focusing assistance on the poorest are also key factors affecting the implementation of ADB operations.

ADB's assistance program in social protection is aligned with its sector strategies and has reflected the priorities and objectives of the Government. Sector assistance has led to some improvements in the delivery of social security services such as upgrading of social welfare facilities and staff skills, pilot testing of community-based social welfare projects, development of a Social Security Strategy Paper, employment-related skills training and business development programs for the poor and unemployed, and capacity building for MSWL and attached agencies. However, the effectiveness of ADB interventions in preventing people from falling into poverty has been limited. Despite measures to assist the unemployed, only a small proportion have received assistance in the form of vocational and skills training, and new business development. The proportion of employees enrolled in pension and unemployment insurance schemes to the total number of employees has been declining in recent years. Effective targeting of social assistance has not been undertaken—access to social welfare benefits is still broadly based, thereby allowing many nonpoor to receive welfare benefits. For these reasons, ADB's sector program in social protection is assessed as "partly successful." Based on the bottom-up and top-down assessments of ADB's strategy and assistance, the overall rating is "partly successful."

ADB's experience in implementing interventions in health and social protection provides important lessons for future and ongoing ADB operations. It highlights the critical importance of securing political support and social consensus before undertaking programs involving sector policy reform. The mixed experience in health and social protection policy reform—a decade after agreements were reached—implies that substantial upfront effort needs to be made in policy analysis, consultation, outreach, and consensus building before policy reforms are framed and loan agreements are reached.

Despite important achievements, outstanding issues for possible ADB involvement in the future remain, including reforming health sector financing, addressing human resource issues in the health sector, and providing health care and social security for undocumented citizens. In health care financing, ADB assistance should be closely linked to the Government's commitment to implement the Health Sector Master Plan policy to rationalize health expenditure by addressing the inefficient allocation of resources between curative (hospital) and preventive (PHC) services. ADB should assist the Government to fast-track civil registration of the unregistered poor to enable them to access education and health services, and other targeted state benefits. ADB should continue to engage in policy dialogue with the Government to determine how it can more effectively provide assistance in efforts to merge the Ministry of Health and MSWL functions.

Ramesh B. Adhikari
Officer-in-Charge
Operations Evaluation Department

I. INTRODUCTION

A. Objective, Purpose, and Methodology

1. The objectives of this rapid sector assessment (RSA, the evaluation) are to provide an independent assessment of Asian Development Bank (ADB) assistance to the Mongolian health and social protection sectors, and to identify lessons and areas for further improving the effectiveness of ADB interventions. The findings of this evaluation also provided inputs to the country assistance program evaluation (CAPE) for Mongolia.

2. The RSA draws upon a review of project documents including reports and recommendations of the President, portfolio review reports, back-to-office reports, project performance reports (PPR), and project completion reports. The RSA also examined other relevant studies including those undertaken by the Government of Mongolia, ADB's Operations Evaluation Department, and other aid agencies. As a desk review study intended to provide inputs to the Mongolia CAPE preparation, the RSA had the following limitations: It did not examine the most appropriate social protection system to serve citizens and the most suitable institutional arrangements for the administration of schemes. The evaluation broadly followed ADB's guidelines for the preparation of a CAPE.[1]

B. Organization of the Report

3. The RSA is divided into four sections, the first being this introduction. The second section on the health sector (i) identifies key sector issues and challenges, (ii) discusses ADB's strategy and assistance program to address these challenges, and (iii) assesses ADB's strategic performance (top-down assessment) and quality of assistance program (bottom-up assessment). The third section on social protection covers (i) the key challenges and issues in the subsector, (ii) ADB's strategy and assistance program to respond to these challenges, and (iii) an evaluation of ADB's strategic performance (top-down assessment) and quality of assistance program (bottom-up assessment). The last section identifies lessons and future challenges and opportunities for ADB's partnership with Mongolia in health and social protection.

C. Social Context

4. Under the command economy before 1990, the social sectors—i.e., education, health, and social protection—in Mongolia were generously financed by the state. About 40% of Government expenditures were devoted to social development. Health, education and other social services were widespread and were accessible because these were provided by each government-owned enterprise. Access to employment was nearly universally guaranteed, and there was essentially no open unemployment. The social security system was based on a combination of consumer subsidies, universal benefits supported by the central budget, and uniform state wages. All sectors of society were covered by the pension system, and the state also provided a comprehensive range of benefits to families, children, and groups designated as "vulnerable".[2]

5. The early years of Mongolia's transition from a centrally planned to a market-oriented economy proved difficult. The economy contracted sharply with the withdrawal of Soviet

[1] ADB. 2006. *Guidelines for the Preparation of Country Assistance Program Evaluation Reports*. Manila.

[2] The Government identified orphans, the physically handicapped, single pensioners, female-headed households, households with more than four children, the unemployed, small-scale herders in remote areas, and those who work outside the formal sector to be particularly vulnerable to poverty.

assistance, which accounted for about 30% of gross domestic product (GDP), and the termination of trade arrangements with members of the Council for Mutual Economic Assistance. The economic restructuring and privatization process led to considerable retrenchment of public sector employees and the closure of many nonviable enterprises, resulting in sharp increases in unemployment and poverty levels. The social costs of the transition are described in greater detail in Appendix 1.

6. Mongolia's transition adversely affected the Government's ability to finance and deliver essential social services. Social expenditure as a percentage of GDP decreased markedly during the transition years.[3] Major cuts had to be made in government expenditure on health services.[4] Consequently, the delivery of preventive and curative health services, which was based on a centralized model heavily dependent on large infusions of state funds, became quickly nonviable. Health services that had been routinely provided, and that had not been particularly responsive to the needs of the population, became even less responsive when needs changed and the population urbanized. The consequences of transition created unique and specific challenges to the health sector, which are discussed in Section II.B.

7. The transition also affected the Government's ability to provide the social security services necessary to cushion the social impacts of a severe economic shock. The social welfare system—which covers retirement, disability and survivor pensions, work injury, unemployment, maternity benefits, and social insurance—was not sustainable when the economy shifted from a centrally planned to a market orientation. With the cessation of Soviet assistance, drastic cuts had to be made in the Government's subsidies and welfare programs. Public expenditure for social security and welfare services, which had stood at about 5.6% of GDP in 1991, declined sharply to about 2.9% in 1993.[5] The key issues and challenges in the social security sector following the transition are discussed in Section III.B.

[3] Social expenditure as a percentage of GDP decreased from 22% in 1991 to 17% in 1992. It declined further to 11.1% of GDP in 1993 but began to increase from 1996 (13.1%). Annual trends in expenditures for social services from 1991 to 2006 are presented in Appendix 2, Table A2.1.

[4] Health expenditure as a percentage of GDP, which stood at 5.3% in 1991, fell to 4.1% in 1992. It fluctuated between 1993 and 1997, but increased from 1998 to 2002. It has been on a declining trend since 2003.

[5] However, social security and welfare expenditures in terms of both GDP and total government expenditures has increased since 1995, constituting about 8.1% of GDP in 2007.

II. MONGOLIA'S HEALTH SECTOR

A. Sector Background

8. Mongolia's health care system was based on the Soviet Union's Semashko model, in which the state was responsible for both the financing and delivery of health care. All citizens were eligible for free medical care. This system emphasized the provision of health care through hospitals, resulting in a large, fragmented and inefficient hospital sector providing generally outmoded and low-quality care, and further characterized by poorly developed primary health care (PHC) (Box 1), financing systems, human resources and planning, and regulatory processes. These factors contributed to the health system's need for overall reform and realignment.

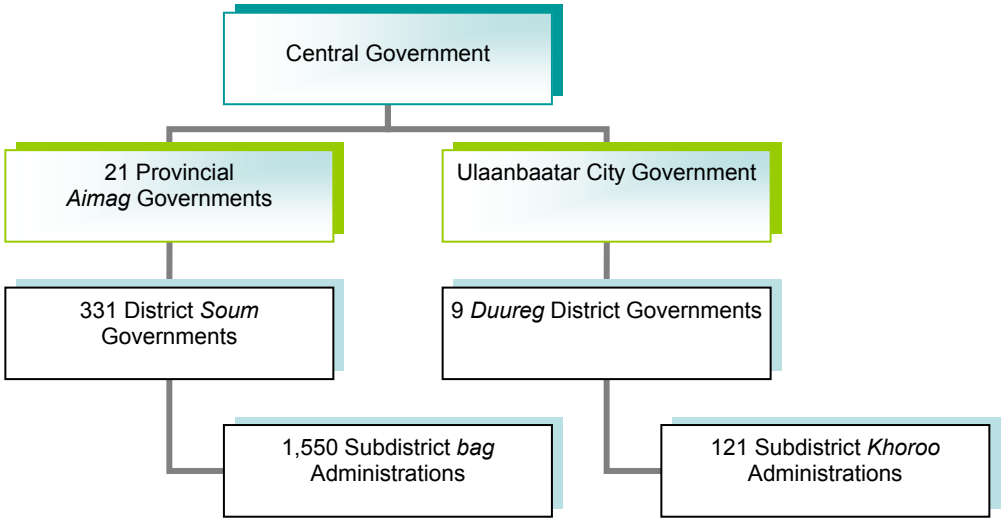
Box 1: Mongolia's Primary Health Care Before Transition

During the socialist period, the primary health care (PHC) system in urban areas was based on polyclinics. Separate polyclinics existed for children, adult men, and women. Each polyclinic had physicians responsible for health and preventive care within a defined geographic area. Each polyclinic had diagnostic services and a laboratory, as well as a large group of mobile subspecialists such as gastroenterologists and cardiologists. The physicians referred most patients to the subspecialists in the polyclinic. In rural areas, polyclinics were associated with particular hospitals, whereas in urban areas, they were often legally independent entities. At the lower level of the rural system, there was either a small rural hospital that provided primary care or a stand-alone primary care unit without beds. At the subdistrict (village) level, basic PHC services were provided by *feldshers* (district nurses).

9. Given the size of the country, the long distances to cover, and the sparse population, the Semashko model was not sustainable without enormous subsidies from the former Soviet Union. In the mid-1990s, with support from ADB and other development partners, the Government commenced reforms in the health sector to shift the emphasis of the health care system from hospital care to PHC. Also, in line with the Government's decentralization policy, responsibility for the health care system was decentralized to provincial governments beginning in the mid-1990s. The local governments became responsible for the delivery of health service, and the main responsibilities of the Ministry of Health (MOH) shifted to policy making, strategic planning, and evaluation.

10. The health care system is administered by province. In addition to the capital city of Ulaanbaatar, which has a system of nine urban local governments, there are 21 provinces, each of which comprises several districts, which are further divided into three or four subdistricts (Figure).

Figure: Decentralized Levels of Rural and Urban Government in Mongolia



11. **Delivery of Health Services.** In urban areas, PHC services are currently delivered by family group practices (FGPs) (Box 2), which were set up under the ADB-financed Health Sector Development Program (HSDP).[6] In rural areas, PHC services are provided by health centers and hospitals at the district level (soum health centers) and by community nurses at the subdistrict level (bag *feldshers*), who are medically trained PHC workers. Community nurses report to and refer emergency patients to district health centers. There is a shortage of doctors at the rural district level, while many unemployed doctors seek employment in urban areas and provincial towns.

Box 2: Family Group Practices

Family group practices (FGPs) provide PHC services to a catchment/community population usually consisting of 1,200 to 1,440 people. They act as referral points for secondary levels of health care. FGPs—teams of doctors and nurses—work as private entities through contracts with local administrations.

The payment method of FGPs entailed shifting from salary-based to capitation-based payment contracts signed with local administrators, with remuneration adjusted to allow higher incentive payments for serving the poor. FGPs were envisaged as private entities, paid by the number of population and vulnerable groups registered for their services, and based on the performance of each practice. A network of FGPs was established in Ulaanbaatar and the pilot project provinces of Hovd, Dornogovi, and Hovsgol.

12. Specialized care is delivered by provincial or urban district general hospitals, which cover all major clinical specialties and typically have capacities of 200–300 beds for delivering inpatient services. The next level of specialized care is provided through state clinical hospitals and specialized health centers, which are located mainly in Ulaanbaatar. Private sector provision of health care is allowed, and is mainly concentrated in Ulaanbaatar but is increasing in provincial towns.

13. **Health Financing.** Since the economic transition, Mongolia has been able to keep public health spending at a higher level than in most other transition countries (around 4–4.5% of GDP, about 5% in 2007). Health care is financed mainly from the budget, accounting for about 10–12% of total government expenditures. In 1994, Mongolia established a Health Insurance Fund (HIF), which contributes about 33% to overall health spending. Private, out-of-

[6] ADB. 1997. *Report and Recommendation of the President on Proposed Loans and Technical Assistance Grant to Mongolia for the Health Sector Development Program*. Manila (Loans 1568-MON[SF] and 1569-MON [SF] for a total of $15.922 million, approved 4 November).

pocket expenses are low compared with other transition countries. Recent amendments to the Health Act mandate PHC to be funded completely from the central government budget.

14. **Planning and Regulation.** MOH sets the health policy agenda and prepares long-term and medium-term plans and budget proposals while monitoring implementation at the central, capital city, and aimag (provincial capital) levels. The Ministry of Finance determines the total budget to be allocated to the health sector. Decisions on financial allocations are made primarily on the basis of historical expenditure; norms and standards in the sector; plus government resolutions, decrees, and national health programs related to the priority areas identified. The HIF is regulated through the State Social Insurance General Office (SSIGO). While there are organizational structures and formal mechanisms to coordinate policies between MOH and SSIGO, there is little or no coordination of service purchasing policies between the HIF and MOH.

15. **Health Indicators.** Despite a relatively low per capita income, Mongolia has fairly strong health indicators. Since 1994, both under-five and infant mortality rates have been declining. On average, Mongolia's infant mortality rate (19 per 1,000 live births in 2006) is significantly lower than that of other countries with similar GDP per capita. The under-five mortality rate (23 per 1,000 live births in 2006) is below the average of low-income countries, and life expectancy at birth (67 in 2005) is higher than the average for low-income countries. Likewise, the maternal mortality rate (MMR), after rising in 2001, has been consistently going down. However, the MMR of 93 deaths per 100,000 live births (in 2006) is still relatively high compared with neighboring countries. In addition, while the overall MMR has decreased, there is significant variation in maternal mortality across the country, with some provinces recording rates three times higher than the national average.

16. While child and maternal mortality appear to be declining, adult mortality rates are rising. This epidemiological transition is similar to those in other post-Soviet countries. Male adult mortality is almost double that of females. Major causes of death are cardiovascular disease, cancer, and injuries. These are partly attributable to high rates of smoking and alcohol consumption. High rates of lifestyle-related diseases and mortality point to the need for more PHC, prevention, and health education. Among communicable diseases, tuberculosis is a major concern. The incidence rate of tuberculosis rose from 79 to 185 per 100,000 between 1990 and 2006. Despite some progress, malnutrition in children, especially in rural areas, remains a major poverty-related concern. In 2006, 6% of children were underweight compared with 12% in 1990.[7]

B. Key Issues and Challenges

17. Progress in transforming health sector institutions has been uneven. Overall, health outcomes and indicators are improving but in the health system generally there are significant problems of poor quality of care, inefficiency, and inadequate implementation of reform and institutional improvements.

[7] To help alleviate chronic malnutrition among children in Mongolia, grant assistance financed from the Japan Fund for Poverty Reduction is planned for approval in 2008 (ADB. 2008. *Draft Grant Assistance Report on a Proposed Grant to Mongolia for Reducing Persistent Chronic Malnutrition in Children.* Manila*)*

18. The health sector continues to face considerable challenges to improve quality, enhance efficiency, and strengthen regulatory capacity. These challenges,[8] which were addressed to some extent by the HSDP and by measures within the ongoing Second Health Sector Development Project (SHSDP)[9] and Third Health Sector Development Project (THSDP),[10] are discussed below.

19. **Improving Efficiency in the Hospital System.** There is continued inefficiency in the allocation of resources between curative (hospital) services and preventive (PHC, FGP) services. The level of expenditure on hospital care is high—the hospital subsector accounts for about two thirds of the health budget—compared with the level of spending on public health and primary care. The hospital sector overall has grown significantly over the last few years, resulting in increased number of beds, admissions, personnel, and costs. With a population of 2.5 million, Mongolia has far too many hospitals: 23.4 hospitals per 100,000 population, or more than twice the average in the European Union and other transition countries.

20. Aside from an oversupply of hospital services, the provision of hospital services by urban districts in Ulaanbaatar is inequitable due to urban migration**,** and favors the nonpoor areas of the city. While the provinces are in some areas inadequately served, Ulaanbaatar is overserved (as shown in Appendix 3). Public hospital facilities and services in Ulaanbaatar include 16 clinical and tertiary hospitals and centers and 46 other hospitals in a city of around one million. There are problems of administration, management, overstaffing, and quality. The system of payment provides incentives that encourage inefficient use of inpatient services, and average hospital stays are unnecessarily long. Increasing the efficiency of the hospital sector could generate savings that could be used to fund investments in public health and PHC.

21. **Providing Adequate Support for PHC.** Despite laws, regulations, and policies that underscore the importance of PHC, financial support for public health and for the most significant element of PHC development in Mongolia—the FGP system—has been insufficient. FGPs receive only around 5.5% of total health funding compared with the hospital sector, which continues to account for about two thirds of the state health budget. Since the establishment of FGPs in 1999–2001, the terms of employment for family doctors have deteriorated and compares poorly with their counterparts in the public sector. Doctors and nurses do not receive competitive wages and have poor incentives to improve performance and provide quality health care. There is no systematic provision of in-service training, and there is a lack of investment in infrastructure, premises, and equipment.

22. **Strengthening Governance, Monitoring, and Regulation.** A principal reason for many of the problems in the health system is weakness in governance and regulation. There are continuing weaknesses in the monitoring and control of public and private health service quality and standards. This is reflected in the unrestricted growth of private medical providers; lack of a legal basis for FGPs; lack of application of routine administrative, financial, and clinical data;

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[8] A health sector study by the World Bank in 2006 supports and amplifies on the afore-cited issues and challenges. (World Bank. 2006. *The Mongolian Health System at a Crossroads: An Incomplete Transition to a Post-Semashko Model*. East Asia and Pacific Human Development).

[9] ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Mongolia for the Second Health Sector Development Project*. Manila (Loan 1998-MON[SF] for $14 million, approved 5 June).

[10] ADB. 2007. *Report and Recommendation of the President to the Board of Directors on the Proposed Asian Development Fund Grant to Mongolia for the Third Health Sector Development Project*. Manila (Grant 0086-MON for $14 million, approved 19 November).

and, until the recent adoption of the Health Sector Strategic Master Plan 2006-2015 (HSMP), lack of an overall strategic direction for sector development.

23. MOH still does not have sufficient capacity for regulation, monitoring, and evaluation. The private sector is rapidly developing in an environment in which the Government has little experience in designing proper legal, regulatory, and contractual frameworks to monitor performance, ensure quality of care, and enforce licensing and accreditation requirements. The THSDP will assist MOH in developing regulatory frameworks and mechanisms for private health operations, financing, and licensing. Criteria to improve the distribution of hospital services and assess competency, quality, and standards in the private sector are also to be developed. The Project will also review and develop options for public-private cooperation in providing health services, including the potential for modern technology to be more widely available to the community and for increased access to quality treatment and diagnostic services.

24. **Addressing Urban Health Service Issues.** PHC in periurban areas faces major problems in keeping up with the demand placed on services by rapid rural to urban migration. Thousands of poor do not have access to state health services because they lack civil registration and are therefore not officially entitled to free health and education services or other social welfare benefits; nor are they eligible to register for state health insurance.

C. Government's Sector Strategies and Policies

25. The Government's Economic Growth Support and Poverty Reduction Strategy (EGSPRS), its National Development Strategy 2021 and National Action Plan, and the Millennium Development Goals (MDG) constitute its main development strategies for health.

26. Under the EGSPRS, adopted in 2003, the Government committed itself to reduce infant and child mortality by 50% by 2005. Building on the EGSPRS, the Government approved the National Action Plan, which identified access to and quality of health care as one of the priorities in Mongolia's development agenda. The Government's long-term strategy—the National Development Strategy for the period through 2021—has two components: (i) private sector-led growth to improve living standards and reduce income disparities, and (ii) social development to improve income opportunities and the quality of public services and access by the poor. Towards its social goals, the long-term strategy targets improved access to health care, particularly maternal and child health services and PHC.

27. The Government's sector goal is to achieve equitable health care by targeting resources especially for the poor and to areas in greatest need. Priorities of the Government include to (a) implement national reproductive health and child health programs, (b) improve quality of health services in rural areas, (c) promote PHC, and (d) encourage private sector participation in health care provision. To promote private sector participation in health care provision, the Government has developed guidelines and a legal framework for social sector restructuring and privatization, and has prepared a list of health facilities for restructuring.

28. The Government developed and endorsed the HSMP in April 2005. Developed through a consultative process, it serves as a comprehensive technical long-term planning document (for 2006–2015) in line with Mongolia's desire to achieve the MDGs. The main strategies of the HSMP include (i) further increasing coverage, access and utilization of health services, especially for disadvantaged groups, through promoting quality PHC; (ii) strengthening health human resources skills and management; (iii) strengthening the financial management system to improve resource use; (iv) improving the health insurance system; and (v) supporting a

sector-wide approach in health care to improve coordination of inputs and resources management.

D. External Assistance to the Sector

29. ADB has been one of the lead aid agencies providing assistance to Mongolia's health sector, supporting the Government's efforts to reform the sector since the early 1990s. Other development agencies that have supported the health sector include the World Health Organization (health policy, programs and standards, child health and nutrition, reproductive health); Japan International Cooperation Agency (JICA—communicable diseases, sector master plan); Japan International Corporation of Welfare Services (sector master plan); United Nations and its agencies (maternal health and child health and nutrition, reproductive health, HIV/AIDS); World Bank (health sector privatization and rationalization); United Kingdom (health training, HIV/AIDS); the Global Fund to Fight Malaria, Tuberculosis, and HIV/AIDS (tuberculosis, HIV/AIDS); and Germany/German Technical Cooperation Agency (GTZ) (reproductive health).

E. ADB's Sector Strategies and Assistance Program

1. ADB's Sector Strategies

30. Appendix 4 summarizes the evolution of ADB's strategy for providing assistance to the health sector.

31. The country operational strategy for Mongolia in 1994–1999 recognized the need to address rising social concerns, but the main emphasis of the strategy was on infrastructure development to underpin economic growth. Technical assistance (TA) was provided to the health sector to address capacity constraints and to improve policy and institutional reform in the sector.

32. Faced with limited assistance resources, the 2000–2005 country strategy acknowledged that the objectives of economic growth and poverty reduction could best be achieved by focusing assistance on a few selected core sectors. Health was chosen as one of the core sectors for ADB interventions to maintain standards of health, raise the general public's health awareness, and improve the accessibility of health care. The health sector strategy was explicit in its focus—general health education, training of health care staff in primary health, vocational training related to the health care industry, capacity building, and health finance management. ADB's country strategy and program (CSP) for 2000–2005 was in line with its health sector policy (1999),[11] which aimed to assist developing member countries in ensuring that their citizens have broad access to basic preventive and curative services that are cost-effective, efficacious, and affordable.

33. ADB's CSP for 2006-2008 is aligned with the government's poverty reduction strategy, which identifies improved access to health care, particularly maternal and child health services and PHC, as immediate targets. Although the health status of Mongolians has improved, the CSP notes that some MDG targets could be at risk, particularly in rural areas. ADB's assistance program for the period aims to focus on health care provision for the poor and for women in community-based programs. The 2007-2009 CSP update[12] affirms the strategic objectives for the health sector as follows: (i) better health services, (ii) improvements at national and local

[11] ADB. 1999. *Policy for the Health Sector.* Manila.
[12] ADB. 2006. *Mongolia Country Strategy and Program Update 2007–2009*. Manila.

levels in health services to poor and vulnerable populations, (iii) reducing inequality in health care, (iv) improving efficiency in the delivery of health care programs, (v) health sector reform; (vi) capacity building for health sector reforms, (vii) decreasing maternal mortality, and (viii) support for ongoing projects for health sector development and health services. Departing from past aims for basic sector development, the indicative lending and nonlending program for 2007–2009[13] is intended to specifically focus on staff rationalization, health care financing, and public-private partnerships. Other development partners, primarily Japan, are expected to provide assistance for infrastructure rehabilitation and equipment.

2. ADB's Sector Assistance Program

34. ADB assistance program in the health sector has developed in line with the evolution of sector strategies. Table 1 shows that sector assistance has reflected the various priorities and objectives in the evolving sector strategies.

Table 1: Alignment of Health Sector Strategies and Assistance Programs

Strategy/Program	1994–1999	2000–2005	2006–2008
A. Sector strategy coverage	a. Sector restructuring and policy reform	a. Improving quality and utilization of health services in rural areas b. Institutional strengthening	a. Improving quality and accessibility of health services for the poor
B. Sector assistance program coverage	a. Institutional strengthening and capacity building b. Improving quality and delivery of health services	a. Improving quality and utilization of health services in rural areas b. Institutional strengthening and capacity building c. General health education	a. Improving quality and accessibility of health services for the poor b. Reforming health care financing
1. Projects/programs by year of approval	a. Loan 1568/1569-MON (SF) Health Sector Development Program	a. Loan 1998-MON (SF) Second Health Sector Development Project	b. Grant 0086-MON (SF) Third Health Sector Development Project
2. Advisory TA by year of approval	a. TA 2252-MON Strengthening Social Insurance (1994) b. TA 2279-MON Strengthening Health Insurance (1994) c. TA 2907-MON Support for decentralized Health Services (1997)	a. TA 4123-MON Health Sector Reform (2003) b. TA 4364-MON Awareness and Prevention of HIV/ AIDS and Human Trafficking (2004)	
3. Grants by year of approval		a. Grant 9053-MON Information and Communication Technology for Improving Rural Health Services (2004) b. Grant 9063-MON Maternal Mortality Reduction (2005)	a. Grant 9115-MON Access to Health Services for Disadvantaged Groups in Ulaanbaatar (2007)

TA = technical assistance.
Sources: ADB Loan, TA, Grant, and Equity Approvals database; Country Strategy and Program, various years.

[13] The assistance pipeline 2007–2009 for the health sector includes the Health Sector Reform Project (planned for 2008) and advisory TA on Administrative Consolidation in the Health Sector (planned for 2008).

35. ADB has been a major partner in Mongolia's efforts to reform its health care system and health financing mechanisms since the early 1990s. ADB has provided three loans for two projects totaling $29.9 million, grant financing of $14 million for one project, eight TA operations amounting to about $3.5 million, and three grants for $4 million for the health sector.

36. **Trends in Lending Operations.** As shown in Table 2, lending operations in the health sector started with the approval of the HSDP in November 1997 for $15.9 million. It consisted of a policy-based loan ($4 million), an investment loan ($11.9 million) and associated TA ($0.6 million). HSDP aimed to support reforms to: (i) make the health system sustainable in a market environment; (jj) maintain universal access to quality health services; and (iii) improve health service quality. To sustain the achievements of HSDP, ADB approved the SHSDP in June 2003. SHSDP had two objectives: to improve rural health service delivery and build the capacity in the health sector. In December 2007, ADB approved THSDP for Asian Development Fund grant financing of $14 million to continue the reform efforts started under the HSDP, which was completed in 2003, and the ongoing SHSDP. The immediate goal of THSDP is effective PHC services, and improved financial protection through health insurance. The long-term goal of THSDP is improved health status and quality of life for the population of Mongolia.

Table 2: Projects/Programs in Mongolia for the Health Sector

Loan		Project Name	Year Approved	Approved Loan/ Grant Amount ($ million)	Rating	
					PCR	PPER
1	1568	Health Sector Development Program	1997	4.00	S	S
	1569	Health Sector Development Project		11.92		
2	1998	Second Health Sector Development	2003	14.00		
3	0086	Third Health Sector Development (Grant)	2007	14.00		
		Total		**43.92**		

PCR = project completion report; PPER = project/program performance evaluation report; S = successful.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; Post-Evaluation Information System; reports and recommendations of the President.

37. Of the three projects approved for the health sector, only the HSDP has been completed. The Project Performance Evaluation Report[14] rates the HSDP "successful" but at the lower end because, although the Project achieved its objective of promoting PHC, key issues remain outstanding such as improved financing of health services, rationalization of the health sector, and upgrading the quality of health services. The SHSDP, which is still under implementation, was making "highly satisfactory" progress according to its PPR as of 30 September 2008. Implementation progress of the THSDP was "satisfactory" as of 30 September 2008.

38. Key outputs achieved to date from ADB's loan operations in the sector include (i) introduction of the FGP system to provide PHC services, (ii) establishment of a licensing and accreditation unit for health facilities and development of a licensing system for health professionals to encourage private sector participation in health services delivery, (iii) development of rationalization plan for hospitals in Ulaanbaatar, (iv) development of a training curriculum and conduct of training for doctors and nurses (over 1,300 doctors and nurses trained), (v) introduction of capitation scheme for FGPs, (vi) setting up of a system to target support and guarantee access of the poor and vulnerable to health services; (vii) rehabilitation and upgrading of health facilities and provision of equipment, (viii) development of a

[14] ADB 2008. *Project Performance Evaluation Report on the Health Sector Development Program in Mongolia*. Manila.

rationalization plan for staff in the health sector, and (ix) preparation of the HSMP 2006-2015. Further information on the achievements of health sector projects is provided in Appendix 5.

39. **Trends in TA Operations.** As of December 2007, ADB had provided five advisory TA grants to support sector reforms and capacity building, and three project preparatory TA (PPTA) grants (Table 3). The HSDP PPTA,[15] completed in September 1996, was of a high standard. It provided a comprehensive analysis of the health sector, health services, and facilities; and was conducted in a consultative manner. It is noteworthy that although the PPTA did not specifically recommend the private FGP model that became central to the HSDP, it emphasized the need to focus on shifting resources from hospital-based services to public health and PHC and to build a comprehensive referral system.

Table 3: Technical Assistance to Mongolia for the Health Sector

	TA Number	Year Approved	TA Title	TA Type	Amount ($'000)	Status	Rating	
							TCR	TPER
1	2252	1994	Strengthening Social Insurance	AD	84	Closed		
2	2279	1994	Strengthening Health Insurance	AD	500	Closed	GS	
3	2414	1995	Health Sector Development	PP	600	Closed		
4	2731	1996	Health Sector Resources Development	PP	100	Closed		
5	2907	1997	Support for Decentralized Health Services	AD	600	Closed	HS	S
6	3750	2001	Second Health Sector	PP	600	Closed		
7	4123	2003	Health Sector Reform	AD	650	Closed	S	
8	4364	2004	Awareness and Prevention of HIV/AIDS and Human Trafficking	AD	350	Ongoing		
			Total		**3,484**			

AD = advisory, PP = project preparatory, TA = technical assistance, TCR = TA completion report, TPER = TA performance evaluation report.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; Post-Evaluation Information System.

40. Aside from preparation of projects, outputs of TA operations have included (i) preparation of rationalization plans for health infrastructure and for health personnel; (ii) training for health insurance and social insurance administrators; (iii) preparation of a plan to integrate national health insurance and social insurance systems; (iv) review of health insurance policies, organizational setup, actuarial data, poverty impacts, and information systems to increase the efficiency of the health insurance scheme; (v) conduct of participatory workshops, short-term in-country and overseas training courses, and on-site training at the provincial level to strengthen local government's capacity to plan and manage local health services (more than 1,000 personnel trained); (vi) procurement of computer equipment and basic software for training activities and to improve efficiency; (vii) development of materials and guidelines on health services planning, financing, management, and evaluation and other reference materials to guide health personnel; and (viii) preparation of draft papers on health care financing and health insurance development strategy (Appendix 6).

41. **Trends in Grant Projects.** Three grants projects were approved for the health sector (Table 4). Two of these were funded from the Japan Fund for Poverty Reduction (JFPR): one supported government efforts to reduce the maternal mortality rate,[16] while the other aimed to

[15] ADB. 1995. *Technical Assistance to Mongolia for Health Sector Development.* Manila (TA 2414-MON for $600,000, approved 12 October).
[16] ADB. 2005. *Grant Assistance to Mongolia for the Maternal Mortality Reduction Project, Manila.* (Grant 9063-MON for $1.0 million, approved 20 February).

improve the access of disadvantaged groups in periurban areas to health services.[17] Another grant project–*Information and Community Technology for Improving Rural Health Services*[18] financed from the Japan Fund for Information and Communication Technology, intended to improve access to and quality of health services for vulnerable groups, especially poor mothers and children. The project focuses on improving technological capacity to link soum health centers to aimag general hospitals, with an emphasis on maternal and child health outcomes.

Table 4: Other Grant-Financed Projects in Mongolia for the Health Sector

	Approval No.	Project Name	Year Approved	Amount ($ million)
1	9053	Information and Communication Technology for Improving Rural Health Services	2004	1.00
2	9063	Maternal Mortality Reduction	2005	1.00
3	9115	Access to Health Services for Disadvantaged Groups in Ulaanbaatar	2007	2.00
		Total		**4.00**

Note: Excludes Grant 0086: Third Health Sector Development Project (amounting to $14.0 million).
Source: ADB. Loan, TA, Grant, and Equity Approvals database.

42. Some of the outputs of grant operations to date include the following: (i) a new information and communication technology (ICT)-supported consultation and referral system interconnecting aimag hospitals and health departments with remote and isolated soum and bag PHC facilities has been installed; (ii) ICT tools like personal digital assistants, internet access, e-mail-based bulletin board system and e-mail access have been introduced; (iii) training and workshops have been conducted on case management for rural health workers, reproductive health and social welfare service, basic and advanced computer skills; (iv) computer training rooms (equipped with laptops and printers) have been set up in three project aimags; (v) training materials on system administration, ICT-supported case management, health information software, and personal digital assistant user guidelines were developed; (vi) electronic patient recording systems are now in use in admissions departments (vii) baseline data for monitoring and evaluation have been collected; and (viii) a survey on ICT use in rural health services was undertaken. Appendix 7 provides details of the status of ADB grant projects for the health sector.

43. **Factors Affecting Implementation.** Implementation of ADB projects, TA, and grants has generally proceeded satisfactorily. The major factors affecting implementation of the sector program have been political instability and inconsistent policy approaches, with leadership oscillating between pro- and antireform agendas. Since 1992, successive governments[19] have

[17] ADB. 2007. *Proposed Grant Assistance to Mongolia for Access to Health Services for Disadvantaged Groups in Ulaanbaatar.* Manila. (Grant 9115-MON for $2.0 million, approved 19 December).

[18] ADB. 2004. *Grant Assistance to Mongolia for Information and Communication Technology for Improving Rural Health Services.* Manila. (Grant 9053-MON, for $1.0 million, approved 02 August).

[19] In 1992, a democratic Constitution was adopted. Successive free elections led to orderly changes of government, with the Mongolian People's Revolutionary Party (MPRP–former communist party) forming most of the governments since 1990. However, in 1996, the Democratic Alliance, an electoral coalition, defeated the MPRP. In 1997, the election of the chairman of the People's Revolutionary Party as President strengthened opposition to reform, but in 1998, a pro-reform Prime Minister was elected, who subsequently resigned. In June 2004, a coalition of the main opposition parties established a Government, but in 2005, the MPRP provided the President, and in 2006, a Prime Minister. In January 2006, the MPRP ministers stepped down from their functions and a new "Government of national unity" under MPRP leadership was formed. The new cabinet also included non-MPRP ministers, partly from the previous Government. In the Parliamentary elections held in June 2008, a majority of the seats was won by the MPRP but there were allegations of electoral fraud from the main opposition party (the

also oscillated between decentralization and recentralization policies. Decentralization has been the formal stated objective, but at times some provincial governments have been free to reject reforms endorsed by the national government such as that proposed for interprovincial referral systems—although the innovative FGP model was accepted by all provincial governments. There have also been issues affecting the staffing of the Project Implementation Unit (PIU),[20] which suggest that relations between ADB and MOH need to be more consultative.

F. Evaluation of ADB Assistance

1. Assessment of Strategic Performance (Top-Down Assessment)

44. This assessment of ADB's strategic performance is used to assess and rate ADB's sector positioning, overall contribution of the assistance effort to sector development results, and the quality and responsiveness of ADB's services.

a. Sector Positioning

45. **Positioning.** Positioning measures how well ADB responded to the evolving development challenges and priorities of the Government, built on the organization's comparative advantage and designed CSPs, while taking into account the assistance of other development partners. The positioning of ADB's strategy in the health sector is assessed as "substantial." Positioning was assessed based on the following criteria: (i) basis for the sector strategy; (ii) government's absorptive capacity and ownership; (iii) ADB's comparative advantage and harmonization with other development partners; (iv) focus, selectivity, and synergies; (v) long-term continuity of sector strategies; and (vi) risk assessment and monitoring mechanisms. Appendix 4 details the positioning of ADB's strategies in the health sector.

46. **Basis for the Strategy.** ADB's health sector strategies have been based on the country strategies, ADB's policy for the health sector, sector studies, government priorities, and policy dialogue with the Government and with other development partners. The sector strategies have been consistent with ADB's and the Government's poverty reduction strategies, which have identified health as one of the core sectors to promote economic growth and poverty reduction. ADB's strategies for the health sector have been in line with the Government's priorities and the country's changing development needs. When Mongolia joined ADB in 1991, the country was undergoing transition from a centrally planned to a market economy. During this period, investments in the social sectors were secondary to promoting economic growth. Thus, ADB interventions at this time consisted mostly of TA for capacity building, institutional strengthening, and support for sector restructuring. Sector strategies from 2000 have been fully aligned with the Government's medium-term development strategies and national poverty reduction strategies, which have underscored the critical role of investments in the health sector in preventing the development of new forms of poverty based on health deprivation.

47. **Government's Absorptive Capacity and Ownership.** The country strategies during the transition period acknowledged weaknesses in the Government's fiscal and administrative absorptive capacity. Consequently, ADB projects included strong TA components to address the administrative and technical constraints within the Government, particularly within MOH and

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Democratic Party). In September 2008, a new Prime Minister of a coalition government between MPRP and the Democratic Party, was elected from the MPRP.

[20] In 2006 and 2007, MOH decided to implement changes in the PIU leadership for SHSDP without adequate consultations with ADB (against ADB policy that PIU staff must be hired competitively and in accordance with ADB procedures and submitted for ADB endorsement).

local governments, to manage and develop local health services. Sector strategies from 2000 have emphasized the need for a highly participatory project and reform preparation process involving consultations with the Government, parliamentary groups, civil society, and the private sector, which have helped to reinforce reform ownership. Both ADB and the Government consider improving the quality of the health care system, ensuring access to and quality of PHC, and reforming health care financing to be key instruments to reduce poverty, accelerate economic growth, and reduce disparities in the development process, particularly between rural and urban areas.

48. **ADB's Comparative Advantage and Harmonization of Development Assistance with Other Development Partners.** The sector strategies have been "relevant" to ADB's comparative advantage and to efforts to harmonize external assistance in the sector. According to the country strategy for 2000–2005, ADB's advantage compared with other aid agencies in the health sector was mostly in the areas of supporting policy and institutional reforms, decentralization, and training—areas that had been the focus of ADB interventions since the early 1990s.

49. ADB's country strategies have acknowledged that development assistance in the health sector has lacked a strategic framework and has remained uncoordinated, with an ambiguous distribution of roles. To improve coordination and effectiveness of external funding, the Government agreed to establish a series of sectoral and thematic working groups. The social sector working group, which focuses on health and education, is co-chaired by ADB and Japan. Although one of the main thrusts of the HSMP (para. 28) is to support a sector-wide health care approach to improve aid coordination, there has been little progress to date in fostering a harmonized approach in the sector. Externally financed projects remain fragmented and are largely planned and implemented on a bilateral basis between the Government and the respective development agencies, thus limiting coordination and coherence between projects, and raising transaction costs. For instance, while ADB is promoting PHC and a referral system, other agencies are supporting the establishment of new and better hospitals. Lack of collaboration among development partners involved in the sector results in ineffective and inefficient use of scarce resources.

50. **Focus, Selectivity, and Synergies.** The focus of the sector strategies has been consistent with the issues and challenges identified, and with the mix of instruments for implementing the strategies. The use of the sector development program (SDP) modality[21] for the HSDP and for a series of successive operations was suitable and responsive to the sector challenges identified.

51. **Long-Term Continuity of Sector Strategies.** ADB's sector strategies have continuously evolved and have built on previous health sector development initiatives. Although ADB interventions have laid the groundwork for further sector reform and development with the introduction of the FGP system, significant challenges remain in health care financing and health insurance, human resource development, and health care for unregistered citizens. ADB is working closely with the Government and other development agencies to address these issues.

[21] An SDP is a combination of an investment (project or sector) component and a policy-based (program) component as well as, where appropriate, attached TA, with a view to meeting sector needs in a comprehensive and integrated fashion. It is considered when a sector requires both investment and policy reform components, and where the former is unlikely to be accomplished in full and on time without the support of a policy-based component (OEM D5/BP, 29 October 2003).

52. **Risk Assessment and Monitoring Mechanisms.** ADB's country strategy in 1994–1999 recognized the need to assess the Government's progress in implementing reforms but did not include monitoring mechanisms, given the prevailing practice at the time. The strategies for 2000–2005 and 2006–2008 included sector roadmaps that identified targets and provided monitoring indicators to measure progress.

b. Contribution to Development Results

53. Contribution to development results, which is assessed based on the extent to which ADB's overall strategy and program have contributed to the achievement of development results at the national level, has been "modest." ADB has been a major partner of the Government in reforming the health sector. However, over the last 5 years, the Government and MOH have made relatively little progress in replacing the inefficient hospital-based system that is biased towards curative care with a system based on PHC and preventive services. The concept of family medicine has been introduced, and a network of FGPs has been established, but much remains to be done to embed the changes and deepen their impact. FGPs continue to face severe challenges in terms of viability, staffing, and quality of services. Further efforts to consolidate and continue implementation of health sector reforms within the framework of the HSMP are ongoing under the SHSDP and THSDP.

c. ADB's Performance in the Sector

54. ADB's performance in the sector has been "modest." Strategies have been responsive to the critical needs in the sector, and consistent with the evolving demands of the transition to a democratic government and a free market economy. However, key reform goals, the need for which is widely recognized by ADB and aid partners in the health sector, have so far faced greater political resistance than was originally anticipated. The policy goals first articulated in the HSDP (e.g., rationalization of health facilities and personnel), although endorsed by MOH, have been refused by some urban district governments, provincial governments, and other state agencies. On hindsight, a more participatory and broadly based consultative approach could have been taken to define what could realistically be achieved on a step-by-step basis. The Government approved a nationally developed HSMP in 2005 that endorses strategic objectives for the sector that have been promoted by ADB over the past 10 years. The broad stakeholder participation and level of ownership involved in formulating the HSMP may eventually increase political support for reforms. However, the policy commitments in the HSMP are still far from being actually implemented.

d. Overall Top-Down Rating

55. ADB's strategic performance is assessed to be "partly successful" using the three criteria of sector positioning, contribution to development results, and performance in the sector (Table 5).

Table 5: Summary Rating of Strategic Performance in the Health Sector

Item	Score (scale of 0-8)	Rating
Positioning	6	Substantial
Contribution to development results	4	Modest
ADB performance	4	Modest
Total score	**14**	**Partly Successful**

Note: The ratings and corresponding score for the 3 criteria are: high (8 points), substantial (6 points), modest (4 points), negligible (0 point). Strategic performance is assessed as highly successful if the total score is greater than or equal to 20, successful if the score is between 16 and 19, partly successful if the score is between 11 and 15, and unsuccessful if the total score is 10 or less.
Source: Operations Evaluation Mission.

2. Assessment of ADB's Sector Assistance Program (Bottom-Up Assessment)

56. The bottom-up assessment of ADB's performance in the health sector is based on the five evaluation criteria of relevance, effectiveness, efficiency, sustainability, and impact.

a. Relevance

57. Relevance was assessed based on the extent to which sector operations have been (i) aligned with the country's evolving circumstances and priorities, (ii) consistent with ADB's mission, (iii) in line with ADB's comparative advantage, and (iv) harmonized with assistance by other development partners. ADB's assistance is rated "relevant" to the Government's changing priorities, sector needs, and ADB's country strategy.

58. Until the early 1990s, Mongolia's health system depended almost entirely on centrally managed, hospital-based health services supplemented by centralized specialist hospitals, designed to meet the requirements of socialist agricultural and industrial collectives, the state bureaucracy, and other state agencies. The early 1990s witnessed major developments—collectives collapsed, the economy moved towards a market system, the bureaucracy was reorganized—while the Government's finances plummeted. Without subsidies from the former Soviet Union, the financial resources to sustain this health system were no longer available by the early 1990s. Health services deteriorated and could not be provided to meet the needs of most of the population at the levels provided before transition. About 40% of staff left the state health service, the net reduction being around 25% because new medical graduates continued to enter the system. On average, in 1990–1996, 8.5% of qualified doctors left employment in the health sector each year. Health sector reforms, which included introduction of a HIF and training in general practice and the principles of PHC within the medical school curriculum, commenced in 1995. However, the health services continued to deteriorate, and it became apparent that there was a need for more fundamental reform to develop a three-tier system in which primary and preventive services would form a foundation, with referral to rationalized secondary and tertiary levels of care, supported by associated training, management assistance, policy advice, new equipment, and the provision or rehabilitation of health service infrastructure. ADB's program of assistance was designed to address these evident and pressing needs.

59. The sector program was congruent with ADB's Poverty Reduction Strategy and Mongolia's EGSPRS. In 2000, Mongolia was the first developing member country to enter into a poverty partnership agreement (PPA) with ADB. Health was chosen as one of the five core sectors for ADB operations to uphold standards of health and to raise the general public's

awareness and improve the accessibility of health care. The PPA set targets, which included (i) reducing by half the mortality rates for infants and children under 5 years of age, and by two-thirds the mortality rates for mothers, by 2005; and (ii) increasing access with the objective of providing universal access to reproductive health services for all females of appropriate age by 2015. The project components of the THSDP, which was approved in 2007, supports the major strategies of the HSMP 2006–2015 (para. 28).

b. Effectiveness

60. Effectiveness was assessed based on how successful assistance has been in contributing to the attainment of sector outputs and outcomes. ADB's program of assistance has thus far been "less effective." Mongolia has been reforming its health care system and health financing mechanisms since the early 1990s, and ADB has been helping the Government plan and implement sector reforms since 1997. ADB has introduced significant and necessary changes in the health system, particularly in effecting the necessary policy shift from a hospital-based curative system to less costly PHC. As noted, a major innovation under the HSDP and SHSDP was the introduction of FGPs to provide PHC in urban areas. By early 2002, the Government had established 237 FGPs in Ulaanbaatar and in all provincial urban centers nationwide. In theory, FGPs work as private entities through contracts with local administrations, and are paid on a capitation basis under performance-based contracts that incorporate incentives for FGPs to treat the poor. Since its establishment, however, the FGP model has been gradually eroded. FGPs continue to face significant challenges, including (i) inadequate funding, (ii) ambiguous legal status (while legally "private," FGPs are fully dependent on state funding and regulation), (iii) inadequate incentives for FGP contractors, and (iv) unsatisfactory quality of services in FGPs serving large periurban areas.

61. Implementation of reforms in many areas has been incomplete. Hospital accreditation has been applied only to a limited extent, reflecting weak reform in the hospital sector. Rationalization of hospitals and health personnel has reduced the number of beds and staff by 40% since 1990 (to 7.5 beds and 13.4 staff per 1,000 population in 2001). However, these ratios are still much higher than in comparable countries. Civil works upgrading of rural hospitals was in many instances of inadequate quality and, under the HSDP, did not include provision of water and sanitation, as a result of which rural hospitals have very poor sanitary conditions. Most rural district hospitals lack complete, functioning sets of basic diagnostic equipment to facilitate appropriate referral, and pharmaceutical supplies are very limited.

62. The barriers to achieving desired outcomes include (i) limited demand for PHC services due to preexisting public attitudes that favor hospital use for medical advice and services of all kinds,[22] which is reinforced by low quality of PHC services; (ii) hospital rationalization was difficult to achieve due to the fragmentation of funding sources, and hospitals tend to take a narrow, overspecialized clinical perspective on general health services needs; (iii) the limited consolidation of hospitals was offset by unregulated growth of private hospitals and clinics; and (iv) state policies on civil registration hinder access to health services by the migrant poor (para. 24).

[22] The socialist-era health system conditioned the people to expect most medicines to be delivered by injection, therefore requiring a trained nurse to administer their medications; and to expect extended hospital stays, even for relatively minor illnesses. The introduction of a nonhospital-based PHC system required a major reorientation of public expectations about the kind of health services they were entitled to.

c. Efficiency

63. Efficiency refers to the extent to which ADB resources provided for the sector have been optimally utilized. ADB's assistance to the sector has been "less efficient." The strategy to combine hospitals to create a smaller number of larger and more efficient facilities, to close small redundant hospitals, and to reduce duplication in services would have generated substantial operating savings for the health sector and created a more efficient distribution of resources between primary and secondary and tertiary services. However, this fundamental reform has not been achieved under the HSDP and the SHSDP to date. Unresolved issues include financing of health services, rationalization of the hospital sector, and improving the quality and accessibility of health services. Other policy elements introduced under the HSDP, such as private sector outsourcing of noncore hospital services, quality-related monitoring mechanisms, supporting human resources movement to rural underserved areas with additional financial incentives, and information campaigns on PHC have not been sustained beyond the HSDP. According to a recent health sector assessment (footnote 8), despite the rapid population growth in Ulaanbaatar due to rural to urban migration, there are still too many hospital beds, inpatients, and specialists; and not enough experienced general practitioners. Furthermore, the "private" FGP model has not solved the problems of the state in finding nonpublic resources to finance PHC services. The overall health system remains burdened with inefficiencies. Table 6 shows that the government share in health spending further increased to about 78% in 2007, while the share of HIF declined significantly from 31.5% in 2002 to 18.5% in 2007.

Table 6: Mongolian Public Health Expenditure, by sources (%)

Source	2000	2001	2002	2003	2004	2005	2006 Revised	2007 Plan
Central Government budget	73.8	66.1	64.0	69.0	70.9	69.1	72.9	77.9
Social Health Insurance Fund	20.4	27.6	31.5	24.9	25.4	26.1	23.3	18.5
Out-of-pocket payments to public providers	5.8	6.3	4.5	6.1	3.7	4.8	3.8	3.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Sources: Ministry of Finance 2007and Ministry of Health 2007.

d. Sustainability

64. Sustainability is assessed based on the likelihood that sector outputs and outcomes will be sustained in the future. ADB's program of assistance is assessed as "likely sustainable." Policy reform promoted by ADB in its sector assistance is reflected in the Government's HSMP, which places central emphasis on PHC and further strengthening of the FGP system. However, the sustainability of the FGP model itself is threatened if FGPs remain dependent on state funding and if the population continues to migrate to urban areas—where ready access to more modern hospitals is available, especially if the economy improves and more urban dwellers choose private health care providers over FGPs. The THSDP will continue to work to resolve financial management issues in an improved policy environment. The Government's commitment to address quality issues—for example, by increasing the requirements for hospital reregistration, an initiative initiated under the HSDP, and by introducing more rigorous requirements for licensing medical practitioners and quality controls on pharmaceuticals—is manifested in the HSMP. Government health expenditures have increased consistently over the years (particularly since 2000), showing that the Government recognizes the critical importance of investments in the health sector. Expenditure for PHC has risen significantly in recent years—from MNT 23.7 billion in 2006 to MNT 32 billion in 2007—and is expected to further

increase to MNT 51 million in 2008, an indication of the Government's growing commitment to preventive health and PHC.

e. Impacts

65. This refers to the extent to which the sector program has contributed to long-term changes in development conditions, including success in contributing to the attainment of the MDGs. The impact of ADB's assistance to the health sector has been "modest." ADB assistance under the HSDP introduced a pro-poor PHC system that is accessible to all urban residents in Mongolia. However, state policies on civil registration, which restrict the right to access public services to those defined by place of legal domicile, continue to be a major obstacle in providing the migrant poor in periurban areas with access to health services.

66. ADB assistance in the health sector has supported efforts to attain three MDGs: (i) Goal 4 (reduce child mortality), Goal 5 (improve maternal health), and Goal 6 (combat HIV/AIDS, malaria, and other diseases like tuberculosis). Based on 2006 data (Table 7), MDG targets for infant mortality and under-five mortality rates have already been achieved. Progress has also been made in reducing MMR and prevalence of underweight children. However, while the overall MMR has decreased, there is significant variation across the country, with some provinces having rates three times higher than the national average.

Table 7: Mongolia's Millennium Development Goals and Targets in Health

Indicator	1990	2006	2015
Infant mortality rate (per 1.000 live births)	64.4	19.1	22.0
Under-five mortality (per 1,000 live births)	88.8	23.2	29.2
Prevalence of underweight children	12.0	6.3	0.0
Maternal mortality rate (per 100,000 live births)	121.6	67.2	50.0
Percentage of births attended by health personnel	100.0	99.7	99.8
Incidence of tuberculosis (per 100,000 population)	79.0	185.3	100.0

Source: UNDP. 2007. *Mongolia Human Development Report 2007: Employment and Poverty in Mongolia* (citing Government of Mongolia. 2007. The Millennium Development Goals Implementation, Second National Report).

f. Overall Bottom-Up Rating

67. Overall, ADB's program in the health sector is assessed as "partly successful." A summary of the assessment of ADB's sector assistance is provided in Table 8. This rating may need to be revised after the completion of ongoing projects and TA operations, and when the outputs of ADB assistance become more clearly visible. If the THSDP succeeds in its goal to consolidate and complete the reform initiatives commenced under the HSDP and SHSDP to strengthen Mongolia's health system, the rating of ADB's sector assistance will likely improve.

Table 8: Performance Rating of ADB Health Sector Assistance

Criterion	Score	Rating
Relevance (0-3)	2	Relevant
Effectiveness (0-6)	2	Less effective
Efficiency (0-3)	1	Less efficient
Sustainability (0-6)	4	Likely
Impact (0-6)	2	Modest
Overall	**11**	**Partly successful**

Note: The ratings and corresponding score for the 5 evaluation criteria are (a) relevance - highly relevant (3 points), relevant (2 points), partly relevant (1 point), irrelevant (0 point); (b) effectiveness - highly effective (6 points), effective (4 points), less effective (2 points), ineffective (0 point); (c) efficiency - highly efficient (3 points), efficient (2 points), less efficient (1 point), inefficient (0 point); (d) sustainability - most likely (6 points), likely (4 points), less likely (2 points), unlikely (0 point); (e) impact - high (6 points), substantial (4 points), modest (2 points), negligible (0 point). Sector performance is assessed as highly successful if the total score is greater than or equal to 20, successful if the score is between 16 and 19, partly successful if the score is between 11 and 15, and unsuccessful if the total score is 10 or less.
Source: Operations Evaluation Mission.

3. Overall Evaluation

68. The overall rating based on the bottom-up and top-down assessments of ADB's strategy and assistance in the health sector is "partly successful" (Table 9).

Table 9: Performance Rating of ADB Health Sector Assistance

Item	Score	Rating
Health sector strategy (top-down)	14	Partly successful
Health sector assistance program performance (bottom-up)	11	Partly successful
Overall	**25**	**Partly successful**

Note: Overall performance rating is assessed as highly successful if the total score is equal to or greater than 40, successful if the total score is between 30 and 39, partly successful if the total score is between 20 and 29, and unsuccessful if the total score is 19 or less.
Source: Operations Evaluation Mission.

III. SOCIAL PROTECTION IN MONGOLIA

A. Sector Background

69. Following the transition, the Government was confronted with mounting poverty and economic uncertainty. The prevailing social protection system had been based on universal access to a number of generously funded programs. Faced with the rising need for social assistance and a decline in resource availability, the Government had to initiate steps to change the social welfare system from provision of universal access to targeted assistance. Towards these ends, the Government established a new social security system comprising (i) social welfare services and social assistance benefits to protect minimum living standards for the poor and vulnerable, (ii) employment services (including information and advisory services as well as support for direct job placement or organization of training courses for the unemployed), and (iii) social insurance to support working people from the risk of falling into poverty.

70. The Ministry of Social Welfare and Labor (MSWL) is the lead agency for the sector. Under MSWL are specialized agencies responsible for the implementation and regulation of

social insurance, social assistance, and employment and labor markets. These include (i) the State Social Welfare Agency, which is tasked with the delivery of social welfare services and social assistance benefits;[23] (ii) the National Centre for Rehabilitation of the Disabled, which is responsible for rehabilitation and training of persons with disabilities (PwD); (iii) the Central Employment Regulation Office (CERO), which is the primary agency responsible for providing employment services to the unemployed in its central office and throughout the country through employment regulation offices (ERO), which serve as the primary point of contact for the unemployed in their search for jobs; (iv) the Labor and Social Welfare Inspection Agency, which is the regulatory agency responsible for occupational safety and health; and (v) SSIGO, which is the lead agency responsible for social insurance.[24] Appendix 8 provides a more detailed description of Mongolia's social security sector.

B. Key Sector Issues and Challenges

71. Social protection, as defined in ADB's Social Protection Strategy,[25] consists of a "set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income. Social protection programs are built primarily to mitigate the impacts of shocks or to help people cope with risks[26] when they occur. ADB interventions in Mongolia for social protection aim to address the following key issues and challenges to enable vulnerable groups to better manage livelihood risks:

72. **Improving the Targeting of Social Welfare Beneficiaries.** With the limited resources available in the Social Assistance Fund (SAF), benefits are insufficient to help the most vulnerable cope with risks. Average pension rates are too small—in 2001, over 228,000 SAF beneficiaries received the equivalent of an average of about $3.82 per month. Moreover, since benefits are provided on a universalized basis, a significant number of beneficiaries are not poor. Existing resources should be better targeted to the poor and ultrapoor who are most in need of financial assistance.

73. **Providing More Equitable Access to Social Assistance Services.** Many elderly, PwD, and children in difficult circumstances depend on institutional care provided through a network of nursing homes and social care shelters. Mongolia's reliance on these centralized institutions is costly and limits coverage of services, thereby excluding many of those in need. Many of these institutions are in a state of disrepair, but the state's ability to upgrade and rehabilitate them is constrained by lack of funds. The Government is moving to promote community-based approaches to welfare services provision[27] to enable those requiring social services to remain close to their communities, and to reduce service delivery costs.

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[23] These comprise (i) in-kind services including residential facilities (nursing homes) for the elderly and disabled as well as services for the poor and homeless (e.g., feeding and bathing); (ii) discounts to the elderly, disabled, and other groups to reduce the costs of housing, health care, wheelchairs, and hearing aids; and (iii) payment of benefits from the Social Assistance Fund, including short-term benefits for pregnancy and delivery, child care and infant nursing, and adoption; and long-term pensions for those not eligible for pensions from the contribution-based Social Insurance Fund.

[24] SSIGO administers five insurance funds − pensions, benefits, health, employment injury and occupational disease, and unemployment − supported by insurance payments and state subsidies.

[25] ADB. 2001. *Social Protection Strategy.* Manila.

[26] Risks include, for example, natural disasters, economic downturns, unemployment, illness, accident, disability, and death.

[27] In Mongolia, this can typically be done at the district level.

74. **Addressing Unemployment and Related Problems.** Formal unemployment figures, which represent only the unemployed who are formally registered with EROs, or those who have paid a minimum level of unemployment insurance contributions, do not capture the real extent of unemployment in Mongolia. The official unemployment rate in 2006 was 3.2%, but actual levels are significantly higher.[28] Of the de facto (unregistered) unemployed, approximately 75% do not have professional qualifications, making it difficult for them to find employment. Many of the poor and unemployed also lack basic literacy and numeracy skills. The registered unemployed are entitled to a small grant for vocational training, but the amount has been insufficient to cover actual training fees. Adult education and training programs are also limited in number and are offered mainly in major population centers. Employment-related training has also been hampered in recent years by low investments. Consequently, the training curricula, materials, equipment, and facilities are outdated, requiring substantial revision to meet the skills requirements of a market economy. Advisory services provided by EROs also need reform, in particular to widen access and to include entrepreneurship training and other business development services to help the unemployed develop their own businesses.

75. **Tackling Social Insurance Issues**. Social insurance programs are designed to help mitigate income risks associated with illness, disability, work injury, unemployment, and old age. However, the social insurance system that has been introduced in Mongolia is underfunded because of (i) budgetary constraints, (ii) evasion of compulsory social insurance contributions by a significant number of employers from both the state and private sectors, and (iii) increasing numbers of workers in the informal sector and the self-employed (including herders) who are not covered by social insurance schemes. The ability of SSIGO to enforce compliance is constrained by lack of access to employment records and the limited powers of social insurance inspectors.

76. Only a small proportion of the unemployed (only the registered unemployed)[29] and none of the unemployed in the informal sector have access to unemployment insurance benefits. The self-employed, which covers some 350,000 herders (the numbers vary) and 130,000 workers in the informal economy, account for about 50% of Mongolia's workforce. Informal workers and livestock herders are eligible to participate in the current programs on a voluntary basis, but only a small percentage (estimated at about 4%) participate in the scheme.[30] ADB is currently providing TA[31] to review the current pension plans and policies and recommend a strategy for further pension reforms.

77. **Strengthening Institutional Capacity.** The delivery and administration of social welfare and employment services and of social insurance benefits across a sparsely populated country like Mongolia are costly in terms of human and financial resources, suggesting the need to develop a more appropriate and cost-effective structure to deliver services, especially at the local level. Institutional capacities of the different agencies in the social security sector need to

[28] According to statistics compiled by the labor and social welfare offices, the unemployment rate has remained stable at about 3.5% over the last 5 years. In 2002-2003, unemployment was estimated at about 3.2% of the labor force. However, a more reliable estimate of unemployment that meets international standards–.e., persons who are without work, available for work, and actively seeking work–is estimated to be around 14% (UNDP. 2007. Mongolia *Human Development Report 2007: Employment Generation and Poverty in Mongolia.* Ulaanbaatar).

[29] Official statistics counted about 33,000 registered unemployed in 2006.

[30] Most employees in the informal sector are unable or unwilling to contribute a percentage of their incomes to finance social protection schemes, since it does not meet their priority needs. The informal sector prioritizes immediate needs such as health, employment or source of livelihood, shelter, food, clothing, and survival from natural disasters.

[31] ADB. 2006. *Technical Assistance to Mongolia for Strengthening the Pension System*. Manila. (TA 4910-MON for $650,000 approved 27 December).

be developed in line with new service delivery mechanisms to enhance efficiency and improve service delivery. The roles and responsibilities of the various agencies should be clearly defined to reduce duplication and overlap. Coordination and linkages across ministries[32] and agencies involved in the sector also need to be strengthened.

78. **Assisting the Unregistered Poor.** Citizens who lack registration in their place of residence comprise a substantial proportion of the poor. They are not eligible for social services like health, education, or targeted benefits for the disabled and unemployed, although some assistance is currently being provided by civil society organizations.

79. A number of measures were adopted in 2008 to assist this group, including the appointment of full-time social workers in urban local government offices to encourage registration by providing information, forms, and assistance in filing of applications for registration. Local municipalities are also establishing livelihood support councils. A revised and simplified civil registration system is currently being considered to facilitate the registration of those described as undocumented citizens.[33]

80. **Adopting Consistent Policy Approaches.** The stated objective of the 2000-2004 Action Plan adopted in September 2000 is that "it shall improve the wealth and income distribution system, stall the decline in the living standard of the people, narrow the income gap among social groups, and eliminate absolute poverty." However, at the political level there has been resistance in adopting the necessary reforms, including those that were endorsed by the Government under the Social Security Sector Development Program (SSSDP).[34]

81. Political influence has been a persistent problem. For example, the social insurance contribution rate was lowered by Parliament from 19% to 10% without consulting the concerned government departments and agencies. The intention was to encourage contributions by small and medium enterprises and the self-employed, but the measure has put the viability of the Social Insurance Fund at risk. The recent Cabinet Resolution merging MOH and MSWL may create more problems, since MOH is already responsible for overseeing a major series of health sector reforms.

C. Government's Sector Strategies and Policies

82. The Government's Poverty Reduction Strategy aims to, among others, contribute to improved living conditions of the poor. The main goals for labor and social welfare sector are to reduce unemployment and poverty, improve the living standards, ensure social guarantees and improve the quality of and access to caring services.

83. The Government's National Development Strategy includes a social welfare policy focusing on low-income poor and vulnerable groups, which sets out key policy objectives

[32] For instance, collaboration and coordination between MSWL and the Ministry of Education, Culture and Science in training for employment purposes is necessary.

[33] Assistance from the United Nations Development Programme, United Nations Fund for Population Activities, and JFPR through ADB is being provided in some localities to support these initiatives. In 2007, ADB approved a JFPR pilot project in three periurban settlement areas of Ulaanbaatar to improve the access of the poor to health services and test a program for social workers to encourage civil registration (ADB. 2007. TA ADB. 2007. *Proposed Grant Assistance to Mongolia for Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila. Grant 9115-MON for $2.0 million, approved 19 December).

[34] ADB. 2001. Report and Recommendation of the President on Proposed Loans and Technical Assistance Grant to Mongolia for Social Security Sector Development Program. Manila (Loans 1836-MON [SF]/1837-MON[SF] for a total of $12 million, approved 28 August 2001).

including to (i) upgrade the quality and access of social welfare services, diversify types and scope of the services, and improve them; (ii) create adequate and efficient infrastructure for the delivery of social protection services to citizens, particularly those living in the rural and remote areas, and regularize operations; (iii) implement a program to deliver employment services to the youth, informal sector employees, workers abroad, and the poor and extreme poor; (iv) provide support to reduce poverty and unemployment, and improve the living standards of citizens; and (v) improve social protection for the population by strengthening the social insurance system and making social welfare and care services more qualified and accessible.

84. Key elements of the National Action Plan relating to the social security system include to (i) reduce the number of poor households living under the poverty line by half through a set of social and economic measures to prevent living standard decline and by providing jobs to poor citizens of working age, and (ii) develop and strengthen a national social security system. In terms of welfare services, the plan aims to (i) improve social protection measures for poor and disabled people and for mothers with many children, (ii) increase the number and types of benefits and services rendered to senior veterans, and (iii) create favorable conditions for neglected children to live in their own homes and provide them with assistance and services. In the area of employment promotion and worker conditions, the plan intends to (i) revise and enforce the labor safety and sanitary standards in accordance with the Labor Law, (ii) provide unemployment insurance for uninsured people and professional training and labor market activities, and (iii) develop the content of vocational training and activities of centers for vocational training. Within social insurance, the plan aims to (i) expand social insurance coverage, strengthen the responsibility for timely payment of insurance contributions, and improve self-financing of social insurance contributions; (ii) cover herders and the self-employed and improve their social protection; and (iii) enforce the regulation on payment from the occupational injuries/diseases insurance fund of benefits to people disabled by industrial accidents or professional sickness, and expenses for the resulting care and treatment.

D. External Assistance to the Sector

85. Various development agencies have provided assistance to address priority issues in Mongolia's social security system. In the area of social welfare, support provided by the United Nations Children's Fund (UNICEF), GTZ, international nongovernment organizations like Save the Children Fund, United Kingdom, and World Vision have centered on the needs of vulnerable children. In employment promotion, the European Union has taken the lead role in strengthening employment services. GTZ has supported efforts to develop the formal vocational training system. The United States Agency for International Development (USAID) has assisted in skills training and entrepreneurship development for the provinces in the region of the Gobi Desert. The United Nations Development Programme (UNDP); Swedish International Development Agency; United Nations Educational, Scientific and Cultural Organization; and Danish International Development Agency have provided support to nonformal training for employment. The employment promotion activities envisaged within the SSSDP is linked to existing externally supported microfinance schemes such as the UNDP-supported Micro-Start Program and other schemes supported by the European Union, GTZ, and USAID. The Nordic Development Fund (NDF) is financing the skills training and entrepreneurship development subcomponents (under the employment promotion component) of the SSSDP. In the area of social insurance, USAID has provided assistance to promote pension reform, with focus on capacity building of SSIGO.

E. ADB's Sector Strategies and Assistance Program

1. ADB's Sector Strategies

86. Appendix 9 summarizes the evolution of ADB's strategy for the social protection subsector.

87. The country operational strategy for Mongolia in 1994–1999 acknowledged the necessity to address rising social concerns, particularly the rising unemployment and deteriorating social safety net allied with an increasing incidence of poverty following the transition. The strategy recognized that long-term growth and social development require continued support for human development including addressing factors that affect access of the poor and near poor to productive employment. However, the main focus of the strategy remained on promoting growth through infrastructure investment. To address the Government's administrative and technical capacity constraints, ADB envisaged the provision of TA to improve efficiency and support policy and organizational reforms being contemplated in the sector.

88. Faced with strict resource constraints, the 2000-2005 country strategy indicated that economic growth and poverty reduction objectives could best be attained by focusing assistance on a few selected core sectors. Social protection (treated with health as one sector) was chosen as one of the core sectors for ADB assistance. The strategy explicitly provided for what was intended as a one-off intervention to put in place a strong safety net for the poor. Moreover, the strategy stressed that ADB did not foresee substantial involvement for social protection, given the sector's constraints and the fact that other aid agencies were already involved in it.

89. ADB's CSP 2006–2008 provided that ADB will focus assistance on a limited number of sectors—viz., agriculture, transport, education, health, and urban development (core sectors)—and discontinue support in other sectors including social security, although assistance in the core sectors will have direct and indirect impacts on social protection.

2. ADB's Sector Assistance Program

90. ADB's assistance program in social protection is aligned with the sector strategies and has reflected the priorities and objectives in the sector strategies as shown in Table 10.

Table 10: Alignment of Social Protection Sector Strategies and Assistance Programs

Strategy/Program	1994–1999	2000–2005	2006–2008
A. Sector strategy coverage	a. Improving sector efficiency b. Institutional strengthening and capacity building	a. Develop an efficient social security sector	
B. Sector assistance program coverage	a. Institutional strengthening and capacity building	a. Establish an efficient social security system b. Institutional strengthening and capacity building	a. Support for pension reform
1. Projects/programs by year of approval		a. Loans 1836/1837-MON (SF) Social Security Sector Development Program (2001)	
2. Advisory TA by	a. TA 2371-MON	a. TA 3709-MON	a. TA 4910-MON

Strategy/Program	1994–1999	2000–2005	2006–2008
year of approval	Administrative Reform of Social Insurance (1995) b. TA 2683-MON Strengthening the National Poverty Alleviation Program(1996) c. TA 2978-MON Social Safety Net (1997)	Strengthening Policy for Social Security Reform (2001)	Strengthening the Pension System (2006)
3. Grants by year of approval		a. Grant 9014-MON Expanding Employment Opportunities for Poor Disabled Persons (2002)	

TA = technical assistance.
Sources: ADB Loan, TA, Grant, and Equity Approvals database; Country Strategy and Program, various years.

91. ADB approved two loans amounting to $12 million for the SSSDP, five TA operations totaling $3.6 million for the sector, and one grant project for $1 million being implemented in conjunction with the SSSDP.

92. **Trends in Lending Operations.** The SSSDP, approved in August 2001, comprised an integrated package of a policy loan ($8 million), an investment loan ($4 million), and associated TA ($0.6 million). The SSSDP aimed to support reforms to strengthen the ability of the country's social security system to deliver essential welfare, insurance, and employment services to vulnerable groups.

93. The PPR for the SSSDP's investment loan (Loan 1836) indicates that, overall, the project was making satisfactory progress as of 30 September 2008. There are no serious issues that could materially affect implementation progress, although the loan closing date was extended from 31 December 2007 to 31 December 2008. On the other hand, implementation progress of the policy loan (Loan 1837) has been partly satisfactory according to the PPR as of 31 December 2007. Although there are important achievements in the areas of employment promotion and social insurance, policy measures in social welfare services have faced some setbacks. In 2006, the Government adopted a social welfare package to increase benefits on a universalized basis to newborn babies, schoolchildren, newlyweds, pregnant mothers, and mothers with five or more children against the third tranche condition requiring narrowly targeted assistance to the poorer segments of the population. The third tranche of the policy loan was subsequently cancelled effective 22 November 2007 (Table 11).

Table 11: Projects/Programs in Mongolia for Social Protection

	Loan No.	Project Name	Year Approved	Approved Amount ($ million)	Status	PPR Rating	
						IP	DO
1	1836	Social Security Sector Development Program (Project)	2001	4.00	Ongoing	S	S
	1837	Social Security Sector Development Program (Program)	2001	8.00	Third tranche cancelled effective 22 Nov 2007		
		Total		**12.00**			

DO = development objective, IP = implementation performance, PPR = project performance report, S = Satisfactory.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; project performance reports; reports and recommendations of the President.

94. Key outputs of the SSSDP (investment loan) thus far include

- For Component 1 (Social Welfare): development of community-based programs for vulnerable groups (e.g., provision of day care and preschool services, counseling services, skills training), renovation of three nursing homes, construction of two pilot social security centers;[35] and training of center staff, participation of social welfare staff in local and international training, development and approval of a Social Security Services Strategy Paper, pilot-testing of community-based projects financed under the Community Social Welfare Innovation Facility [36] and Livelihood Enhancement Assistance Program, and renovation and procurement of equipment for MWSL and State Social Welfare Agency
- For Component 2 (Employment Provision): rehabilitation of 31 training centers and schools, training to upgrade skills of vocational teachers, procurement of training equipment for 71 training centers, establishment of six regional resource centers, establishment of five business incubators to support entrepreneurs in developing their own businesses, business training for 800 individuals interested in establishing businesses, and restructuring of CERO and the Labor and Social Welfare Inspection Agency
- For Component 3 (Social Insurance): procurement of ICT equipment for MSWL agencies and SSIGO, development and execution of an Information Education and Communication Strategy on the new social security reforms and innovations, and study tours and international training for MSWL staff

95. The program loan component of SSSDP resulted in the employment of 221,617 individuals through employment offices between 2001 and 2006, skills training and retraining of 111,715 persons, establishment of an accreditation system for vocational skills and training institutions, and social insurance benefit coverage for 390,900 individuals compared with 351,200 in 2003. Further details on the outputs of the SSSDP are provided in Appendix 10.

96. **TA Operations.** ADB provided five TA operations amounting to $3.6 million for social protection (Table 12), one of which was a PPTA for the development of the project proposal for the SSSDP. The four advisory TA grants focused on assisting the government in developing a sustainable social security system appropriate to a market economy and building capacity for its implementation. The associated TA for SSSDP aimed to support reforms to strengthen the social security system's ability to deliver essential welfare, insurance and employment services to vulnerable groups.

[35] Pilot social security centers offer a full range of social services in one facility.
[36] The Community Social Welfare Innovation Facility was established to finance community-based social welfare service interventions on a pilot basis.

Table 12: Technical Assistance to Mongolia for Social Protection

TA No.	Year Approved	TA Title	TA Type	Amount ($'000)	Status	Rating	
						TCR	TPER
1 2371	1995	Administrative Reform of Social Insurance	AD	900	Closed	GS	
2 2683	1996	Strengthening the National Poverty Alleviation Program	AD	422	Closed	GS	
3 2978	1997	Social Safety Net	PP	985	Closed		
4 3709	2001	Strengthening Policy for Social Security Reform	AD	600	Closed	PS	
5 4910	2006	Strengthening the Pension System	AD	650	Ongoing		
		Total		**3,557**			

AD = advisory, PP = project preparatory, TA = technical assistance, TCR = TA completion report, TPER = TA performance evaluation report.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; Post-Evaluation Information System.

97. Of the five TA grants for the sector, four have been completed, and TA completion reports are available for three. Two were rated "generally successful" - TA activities were completed as scheduled and outputs were successfully attained; and one was rated "partly successful." Although the design of the TA rated partly successful was relevant and the performance of the executing agency (EA) was highly satisfactory, expected outputs were achieved with some success largely due to the EA's own efforts and only after additional consultants were engaged to support the development of the social security system strategy. The performance of the only ongoing TA was "satisfactory" as of 30 September 2008 according to the TA performance report.

98. Aside from preparation of projects, outputs of TA operations to date include provision of training courses on social insurance, establishment of a computer training center for social insurance, procurement and installment of computer hardware and software for the computerization of social insurance contributions, completion of actuarial and economic studies, development of guidelines and training courses for implementation of the SAF and the Employment Promotion Fund, development of a national strategy for poverty monitoring and assessment for 1996–2000, provision of hardware and software to the National Statistics Office and MSWL for the conduct of poverty-specific analysis, and development of a Social Security Sector Strategy and preparation of studies underpinning the strategy. Appendix 11 provides information on the status and outputs of TA operations for social protection.

99. **Grant Project.** One JFPR grant-financed project[37] was provided for social protection (Table 13). The grant project aimed to pilot sustainable approaches to reduce poverty among disabled members of the labor force. The project complemented the SSSDP, which sought to reduce poverty and increase security among vulnerable groups including PwDs.

[37] ADB, 2001. *Grant Assistance to Mongolia for Expanding Employment Opportunities for Poor Disabled Persons*. Manila. (Grant 9014-MON for $1.0 million, approved 1 April.)

Table 13: Other Grant-Financed Projects to Mongolia for Social Protection

	Approval No.	Project Name	Year Approved	Amount ($ million)	Status
1	9014	Expanding Employment Opportunities for Poor Disabled Persons	2002	1.00	Project completed

Sources: ADB. Loan, TA, Grant, and Equity Approvals database; grant assistance reports.

100. Activities and outputs of the grant project include training courses of 4-6 weeks duration for 1,905 PwDs; organization of job fairs, which resulted in the employment of 200 disabled job seekers; public awareness workshops and seminars for 1,530 employers on services provided by PwDs; basic and advanced training courses for disabled entrepreneurs; provision of startup capital to over 200 PwDs and 122 groups generating over 500 jobs; organization of trade and product fairs where more than 500 disabled entrepreneurs participated to market their products and services; construction of four workshops for PwDs; job placement for 301 disabled persons in sheltered employment; renovation of two large sheltered employment workshops for the blind and physically handicapped; and a nationwide public awareness raising campaign to inform PwDs of their rights and to raise awareness in the community of the potential of PwDs to contribute to economic development (Appendix 12).

101. **Factors Affecting Implementation**: Weak project management unit capacity, staff turnover and policy vacillation affected the implementation of the project. MSWL took on a new and unfamiliar venture for Mongolia—establishing three new programs for (i) social welfare to provide benefits to the poorest and most vulnerable citizens; (ii) social insurance based on employer and employee contributions; and (iii) employment services to assist the unemployed in finding work and, if necessary, acquiring job skills. However, Mongolia had few staff trained in modern social welfare approaches consistent with a free market economy, so much of the initial policy work was led by international consultants, with associated issues of ownership. Slow progress in the social welfare component was also linked to weak institutional capacity for undertaking policy reforms in the area, and delays in the development of the Social Security Master Plan (SSMP), which was partly a result of less than satisfactory performance of advisory services provided under the TA to support the Government in developing the SSMP. Other factors affecting implementation include the need for improved coordination between the Ministry of Finance and the Economy (EA for the policy loan), MSWL (EA for the investment loan), and the Ministry of Education, Culture and Science (implementing agency for the skills training and entrepreneurship development subcomponents of the investment loan); and the need for close collaboration with NDF for NDF-financed activities. As noted in the assessment of the effectiveness of ADB assistance (para. 113), a key issue affecting implementation of the policy loan was the lack of political will to implement reforms aimed at targeting social welfare assistance to the most vulnerable.

F. Evaluation of ADB Assistance

1. Assessment of Strategic Performance (Top-Down Assessment)

a. Sector Positioning

102. **Positioning.** The positioning of ADB's strategies in the social protection subsector (which is summed up in Appendix 9), is rated "modest."

103. **Basis for the Sector Strategy.** Sector strategies have been based on the country strategies, stated priorities of the Government, and policy dialogue with the Government and with other development partners. The sector strategies have been consistent with ADB's and the Government's poverty reduction strategies, which have recognized the importance of social protection to help prevent more people from falling below the poverty line. ADB's strategies have been in line with the government's priorities and the country's changing development needs. The SSSDP was designed to address the sector challenges cited in Section III.B above—project components have been responsive to the critical needs of the subsector.

104. **Government's Absorptive Capacity and Ownership.** The country strategies during the transition period recognized the constraints in the Government's financial and administrative absorptive capacity. ADB TA including the associated TA for the SSSDP aimed to address the administrative and technical weaknesses within the Government, particularly within MSWL and attached agencies. The sector strategies from 2000 have indicated that the preparation process involved consultations with the Government, parliamentary groups, civil society, and the private sector.

105. **ADB's Comparative Advantage and Harmonization of Development Assistance with Other Development Partners.** The SSSDP was designed to be fully compatible with external support for social security development provided by other aid agencies. The development of an SSMP within the SSSDP, an initiative supported by other development partners, will facilitate aid coordination and resource mobilization for key interventions in the area that are not covered by the current program.

106. **Focus, Selectivity, and Synergies.** The focus of the sector strategies has been relatively broad but consistent with the issues and challenges identified. The mix of instruments to implement the strategies, particularly the use of the SDP modality for the SSSDP, has been suitable and responsive to the sector challenges identified.

107. **Long-Term Continuity of Sector Strategies.** ADB's sector strategies have evolved in line with the critical needs in the subsector. ADB interventions have laid the groundwork for future sector reform and development. However, the reform agenda remains largely unfinished, and outstanding sector issues include major initiatives such as targeting social assistance, the restructuring of MSWL, and provision of social security for unregistered citizens. In light of the long-term nature of reform and the continuing requirement for institutional assistance in this area, the use of a one-off loan to support what is inevitably a more protracted reform process could be questioned.

108. **Risk Assessment and Monitoring Mechanisms.** ADB's country strategies during the transition phase did not include monitoring mechanisms, given the prevailing practice at that time. But the strategy for 2000-2005 included sector roadmaps that identified targets, and provided monitoring indicators to measure progress. Appendix 9 describes in more detail the positioning of ADB's strategies for social protection.

b. Contribution to Development Results

109. ADB's contribution to development results is rated "modest" but on the low side. ADB projects and associated TA have helped introduce the necessary initial reforms in social security provision such as sector restructuring, institutional strengthening and capacity building, and improvements in infrastructure (e.g., nursing homes, employment centers) and service delivery (e.g., establishment of community-based approaches to social welfare delivery,

construction of pilot socials security centers). However, a key objective of ADB assistance to the sector—more effective targeting of beneficiaries—was not attained when the Government decided to adopt a new social welfare package in 2006 providing cash benefits to all newborn, schoolchildren, newlyweds, pregnant mothers, and mothers with five or more children (para. 93). The measure expanded the coverage of social assistance,[38] but welfare benefits have remained too small to provide sufficient assistance to beneficiaries to overcome vulnerability and poverty.

c. ADB's Performance in the Sector

110. ADB's performance in the sector has been "modest." While the SSSDP aims to respond to key issues and challenges affecting social protection, the project has tried to cover too many areas all at once. The SSSDP (as designed) comprises an ambitious reform agenda covering three (of the five) major components of social protection.[39] There has been limited selectivity and focus, given the broad variety of reform priorities and interventions in the subsector. The preparatory work for the SSSDP failed to identify what could reasonably be achieved, given the acknowledged lack of institutional capacity to undertake and sustain wide-ranging reforms in the subsector. There appears to have been inadequate diagnostic work on the Government's ability to implement a welfare system that would involve narrow targeting. Although the risk assessment for the SSSDP identified political resistance to implement reform measures that would change the eligibility criteria for entitlement to social welfare benefits as a significant risk, the proposed mitigating measures (participatory approach to design and implementation, and public education campaigns) have proved inadequate to counter political opposition. Moreover, ADB policy dialogue failed to convince Parliament of the necessity of focusing assistance on the income poor or to include periurban ger communities in the social protection safety net.

d. Overall Top-Down Rating

111. ADB's strategic performance is assessed as "partly successful" using the three criteria of sector positioning, contribution to development results, and performance in the sector (Table 14).

Table 14: Summary Rating of Strategic Performance in Social Protection

Criterion	Score (scale of 0-8)	Rating
Positioning	4	Modest
Contribution to development results	2	Modest but on the low side
ADB performance	5	Modest
Total score	**11**	**Partly successful**

Note: The ratings and corresponding score for the 3 criteria are: high (8 points), substantial (6 points), modest (4 points), negligible (0 point). Strategic performance is assessed as highly successful if the total score is greater than or equal to 20, successful if the score is between 16 and 19, partly successful if the score is between 11 and 15, and unsuccessful if the total score is 10 or less.
Source: Operations Evaluation Mission.

[38] The number of SAF beneficiaries has increased significantly in the last 3 years – from 155,500 in 2004 to 754,800 in 2005. In 2006, the number of people who received social welfare assistance reached about 1.05 million.

[39] These are (i) labor market policies and programs designed to generate employment and improve working conditions; (ii) social insurance programs to cushion the risks associated with unemployment, health, disability and work injury, and old age; and (iii) social assistance and welfare service programs for the most vulnerable groups with no other means of adequate support. The two other major elements of social protection, according to the Social Protection Strategy, are (i) micro and area-based schemes to address vulnerability at the community-level, and (ii) child protection to ensure the healthy and productive development of children.

2. Assessment of ADB's Sector Assistance Program (Bottom-Up Assessment)

a. Relevance

112. ADB's assistance to the sector is assessed as "relevant." ADB interventions have been aligned with the Government's sector goals and priorities to develop and strengthen the national social security system in order to reduce poverty, prevent living standard decline, and provide employment to poor unemployed citizens. Sector assistance has been consistent with ADB's and Mongolia's poverty reduction strategies, and has supported the PPA between ADB and Mongolia. The assistance program, particularly project preparation of the SSSDP, has been undertaken in close coordination with other aid agencies like GTZ, JICA, UNDP, UNICEF, USAID, and the World Bank to ensure optimal coordination and to benefit from the experience of other agencies active in the sector. The SSSDP, as designed, is an "example of an integrated, comprehensive social protection intervention."[40] However, the scope of the project proved too ambitious, considering the Government's technical capacity constraints, lack of experience in implementing a social security system appropriate for a market-based economy, and lack of political will to reform.

b. Effectiveness

113. The program of assistance is rated "less effective" on the high side. Most of the planned activities to support social welfare, social insurance, and employment services were satisfactorily completed, including capacity building within MSWL and attached agencies, and public awareness campaigns regarding social security reforms and innovations (Appendixes 10–12). The desired outcome of the SSSDP—to strengthen the social security system's ability to deliver essential welfare, insurance, and employment services to the ultra poor, very poor, and those close to the poverty line—has been partly achieved, but much remains to be done. Sector interventions under the SSSDP have helped improve services in social welfare facilities for the elderly and the disabled (with the upgrading of facilities and skills of center staff), and have brought social welfare services to the vulnerable in their own communities (by way of pilot testing of community-based social welfare projects). In the area of employment promotion, sector operations have helped upgrade the employment-related skills of the poor and unemployed (through the provision of skills training and entrepreneurship development programs). Sector activities within the social insurance component have also helped strengthen SSIGO's capacity to manage social insurance programs (with the upgrading of the agency's facilities and staff skills). Sector operations have also helped expand employment opportunities for PwDs through direct job placement; provision of training, counseling services, and financial support for business startups; organization of trade and product fairs; and an information campaign to inform PwDs of their rights, and to raise awareness in communities of the potential economic contributions of PwDs.

114. Although sector assistance has led to some improvements in the delivery of social security services, the effectiveness of ADB interventions in preventing people from falling into poverty remains limited. Despite measures to assist the unemployed, only a small proportion of them have received assistance in the form of vocational and skills training, and business development programs. The number of people contributing to social insurance schemes has increased only modestly. While the total number of employed individuals increased by about 32% (from 768,000 to 1.01 million), the number of employees enrolled in social insurance

[40] ADB. 2002. *Social Protection Strategy: 2003 Progress Report to the Board of Directors.* Manila.

programs increased by only about 4% (from 409,000 to about 428,000) between 1995 and 2006.[41] The proportion of employees enrolled in pension, industrial injury, and unemployment insurance to the total number of employees has been on a downward trend—from 53.3% in 1995 to 47.1% in 2000 to 42.4% in 2006 (Appendix 2, Table A2.3). While ADB assistance has helped develop the basic legal and regulatory foundations for a social security system with the preparation of a Social Security Strategy Paper, the framework has not been adopted so far. Effective targeting of assistance to the poor was not undertaken after the Government adopted a new social welfare package in 2005 (para. 93).

c. Efficiency

115. The program of assistance was assessed as "less efficient." A key objective for the sector was to ensure that limited resources were used efficiently through effective targeting of assistance to the poor. This has not occurred, largely because social welfare assistance is not targeted at those who need it the most. Eligibility is still broadly based, including payment of baby bonuses,[42] and assistance to single parents, the unemployed, the disabled, mothers with many children, and the elderly, without effective means testing, thereby allowing the nonpoor to capture many of the benefits (para. 93). Consequently, welfare payments are small, thinly spread, and inadequate to alleviate the poverty of beneficiaries. Implementation of reforms has been constrained by public sensitivities, popular expectations, and political demands that access to social welfare benefits should be broadly based.

d. Sustainability

116. The assistance is rated "less likely to be sustainable." Although the Government remains committed to finance social welfare services[43] and has provided adequate counterpart funds and staff to implement project activities under the SSSDP, the sustainability of the social security system is threatened by the Government's inability to better target social assistance to the poorer segments of society.

117. A recently enacted law revised the eligibility criteria for recipients of social welfare benefits but does not distinguish those who have low incomes from those with incomes above the poverty line. The legislation does not address the urgent need for the Government to direct public resources towards the poorest and most vulnerable citizens to allow for increased levels of assistance per beneficiary. The social security system will likely be sustainable if better targeting mechanisms such as those proposed in the Social Security Strategy Paper are adopted to identify those who are most in need of social welfare assistance.

e. Impacts

118. The contribution of ADB assistance to the social protection subsector has been "modest". Notable achievements to date include approval of a center-based program for extremely vulnerable people; an integrated community-based social service program, with draft standards prepared for formal legal approval; charters for employment training centers and business incubation centers; required amendments to the employment promotion law; and preparation of

[41] Between 2000 and 2006, about 203,000 new non-agricultural jobs were created, but enrollment in the pension fund increased by only about 46,300 during the period.

[42] Beneficiaries of baby bonuses increased sharply from 33,500 in 2004 to 647,500 in 2005 to 872,400 in 2006 (Appendix 2, Table A2.2)

[43] Expenditures on social security and welfare have remained high, averaging about 7.7% of GDP and 19.5% of total government expenditure) between 2000 and 2006.

the Social Security Strategy Paper. However, the primary objective of ADB interventions—to rationalize the system of social assistance to focus resources on the poorest—has not been realized. The adoption of a social welfare package in 2005 providing increased benefits to all newborns, schoolchildren, newlyweds, pregnant mothers, and mothers with five or more children led to a significant increase in the number of people receiving social welfare assistance. However, welfare assistance per beneficiary is still too small to help the poor cope with economic risks and to protect welfare levels.

f. Overall Bottom-Up Rating

119. Overall, ADB's sector program in social protection is assessed as "partly successful." A summary of the assessment of ADB's sector assistance is provided in Table 15.

Table 15: Performance Rating of ADB Sector Assistance in Social Protection

Criterion	Score	Rating
Relevance (0-3)	2	Relevant
Effectiveness (0-6)	3	Less effective
Efficiency (0-3)	1	Less efficient
Sustainability (0-6)	3	Less likely to be sustainable
Impact (0-6)	2	Modest
Overall	**11**	**Partly successful**

Note: The ratings and corresponding score for the 5 evaluation criteria are (a) relevance - highly relevant (3 points), relevant (2 points), partly relevant (1 point), irrelevant (0 point); (b) effectiveness - highly effective (6 points), effective (4 points), less effective (2 points), ineffective (0 point); (c) efficiency - highly efficient (3 points), efficient (2 points), less efficient (1 point), inefficient (0 point); (d) sustainability - most likely (6 points), likely (4 points), less likely (2 points), unlikely (0 point); (e) impact - high (6 points), substantial (4 points), modest (2 points), negligible (0 point). Sector performance is assessed as highly successful if the total score is greater than or equal to 20, successful if the score is between 16 and 19, partly successful if the score is between 11 and 15, and unsuccessful if the total score is 10 or less.
Source: Operations Evaluation Mission.

3. Overall Evaluation

120. The overall rating based on the bottom-up and top-down assessments of ADB's strategy and assistance in the social protection subsector is "partly successful" (Table 16).

Table 16: Performance Rating of ADB Social Protection Sector Assistance

Item	Score	Rating
Social protection sector strategy (top-down)	11	Partly successful
Social protection sector performance (bottom-up)	11	Party successful
Overall	**22**	**Partly successful**

Note: Overall performance rating is assessed as highly successful if the total score is equal to or greater than 40, successful if the total score is between 30 and 39, partly successful if the total score is between 20 and 29, and unsuccessful if the total score is 19 or less.
Source: Operations Evaluation Mission.

IV. LESSONS, AND FUTURE CHALLENGES AND OPPORTUNITIES

A. Identified Lessons

121. ADB's experience in implementing projects, TA operations, and grants in health and social protection highlight important lessons for ongoing and future ADB assistance:

122. In the health sector, ADB needs to improve its engagement with MOH, as well as the political levels of government, in order to achieve consensus on the development of policies and measures to implement the objectives of the HSMP to improve health services to the poor, target diseases of the poor, and reduce the financial burden on poor people.

123. Past assistance in the health sector underscored the need for vigilance in relation to the design and construction of civil works for health infrastructure. The Project Performance Evaluation Report for the HSDP noted poor quality of civil works in many rural hospitals visited by the Operations Evaluation Mission that were renovated under the project, and frequent lack of provision for water and sanitation facilities. Vigilance is also needed in future tender processes. On 23 October 2006, the East Asia Department Social Sectors Division informed the Office of the Auditor General of the Government's decision to blacklist several construction companies after an administrative inquiry established that falsified financial information had been provided by these companies in bids submitted under the SHSDP. The Office of the Auditor General conducted its own investigations to confirm the Government's findings and found that 11 companies committed fraud under ADB's Anticorruption Policy.

124. PHC services in periurban areas face major problems in keeping up with the demand placed on them by rural to urban migration. However, while poor periurban areas are underserved, some urban areas are overserviced because prospective clients bypass FGPs and go directly to hospitals. There is a risk that the health system will become a dual system in which public facilities are used by the poor and private facilities by the better off. The growing middle and upper classes in Ulaanbaatar provide a potential market for the growth of private PHC practice. Along with the growth of private hospitals, "real private" primary care clinics are likely to emerge as for–profit enterprises in Ulaanbaatar and other cities with more affluent populations. Such enterprises may, for instance, bypass the HIF by registering individuals under subscription payments and charging fees or by entering into service contracts for PHC services with private enterprises.

125. ADB's sector program in health as well as that in social protection have been affected to some extent by political instability and inconsistent policy approaches, with leadership oscillating between pro and anti-reform agendas. Lack of consistent decision making based on stated policy issues underlies some of the challenges identified in Section II.B above. MOH's plan to close or merge hospitals was suspended during the SHSDP due to political and popular resistance to the rationalization of hospitals. External assistance has not been coordinated to facilitate rationalization. New hospitals are being built, and the number of hospital beds has been increasing in Ulaanbaatar since 2000. Hospital services still account for about 70% of health expenditure, while PHC remains severely underfunded.

126. ADB operations in the health and social protection sectors also highlight the critical importance of securing political support and social consensus before undertaking programs involving sector policy reform. The mixed experience in health and social protection policy reform − a decade after agreements were reached—implies that substantial upfront effort needs

to be made in policy analysis, consultation, outreach, and consensus-building before policy reforms are framed and loan agreements are reached.

127. In social protection, the achievements of the SSSDP to date indicate that reforms in the subsector are not yet complete. Much of what can be achieved critically depends on the Government's commitment to undertake essential reforms to ensure the sustainability of the social security system. In social welfare provision, the Government should implement its endorsed policy to provide targeted social assistance benefits only to the poorest and most vulnerable. In social insurance, the Government must continue efforts to enforce compliance of employers with compulsory contributions. To help address unemployment, employment-related programs and services should be accessible not only to the registered unemployed but should be made available to all the unemployed. A positive development in this regard is the amendment in January 2008 of the Law on Employment Promotion, expanding coverage of the Employment Promotion Fund to those in the informal sector (e.g., herders) and PwDs.

B. Future Challenges and Opportunities

128. Despite some significant achievements, the reform agenda in the health and social protection sectors remains largely unfinished. Outstanding sector issues for possible ADB assistance in the future are discussed below.

129. **Health Care Financing.** Mongolian public health care expenditure is relatively low at around 5% of GDP, but increasing funding and investment will only partly address the problems in the health sector. Despite relatively low expenditure on health, the health system has the potential to perform more effectively through improvements in operating efficiency linked to better financing strategies and targeted funding based on performance. Currently, health financing is inefficient and, as noted in section II.B, hospital funding from the government budget and health insurance are not linked to performance, which encourages unnecessary admissions and long hospital stays. There is a lack of costing data; financial allocations favor larger hospitals over smaller rural facilities; and there is disproportionate spending overall on hospitals vis-à-vis public health or preventive services. ADB provided TA support[44] to (i) strengthen MOH and MSWL capacity and improve understanding of output-based and performance-based budgeting as required under the Public Sector Management and Finance Law,[45] and (ii) improve sustainability of the HIF. The TA will, among others, build capacity in MOH and SSIGO to streamline and formulate pricing and payment mechanisms in health care financing, including capitation, single purchaser systems, case mix and per capita funding.

130. Future ADB assistance to the sector should be linked closely to the Government's commitment to implement its HSMP 2006-2015, particularly the HSMP policy to rationalize health expenditure by addressing the inefficient allocation of resources between hospital (curative) services and PHC (preventive) services. The reform of health financing has been

[44] ADB. 2003. *Technical Assistance to Mongolia for Support for Health Reform.* Manila. (TA 4123-MON, for $650,000, approved 5 June)

[45] The Public Sector Management and Finance Law was adopted in 2002 to provide the legal basis for improving budget formulation and execution, and public sector performance management. It requires public agencies (including hospitals) to be funded based on their outputs or products, i.e., outputs that hospital and health services provide need to be defined and their costs estimated to help identify population needs, assess budget needs to address these concerns, and target resources to areas with the greatest need and with the greatest inequity in health outcomes. ADB provided TA to support implementation of the Public Sector Management and Finance Law (ADB. 2002. *Technical Assistance for Strengthening Public Sector*. Manila. [TA 3920-MON, for $522,562.68, approved 5 September]).

agreed upon with ADB in the past but has not been implemented to date. This declared and widely endorsed objective necessary for health sector development will require political commitment. Reallocation of financial support to primary and preventive health services is urgently needed to sustain the sector reforms that have been supported by ADB over the past 10 years.

131. **Health Sector Human Resources Development.** The system is characterized by an oversupply of doctors. The HSDP succeeded in reducing the number of doctors in public facilities (by 932) during 1997–2000, but since 2000, the overall number of doctors has increased (by 40% in specialist hospitals and 80% private hospitals). The increase was partly due to the large intake of students into the Health and Sciences University (about 600 students per year), which benefits the university, since tuition fees are its main source of income, but provides no incentive to improve quality or reorient medical education to address the need for general practitioners (most medical students aim to specialize). Despite the large numbers of doctors graduating, there is a shortage of experienced doctors in rural areas. Support from the Government is needed to regulate medical university enrolments, and to provide an incentive system to encourage experienced health personnel to serve in rural areas. The system is also marked by a low ratio of nurses to doctors; ineffective distribution of key personnel, with critical shortages in rural and remote areas; and poor career development opportunities.

132. The Government should adopt policies to address the mismatch between the number of medical and paramedical education slots available to the human resource requirements in the sector by (i) reorienting the focus of the medical school curriculum to address the paradoxical situation in which there is an oversupply of doctors, yet positions in PHC clinics and rural hospitals and health centers remain vacant; (ii) reorienting medical and paramedical training so that graduates are encouraged to take up careers in providing public, family, and PHC services; (iii) supporting incentives to encourage experienced health personnel to serve in rural areas; and (iv) increasing the extent and quality of nursing education so that the ratio of nurses to doctors will increase in all health facilities.

133. **Provision of Health Care and Social Security for Unregistered Citizens.** Urban areas in Ulaanbaatar are growing rapidly because of migration from rural areas, and 60% of the total population live in *ger* areas. Precise statistics are not available, but it is estimated that 60,000 urban residents are unregistered. Significant numbers of the poor are ineligible for health insurance, free access to PHC facilities, and other state social services because they have not legally registered in their places of residence.

134. The absence of effective social protection, i.e., the dysfunctional social and health insurance and the lack of access of unregistered poor to education, health, and social protection services, negatively affects ADB's poverty reduction efforts. However, nonregistration will probably continue to be a significant barrier to access for many poor urban migrants unless registration processes are simplified. At present, the registration process is complicated, inefficient, and time consuming; and many migrants are unaware of or inadequately informed about the legal requirements for registration, or are unable for one reason or another to obtain the documents required for registration. Moreover, an undetermined but substantial number of families and individuals may have documentation but are still ineligible because they have not settled. These so-called “urban nomads” move around between urban districts and neighborhoods looking for work and accommodation. Since they are not registered permanent residents, they lack legal access to health and other social services. Further research is needed to determine the magnitude of this problem and to assist the Government to ensure that all citizens have access to basic health care and social security services. Despite recent initiatives

(e.g., appointment of social workers to help in the civil registration process in some localities, and establishment of household livelihood support councils in urban local governments), thousands of poor urban migrants will likely remain undocumented unless the existing registration policies and processes are changed. Ongoing discussions to reform civil registration so that all citizens have admission to state services, to simplify registration processes, and to increase awareness of the legal requirements should be supported by ADB. ADB should assist the Government to fast-track civil registration of the unregistered poor to enable them to access education and health services, and other targeted state benefits.

135. **Restructuring of MSWL.** The recent Cabinet Resolution to merge MOH and MSWL may further complicate the delivery of social protection services. If the Government is committed to restructure MSWL, it may be more efficient and effective to transfer some of the functions of MSWL to other government agencies. For instance, employment and training-related functions could be reassigned to the Ministry of Education, Culture and Science, while functions pertaining to disability and care of the aged could be transferred to MOH; MSWL social work functions could be moved to city and provincial governments; and, in particular, a new agency could be established for managing an appropriately targeted social and health insurance system. ADB should continue to engage in policy dialogue with the Government to determine how it can more effectively provide assistance in efforts to merge MOH and MSWL functions.

THE SOCIAL COSTS OF MONGOLIA'S ECONOMIC TRANSITION[1]

1. Mongolia's transformation from a centrally planned to a market-based economic system has had adverse social impacts. The transition has been accompanied by a concomitant increase in poverty and unemployment levels, a deterioration in the status of women and the disabled, and a surge in rural to urban migration.

2. **Poverty.** Poverty increased from 15% of the population in 1991 to 36.3% in 1995. Poverty was disproportionately urban, with 57.2% of the poor residing in urban compared with 42.8% in rural areas.[2]

3. Three groups stand out among the poor: (i) subsistence, seminomadic herder households with approximately 100 animals or less (ii) migrants in urban centers and on the periphery of Ulaanbaatar and (iii) the aged and disabled. Poor herder households have few income opportunities. They are vulnerable to weather shocks and often lack access to public services, particularly in health and education. Poor migrant households have often failed to make a sustainable living in herding. They lack basic urban services, cannot easily access health facilities and education, and mostly find only intermittent employment in the informal sector.[3] Along with the uneducated, older Mongolians have generally been unable to access opportunities provided by the market economy and were not able to accumulate financial savings during communism. The social security and welfare system consumes a large share of the national budget but is unable, partly due to poor targeting, to provide the aged and disabled with a reasonable standard of living.

4. **Unemployment.** Under the command economy before 1990, access to employment was nearly universally guaranteed, and there was no recognized unemployment. The transition brought about a rise in unemployment—from 6.5% in 1991 to a high of 9% in 1994—due to retrenchment, privatization of state-owned enterprises, and bankruptcies. The official unemployment rate in 2001 was 6.5% (39,000 people), but actual levels were considerably higher and are estimated (after adjusting for persons employed outside the formal sector) at 17%–23% of the population.[4] The provinces in particular have suffered from massive layoffs of workers by private firms and the public service. Also, the incidence of young people unable to find work is

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[1] This appendix is based on a review of project documents including the report and recommendation the President and back-to-office reports for the Social Security Sector Development Program; and other relevant studies prepared by ADB and other development agencies, particularly the United Nations Development Programme (UNDP) Human Development Report for 2007 (UNDP. 2007. Mongolia *Human Development Report 2007: Employment Generation and Poverty in Mongolia.* Ulaanbaatar; and ADB. 2007. *Key Indicators 2007: Inequality in Asia.* Manila)

[2] The most recent data indicate a drop in poverty incidence to 32.2% as of 2006. The magnitude of poverty in 2002-2003 was 43.4% in rural areas compared with 30.3% in urban areas ─ a reversal of the findings of the 1995 and 1998 Living Standards Measurement Survey reports, both of which found that urban poverty was significantly higher than rural. The enormous loss of livestock from harsh winters of 2002 and 2003 accentuated rural poverty. At the same time, the gradual revival of the manufacturing and service sectors in urban areas made urban poverty less acute, thereby reversing the poverty rankings between rural and urban Mongolia. (UNDP, 2007. Mongolia *Human Development Report 2007: Employment Generation and Poverty in Mongolia.* Ulaanbaatar; and ADB. 2007. *Key Indicators 2007: Inequality in Asia.* Manila).

[3] The informal sector in Mongolia consists of small-scale, mostly family-based economic activities unrecorded in official statistics, and usually not subject to the same set of regulations and taxation as the formal sector. Examples include taxicab drivers, newspaper vendors, small kiosk operators, individuals selling used tools, and boot repairmen.

[4] According to official statistics, the unemployment rate in 2002-2003 stood at about 3.2% of the labor force. However, the actual level, after adjusting for persons employed outside the formal sectors, is estimated to be around 14%.

increasing,[5] with severe social, economic, and potential political consequences. Loss of employment is the most prevalent trigger of poverty in Mongolia.[6] Nearly 49% of the unemployed are poor.

5. **Gender.** Women achieved a high degree of equality under the socialist system. During the transition, the economic and social independence of women was severely undermined. Women were disproportionately affected by the transition. Women accounted for 52.2% of the unemployed. More women than men were retrenched when state factories closed, and women were the first to be laid off during restructuring of the processing, service, and trade industries, where women workers predominated. After Government-owned farms were closed and livestock and machinery were privatized, more than 20,000 trained women lost their jobs. Many kindergartens and maternity centers closed, and the reduction in social services placed new demands on women to care for the young, the sick, and the elderly. By 1998, the proportion of poor female-headed households in Ulaanbaatar (44%) was more than twice the proportion of male-headed households (21%).[7]

6. **Impact on the Disabled.** According to a survey conducted in March 2001 by the National Center for Rehabilitation for the Disabled, Mongolia had 115,000 persons with disabilities (PwD). The unemployment rate of PwDs was extremely high at 86.9%.[8] Of an estimated 39,700 PwDs capable of working, only 5,200 (13.1%) were employed. Due to the decline of social welfare and social insurance services for PwDs since 1991, 50% of PwDs live in poverty, 60% of them women. Despite legislation protecting and supporting PwDs, budgetary constraints limit assistance that can be provided by the state.

7. **Impact on Rural to Urban Migration.** The breakdown of rural collectives, the closure of industries in small provincial towns (in which employment was linked to a wide range of social services), and the privatization of the livestock sector led to the emergence of a new underclass of ultrapoor families—herding families with small herds of livestock who have marginal subsistence livelihood. The many that lost their herds in severe storms in the winters of 1999–2000 and 2000–2001, and in the intervening drought in the summer of 2000, who were left without means of livelihood moved to semiurban and urban areas. Rural poverty and unemployment are the major causes of rural-to-urban migration. The provincial cities of Darkhan and Erdenet and the capital Ulaanbaatar have been the main destination of migrants. Between 1990 and 2005, Ulaanbaatar experienced a net gain of migrants, while all the provinces experienced net losses. Nearly 70% of the increase of 427,000 in the capital's population since 1990 has been due to migration.[9] Poor people moving from rural areas to aimag centers or the capital face great hardships due to lack of registration, which is a requirement to access to basic social services. Substantial rural-to-urban migration is continuing,[10] placing enormous strain on urban social services.

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[5] Every year the country needs to absorb 25,000 new workers into the labor market, making new job creation a major challenge for the country.

[6] The Poverty Partnership Agreement between ADB and the Government identified unemployment as one of the leading causes of poverty.

[7] The most recent living standards survey, conducted in 2002–2003, indicated that the proportion of female-headed households in Ulaanbaatar living under the poverty line remained at 44%, while about 35% of male-headed households were poor.

[8] According to the National Statistics Office, there were 82,300 working age PwDs in 2006. The unemployment rate of PwDs is estimated to have remained at about 87%. Only about 13% of PwDs are employed, although the Ministry of Social Welfare and Labor estimates that about 80% are capable of working.

[9] UNDP. 2007. *Mongolia Human Development Report 2007: Employment Generation and Poverty in Mongolia*. Ulaanbaatar.

[10] As of 2006, some 61% of Mongolia's population was classified as urban, most living in and around the capital city of Ulaanbaatar and other large cities such as Erdenet and Darkhan.

SOCIAL SECURITY INDICATORS

Table A2.1: Social Expenditures, 1991–2006 (current prices)

Item	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
GDP (in billion Tug)	18.9	47.3	194.8	324.4	550.3	646.6	832.6	817.4	925.3	1018.9	1115.6	1236.9	1479.7	1945.6	2524.3	3172.4
Total Government Expenditure (in billion Tug)	8.7	12.0	61.6	98.9	143.9	176.6	287.6	342.2	361.7	429.7	489.7	548.6	615.8	752.5	764.6	1237.0
Total Social Expenditure (in billion Tug)	4.2	8.0	21.6	41.5	62.9	84.7	118.1	134.5	160.4	204.1	236.3	258.6	291.1	364.9	413.6	550.1
Education	2.1	3.3	9.6	16.4	23.5	33.7	46.6	52.9	64.8	82.1	98.7	103.7	115.4	141.0	147.8	193.4
Health	1.0	1.9	6.3	11.6	16.0	22.4	28.6	30.0	35.7	46.0	53.1	58.0	58.1	73.2	80.2	99.4
Social Security and Welfare	1.1	2.8	5.7	13.5	23.4	28.7	42.9	51.5	59.9	76.0	84.5	96.9	117.6	150.6	185.7	257.2
Social Assistance Fund Expenditure			0.0	1.4	1.3	2.8	6.3	7.9	12.1	11.5 [a]		17.3	19.8	23.0	41.7	74.8
Social Insurance Fund Expenditure			6.9	n/a	18.9	25.0	31.6	39.9	42.8	59.8 [a]		73.3	87.5	116.2	132.0	173.0
Percent of GDP																
Total Social Expenditure	22.0	17.0	11.1	12.8	11.4	13.1	14.2	16.5	17.3	20.0	21.2	20.9	19.7	18.8	16.4	17.3
Education	11.1	6.9	4.9	5.1	4.3	5.2	5.6	6.5	7.0	8.1	8.8	8.4	7.8	7.2	5.9	6.1
Health	5.3	4.1	3.2	3.6	2.9	3.5	3.4	3.7	3.9	4.5	4.8	4.7	3.9	3.8	3.2	3.1
Social Security and Welfare	5.6	5.9	2.9	4.1	4.2	4.4	5.1	6.3	6.5	7.5	7.6	7.8	7.9	7.7	7.4	8.1
Social Assistance Fund Expenditure			0.0	0.4	0.2	0.4	0.8	1.0	1.3	1.1		1.4	1.3	1.2	1.7	2.4
Social Insurance Fund Expenditure			3.5	n/a	3.4	3.9	3.8	4.9	4.6	5.9		5.9	5.9	6.0	5.2	5.5
Percent of Total Expenditure																
Total Social Expenditure	47.9	66.7	35.1	42.0	43.7	48.0	41.1	39.3	44.3	47.5	48.3	47.1	47.3	48.5	54.1	44.5
Education	24.2	27.2	15.6	16.6	16.4	19.1	16.2	15.5	17.9	19.1	20.2	18.9	18.7	18.7	19.3	15.6
Health	11.6	16.2	10.3	11.7	11.1	12.7	9.9	8.8	9.9	10.7	10.8	10.6	9.4	9.7	10.5	8.0
Social Security and Welfare	12.1	23.4	9.3	13.6	16.3	16.2	14.9	15.0	16.6	17.7	17.3	17.7	19.1	20.0	24.3	20.8
Social Assistance Fund Expenditure			0.0	1.4	0.9	1.6	2.2	2.3	3.3	2.7		3.2	3.2	3.1	5.5	6.0
Social Insurance Fund Expenditure			11.2	n/a	13.1	14.2	11.0	11.7	11.8	13.9		13.4	14.2	15.4	17.3	14.0

Sources: ADB. 2007. *Key Indicators 2007: Inequality in Asia.* Manila; National Statistical Office of Mongolia. 2006. *Mongolian Statistical Yearbook*. Ulaanbaatar.

Table A2.2: Social Assistance Fund Beneficiaries (thousand persons)

Item	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Short-term Benefits	**275.1**	**260.8**	**145.3**	**101.0**	**233.5**	**171.6**	**160.0**	**114.5**	**0.0**	**129.3**	**152.4**	**155.5**	**754.8**	**1047.5**
Pregnancy care and delivery	36.3	29.4	15.2	27.0	70.8	69.0	47.8	50.0		49.3	51.5	54.5	45.6	37.9
Child care	46.3	53.8	47.6	28.7	93.5	40.3	42.6	31.5		57.1	58.4	59.1	53.9	44.3
Infant nursing	9.3	6.3	17.3	3.2	4.3	5.8	5.3	3.5		4.6	5.9	7.5	6.7	3.3
Twins	0.1	0.1	0.1	0.2	0.4	0.4	0.3	0.4		0.3	0.3	0.3	0.4	0.2
Adoption orphan child	0.0	0.0	0.0	0.0	0.1	0.2	0.3	0.4		0.5	0.6	0.6	0.7	0.4
Large family	69.7	63.8	65.1	42.0	64.4	55.9	63.8	28.7		17.5	35.7	33.5	647.5	872.4
Others	113.3	107.4	0.0	0.1	0.0	0.0	0.0	0.0		0.0				89.0
Discounts				**22.1**	**43.3**	**62.8**	**54.4**	**57.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0**
Disabled				0.8	2.6	5.2	4.5	9.3						
Elderly				18.2	40.7	57.6	46.8	47.5						
Others				3.2	0.0	0.0	3.0	0.5						
Assistance in Kind			**11.0**	**9.1**	**16.5**	**17.6**	**30.8**	**30.8**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0**
Poor and homeless			11.0	9.1	16.5	17.6	24.6	23.4						
War veterans			0.0	0.0	0.0	0.0	6.1	2.3						
Long-term Benefits			**19.7**	**22.9**	**23.2**	**24.8**	**28.6**	**30.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0**
Total	**275.1**	**260.8**	**176.1**	**155.1**	**316.5**	**276.9**	**273.7**	**233.1**	**0.0**	**129.3**	**152.4**	**155.5**	**754.8**	**1,047.5**

Sources: ADB. 2007. *Key Indicators 2007: Inequality in Asia.* Manila; National Statistical Office of Mongolia. 2005-2006. *Mongolian Statistical Yearbook*. Ulaanbaatar

Table A2.3: Social Insurance Indicators

Indicator	1995	2000	2006
Total employees (thousands)	767.6	809	1,009.9
Agriculture	354.2	393.5	391.4
Non-Agriculture	413.4	415.5	618.5
Employers who pay social security contributions	14069	13017	18,535
Number of people under pension, industrial injury, and unemployment insurance (thousands)	409.1	381.4	427.8
Mandatory insurance	395.4	363.9	401.4
Voluntary	13.7	17.5	26.4
Share of employees enrolled in pension, industrial injury, and unemployment insurance (%)	53.3	47.1	42.4
Increase in employees from previous period		41.4	200.9
Non-agriculture		2.1	203
Increase in enrolled employees from previous period		27.7	46.3

Source: UNDP. 2007. *Mongolia Human Development Report 2007: Employment Generation and Poverty in Mongolia.* Ulaanbaatar.

HOSPITALS IN ULAANBAATAR

Table A3.1 Distribution of Hospital Beds by District and Population

Administrative District	Population 2000	Number of Beds	Bed/Population
Bayanzurkh	172.824	1237	72 per 10.000
Songinokhairkhan	182.153	328	18 per 10.000
Khan Uul	81.140	298	38 per 10.000
Chingeltei	122.483	355	28 per 10.000
Sukhbaatar	106.167	1163	109 per 10.000
Bayangol	153.562	1707	111 per 10.000
Nalaikh	24.687	135	54 per 10.000
Bagakhangai	3.647	15	41 per 10.000
Baganuur	23.249	135	58 per 10.000

Table A3.2. Hospitals, Beds and Condition of Buildings in Nine Administrative Districts of Ulaanbaatar

Hospitals	Beds	Condition of Building
Bayanzurkh		
State Hospital No. 2	190	Reasonable
National Cancer Center	190	Reasonable
Infectious Disease Center	500	Poor
Maternity Hospital No. 3	45	Poor
Bayanzurkh District Hospital	225	Poor
UB Gachuurt Khoroo Hospital	15	Poor
UB KhonKhor Khoroo Hospital	12	Poor
Enerel Hospital	60	Poor
Songinokhairkhan		
Songinokhairkhan District Health Center	108	Poor
Songinokhairkhan District Hospital	115	Poor
Songinokhairkhan District Hospital for Elderly	30	Poor
Traditional Medical Liver Clinical Hospital	60	Poor
UB Jargalant Khoroo Hospital	15	Poor
Khan Uul		
Khan Uul District Health Center	68	Poor
Khan Uul District Hospital	115	Poor
UB Tuul Horoo Hospital	15	Poor
Corporation of Traditional Medicine Research Center	100	Poor
Chingeltei		
Chingeltei District Health Center	167	Poor
General Hospital for Ministry of Interior	188	Poor
Sukhbaatar		
State Hospital No. 1	498	Reasonable
Hospital for Dermatology	170	Poor
Maternity Hospital No. 1	240	Reasonable
Maternity Hospital No. 2	75	Poor
Sukhbaatar District Hospital	180	Poor
Bayangol		
State Hospital No. 3	400	Reasonable
Trauma and Injury Hospital	420	Reasonable
Maternal and Children Research Center	662	Poor
Railway Hospital	180	Reasonable
Bayangol District Health Center	45	Poor
Nalaikh		
Nalaikh District Health Center	135	Poor
Bagakhangai		
Bagakhangai District Hospital	15	Poor
Baganuur		
District Health Center	135	Poor

Source: World Bank. 2007. *The Mongolian Health System at a Crossroads: An Incomplete Transition to a Post-Semashko Mode*l. Paper No. 2007-1. Washington, DC.

POSITIONING OF ADB'S HEALTH SECTOR STRATEGIES IN MONGOLIA

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
Basis for the sector strategy	• The interim strategy did not have a separate section on the health sector in Mongolia • The central objective of ADB's interim country strategy was to support Mongolia's transformation from a centrally planned to a market-oriented economy. • ADB assistance focused on projects and programs in the agriculture and industry sectors, and in the energy and transport and communications sector—sectors considered crucial in the country's economic transformation. • The social sector (education, health and social protection) was accorded a lower priority in the allocation of external assistance to Mongolia because (a) performance indicators for social sectors were good; and (b) public resource allocations for social sectors were considered too high, and it was recommended that efficiency gains should be attained before further investments were made.	• The overall strategy aimed to strengthen Mongolia's transition to a market-based economy to promote more efficient resource use and a more vigorous private sector. • The strategy acknowledged that long-term productivity growth and social development require continued support for human development including health care. Mongolia's transformation to a market economy required reform in its health system. However, due to severe budgetary constraints, investments in the social sectors remained secondary to promoting economic growth.	• In 1994, the Government also introduced a National Poverty Alleviation Program (NPAP) to reverse the increasing trends of human deprivation and human capital erosion. The NPAP has six components including improved delivery of education and health services. • The Government's medium-term development strategy (1999–2002) aimed to accelerate economic growth to enhance the living standards of the population. One of the key components of the Government's growth strategy included a human development and social sector strategy. Improved living standards and development of human resources were key medium-term objectives. • ADB's country strategy, which aimed to foster economic growth and poverty reduction through private sector-led income and employment generation, complemented the Government's medium-term development strategy. The strategy identified the social sector, which includes health, as one of the core sectors for ADB operations because of the sectors' potential to maintain standards of health, raise the general public's health awareness, and improve accessibility of health care.	• ADB's strategy supports the implementation of the 2 major elements of the Government's poverty reduction strategy—the Economic Growth Support and Poverty Reduction Strategy (EGSPRS): (a) stable, broad-based growth; and (b) inclusive social development. The inclusive social development pillar aims, among others, to contribute to improved education, health, and living conditions among the poor. • The EGSPRS identified improved access to health care (particularly maternal and child health services and primary health care) as immediate targets.

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
Government's absorptive capacity and ownership	• There was no sector-specific discussion, but the overall country strategy acknowledged constraints in the Government's (financial and administrative) absorptive capacity.	• There was no sector-specific discussion, but the overall country strategy recognized the country's limited financial and administrative absorptive capacity.	• A sector-specific assessment of absorptive capacity was not undertaken, but the strategy acknowledged the lack of domestic budget to provide counterpart funds for development projects in most sectors. • The overall country strategy was prepared following a collaborative and participatory process involving key stakeholders: detailed discussions were conducted with the Government and in close coordination with other aid agencies. A participatory workshop and high-level forum involving government, other parliamentary groups, civil society, and the private sector was held in Mongolia to generate support and agreement for the strategy.	• The strategy noted that in the intermediate term domestically generated revenues are unlikely to be sufficient to support proposed initiatives. • The Government's sector goal is to achieve equitable health care by targeting resources especially for the poor and to areas in greatest need. Priorities of the government include to (a) implement national reproductive health and child health programs, (b) improve quality of health services in rural areas, (c) promote primary health care, and (d) encourage private sector participation in health care provision. • To promote private sector participation in health care provision, the Government has developed guidelines and a legal framework for social sector restructuring and privatization, and has prepared a list of health facilities for restructuring.
ADB's comparative advantage in the sector and harmonization of sector strategies with other development partners	• No sector-specific discussion of ADB's comparative advantage in the interim strategy.	• There was no discussion of ADB's comparative advantage in the sector. • Since Mongolia became a member of ADB, the International Monetary Fund (IMF), and the World Bank in 1991, the 3 institutions have coordinated their operations	• According to the strategy, ADB's comparative advantage vis-à-vis other donors is mostly in the areas of management of reforms, decentralization and training. • ADB's strategy was developed with an awareness of other aid agencies' strategies in order to avoid duplication and overlap, and to ensure that basic development needs of the	• ADB has been a major partner in Mongolia's efforts to reform its health care system and health financing mechanisms since the early 1990s. • The strategy recognizes that development assistance has lacked a strategic framework and remains uncoordinated, with an ambiguous distribution of roles.

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
		closely to support the Government's stabilization and reform efforts. ADB missions frequently visited Mongolia concurrently with missions from IMF and the World Bank to share operational information and discuss policy approaches. • Major aid coordination meetings for Mongolia, arranged jointly by the World Bank and Japan, were held annually in Tokyo to coordinate external assistance. • The strategy mentioned other agencies involved in the health sector, notably the United Nations Development Programme (UNDP) and other United Nations (UN) agencies, which play important roles in the areas of health and population, poverty reduction, and the development of human resources and management capacities.	country are met. • ADB has taken the lead role in providing assistance in several key sectors including the health sector. • The strategy mentioned other development partners involved in the sector including Japan (assistance for health equipment, human development) and UNDP and other UN agencies (health and population, poverty reduction, and human development).	• Recognizing the need to improve coordination and effectiveness of external funding, the Government agreed to establish working groups (jointly chaired by ADB with other multilateral/bilateral agencies) for infrastructure, social sectors, private sector development and aid coordination to pursue harmonization. ADB has played a key role in aid coordination. The social sector working group focusing on health and education is co-chaired by ADB and Japan. • A Health Sector Master Plan aimed at defining the overall policy framework of health sector development and facilitating the coordination of international agencies has been formulated with the support of Japan International Cooperation for Welfare Services. A sector-wide approach (SWAp) is planned under the master plan. • The strategy cites other development partners involved in the sector including: (a) Germany/German Technical Cooperation Agency (GTZ) (reproductive health), (b) Japan (communicable diseases, sector master plan), (c) UN agencies (Millennium Development Goals [MDGs]), (d) World Bank (health sector privatization and rationalization), and (e) United Kingdom (health training, HIV/AIDS).

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
Focus/Selectivity and Synergies				
(i) Issues/challenges addressed	• The interim strategy did not discuss sector issues/ challenges specific to the health sector	• The strategy underscored the following key issues/challenges in the sector: (a) quality of health care was not commensurate with expenditure, and health spending was higher than the economy could afford; (b) deteriorating quality of health care (e.g., deterioration of health services in rural areas, shortage of drugs, vaccines and equipment and an increasing proportion of ambulance fleet lying inoperative; (c) deteriorating health status indicators; and (d) strengthening health insurance scheme.	• The strategy highlighted the following issues/challenges in the sector: (a) improving the quality and delivery of health services, particularly in rural areas; and (b) strengthening the reform process and capacity of the Ministry of Health.	• The health sector strategy identifies the following issues: (a) double burden of communicable and non-communicable diseases; (b) poorer health conditions and poorer health services in rural areas compared with urban areas; (c) overstaffing and maldistribution of staff across regions, skills, and the level of the health system; (d) hospital-dominated inefficient system and inefficient hospital management; (e) limited sector capacity for planning, budgeting, and management; (f) limited and inefficient health care financing; and (g) limited understanding of the health reform agenda among the population.
ii) Sector focus	• There was no discussion of sector focus included in the strategy.	• Sector focus was broad but responsive to sector challenges: (a) shifting emphasis from hospital-based curative services to primary health care, (b) developing private sector delivery of health care services, (c) rationalizing health personnel and facilities, and (d) institutional strengthening and capacity building for efficiency improvements and rationalization of expenditures.	• The sector strategy opted to focus on: (a) general health education, (b) training of health care staff in primary health, (c) vocational training related to the health care industry, (d) capacity building, and (e) health finance management on a broad basis.	• ADB's sector strategy is to remain focused on reforming the sector to promote equitable, efficient, and sustainable sector development and on building the capacity for planning, managing, and monitoring programs and budgets. Women's health issues will receive particular attention, given their crucial role in meeting MDG targets.
(iii) Instruments used to address challenges	• No loans and TA grants were provided for the health sector during this period.	• ADB's assistance consisted of TA grants (for sector restructuring, institutional strengthening, and policy reform) and loans for the Health Sector Development Program (to support health sector reforms aimed at	• The instruments for strategy implementation included (a) concessional loans (to improve the quality and delivery of health services, particularly for the poor and vulnerable, and for further sector reform), and (b) TA (to	• The strategy indicates that further project-based support is not expected in the health sector but that budget support for specific elements of the Government's program focused on rural health care, women's health, and the poor

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
		promoting primary health care, rationalizing health facilities, rationalizing health personnel and upgrading their qualifications, improving health care financing, and protecting vulnerable groups).	develop projects to improve health service delivery in rural areas).	with demonstrable benefits towards meeting MDG targets will receive attention.
(iv) Coherence of issues, focus, and instruments		• The strategy was in line with the sector issues/challenges, focus, and instruments discussed above. The choice of giving TA grants was correct, given the need for capacity building and advisory services.	• Given the challenges in the sector, and the constraints in the Government's absorptive capacity, the strategy appears coherent. Its sector focus and choice of instruments for implementing the strategy was logical.	• The sector strategy seems consistent with the sector issues, focus, and choice of instruments for implementing it.
Long-term continuity of the sector strategy	• Mongolia became a member of ADB in 1991 but there were no loans or TA operations for the health sector during this period.	• Because of fiscal constraints, priority in the health sector was to improve cost effectiveness and develop a sustainable health system. Consequently, initial ADB assistance centered on support for health sector reform focusing on key policy measures such as reforms of health sector insurance, and staff rationalization.	• ADB built on previous assistance for health sector reform but also supported efforts to improve the quality and delivery of health care, particularly in rural areas.	• The strategy continued to focus on reforming the sector to promote equitable, efficient, and sustainable sector development and capacity building for planning, managing, and monitoring programs and budgets. Rural health care initiatives, women's health issues, and wider development of community health services will receive particular attention.
Risk assessment and monitoring mechanisms to achieve the sector strategy's envisaged results	• There was no assessment of risks specific to the sector.	• There was no sector-specific assessment of risks. • The strategy recognized the need to assess the Government's progress in following the reform agenda but did not discuss the expected outcomes and impacts and the procedures to monitor progress in attaining the stated objectives.	• The sector strategy cited exogenous risk factors to the country as a whole. An assessment of risks specific and unique to the health sector was not undertaken. • The strategy proposed selected variables that could be used as monitoring indicators to measure the contribution of health to the overall objective of poverty reduction such as infant mortality and maternal mortality rates. • The strategy also identified	• The strategy does not cite sector-specific risks • The Country Strategy and Program was designed to adopt a results-based approach. A results-based matrix was prepared to help Management to focus ADB assistance on delivery of development results. • The sector strategy includes a road map with sector

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
			relevant targets for health in the Strategy 21 (international targets for poverty reduction and human development adopted by Organisation for Economic Cooperation and Development Development Assistance Committee in 1996): (a) reducing by half the infant and under-5 mortality rates, and by two thirds the maternal mortality rate by 2005; (b) providing universal access to reproductive health services for all females of appropriate age by 2015.	indicators and outcomes envisaged by year 5. • However, the strategy recognizes that the Government's monitoring and evaluation system, including the project performance monitoring system, is weak and needs to be strengthened.

PROJECTS/PROGRAMS IN MONGOLIA FOR THE HEALTH SECTOR

	Loan	Project Name	Objectives	Year Approved	Loan/ Grant Amount (Actual)[a] ($ million)	Total Project Cost (Actual) ($ million)	Achievements	Rating		
								PPR IP	PCR	PPER
1	1568	Health Sector Development Program	The goal of the HSDP is to improve the health status of the population through the provision of better quality health services. The objectives of the HSDP are to support health sector reforms to (i) make the health system sustainable in a market environment, (ii) maintain universal access to quality essential health services, and (iii) improve health service quality.	1997	3.84	3.84	• **Project Completed** Outputs: • **Promoting Primary Health Care (PHC)** – (a) the HSDP successfully introduced a system of family group practices (FGPs) comprising two or three family doctors and nurses to provide an essential package of primary health care (PHC) services to those people who registered with them. From 1999 to 2002, a total of 234 FGPs were established throughout Mongolia—118 in Ulaanbaatar and 116 in *aimag* centers—but the number subsequently decreased to 224 (116 in Ulaanbaatar) in 2006; (b) HSDP developed and implemented a nationwide information campaign that initially increased public awareness of HSDP reform initiatives such as FGPs, but the campaign was carried out over a short term and was not sustained; (c) the government's health budget allocations to PHC increased from 17% to 24% but remained below 40%, the target set at appraisal. • **Encouraging Private Sector Participation in Health Services Delivery** – (a) a licensing and accreditation unit under the National Health and Development Center was established in September 1998, and the licensing system for health professionals and the accreditation framework for health facilities were developed; (b) guidelines and the legal framework for leasing public building facilities and outsourcing noncore hospital services were developed.		S	S

Loan	Project Name	Objectives	Year Approved	Loan/ Grant Amount (Actual)[a] ($ million)	Total Project Cost (Actual) ($ million)	Achievements	Rating		
							PPR IP	PCR	PPER
						• **Rationalizing Health Facilities** – (a) a rural facility mapping was developed, based on which the Ministry of Health (MOH) identified and approved the appropriate location of first referral units (FRU) in project provinces by 2003; (b) hospital beds were reduced to 7.5 beds per 1,000 population in 1999, the target set at appraisal, but increased again in 2000; (c) rationalization plan for the hospital sector in Ulaanbaatar was developed; (d) frameworks for role delineation and levels of services in health care were established, but their contribution to improving the referral system was limited. • **Rationalizing Health Personnel** - (a) the HSDP established a policy framework for workforce planning, general principles, and criteria for choosing family doctors; (b) the HSDP developed a training curriculum for FGPs and PHC, and trained doctors and nurses; and provided guidelines on clinical retraining to FGPs, but training was short term, without continuity or follow-up; (c) the number of doctors in public facilities decreased (by 932) during 1997–2000 but has increased (by 40% in specialist hospitals and by 80% in private hospitals) since 2000; (d) 40 doctors were contracted to work in rural areas and *soum* clinics where there were shortages, but this program was not sustained after the HSDP due to lack of funds. • **Improving Health Care Financing and Management** – (a) a capitation scheme was introduced by MOH in 2000 whereby FGPs were paid from the local budget. From 2003 to 2006, 40% of capitation payments were financed by local governments and 60% from the health			

Loan	Project Name	Objectives	Year Approved	Loan/ Grant Amount (Actual)[a] ($ million)	Total Project Cost (Actual) ($ million)	Achievements	Rating		
							PPR IP	PCR	PPER
						insurance fund, but beginning in 2007, FGPs are fully financed from the government budget; (b) hospital management boards were established by ministerial order in 1999, but the concept was discontinued after the HSDP; • **Protecting the Poor and Vulnerable Groups** – (a) a system to identify vulnerable groups (to target support and guarantee access by the poor and vulnerable) was established and procedures for monitoring access of the poor to health services was set up; (b) related procedures and a set of indicators for integration into the Health Management Information Systems were developed.			
1569	Health Sector Development Project		1997	11.21	14.29	Outputs: • **Civil works and Rehabilitation** – Health facilities have improved in terms of facilities and equipment, but there were cases of low quality upgrading and construction, and shortcomings were noted in design elements not suited to local conditions and lack of attention to the needs of providing water and sewerage facilities. • **Equipment Provision** – Most equipment provided was generally useful and well maintained, but some items were underutilized or nonfunctional. • **Training of Family Health Doctors** – (a) a PHC training curriculum comprising 10 modules was developed, (b) over 1,300 doctors and nurses were trained, and (c) guidelines on clinical retraining to family doctors were provided. However, PHC and FGP training was short and limited, and viewed as inadequate by MOH staff.			

	Loan	Project Name	Objectives	Year Approved	Loan/ Grant Amount (Actual)[a] ($ million)	Total Project Cost (Actual) ($ million)	Achievements	Rating		
								PPR IP	PCR	PPER
2	1998	Second Health Sector Development Project	The SHSDP's goal is to improve the health of people, especially the poor and vulnerable such as women and children, in target areas. The SHSDP has two objectives: (i) Improve quality and utilization of health services in rural areas, especially for the poor and vulnerable; (ii) build the institutional capacity of the health sector, based on the reform achievements and institutional developments of the HSDP in sector efficiency, effectiveness, and sustainability.	2003			• **Implementation ongoing**. Progress to date: • Project progress: 75% vs. elapsed loan period of 84% • Overall, satisfactory progress on Component 1 but slow progress on Component 2 ○ **Component 1: Integrated Improvement of Rural Health Services** - (a) training programs ongoing to upgrade knowledge and skills of health center staff and health workers; (b) preparatory activities on the provision of health education and promotion campaigns ongoing; (c) MOH has implemented a capitation payment for FGPs and health centers nationwide; (d) progress of civil works for rehabilitation of soum health centers, equipment supply on target to be completed in 2008, construction of houses for soum doctor ongoing. ○ **Component 2: Institutional Capacity Development** - (a) 160 doctors attended certificate course, and 7 FGP doctors completed residential training in family medicine; (b) hospital accreditation criteria revised; (c) career and rural area medical service development fund established (for health workers moving to rural areas or leaving health care practice); (d) staff rationalization action plan endorsed; (e) Memorandum of Understanding on multisectoral collaboration for human resources for health signed by all stakeholders including international partners; (f) policy review of patients' rights completed; (g) Health Sector Strategic Master Plan (2006-2015) developed through a consultative process with inputs from SHSDP staff.	HS		

	Loan	Project Name	Objectives	Year Approved	Loan/ Grant Amount (Actual)[a] ($ million)	Total Project Cost (Actual) ($ million)	Achievements	Rating		
								PPR IP	PCR	PPER
							○ **Component 3: Project Management -** (a) project implementation unit staff trained on SHSDP components and project implementation arrangements; (b) project performance management system indicators have been developed, but collection of baseline data has been delayed.			
3	0086	Third Health Sector Development Project (Grant)	The impact of the THSDP will be improved health status and quality of life for the population of Mongolia. The outcome of the Project will be PHC services that are more effective and improved financial protection through health insurance.	2007			• Loan became effective on 27 March 2008	S		
		Total								

HS = highly successful, HSDP = Health Sector Development Program, IP = implementation progress, PCR = project completion report, PHC = primary health care, PPER = project/program performance evaluation report, PPR = project performance report, S = successful (PCR and PPER rating)/satisfactory (PPR rating), SHSDP = Second Health Sector Development Project.

[a] Net loan amount.

Sources: ADB. Loan, TA, Grant, and Equity Approvals database; Post-Evaluation Information System; project performance reports (as of 30 September 2008); reports and recommendations of the President.

TA OPERATIONS IN MONGOLIA FOR THE HEALTH SECTOR, 2002–2007

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Achievements	Rating	
							TCR	TPER
2252	1994	Strengthening Social Insurance	The objectives of the TA were to help the Government outline priorities for the State Social Insurance General Office's (SSIGO's) action and identify needs for TA for 1995 and to strengthen the capacity of SSIGO in carrying out its new mandate as an autonomous social insurance body.	AD	84	• TA financial closing on 1 May 1998 Outputs • Training and implementation plans for SSIGO developed • Information needs for policy development outlined		
2279	1994	Strengthening Health Insurance	The objectives of the TA were to (a) help the Government increase the efficiency of the health insurance scheme by resolving technical issues and improving accountability; (b) assess the impact of health insurance on the health status of the population, especially vulnerable groups; and (c) help the Government prepare the transfer from an independent health insurance program under Mongol Insurance Company to an integrated social insurance system under SSIGO.	AD	500	• TA financial closing on 1 May 1998 Outputs • Reviewed health insurance policies, organizational setup, actuarial data, poverty impacts, and information systems; and provided recommendations for improvement • Prepared special studies on the impact of health insurance on the poor • Training for health insurance and social insurance administrators on management and health insurance principals • Study tours to Rep. of Korea, Philippines, and Thailand organized to review and debate health insurance issues • Procured and installed office equipment (e.g., computers, printers, photocopies, overhead projectors) for training activities and to improve efficiency • Acquired computer hardware and software to implement a computerized system to manage the health insurance scheme. • Preparation of a plan to integrate national health insurance with the social insurance system	GS	

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Achievements	Rating	
							TCR	TPER
2414	1995	Health Sector Development	The objective of the TA was to assist the Government in preparing a Health Sector Development Project (HSDP) to improve efficiency in the health sector while maintaining equity. The TA had three specific objectives: (i) identify health sector needs and health system reforms appropriate for a new economic and social environment; (ii) determine the best way for ADB to support the health sector; and (iii) prepare a program and/or a project for possible ADB financing.	PP	600	• TA financial closing on 1 May 1998 Outputs • Comprehensive sector analysis undertaken • Policy options paper developed and discussed in a national workshop with stakeholders in the health sector and related sectors and other aid agencies • Preparation of project proposal for HSDP identifying necessary reforms and essential investments in the health sector		
2731	1996	Health Sector Resources Development	The TA assisted the Government in finalizing proposals for reforms and rationalization in the health sector. The TA had two specific objectives: (i) finalize the rationalization plan for health infrastructure (health facilities and referral system); and (ii) finalize the rationalization plan for health personnel.	PP	100	• TA financial closing on 1 June 1998 Outputs • Rationalization plan for health infrastructure (health facilities and referral system) finalized • Rationalization plan for health personnel finalized		

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Achievements	Rating	
							TCR	TPER
2907	1997	Support for Decentralized Health Services	The objectives of the TA were to (i) strengthen local government's capacity for planning and managing local health services, (ii) identify issues and develop coordination mechanisms between local government and Ministry of Health and Social Welfare (MOHSW), and (iii) assist local governments in implementing health sector reforms.	AD	600	• TA financial closing on 14 Mar 2005 Outputs • Direct training and skills transfer via workshops and seminars. A total of 35 workshops for various target groups were organized. • Materials and guidelines on health services planning, financing, management, evaluation, and other reference materials were developed to provide practical guides for health personnel use. • In-country and overseas training courses were organized. About 1089 personnel were trained. • Computer equipment was procured and basic software developed to help local governments.	HS	S
3750	2001	Second Health Sector	The objective of the TA was to develop a project proposal to improve the health services delivery system, particularly in rural areas, to ensure better health status for the population. The proposal and included recommendations for further health sector reforms and investments, and reflected the Government's priorities and the needs expressed by the proposed beneficiaries.	PP	600	• TA financial closing on 22 August 2006 Outputs • Project proposal that included analysis, recommendations, and cost estimates concerning (i) health services organization (health sector reforms and investments), (ii) use and benefits of information and communication technology in the health sector, and (iii) poverty impact assessment		

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Achievements	Rating	
							TCR	TPER
4123	2003	Health Sector Reform	The overall goal of the TA was to support the Government's initiatives in public sector management and health care financing mechanisms. The objectives were to (i) strengthen the Ministry of Health's and Ministry of Social Welfare and Labor's (MSWL) understanding and capacity on output-based budgeting; and (ii) improve the effectiveness and sustainability of the health insurance fund.	AD	650	• TA closed in December 2006 Outputs • Draft papers on health care financing and health insurance development strategy prepared • Costing of basic health services and essential health care package was conducted at primary health care and hospital levels • Guidelines prepared and training conducted to support implementation of policies and strategies	S	
4364	2004	Awareness and Prevention of HIV/AIDS and Human Trafficking	• The goal of the TA is to reduce the risks of HIV/AIDS and human trafficking that may be associated with the construction of the project road and operation of the north-south road transport corridor after project completion. The purposes of the TA are to (i) raise public awareness of HIV/AIDS and human trafficking; (ii) address the risk of HIV/AIDS transmission among construction workers, sex workers,	AD	350	• TA implementation ongoing. Implementation progress satisfactory according to TA Performance Report as of 30 September 2008 Progress • Advocacy workshops on HIV/AIDS and human trafficking were conducted, participated in by representatives of local governments, nongovernment organizations, private sector, media, and educational organizations. • Trainings courses on HIV/AIDS and human trafficking conducted • Provision of comprehensive medical package • Training on human trafficking control for border control officers provided and equipment procured		

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Achievements	Rating	
							TCR	TPER
			local communities, truck drivers, and other road users; and (iii) strengthen border control capacity against human trafficking.					
		Total			**3,484**			

AD = advisory technical assistance', GS = generally successful, HS = highly successful, PPTA = project preparatory technical assistance, S = successful, TA = technical assistance, TCR = technical assistance completion report, TPER = technical assistance performance evaluation report.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; reports and recommendations of the President; TA completion reports; TA performance reports; TA reports.

OTHER GRANT-FINANCED PROJECTS IN MONGOLIA FOR THE HEALTH SECTOR

	Approval No.	Project Name	Project Objective	Year Approved	Amount ($ million)	Achievements
1	9053	Information and Communication Technology for Improving Rural Health Services	The Project's goal is to improve access to and quality of health services for vulnerable rural groups, especially poor mothers and children. The purpose is to demonstrate the feasibility of introducing a basic information and communication technology (ICT) network to reduce infant and maternal mortality at the primary health care (PHC) level. The grant, through application of ICT tools, will seek to achieve (i) increased quality of primary health care (PHC) services through better disease and pregnancy case registration and management, (ii) increased efficiency of the PHC patient referral and consultative system, (iii) better training opportunities for rural PHC workers, (iv) improved epidemiological surveillance and control, and (v) support for the ADB-financed Second Health Sector Development Project ICT component at the PHC level.	2004	1.00	• Implementation ongoing. According to the grant status report as of January 2008, the Project is making highly satisfactory progress in Components A and B, and satisfactory progress in Components C and D. Progress to date: • **Component A: ICT-supported consultative, referral, and epidemiological surveillance system** o E-consultation system now available in 3 (of 5) project aimags o Health Info software developed under the Grant now used nationwide. Ulaanbaatar staff of tertiary hospitals has been trained in the use of the software. o Personal digital assistants (PDAs) distributed to 45 bag feldshers from 5 pilot aimags o Information networks have been set up in 5 project aimags. Health departments and general hospitals are interconnected through a local area network • **Component B: Institutional Support and Training** o Western and Regional Workshop on Rural Hospital Networking organized in collaboration with State Social Insurance General Office. Rural Health Information Networking regional workshops conducted in project aimags o Case management training for rural health workers on improving quality of health care in clinical management (with 367 medical personnel trained) o Basic training on use of PDAs (in case management) conducted in 5 pilot aimags o Reproductive Health and Social Welfare Service Training took place in 2 project aimags o Basic and advanced computer skills

Approval No.	Project Name	Project Objective	Year Approved	Amount ($ million)	Achievements
					training for 500 health workers ○ Computer training rooms have been set up in 3 project aimags ○ Admission departments now using electronic patient recording systems ○ 3 national workshops on ICT-supported case management and project implementation issues organized with the participation of 149 hospital administrative workers ○ Training materials developed on the following: (i) system administrator's handbook, (ii) ICT-supported case management handbook for clinical personnel, (iii) Health Info software utilization guideline widely distributed across the country, (iv) printing of a book on Development of Health Sector Information Strategy, and (v) the PDA user's guidelines for midwives and bag feldshers. • **Component C: Monitoring Evaluation and Auditing** ○ Evaluation of benefits of ICT-based tools impact on the quality of PHC services and community development conducted in 2 project aimags ○ Baseline data collected in the pilot project areas ○ Survey on ICT Use in Rural Health Services conducted; survey results ready to be presented in a national workshop

	Approval No.	Project Name	Project Objective	Year Approved	Amount ($ million)	Achievements
2	9063	Maternal Mortality Reduction	The Project's goal is to reduce the maternal mortality ratio in Mongolia. The objective is to allow universal usage of quality reproductive health services by reaching underserved mothers with reproductive health information and quality services. To do this, the Project will (i) design reforms to respond to reproductive health needs, specifically in resource allocations, service organization, and service provider performance; (ii) expand information channels and health services options; (iii) mobilize social support to promote mothers' healthy behavior and proper health-seeking behavior; (iv) improve the quality of reproductive health services; and (v) continue assessing local actions for improving access to and quality of services for the medically indigent and the socially and culturally displaced.	2005	1.00	• No record of grant status report submission from approval year (2005)
3	9115	Access to Health Services for Disadvantaged Groups in Ulaanbaatar	The general objective is to improve access to health services for disadvantaged groups in Ulaanbaatar. The specific objectives are to (i) analyze the constraints that prevent the disadvantaged from accessing health services, using participatory survey methods that include stakeholders; (ii) identify and test demand-driven schemes to improve the access to health services of disadvantaged groups living in the poorest duuregs (districts) of Ulaanbaatar; and (iii) analyze the policy implications of successful schemes, and submit draft policy amendments to the Government.	2007	2.00	• Letter of Agreement not yet signed
		Total			**4.00**	

Note: Excludes Grant 0086-Third Health Sector Development Project (amounting to $14.0 million).
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; grant status reports.

MONGOLIA'S SOCIAL SECURITY SECTOR

1. The Government established a new social security system with the following key elements: (i) social welfare services and social assistance benefits, (ii) employment services, and (iii) social insurance.

2. The Ministry of Social Welfare and Labor (MSWL) is the lead agency for the sector and is responsible for ensuring the welfare of vulnerable groups. Under MSWL are specialized agencies responsible for the implementation and regulation of social welfare services, employment and worker safety, and social insurance.

3. **Social Welfare Services.** The main objective of social assistance, which is an integral part of social protection, is to ensure the livelihood safety of vulnerable groups, the very poor, and those who are incapable of living without social support services, by providing them social assistance benefits and welfare services (e.g. nursing homes).

4. A number of laws govern the provision of social welfare services in Mongolia such as (i) Social Welfare Law (November 1998), which regulates provision of social welfare to vulnerable groups; (ii) Elderly Persons Social Welfare Law (November 1998), which defines requirements for the elderly to be eligible for social welfare services and discounts. (iii) Disabled Persons Social Welfare Law (November 1998), which defines eligibility requirements for the disabled for social welfare services and discounts. However, effective implementation of laws has been constrained by severe budgetary limits.

5. The National Centre for Rehabilitation of the Disabled is responsible for rehabilitation and training of persons with disabilities (PwDs). The State Social Welfare Agency, established in April 1997, is responsible for the delivery of social welfare services and social assistance benefits comprising (i) in-kind services including residential facilities (nursing homes) for the elderly and disabled as well as services for the poor and homeless (e.g., feeding and bathing); (ii) discounts to the elderly, disabled, and other groups to reduce the costs of housing, health care, wheelchairs, and hearing aids; and (iii) payment of benefits from the Social Assistance Fund, including short-term benefits for pregnancy and delivery, child care and infant nursing, and adoption, and long-term pensions for those not eligible for pensions from the contribution-based Social Insurance Fund (SIF).

6. **Employment Services and Worker Safety.** The Central Employment Regulation Office is the primary agency responsible for providing employment services to the unemployed such as information and advisory services as well as support for direct job placement or organization of training courses for the unemployed. The Central Employment Regulation Office has 20 staff in its central office responsible for 117 staff throughout the country in 29 employment regulation offices (ERO). The EROs are the primary point of contact for the unemployed in their search for jobs. However, availability of these services is restricted to only a small proportion of the unemployed due to complex registration requirements. To be formally registered with EROs, a worker must have contributed to the unemployment insurance fund for 2 years prior to being unemployed, or have worked continuously for the preceding 9 months, effectively excluding the young and recent school graduates with no work experience, who comprise the majority of the population looking for work, and people working in the informal sector.

7. Training for employment is a key element of the Government's active labor market policy. MSWL is responsible for organizing such training and contracting training providers for this purpose.

8. The Labor and Social Welfare Inspection Agency (LSWIA), established in 1996, is the regulatory agency responsible for occupational safety and health. LSWIA has a wide range of functions related to labor issues, particularly to ensuring compliance with the Labor Law, and is responsible for monitoring wage rates, hours of work, and industrial relations; inspecting working conditions in industrial establishments to ensure that they meet safety standards; monitoring employment injuries and occupational disease insurance; and assessing loss of capacity for PwDs claiming insurance benefits (whether under employment injuries or normal disability insurance). LSWIA is also responsible for monitoring the implementation of laws and regulations governing all social insurance and social welfare payments.

9. **Social Insurance.** Social insurance plays a major role in the social welfare sector: it helps to cushion the risks associated with unemployment, ill health, disability, work-related injury, and old age. Today the pay-as-you-go system is in effect, which provides for an establishment of a pension fund through contributions paid by the insured and their employers, to be used for disbursement of pensions to pensioners.

10. A number of laws define social insurance provision in Mongolia, including (i) Law on Unemployment Benefits provided by the Fund of Social Insurance (June 1994), which governs eligibility for payment of unemployment benefits; (ii) Law on Benefits provided by the Fund of Social Insurance Against Employment Injury and Occupational Diseases (January 2000), which governs matters relating to pensions, benefits, and other payments for employment injuries and occupational diseases; and (iii) Law on Social Insurance (June 1999), which defines the branches of social insurance and its operations, financing, and services.

11. The State Social Insurance General Office, which was established in 1994, is the lead agency responsible for social insurance. Initially, heath insurance was the responsibility of the Ministry of Health but was merged with the administration of the social insurance system in 1995. The State Social Insurance General Office administers five insurance funds including pensions, benefits, health, employment injury and occupational disease, and unemployment. The funds are supported by insurance payments and state subsidies. In 2000, 92% of the employed were covered by compulsory social insurance. Compulsory contributors and their employers paid 29% of their salaries (10% and 19%, respectively) to the SIF, while voluntary contributors paid only 11.5% of salaries. Twenty-two percent of herders and other self-employed workers were covered by the SIF through voluntary contributions. Over 92% of the population was covered by health insurance in 2000.

POSITIONING OF ADB'S SOCIAL PROTECTION SECTOR STRATEGIES IN MONGOLIA

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
Basis for the sector strategy	• The interim Country Operational Strategy did not have a separate section on social protection. • The central objective of ADB's interim country strategy was to support Mongolia's transformation (from a centrally planned to a market-oriented economy). • ADB assistance focused on projects and programs in the agriculture and industry sectors, and in the energy and transport and communications sector – sectors considered crucial in the country's economic transformation. • Because of the considerable progress in social development under the socialist regime, the social sectors (which include social protection) appeared to have a lower priority in the allocation of external assistance to Mongolia for 2 reasons: (a) performance indicators for social sectors were good; and (b) public resource allocations for social sectors were considered too high, and it was recommended that efficiency gains should be attained before making further investments.	• There was no separate section on social protection in the strategy. • The overall strategy aimed to strengthen Mongolia's transition to a market-based economy. • The strategy recognized emerging social concerns (poverty and unemployment), but maintained that sustainable economic growth would be the primary focus. Economic growth would generate employment, provide the poor opportunities to engage in productive activities to lift themselves out of poverty, and generate surpluses to finance a viable safety net. • In 1994, the Government introduced the National Poverty Alleviation Program with the objective, among others, of strengthening the social safety net.	• To address poverty, the Government introduced the National Poverty Alleviation Program in 1994, to, among others, strengthen the social safety net through targeted assistance to the severely poor, who cannot benefit from new employment opportunities. • The Government's medium-term development strategy (1999–2002) aimed to accelerate economic growth to enhance the living standards of the population. One of the key components of the Government's growth strategy included a human development and social sector strategy. • ADB's country strategy, which aimed to foster economic growth and poverty reduction through private sector-led income and employment generation, complemented the Government's medium-term development strategy. • ADB's country strategy noted that the objectives of growth and poverty reduction can best be achieved by focusing on selected core sectors, one of which is the social sector (which includes social protection). The country strategy recognized the need to strengthen and reform the social protection system to reach the severely poor, who might be beyond the reach of self-help opportunities.	• ADB's strategy supports the implementation of the 2 major elements of the Government's poverty reduction strategy – the Economic Growth Support and Poverty Reduction Strategy (EGSPRS): (a) stable, broad-based growth; and (b) inclusive social development. The inclusive social development pillar aims, among others, to contribute to improved education, health, and living conditions among the poor. • The strategy stresses that ADB will focus on a limited number of sectors based on relevance of strategy objectives and value-added of assistance so as to maximize development impact of limited resources. • Consequently, ADB has opted to focus operations on a narrow number of sectors. and **to discontinue support in a number of sectors including social security,** although assistance in other sectors (agriculture, roads, health, education, and urban development) will have direct and indirect impacts on social protection.

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
Government's absorptive capacity and ownership	• There was no sector-specific discussion, but the overall country strategy acknowledged constraints in the Government's (financial and administrative) absorptive capacity.	• There was no sector-specific discussion, but the overall country strategy recognized the country's limited financial and administrative absorptive capacity. Severe fiscal constraints hampered the Government's ability to provide counterpart funds. Administrative and technical weaknesses within the Government also limited physical implementation capabilities of most agencies.	• The strategy acknowledged that the country's severe fiscal constraints limited the Government's ability to provide counterpart funds.	• A sector-specific assessment of absorptive capacity was not undertaken but the strategy recognized constraints in the Government's financial absorptive capacity.
			• The overall country strategy was prepared following a collaborative and participatory process: detailed discussions were conducted with the Government and in close coordination with other aid agencies. A participatory workshop and high-level forum involving Government, other parliamentary groups, civil society, and the private sector was held in Mongolia to generate support and agreement for the strategy.	
ADB's comparative advantage in the sector and harmonization of sector strategies with other development partners	• No sector-specific discussion of ADB's comparative advantage was included in the strategy	• No sector-specific discussion of ADB's comparative advantage was included in the strategy	• The strategy did not include a discussion of ADB's comparative advantage in the sector.	• The strategy does not include a discussion of ADB's comparative advantage in the sector.
		• Since Mongolia became a member of ADB, the International Monetary Fund (IMF), and World Bank in 1991, the 3 institutions have coordinated their operations closely to support the Government's stabilization and reform efforts. ADB missions frequently visited Mongolia concurrently with missions from IMF and the World Bank to share operational	• The strategy cited other development agencies involved in the sector including (a) the World Bank, (b) United Nations Development Programme (UNDP) and other United Nations (UN) agencies (poverty reduction), and the (c) United Kingdom (social work/welfare projects).	• The strategy notes other development agencies involved in the sector including (a) Canada (employment promotion among vulnerable groups), (b) Nordic Development Fund (social security sector development program), (c) Sweden (employment facilitation, (d) World Bank (pension reform).

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
		information and discuss policy approaches. • Major aid coordination meetings for Mongolia, arranged jointly by the World Bank and Japan, were held annually in Tokyo to coordinate external assistance. • The overall strategy recognized the need to improve Mongolia's capacity for aid coordination and management, given the institutional weaknesses across sectors and agencies. • Among donors, UNDP and other UN agencies have played an important role in poverty reduction.		
Focus/Selectivity and Synergies				
(i) Issues/Challenges Addressed	• The interim strategy did not discuss sector-specific issues/ challenges. • When the interim strategy was formulated in 1991, poverty and unemployment were not yet serious concerns.	• The strategy cited the following issues and challenges pertaining to social protection: (a) rationalization of pension and other social security payments), (b) introduction of a contributory social security scheme, and (c) addressing the deterioration of the country's social safety net system	• The strategy underscored the need for developing a sustainable social security system comprising (a) social welfare services provision to vulnerable groups including the disabled, elderly, orphans, and parents with many children; (b) providing employment services to the unemployed; and (c) social insurance (unemployment, occupational injury and disease) provision.	The social security system is unable to provide the aged and the disabled with a reasonable standard of living.
(ii) Sector Focus		• Sector focus was on policy development and sector restructuring for efficiency improvements and rationalization of expenditures.	• Sector focus was broad but consistent with the identified sector issues and challenges. The strategy explicitly provided for a one-time intervention to establish a strong safety net for the poor but aside from the said project, the strategy indicated that ADB does not envision substantial involvement in the sector.	There was no discussion of sector focus in the strategy.

Criteria for Positioning/Coherence	1991 Interim Strategy	1994–1999 Country Strategy	2000–2005 Country Strategy	2006–2008 Country Strategy
(iii) Instruments used to address challenges	• No loans and TA for social protection were provided during this period. .	• In view of the Government's absorption limits, ADB assistance for the sector consisted of project preparatory and advisory TA only.	• ADB's assistance consisted of TA and 2 loans for the Social Security Sector Development Program (approved in 2001) to finance a combination of policy reforms (program loan) and investments (project loan) in the sector.	
(iv) Coherence of issues, focus and instruments		• The strategy was responsive and relevant to the sector issues, constraints, focus, and choice of instruments for implementing the strategy.	• Given the challenges and constraints, and harmonization issues, the sector strategy was coherent. The choice of issues, sector focus, and instruments complemented each other.	
(v) Long-term continuity of the sector strategy	• Mongolia became a member of ADB in 1991, but there was no loan or TA for social protection during this period.	• ADB assistance in the sector commenced in 1995 with advisory TA to introduce administrative reforms and undertake capacity-building activities to strengthen Mongolia's social insurance system (unemployment, occupational injury, and disease insurance).	• The strategy continued previous support for the development of social insurance but expanded to include the two other components of the restructured social security system - (i) provision of social welfare services and assistance benefits (to vulnerable groups including the disabled, very poor, elderly, orphans, and parents with many children), and (ii) employment services (to the unemployed)	
(vi) Risk assessment and monitoring mechanisms to achieve the sector strategy's envisaged results	• There was no assessment of risks specific to the sector.	• The strategy did not include an assessment of risks that were specific to social protection.	• The sector strategy cited exogenous risk factors to the country as a whole, but an assessment of risks specific and unique to the sector was not undertaken.	• No sector-specific assessment of risks was undertaken.
		• The strategy recognized the need to assess the Government's progress in following the reform agenda but did not discuss the expected outcomes and impacts and the procedures to monitor progress in attaining the stated objectives.	• The strategy did not discuss mechanisms to monitor progress in attaining sector objectives.	

PROJECTS/PROGRAMS FOR THE SOCIAL PROTECTION SUBSECTOR

	Loan	Project Name	Objectives	Year Approved	Status	Rating PPR IP
1	1836	Social Security Sector Development Program (Project)	The sector goals are to reduce poverty and increase security among vulnerable groups by increasing employment and providing essential social security services for those incapable of working. The specific purpose of the SSSDP is fully compatible with the sector goals and aims to strengthen the social security system's ability to deliver essential welfare, insurance, and employment services to the ultra poor, very poor, and those close to the poverty line.	2001	• **Implementation ongoing** Progress to date: • Project progress: 95%. Loan closing date extended to 31 December 2008 from 31 December 2007. o Component 1: Social Welfare - (a) civil works for renovation of 3 nursing homes, and delivery of equipment and furniture completed; (b) 2 pilot social security centers built and equipped in 2005 with 48 employees trained; (c) social workers participated in local and international training; (d) Social Security Services Strategy paper developed and approved; (e) pilot-testing of Community Social Welfare Innovation Facility and Livelihood Enhancement Assistance Program completed; (f) public awareness campaign conducted; (g) Ministry of Social Welfare and Labor (MSWL) renovation completed; procurement of equipment for MSWL and State Social Welfare Agency completed; (h) feasibility study for the establishment of a Social Security Sector management information system conducted and terms of reference prepared. o Component 2: Employment Promotion - (a) rehabilitation of 31 training centers and schools completed; (b) project organized skills upgrading training of vocational training teachers; (c) 71 training centers provided training equipment; (d) 6 regional resource centers established; (e) 5 business incubators (BIs) established, attracting 100 clients in 2005; (f) equipment and furniture for 4 BIs procured; (g) business training for 800 persons interested in establishing businesses and skills training of 668 persons conducted; (h) Central Employment Regulation Office and Social Welfare Inspection Agency restructured.	S

Loan	Project Name	Objectives	Year Approved	Status	Rating PPR IP
				• Component 3: Social Insurance - (a) information and communication technology equipments procured for MSWL agencies and State Social Insurance General Office; (b) Information, Education and Communication Strategy developed and executed regarding the new social security system reforms and innovations; (c) 45 social insurance fund accountants introduced to international accounting standards; (d) study tours and international training for MSWL representatives conducted; (e) surveys and projections carried out on the inclusion of self-employed in social insurance schemes; (f) monitoring and evaluation indicators identified and software developed.	
1837	Social Security Sector Development Program (Program)		2001	• ADB cancelled the third tranche of the loan effective on 22 November 2007 (against closing date in the report and recommendation of the President of 31 October 2005), thereby reducing loan amount to $3.987 million. • Good achievements in the areas of employment promotion and social insurance, but significant delay in implementation of social welfare reform measures. o Employment Promotion: (a) from 2001 to 2006, 221,617 persons employed through employment offices, 111,815 persons covered by skills training and retraining, 95,629 involved in public works; (b) accreditation system for private and public vocational and skills training entities in place. o Social Insurance: 390,900 persons currently covered by social insurance benefits versus 351,200 in 2003. o Social welfare reforms suffered setbacks following government's decision to adopt a social welfare package to increase benefits on a universalized basis to newborn, schoolchildren, newlyweds, pregnant mothers, and mothers with 5 or more children, which is against the third tranche condition requiring targeted assistance to the poorer segments of the population.	PS
Total					

IP = implementation progress, PPR = project performance report, PS = partly satisfactory, S = satisfactory, SSSDP = Social Security Sector Development Program.
Sources: ADB. Loan, TA, Grant, and Equity Approvals database; project performance reports (as of 30 September 2008); reports and recommendations of the President.

TA OPERATIONS IN MONGOLIA FOR SOCIAL PROTECTION

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Status	TCR Rating
2371	1995	Administrative Reform of Social Insurance	The objective of the TA was to assist the Government in introducing essential administrative reforms and building capacity to improve the implementation and sustainability of the state social insurance system.	AD	900	• TA financial closing on 1 June 1999 Outputs • Training courses were developed and staff were trained on a variety of management, social insurance and administrative topics • Administrative systems and procedures were standardized and documented in manuals provided to field offices. • Computer training center for social insurance established • Computer hardware procured and software developed and installed for computerization of social insurance contributions • Public information campaign developed and implemented through local media • Actuarial and economic studies completed	GS
2683	1996	Strengthening the National Poverty Alleviation Program	The goal of the TA was to strengthen the Government's capacity to implement and evaluate planned poverty reduction activities, particularly in rural areas. Specific objectives were to (i) develop institutional capacities to implement the Social Assistance Fund (SAF) and Employment Promotion Fund (EPF) at district and provincial levels, (ii) improve poverty-specific monitoring, and (iii) formulate appropriate policy responses based on analysis of poverty data.	AD	422	• TA financial closing on 1 December 1999 Outputs • Developed implementation guidelines for the SAF and EPF • Developed and implemented Poverty Alleviation Council's training courses for SAF/ EPF implementation • Developed a national strategy for poverty monitoring and assessment for 1996-2000 • Provided hardware and software to National Statistics Office and Ministry of Health and Social Welfare (MOSHW) for conduct of poverty specific analysis	GS

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Status	TCR Rating
2978	1997	Social Safety Net	The objective of the TA was to design a social safety net sector development program through which to assist the Government in strengthening the social safety net as a means of improving the lives of the poor, the unemployed, and other vulnerable persons.	PP	985	• TA financial closing on 31 August 2005 Outputs • Preparation of the project proposal for the Social Safety Net Social Development Program	
3709	2001	Strengthening Policy for Social Security Reform	The objective of the TA was to assist the Government in the development of a comprehensive Social Security Sector Strategy comprising policies and strategies designed to establish an efficient social security sector appropriate to a market-oriented economy. The TA was intended to support the Government of Mongolia, and the Ministry of Social Welfare and Labor (MSWL) in particular, to develop a comprehensive framework for the medium- and long-term development of the social security sector. It was also intended to render support for mobilization and coordination of internal and external resources for financing of the social security sector.	AD	600	• TA financial closing on 22 June 2005 Outputs • Development of a comprehensive Social Security Sector Strategy • Preparation of studies designed to provide the diagnostic underpinning for the Social Security Sector Strategy	PS

TA No.	Year Approved	TA Title	TA Objective	TA Type	Amount ($'000)	Status	TCR Rating
4910	2006	Strengthening the Pension System	The TA objectives are to (ii) review the current pension policies and practices and existing plans for pension reforms, identify merits and shortcomings of the current system and existing plans, and recommend a strategy for pension reforms; (ii) review the potential of financial products as investment and management of pension funds; (iii) provide legal assistance to implement the recommended pension reforms and to facilitate the investment and management activities of the pension fund; and (iv) support activities to increase awareness of the benefits of the pension system and the importance of pension reforms.	AD	650	• TA implementation ongoing. Implementation progress satisfactory according to TA Performance Report as of 30 September 2008 Progress • Final Consultant report submitted. The Report includes recommendations on a strategy to further reform the pension fund, and investment policy and guidelines to restructure the pension fund,	
		Total			**3,557**		

ADTA = advisory technical assistance, GS = generally successful, PPTA = project preparatory technical assistance, PS = partly successful, TA = technical assistance, TCR = technical assistance completion report.

Source: ADB. Loan, TA, Grant, and Equity Approvals database; project performance reports; reports and recommendations of the President; TA completion reports; TA performance reports; TA reports.

OTHER GRANT-FINANCED PROJECTS IN MONGOLIA FOR SOCIAL PROTECTION

Approval No.	Project Name	Project Objective	Year Approved	Amount ($ million)	Status
9014	Expanding Employment Opportunities for Poor Disabled Persons	Purpose of the project was to pilot sustainable approaches for reducing poverty among disabled members of the labor force (DMLF). The specific objectives were to (i) upgrade employment-related skills of persons with disabilities (PWD); (ii) support business development by DMLFs; (iii) integrate PwDs into the mainstream workforce as well as provide selective support for maintaining employment, in sheltered employment; and (iv) raise public awareness about the potential of DMLFs to participate productively in the workforce.	2002	1.00	• Project completed. Account closing date on 8 November 2006. • Project Executing Agency rated the project highly successful. Outputs/Accomplishments: • **Employment services** component provided training, information, and counseling services to DMLFs: o training courses of 4-6 weeks duration on vocationally oriented programs for 1,905 PwDs in 6 project sites o public awareness workshops and seminars on employment service of PwDs organized for 1,430 employers o causal studies undertaken in project sites to identify potential employers who are able to recruit PwDs o website targeted to disabled job seekers developed and successfully operated o job fairs organized, resulting in the employment of 200 disabled job seekers in the private and public sector o baseline survey conducted in project aimags to identify employment opportunities for PwDs and determine employer attitudes toward disabled persons o translation of 3 International Labor Organization books on job placement and distribution of 2.500 copies o financial support and capacity building for over 20 local NGOs working on disabilities • **Business support** consisted of training activities, financial support, and trade fairs for disabled entrepreneurs: o basic and advanced training courses provided for disabled entrepreneurs at the project sites o training packages developed and delivered to about 1640 participants including

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					employers, NGO representatives, trainers from vocational training centers, and other key stakeholders o financial support in the form of startup capital given to over 200 disabled persons and 122 groups, generating about 500 jobs o business counseling for 1,871 PwDs (average grant of $200-500 per person) o trade and product fairs, where more than 500 disabled entrepreneurs participated to market their products and services • **Creating job opportunities** in the open market and sheltered employment: o job placement for 301 disabled persons in the sheltered employment in 6 project sites o construction of 4 workshops for PwDs in the project sites o renovation of the 2 largest sheltered employment workshops for blind and physically handicapped • **Public education** o Nationwide public awareness-raising campaign using local radio, television, and newspapers launched in the project sites to inform up to 10,000 DMLFs of their rights and opportunities for seeking employment as well as to raise awareness in communities and among employers of the potential for DMLFs to contribute to economic development o nongovernment organization capacity building • **Project management and impact assessment** o project implementation unit established to coordinate implementation of project activities

Source: ADB. Loan, TA, Grant, and Equity Approvals database; grant status reports.