Application GAVI Alliance Health System Strengthening (HSS)

Ministry of Health
Government of Mongolia

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Abbreviations and Acronyms

ADB	Asian Development Bank
AEFI	Adverse Events Following Immunization
ANC	Ante-Natal Care
APR	Annual Progress Report
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CMYP	Comprehensive Multi-Year Plan on Immunization
CSO	Civil Society Organization
DSA	Daily Supportive Allowance
DTP	Diphtheria-Tetanus-Pertussis vaccine
EPI	Expanded Program on Immunization
EVSM	Effective Vaccine Storage Management
FGP	Family Group Practice
FMA	Financial Management Assessment
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Mongolia
HCW	Health Care Worker
Hep B	Hepatitis B
Hib	Haemophylus Influenza type B
HSCC	Health Sector Coordinating Committee
HSDP	Health Sector Development Project
HSSMP	Health Sector Strategic Master Plan
HSS	Health System Strengthening
HSUM	Health Sciences University of Mongolia
ICC	Inter-Agency Coordinating Committee for Immunization
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IRC	Independent Review Committee
ISPT	Inter-sectoral Service Provision Team
IT	Information Technology
JICA	Japanese International Cooperation Agency
MCH	Maternal and Child Health
MCHRC	Maternal and Child Health Research Center
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoECS	Ministry of Education, Culture and Science
MoH	Ministry of Health
MoF	Ministry of Finance
MPMT	Multi-disciplinary Project Management Team
NCCD	National Center for Communicable Diseases
NCHD	National Center for Health Development
NCIDNF	National Center of Infectious Disease with Natural Foci
NID	National Immunization Day
NIP	National Immunization Programme
NGO	Non-Governmental Organization
NRC	Nutrition Research Center
PHI	Public Health Institute
RED	Reaching Every District
UB	Ulaanbaatar
UN	United Nations

UNESCO	United Nations Education, Science and Culture Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
U5-MR	Under-five Mortality Rate
WHO	World Health Organization

Executive Summary

The Government of Mongolia seeks support from the Global Alliance for Vaccines and Immunization (GAVI) and the Vaccine Fund (VF) for Health System Strengthening (HSS) for the amount of U$ 503,561 over a period of three years 2010-2012. Funding is being requested to strengthen and expand the Reaching Every District (RED) strategy in selected urban and rural districts settings in Mongolia. On the success of this model, the government will be able to expand this model nation-wide, with support from its own resources and that of its partners.

1. Country Background

Situated in the Central Asia, Mongolia is a landlocked country between the Russian Federation to the north and the People's Republic of China to the south. It is the fifth largest country in Asia with a total area of 1565 million square kilometers. In 2007, the population of Mongolia reached 2.635 million with an overall population density of 1.7 persons per square km, making it one of the least densely populated countries in the world. The population is predominantly young. The percentage of population under 15 years of age is 28.9 percent, 67.0 percent are between 5-64 years old, and 4.1 percent are 65 and over. Of the total population, 61 percent live in cities, and the remaining 39 percent reside in rural areas. Males comprise of 48.7 percent of the total population, while 51.3 percent are female (NCHD, 2007). The adult literacy rate is reported as 97.80% (UNDP, 2007).

Since 1990, Mongolia has undergone a demographic transition defined by reduction in fertility and death rates, and an increase in aging. The growth rate of the population fell from 2.7% in 1990 to 1.17% in 2003-2005. The crude birth rate per 1,000 populations reduced from 35.3 in 1990 to 18.0 in 2003 – by half. It increased to 21.7 in 2007. Meanwhile, the total fertility rate was 4.3 in 1990. The total fertility rate experienced a two-fold decline during the period of 2000-2003. The rate was stable at 1.9 in 2004-2006 until it increased to 2.36 in 2007 (NCHD, 2007).

Due to increased urbanization and socio-economic development in recent years, rural-to-urban migration is increasing. In 2007, 39.4% of the population resided in the rural areas, down from 42.8% in 2000.

2. Immunization profile and Maternal, Child and Infant health

Mongolia has placed a high priority on childhood immunization and achieved notable successes in controlling vaccine preventable diseases. The EPI in Mongolia began in 1962. Routine immunization coverage over 90% nation-wide of all EPI vaccines has been achieved in children less than one year of age since 1998. However, a recently conducted Impact Assessment of Hepatitis-B vaccination programme in Mongolia (2004) survey data indicates a high prevalence of Hepatitis B infection among vaccinated children, particularly in rural areas. Data Quality Self-Assessment also indicates the considerable discrepancy between the measles vaccine official coverage report figure (97.5%) and the actual coverage figure (77%) in selected rural areas in 2005. These survey data indicate the need to improve the data quality of the EPI programme, as well as immunization services quality.

The high national average of immunization masks low coverage in some remote provinces and districts. Lower coverage is attributed to under-motivated or under-trained staff, inadequate local financing and fuel for transport and outreach activities, and incorrect denominators due to internal migration. Economic hardship and recent winter harshness has caused significant internal migration. Rapid migration of population increases the challenges in relation to registration and tracking of immunization coverage. Unregistered migrants lack access to basic local social and health services - a direct consequence being that about 5-6 percent of children (3,000-4,000) do not receive their scheduled vaccinations each year. In brief, immunization service delivery is still less than optimal and often delayed for the remote and mobile population.

With respect to Mother and Child Health (MCH), as a result of the successful implementation of policy documents including the State Policy on Population Development, State Policy on Public

Health, Maternal Mortality Reduction Strategy and National Program on Reproductive Health, Integrated Management of Childhood Illness program, the maternal and child mortality continues to fall in recent years.

The MMR per 100,000 live births was reduced to 69.7 in 2006 compared to 170 of 1996, which is the lowest for the last 10 years. According the 2007 health statistics, the ratio then reached 86.9, which is an increase of 9.1 compared with 2006. This can be explained in relation to the dramatic increase in the number of births in 2007. The total births increased from 47,361 births in 2006 to 55,634 births – an additional 8,273 - in 2007

Under 5 mortality rate per 1000 live births has decreased by almost fourfold from 87.5 in 1990 to 22.1 in 2007. In addition, the infant mortality rate per 1000 live births decreased from 63.4 in 1990 to 17.8 in 2007 (the most recently available data show a slight increase, however). These figures indicate that Mongolia has achieved its MDG goals for child health to reduce the under five mortality rate per 1000 live births to 29.2 and the infant mortality rate per 1000 live births to 22.00 by 2015. As stated in the Short program review for child health (2007), the proportion of child deaths due to acute respiratory infection and diarrhoea has fallen: neonatal causes and injury have increased as proportional causes. Neonatal deaths represent 62% of infant deaths and 80% of newborn deaths occur in the first week of life. The prevalence rate of wasting, underweight and stunting have generally fallen since 2000. Stunting rates have decreased less rapidly, where 21% of children are still stunted. The prevalence rates of iodine and iron deficiency have fallen in the last 2-3 years, but remain a problem with 22% of children under 5 being anaemic.

3. Process of HSS Proposal Development

The Department of Public Health Policy Implementation and Coordination of the MoH, in collaboration with the ICC for Immunization and the WHO country office, coordinated and provided oversight to the overall development process. The drafting of the application was led by the proposal working group, composition and terms of reference of which were approved by the Vice Minister of Health. The Director of the Department of Public Health Policy Implementation and Coordination of the MoH chaired the working group and it included representatives from MoH, EPI team, civil society, multi and bilateral partners and the private sector. The country received financial support from GAVI to assist in the application process. The funds were in part utilized to obtain external and country-based technical support for developing the current proposal.

4. Human Resources for Primary Health Care

Mongolia is a vast country with extreme climatic conditions and difficult terrain. About 40 percent of the population lives in rural and remote areas where infrastructure such as roads, electricity and water supply systems are poorly developed. The primary health care system is faced with many challenges – the most important being an appropriately trained health workforce, their retention at the rural posts, ongoing support and supervision – this remains the key issue to be resolved. As a result, the utilization, quality and safety of health care have deteriorated over the years. If the problems related to human resources, especially at primary health care settings, are not resolved in the near future then it will be difficult to achieve the health related millennium development goals (MDG).

Despite the oversupply of doctors nationally, there remains a serious shortage of doctors and other midlevel health care workers in rural and remote areas. Fewer nurses and midwifes are being trained compared to doctors, and other specialists mostly prefer to work in hospitals in Ulaanbaatar and other province centres, or move to private sector for better pay and remunerations. As staff currently working at city-district and province sub-district level retire, it may not be possible to fill these vacant posts as the recruited health personnel do not have incentive to work in most remote areas. Poor working conditions, low salary, lack of housing and incentives, alongside infrequent support and supervision from higher levels are some of the reasons that health staffs are not motivated to work in rural areas.

5. The project Goal, Objectives and main activities

The Goal of this GAVI HSS proposal is to improve the health of mothers and children, especially the poor, disadvantaged groups and difficult to reach populations, through strengthening of the health system to deliver an integrated package of maternal and child health services. The following pilot project areas have been selected for the project implementation: (i) Galuut and Bayan-Ovoo districts in Bayankhongor province and (ii) Sub-districts No 1 and No 21 of Songinokhairkhan district of Ulaanbaatar City. The districts have been selected based up on the following criteria: (i) Maternal Mortality Rate higher then national average, (ii) Infant and under 5 Mortality rate higher than the national average, (iii) High percentage of migrant and unregistered population, (iv) Epidemiological profile of infectious diseases, (v) Lower routine immunization coverage than the national average, (vi) High staff turnover during the last 3 years, (vii) Commitment of local government to implement and sustain the project, (viii) Population size, (ix) Total number of households living in remote areas as well as in disadvantaged conditions, (x) `Difficult to reach topography areas, (xi) Geographical access to health service facilities, (xii) Percentage of family with low income and percentage of poor citizens among the total population, (xiii) Low coverage of social welfare, (xiv) Unemployment rate, (xv) Number of working children.

The objectives of this GAVI HSS proposal are:

1. By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas.
2. By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas.
3. By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.
4. Carry out safe and quality health services in project areas by providing regular on-site training and assistance.
5. Produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies.

One of the strategies of the Health Sector Strategic Master Plan is the delivering of the essential health services package at the primary health care level. However, the exact mechanism for such a delivery had not been clearly stated and define, and it is expected that the integrated delivery of maternal and child health services planned within the current GAVI HSS proposal will serve as a model mechanism to implement one of the key strategies of HSMP.

The main project activities will create HSS and deliver an integrated package of maternal and child services which have been defined as follows: **Health Service:** (1) Routine immunisation for all children under 16 years of age, (2) active home visits of children under 1 year of age, (3) ante and postnatal care to women in reproductive age, (4) micronutrients and vitamins, (5) IMCI. **Health Support Service:** (1) Civil registration (ID and documents), (2) Social welfare services, (3) IEC including health education and civil registration information.

5. Mechanism of Coordination

The GAVI HSS support will provide an excellent opportunity to utilise the existing ICC coordination mechanism, as well as institutionalising the newly ad hoc created bodies such as MPMT and ISPT throughout the duration of the project, with the aim to make this a permanent forum for discussion of health sector development issues at the local level. A detailed team composition and its terms of reference will be developed at the beginning of the project implementation phase. Existing mechanisms of the Ministry of Health will be the basis for approving policies, guidelines, standards, use and channelling of funds to project sites. The existing Health Information System of the Ministry of Health will be used to collect routine and additional information on indicators set to monitor and evaluate the project.

At province and district level, the heads of the local health department will hold overall responsibility for the project, and similar committees of all stakeholder representatives will be the project implementation committees. The aim of such committees will be to become permanent mechanisms for coordination of primary health care development at the respective levels.

6. Complementarities, Partnership & Synergies

The GAVI HSS proposal has been designed to complement and build upon major initiatives now under implementation in Mongolia. These include the UNICEF Convergent Basic Social Services, 2007-2011 project, which provides Community Based Services Support (CBSS) to ensure that every child will have equitable access to, and make use of, basic social services that are critical to the attainment of his/her full growth and development potential. UNICEF are also implementing the RED strategies in one district of Ulaanbaatar city (they were unable to expand due to lack of funds). Lessons learned from this project have been considered in the formulation of this GAVI HSS proposal, and will be utilized in this proposed HSS project supported by GAVI.

Since June 2003, the MoH and the Asian development Bank (ADB) jointly are implementing the Health Sector Development Project 2 (HSDP2), the goal of which is to improve the health of the people, especially the poor and vulnerable in the Project's target areas. Synergies between the two projects will be strengthened through integrated health workforce training, monitoring and supervision of both projects carried out by teams from GAVI HSS as well as ADB HSDP2

7. Challenges for Health System Strengthening

Aggravating factors affecting the health system include: A thin population spread over huge areas and overprovided health system (28.33 physicians and 69.52 beds per 10,000 population in 2007) with problems in cost-effectiveness (high hospital admission rate of 2,392 per 10,000 population and average length of stay 8.7 days in 2007). The excessive admissions and long length of stay are related to the efficiency of the health care system financing.

As health expenditure has been on the rise, the percentage of funding for each health care level also increased in 2000-2007. However, in past years, the expenditure increase for preventive health care and public health services was less compared to curative care expenditure, according to the NCHD statistics. In 2007, of the total health expenditure, 68.8 % (26.6% for tertiary health care level, 42.2% for secondary health care) was spent for secondary and tertiary health care levels while 28.8 % was for primary health care (NDHD, 2007).

The total health expenditure has increased year by year due to a rise in economy and increase in GDP. However, increased funding to the health sector does not necessarily solve problems. The main incentive for improving the health services quality, outcome and efficiency and for providing the sustainability for health sector reforms, is an appropriate financing mechanism. Although hospitals are starting to be financed from the Health Insurance Fund, on the basis of case mix approach in accordance with the recent amendments to Health Package Laws, this financing mechanism is currently theoritical. Preparatory stages for the change are not satisfactory in both hospital and financing organisations and performance monitoring is weak.

The ownership of the Health Insurance Fund and the control over its operations is split and this makes management, use and monitoring of Health Insurance Fund cumbersome. This contributes to the poor management of this fund and weaknesses in the reimbursement and payment methods.

Ensuring regular and increasing flow of funds to the health sector, strengthening the financial management system to improve the efficient and effective use of health sector financial and related resources, and the health insurance system have been identified as strategies in the health care financing system in order to enhance access, equity and effectiveness, resource mobilization and allocation and use of health services.

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):
The Inter-Agency Coordinating Committee for Immunization (ICC) is the country equivalent of HSCC.

HSCC operational since:
The ICC was established in June 2002 by the Order Number 91 of the Minister of Health (Refer to document number 1 of the Annex 1)

Organisational structure (e.g., sub-committee, stand-alone):
The ICC is a stand-alone committee chaired by the Vice Minister of Health. Its members are drawn from the Ministry of Finance, Public Health Institute, development partners such as WHO, UNICEF, JICA and ADB (Refer to document number 1 of the Annex 1)

Frequency of meetings:[1]
The ICC is scheduled to meet every quarter and whenever necessary. The proposal development process for this GAVI-HSS support was discussed at the ICC meeting held on 19 June 2008. The ICC made a formal decision to establish a proposal working group (Refer to document number 2 of the Annex 1) and a total of seven (7) meetings were held during the period between November 2008 and April 2009 (Refer to document number 3.1-3.7 of the Annex 1).

Overall role and function:
The overall role and function of the ICC are:

- reviewing Multi-year and Annual Plans for Immunization
- monitoring the progress of the National Immunization Program
- providing technical inputs to the EPI national strategic and financial planning
- identifying resource gaps
- securing funding for the National Immunization Program
- coordinating the GAVI HSS proposal development process
- endorsing the final draft of the proposal.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?
The Department of Public Health Policy Implementation and Coordination of the MoH, the ICC for Immunization and WHO country office.

Who led the drafting of the application? Was any technical assistance provided?
The drafting of the application was led by the proposal working group, composition and terms of reference of which were approved by the Vice Minister of Health (Refer to document number 2 of the Annex 1). The working group was chaired by the Director of the Department of Public Health Policy Implementation and Coordination of the MoH and included representatives from MoH, EPI team, civil society, multi and bilateral partners and private sector. The country received financial support from GAVI to assist in the application process. The funds were in part utilized to obtain external and country-based technical support for developing the current proposal.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

[1] Minutes from HSCC meetings related to the HSS proposal preparation should be attached as supporting documentation, together with the minutes of the meeting where the application was endorsed by the HSCC. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

Background: Prior to the GAVI HSS proposal development the MoH was awarded U$ 50,000 TA funds in support of the proposal development process. These funds were to be managed by the WHO Mongolia country office through MoH.

19 Jun 2008: during the ICC meeting the implementation and expansion of RED strategy in Mongolia was discussed, as well as to submit an HSS proposal to GAVI. (Refer to document number 4.1 of the Annex 1)

27 Nov 2008: A joint stakeholder meeting - chaired by the Director of the Department of Public Health Policy Implementation and Coordination of the MoH - on the GFATM Round 9 and GAVI HSS proposal development was conducted. The workshop participants included a vast number of health stakeholders. During the workshop, participants identified priorities, intervention areas for health system strengthening with particular focus on AIDS, tuberculosis, EPI and maternal and child health (refer to document No5.1, Annex 1).

15 Jan 2009: A working group meeting chaired by the Director of the Department of Public Health Policy Implementation and Coordination of the MoH was held with the participation of an independent international consultant and WHO officer. It was decided to identify two national consultants in order to carry out an EPI Rapid Needs Assessment (Refer to document number 3.1 of the Annex 1).

12 Feb 2009: Presentation to the proposal writing working group and international partners of the findings of the EPI Rapid Needs Assessment conducted by the national consultants (Refer to document number 3.2 of the Annex 1).

6 Mar, 2009: Technical working group meetings (Refer to document number 3.3 of the Annex 1)

9 to 20 March 2009: An international consultant was involved in the proposal development

19 Mar 2009: A presentation workshop was organized by the MoH in order to share and discuss the selected topics for the GAVI and GFATM HSS proposals with main stakeholders. Feedback and recommendations were given by the participants in order to better define the selected options. (Refer to document No5.2, Annex 1)

1 Apr, 7 Apr and 11-12 Apr 2009: Technical working group meetings (Refer to document number 3.4-3.7 of the Annex 1)

23 April 2009: The proposal was approved and endorsed by the members of ICC on the meeting held April 23, 2009 (Refer to document number 4.2 of the Annex 1)

27 April 2009: Submission of the proposal to the GAVI secretariat.

Who was involved in reviewing the application, and what was the process that was adopted?

An Independent Review Committee was established by decision of the Vice Minister of Health. This committee was comprised of key stakeholders, including WHO, UNICEF, ADB, Mongolian Association of Family Clinics and Mongolian Public Health Professionals' Association. After reviewing the proposal, comments and recommendations were incorporated. A second level of the application review was performed by different stakeholders including the international consultant during his second round mission.

Who approved and endorsed the application before submission to the GAVI Secretariat?

The proposal was approved and endorsed by the ICC during its meeting on 23 Apr 2009 (Refer to document number 4.2 of the Annex 1)

Was funding received from GAVI for HSS proposal development? If so, how much, when was it received, and what was it used for, or what will it be used for?
The MoH received funding in the amount of US$ 50,000 from GAVI for HSS proposal development via the WHO Mongolia country office on 13th November 2008. These funds were used for stakeholders and consultative meetings, consultancy fees for an international and two national consultants, and for the translation of background materials for proposal development.

1.3: Roles and responsibilities of key partners (HSCC members and others)

Table No. 1: Roles and responsibilities of key partners

Title / Post	Organisation	HSCC member yes/no	Please list the specific roles and responsibilities of this partner in the GAVI HSS application development
Vice Minister of Health, Chair of ICC	Ministry of Health	Y	Provided leadership and coordinated the proposal development process, participated in the proposal endorsement.
Director of Department of Public Health Policy Implementation and Coordination	Ministry of Health	Y	Provided oversight to the application development process, chaired the Proposal Writing Working Group, participated in the proposal endorsement.
Senior Officer in charge of Communicable Disease Control	Ministry of Health	Y	Served as a member of the Proposal Writing Working Group, participated in a desk review of background materials, participated in the proposal endorsement.
Director	Budget Department, MoF	Y	Participated in ICC discussions and the proposal endorsement.
Director	Public Health Institute	Y	Participated in ICC discussions and the proposal endorsement.
Resident Representative	WHO	Y	Assisted in obtaining financial support from GAVI for proposal writing, assisted in identification and recruitment of external consultants, participated in the proposal endorsement.
Resident Representative	UNICEF	Y	Participated in ICC discussions and the proposal endorsement.
EPI Technical Officer	WHO	Y	Served as a member of the Proposal Writing Working Group, performed a desk review of studies and assessments funded by WHO, participated in the proposal endorsement.
Representative	JICA	Y	Participated in ICC discussions and the proposal endorsement.
Planning Coordinator	ADB-supported 2nd HSDP	Y	Served as a member of the Proposal Writing Working Group, performed a

			desk review of studies on maternal health, participated in the proposal endorsement.
Executive Director	Mongolian Public Health Professionals' Association	N	Performed an independent external review of the proposal
Head	Mongolian Association of Family Clinics	N	Performed an independent external review of the proposal
Executive Director	Health and Immunization NGO	N	Served as a member of the Proposal Writing Working Group
Director	"Etugen" Private Medical School	N	Served as a national consultant for the proposal development
Professor	"Ach" Private Medical School	N	Served as a national consultant for the proposal development, conducted a Rapid Assessment of Vaccination and Immunization System
Communicable Diseases Medical Officer	WHO	N	Performed an independent external review of the proposal
Deputy Representative	UNICEF	N	Performed an independent external review of the proposal
Health and Nutrition Specialist	UNICEF	N	Served as a member of the Proposal Writing Working Group, provided access to technical resources for the proposal development
Epidemiologists (3)	EPI Team	N	Participated in the proposal development process.
Officer in charge of Nutrition and Food Safety	MoH	N	Served as a member of the Proposal Writing Working Group, performed a desk review of studies on child nutrition
Officer in charge of Maternal and Child Health	MoH	N	Served as a member of the Proposal Writing Working Group, provided access to technical resources on maternal and child health for the proposal development
Family Practitioners (4)	FGP	N	Participated in the proposal development process.
District Child Health and EPI Managers (4)	District Health Department	N	Participated in the proposal development process.

1.4: Additional comments on the GAVI HSS application development process

Lessons learnt:

- The proposal development process greatly benefited from extensive consultation with key health stakeholders, particularly civil society. Through this broad consultation process the proposal was able to enrich its content especially in relation to practical aspects of health services delivery in the most remote areas, as well as in reaching the most disadvantage strata of the population.

- It was important to formalize the involvement of key stakeholders (e.g. via ministerial order), as it was quite challenging to coordinate a multi-disciplinary working group, as well as ensure a meaningful participation of all stakeholders

- National expertise and knowledge in linking HSS component to immunization services was lacking, therefore the application participative process allowed a better understanding of the overall possible synergies.

- Use of international consultants although helpful requires sufficient time to allow the experts to understand local specifics. Therefore, the expert's prior experience in the country should be made one of the main criteria for consultant selection.

- Additionally, although internationally the RED strategy is intended to be an immunization-specific intervention, evidence from the development and trial of the process in Mongolia indicates its potential for wider health system strengthening application. This is particularly for detecting and responding to the maternal and child health services needs of the more difficult to reach sub-population.

- In Mongolia, planners included a wider MCH package (rather than a sole immunization focus) in order to be consistent with the national health-sector plan and the health system's essential service package. An additional rationale for adopting the wider health system focus for RED is that the determinant of low immunization coverage (distance, level of education and poverty) are the same as those for low access to maternal and other child care services.

Section 2: Country Background Information

Mongolia made clear progress in poverty reduction and the attainment of MDGs during the last decade. The last EPI review showed high vaccination coverage. Implementation of the national EPI programme was satisfactory in general, with immunization coverage higher than 90% for all antigens. However, programme management, cold chain and logistics, social mobilization and disease surveillance were cited as areas needing improvement.

Notwithstanding this progress, there has been rapid migration to the urban areas of the capital Ulaanbaatar due mainly to the social sector decline in rural areas, and the potential for employment opportunities in urban areas. Also recent developments in the economic sector have led to new patterns of internal migration in rural areas, partially responsible for the development of informal mining sites and child labour, school drop outs and homelessness. These combined factors create new pockets of poverty both in urban and rural areas where health service delivery is inadequate to the basic needs of the poorest and most disadvantage strata of the population.

2.1: Current socio-demographic and economic country information[2]

Table No. 2: National data

Information	Value	Information	Value
Population [2007]*	2.6 million	GNI per capita [2006]*	995 USD
Annual Birth Cohort [2008]**	63,262	Under five mortality rate [2008]**	23.4/1000
Surviving Infants [2008]**	61,847	Infant mortality rate per [2008]**	19.6/1000
Percentage of GNI allocated to Health [2007]***	4.5%	Percentage of Government expenditure on Health [2007]*	7.3%
DPT3 coverage rate (by sex, where available) [2008]**	96%		

Table No. 3: Health Indicators of Project Implementing Sites:

Information	Value		Information	Value	
	Songinohairhan district of UB	Bayanhongor Province		Songinohairhan district of UB	Bayanhongor Province
Population [2008]**	227,827	84,200	DPT3 coverage rate (by sex, where available) [2008] **	97.6%	98.5%
Annual Birth Cohort [2008]**	5,461	2,043	Under five mortality rate [2008] **	3.7	5.8
Surviving Infants [2008] **	5,302	1, 988	Infant mortality rate [2008] **	12.6	26.9

* Mongolian Statistical Yearbook 2007, National Statistical Office
** Health Indicators – 2008, Health Statistics Office, National Center for Health Development, 2009
*** Health Indicators – 2007, Health Statistics Office, National Center for Health Development, 2008 (refer document number 7, Annex 1)

[2] **If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.**

2.2: Overview of the National Health Sector Strategic Plan and how it links to the cMYP

The Government of Mongolia endorsed a Health Sector Strategic Master Plan (HSMP) for 2006-2015 on the 13th April 2005 to bring together resources, policies and strategies to guide the health sector reform agenda (refer to Document No8, Annex 1). The goal of HSMP is to improve the health status of all the people of Mongolia, especially mothers and children, through implementing sector wide approach and providing responsive and equitable pro-poor, client-centered and quality services.

Overall, the HSMP underlines the following main points:

- Serves primarily as a comprehensive technical long-term planning document that can be implemented by any government whatever its ideology or political mandate;
- Highlights pro-poor interventions;
- Takes a predominantly primary health care and health promotion approach;
- Takes an incremental and gradual approach to change;
- Recognises that improving the health status of the people of Mongolia depends not only on actions within the health sector, but also a crosscutting sector approach

The HSMP identifies the following strategies related to immunization and child and maternal health services to be the main actions of MoH and all health sector partners:

- Further increase the coverage, access and utilization of health services especially for mothers and children, the poor and other vulnerable groups;
- Strengthen the delivery of quality primary health care through district health services facilities and FGPs

The Comprehensive Multi-year Plan (cMYP) for Immunization is an integral part of the HSMP. The cMYP covers the period between 2007 and 2012 (refer to document No9, Annex 1). The Mongolia's EPI has achieved high levels of immunization coverage and has made consistent progress towards eradicating polio as well as measles elimination. However, the coverage is based on the number of the registered children within the local civil registration offices, which means that this figure does not include children from migrant and/or poor families with no registration and place of residence. Therefore the actual immunization coverage could be lower than the official statistics. Many challenges still remain to be tackled in order to achieve full immunization coverage. The following socio-economic barriers still jeopardize sustainable immunization coverage and access to immunization services:

Geographical distance: Mongolia has one of the lowest population density/rate in the world (1.7 persons per square kilometre). In addition: (i) high cost associated to transport and communication, (ii) severe climatic conditions in rural and remote populations (iii) service providers being often cut off from road communications. The high national average coverage figures masks lower coverage figures in remote rural and peri-urban areas.

Rapid urbanization: the country is rapidly urbanizing with approximately 60% of the population now residing in urban areas. Rapid migration of population to the capital city presents significant challenges in relation to registration and tracking of migrant population and subsequently on real data on immunization coverage. This high internal migration provides further challenges to the health systems to reach these poor floating urban populations with basic health services.

Financial barriers: The EPI costs are continually increasing due to introduction of new vaccines, relatively high unit costs of immunization resulting from comparatively low absolute size of the annual birth cohort (of 63,262 in 2008), extra costs resulting from severe climate, lack of infrastructure such as roads in remote areas and remoteness of rural and peri-urban population in

a country with the world's lowest population density. Primary health care facilities receive their financing from the budget based on capitation method. Therefore, the PHC facilities do not receive funding for service provision for migrant and poor residents who are not registered with the local authorities.

Low awareness among the poor and unregistered migrants of rights and entitlements: These population groups are often unaware of where to seek appropriate health care. Health information may not reach poor and marginalized populations for a variety of reasons, including physical distance to health centers and limited outreach in many areas.

High turn-over of medical staff and resulting shortage of trained doctors and nurses: Inadequate working conditions and lack of incentives to work in remote areas serving the poor and marginalized populations result in high turn-over of medical staff and shortage of qualified specialists to provide quality care to the poor. The actual family doctor ratio per 10,000 populations is 1.5 in the provinces compared to 3.6 in UB city, the overall national rate is estimated to be 2.3. The general ratio for all doctors is 18.1 in the provinces, 44.4 in UB city and 28.3 nationwide respectively.

Section 3: Situation Analysis / Needs Assessment

The present health situation analysis, as well as the immunization profile of the country, can be drawn from a great number of recent available surveys, needs assessments, studies and project reports. The most recent are summarized in the table below, as well as the main findings pertinent to the HSS proposal goal.

3.1: Recent health system or immunization assessments[3] (refer to document in Annex 1 for complete list)

Table No 4: Summary of assessments and their main findings

Title of the assessment	Participating agencies	Main Findings pertinent to HSS proposal	Dates
Review of Immunization Service in Mongolia (refer to document No10, Annex 1)	B. Orgil and B. Batsereedene, National consultants for GAVI HSS Proposal Development	**Constraints to sustaining high immunization coverage in Mongolia:** • **Demographic constraints** - Increased internal migration to Ulaanbaatar and a resulting increase in the number of population without registration of the place of residence. • **Geographic constraints** - Lack of financing for communication and transportation for immunization of children in remote areas. • **Health Sector constraints** - Lack of financing for operational expenditure - Low motivation of health staff (high turn-over of nurses, little or no support from the management) - Vaccinators/nurses perform combined duties, and there is no incentive/motivation for additional work - Inadequate control or surveillance of AEFI - Inadequate IEC activities on health education for the public	2009
Assessment of Effective Vaccine Storage and Management (refer to document No11, Annex 1)	UNICEF/MoH	**Weaknesses identified** • Lack of maintenance for cold chain equipment, transport and building • Inadequate stock control procedures • Inadequate vaccine delivery and vaccine damage prevention procedures	2008
Barrier Analysis for the Development of RED Strategy (refer to document No12, Annex 1)	MoH, Ulaanbaatar City Health Department, NCCD, UNICEF, WHO, UNFPA and the University of Melbourne	**Health System Barriers** • Problems with human resource motivation • Lack of analysis of health information (ineffective data management) • Inadequate financing and budgeting • Inadequate skills and attitude of health workers • Inadequate or no supportive supervision of health providers **Immunization Barriers** • Cold chain deficiencies • Logistics (vaccine management skills), transport limitations • Insufficient training of staff	2008

[3] Within the last 3 years

		• Data quality (particularly for registration of populations and lack of data analysis) **Population Barriers** • Inadequate knowledge and attitude of population • Lack of community involvement for more accurate population estimation	
Study of Infant Mortality in Ulaanbaatar and Its Causes (refer to document No13, Annex 1)	Ulaanbaatar City Health Department, Association of Mongolian Perinatologists, HSUM	**Key findings:** - Infant mortality rate (IMR) in Nalaikh and Bayanzurkh districts (remote districts of the capital city with high proportion of migrant and poor families) was the highest **Recommendations:** - To improve nutritional status of pregnant women - To increase community involvement in maternal and child health	2008
Situation Analysis of Children and Women in Mongolia (refer to document No14, Annex 1)	UNICEF	**Key findings:** - In Mongolia, stunting, which reflects chronic malnutrition is the most prevalent form of malnutrition. Moderate or severe stunting affects one in five children under age five years. Children in rural areas are more likely to be stunted than children in urban areas. - IMR and under-five mortality rate are more than twice as high in rural as compared to urban areas. - Herder women accounted for 29 percent of the total number of pregnant women in Mongolia, but for 49 percent of the total number of mothers who died. - The urban-rural disparity in access to quality medical services has persisted even though the Government of Mongolia has allocated a larger amount of health sector resources in the remote provinces. **Key challenges:** - addressing urban poverty - breaking the vicious cycle of "poverty hunger – illness" - implementing IMCI-linked health programs - promoting reproductive health and family planning for high risk groups - providing access to quality reproductive health care in both urban and rural areas - tackling urban-rural disparities in maternal and child health - decreasing intra-urban disparities especially regarding the ger districts - building partnerships with communities	2007
The Mongolian Health System at a Crossroads: an Incomplete Transition to a Post Semashko Model (refer to document No15, Annex 1)	World Bank	**Key findings:** - Maternal mortality continues to be a problem, particularly in remote and rural regions - The poor reported an unwillingness to ask questions of care providers or demand better service for fear of being denied service	2007
Review of the Integrated Early	UNICEF, UNESCO,	**Key findings:** - Although the years of the policy implementation have seen decrease in the	2007

Childhood Development Policy Implementation (refer to document No16, Annex 1)	MoECS, Mongolia	maternal and child mortality, this indicator is varied by geographical area: - 2.2 times higher incidence of respiratory diseases in rural vs. urban areas - 1.8 times higher incidence of diarrhoea in rural vs. urban areas	
Socio-economic Situation of Migrants and Their Access to and Need for Social Services (refer to document No17, Annex 1)	UNFPA, HSUM, JICA	**Key findings:** - Although maternal and child health services are provided free regardless of the registration status, this creates extra workload on PHC facilities and causes deficits of drug and supplies because PHC facilities receive their funding based on the number of registered residents. Therefore, due to the shortage of contraceptives for free distribution they are distributed only to registered residents - Migrants often do not know about their entitlement to free services at PHC facilities regardless of registration status - The proportion of children who missed vaccination was highest in Ulaanbaatar. The main cause for this was unregistered status of their parents	2007
Short Programme Review for Child Health (refer to document No18, Annex 1)	WHO	**Core problems:** – Health care service provision for poor, vulnerable and migrating mothers and children remains a problem – Caretakers of children under five years are required to purchase drugs at first-level facilities, while drugs at the referral level are given free – Retention of doctors at the primary level is difficult due to problems with supplies and a lack of economic incentives – The quality of antenatal care is limited – The knowledge and practices of caretakers on key home practices for newborns and child care needs improvement – Maternal and child health activities are not monitored regularly	2007
Mongolia: Health system review. Health Systems in Transition. Vol. 9 No.4 2007 (refer to document N19, Annex 1)	European Observatory on Health Systems and Policies, WHO, MoH Mongolia	- At the beginning of the 1990s, the abrupt end of assistance to the health sector from the Soviet Union brought about extreme difficulties in financing the system that was in place. - Official user fees and social health insurance have been gradually introduced in order to plug the funding gap, along with significant contributions from international donors for health care delivery. - Problems with access and quality have been exacerbated by the deteriorating socioeconomic situation and public funding shortfall for the health sector. - The health indicators have improved since the early 1990s as a result of the implementation of concerted measures to protect the population through the health	2007

[4] Ger is traditional Mongolian dwelling suitable for nomadic lifestyle. Recent internal migration to UB city led to the expansion of ger district area. Population of ger district lack centralized water supply and sanitation condition is often inadequate.

		system. - However, the country is still challenged by the double burden of non-communicable and communicable diseases and health disparities between its socioeconomic groups. - An appropriate response to these health issues demands a stronger health system. - The huge differences in socioeconomic development and living standards for people living in rural and urban areas have contributed to the high level of internal migration, which has also led to a rapid ad hoc urbanization as formerly nomadic households try to improve their prospects by settling around urban centres, particularly Ulaanbaatar, and creating ger[4] districts.	
Strategic Analysis for Reaching MDGs 4 and 5 in Mongolia through HSS and Scale-up of Integrated Packages of High Impact and Low Cost Interventions (refer to document No20, Annex 1)	MoH, UNICEF, HSMP	**Bottlenecks:** – Inadequate training of primary health care providers – High workload of primary health workers – Lack of performance incentive and hardship allowance – Lack of counselling and communication for development skill – Poor accountability and attitude of health workers – Lack of sufficient time for communication for development – Poor human resource management at district and central levels – High turn-over of health staff **Bottlenecks in health care financing:** – Lack of budget for essential commodities – Lack of in-country evidences on inequity of health services – Lack of budget for outreach services **Bottlenecks in quality assurance and accreditation:** – Poor quality of basic services **Bottlenecks in Health Management Information System and IT:** – Too much time spent on reporting by primary health workers – Lack of distance learning – Information not used for planning budgeting – Shortage of electricity, electricity supply is not reliable – Shortage of cold chain equipment at district and sub-district level of the province – Lack of motivation to work in rural areas – Poor maintenance of cold chain equipment & vehicles	2008
Migration and its Health Consequences	NCHD, WHO	**Key Findings:** - 27% of surveyed households had children who were not immunized in accordance with the national EPI schedule. Reasons for that included: - parents did not know where to get vaccination (15.9%) - households were not registered with the	2006

		local authorities (31.7%) - parents did not seek health services for their children (35%) **Recommendation:** - To implemented a special program for migrant families to assist in obtaining residency registration and to improve their knowledge of the importance of immunization	
Why Mothers Die (refer to document No21, Annex 1)	MoH, ADB, MCHRC	Women of vulnerable and high-risk groups died due to complications of pregnancy and childbirth. They did not use effective family planning methods. Some mothers died due to a lack of attention for their own health and inadequate knowledge on making pregnancy safer. **Recommendations:** - To target mothers who live in outlying regions with interventions to improve the quality of safe motherhood services - To educate women and their families about danger signs of pregnancy, childbirth and postpartum period, and the importance of antenatal visits - To make family planning methods available for women of vulnerable, poor, and high risk groups	2006

3.2: Major barriers to improving immunization coverage identified in recent assessments

- Increased internal migration to Ulaanbaatar city resulting in increased population without official registration of the place of residence
- Lack of financing for outreach services, communication and transportation for vaccination of children in remote areas. The EPI costs are continually increasing due to introduction of new vaccines, relatively high unit costs of immunization resulting from comparatively low absolute size of the annual birth cohort, and extra costs resulting from severe climate and lack of infrastructure.
- Problems with human resource motivation due to inadequate working conditions and lack of incentives to work in remote areas serving the poor and marginalized populations. Therefore high turnover of medical staff and shortage of qualified specialists to provide quality care to the poor. Inadequate or no supportive supervision of health providers.
- Inadequate logistics management system as well as lack of cold chain equipment and unreliable supply of electricity in soums and peri-urban areas. Weak stock control procedures, inadequate vaccine delivery and vaccine damage prevention and waste management procedures.
- Poor maintenance of existing health services infrastructure as well as medical equipment and vehicle.
- Poor data quality (particularly for registration of populations and lack of data analysis).
- Inadequate communication activities for the public remote and marginalized population groups are often unaware of where to seek appropriate health care. Health information may not reach poor and marginalized populations for a variety of reasons, including physical distance to health centers and limited outreach in many areas.
- Poor community involvement as well as accountability.

3.3: Barriers that are being adequately addressed with existing resources

- The Government of Mongolia has taken responsibility for funding of vaccines and injection devices for routine immunization starting 2003. As of 2008, the GoM provides full funding for the above vaccines and devices except Penta-valent vaccine.
- Primary health care providers are charged with conducting outreach twice a year during National Immunization Days to register and provide immunization services to unregistered migrants, out of school, street and working children.
- 80% of the districts in Bayankhongor province are not connected to a permanent electricity source. The districts with no electricity operate generators for 3-4 hours a day, which can not provide the cold chain standard.
- 60 % of cold chain equipment became too old. Cold chain equipment often breaks down, especially at province and district level.
- Position for cold chain equipment maintenance engineer has been created at the NCCD in Feb 2008, who is responsible for repair of broken cold chain equipment on call. However, this is hardly sufficient for provision of nationwide troubleshooting services and preventive maintenance.
- IEC for public on the importance of vaccination is conducted twice a year during NID.

3.4: Barriers not being adequately addressed (in order of highest priority)

1. **Lack of finance for outreach services, communication and transportation for vaccination of children in remote areas.** This is the most important barrier, which jeopardises sustainability of high immunization coverage in the country where the population is scattered over vast territory. 70% of rural and peri-urban population lives 50 and more km away from primary health care facilities; thus requiring provision of outreach and mobile immunization services.

2. **Lack of efficient mechanism for timely registration of migrants.** There is a growing internal migration from rural to urban settings. In Ulaanbaatar city alone there is an influx of more than 50,000 migrants per year, and the number population without fixed place of residency in the capital city is more than 100,000. These population groups place a significant burden on primary health facilities, which receive their funding based on the number of people registered in the catchments area.
3. **Inadequate or no supportive supervision of health providers**. In Mongolian health care system, punitive inspection and supervision are prevailing, which is the major disincentive for health care workers to provide services, particularly in poor and remote areas. Therefore, a culture of supportive supervision needs to be instilled. Supportive supervision focuses on promoting quality services by periodically assessing and strengthening service providers' skills, attitudes and working conditions.
4. **Lack of community involvement.** Community involvement is crucial in building the ownership of health promoting initiatives and tailoring the services to the community needs. This is one of the least developed areas in health sector in general.
5. **Poor management and maintenance of existing infrastructure – medical equipment and vehicle.** There is only one cold chain equipment maintenance engineer at the NCCD, who is responsible for technical maintenance of cold chain equipment at the national level. This is hardly sufficient for provision of nationwide troubleshooting services let alone preventive maintenance.
6. **Inadequate behaviour change communication activities for the public.**
7. **Lack of data analysis, feedback and use of data for planning.** The system for collection of routine health statistics is quite well developed throughout the country, however, the data is rarely analysed, fed back and used for planning. There is no integrated national database on immunization in the country.

3.5: Describe specific barriers to civil society and the private sector in delivering immunization services and strengthening health systems or becoming part of the national process to increase Immunization coverage

Family group practices, which provide primary health care services including immunization in urban areas and provincial centres are not properly defined institutionally (semi private/public). They receive funding on per capita basis and are responsible for provision of basic maternal and child health services free of charge irrespective of clients' registration status. Therefore, increase in the number of unregistered migrants causes extra workload on FGPs, resulting in deficit of drugs and supplies and affecting the quality of health services overall.

There is no regulatory mechanism for civil society and for profit private sector to coordinate their partnership with the government sector in provision of immunization services.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS support

The Goal of this GAVI HSS proposal is to improve the health of mothers and children, especially the poor, disadvantaged groups and difficult to reach populations, through strengthening of the health system to deliver an integrated package of maternal and child health services. The following pilot project areas have been selected for the project implementation: (i) Galuut and Bayan-Ovoo districts in Bayankhongor province and (ii) Sub-districts No 1 and No 21 of Songinokhairkhan district of Ulaanbaatar City.

The districts have been selected based up on the following criteria: (i) Maternal Mortality Rate higher then national average, (ii) Infant and under 5 Mortality rate higher than the national average, (iii) High percentage of migrant and unregistered population, (iv) Epidemiological profile of infectious diseases, (v) Lower routine immunization coverage than the national average, (vi) High staff turnover during the last 3 years, (vii) Commitment of local government to implement and sustain the project, (viii) Population size, (ix) Total number of households living in remote areas as well as in disadvantaged conditions, (x) `Difficult to reach topography areas, (xi) Geographical access to health service facilities, (xii) Percentage of family with low income and percentage of poor citizens among the total population, (xiii) Low coverage of social welfare, (xiv) Unemployment rate, (xv) Number of working children.

4.2: Objectives of GAVI HSS Support

The objectives of this GAVI HSS proposal are:

1. By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas.
2. By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas.
3. By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.
4. Carry out safe and quality health services in project areas by providing regular on-site training and assistance.
5. Produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies.

One of the strategies of the Health Sector Strategic Master Plan is the delivering of the essential health services package at the primary health care level. However, the exact mechanism for such a delivery had not been clearly stated and define, and it is expected that the integrated delivery of maternal and child health services planned within the current GAVI HSS proposal will serve as a model mechanism to implement one of the key strategies of HSMP.

The main project activities will create HSS and deliver an integrated package of maternal and child services which have been defined as follows: **Health Service:** (1) Routine immunisation for all children under 16 years of age, (2) active home visits of children under 1 year of age, (3) ante and postnatal care to women in reproductive age, (4) micronutrients and vitamins, (5) IMCI. **Health Support Service:** (1) Civil registration (ID and documents), (2) Social welfare services, (3) IEC including health education and civil registration information.

Barrier	Objective	Output
Lack of financing for outreach services, communication and transportation for vaccination of children in remote areas.	By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas. By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas	Mapping of target population in project sites is completed and regularly revised on an annual basis. Package of essential maternal and child health services and delivery mechanism are defined and agreed upon. Integrated package of health services is delivered to all mothers and children in project areas. Microplans with health facilities are developed, costed, implemented and monitored. Capitation method is reviewed to reflect cost implications of service (routine and outreach) provision to unregistered residents.
Lack of efficient mechanism for timely registration of migrants and mobile population.	By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas. By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.	Multidisciplinary project management team is established. Effective community partnership model established and tested.
Inadequate or no supportive supervision of health providers	Carry out safe good quality health services in project areas by providing regular on-site training and assistance.	Supportive supervision tools developed. Supportive supervision team comprised of chief pediatrician, chief gynecologist, EPI manager, state inspector and NGO is established and regular supportive supervision visits conducted. Management capacity of aimag/district ISPT and MPMT is built. In-service training module for the delivery of integrated maternal and child health services is developed. In-service and refresher trainings for health providers conducted.
Poor and weak community involvement.	By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.	Effective community partnership model established and tested.
Poor management and maintenance of existing infrastructure	Carry out safe good quality health services in project areas by providing regular on-site training and assistance.	Preventive maintenance plan is developed based on EVSM assessment. Cold chain equipment is provided to project sites.
Inadequate behaviour change communication activities for the public.	By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas.	Behaviour change communication is included into integrated package of maternal and child health services.

	By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.	CSOs are involved in public awareness raising and social mobilization activities.
Poor data analysis as well as use of data for planning, decision making and feedback.	Produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies.	Child health database is established in project sites. Baseline and end of project evaluation survey is performed. Evidence from project implementation is used for advocacy to expand delivery of integrated maternal and child health services.

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

Mongolia has a good experience in sustaining impact achieved with the previous development assistance. JICA provided full support to the national EPI program in between 1996 and 2003, and the Government of Mongolia has gradually taken the responsibility for funding of vaccines and injection devices for routine immunization starting 2003. Currently, the GoM provides full funding for the above vaccines and vaccine injection devices except Penta-valent (DTP-Hib-Hep B) vaccine.

It is expected that a similar approach will be taken to sustain impact achieved with the GAVI HSS support. This will be done through the incorporation of micro-planning for integrated delivery of maternal and child health outreach services into city district annual plans. Planning at the national level will be done using existing structures such as ICC, Foreign Aid Coordination Committee of MoH (refer to document number 22, Annex 1) and related health institutions. What will be important is to avoid duplication with other donors' assistance and build up institutional memory and capacity which will be essential for sustaining project impact within the system after GAVI support end.

One of the strategies of the Health Sector Strategic Master Plan is the delivering of the essential health services package at the primary health care level. However, the exact mechanism for such a delivery had not been clearly stated and define, and it is expected that the integrated delivery of maternal and child health services planned within the current GAVI HSS proposal will serve as a model mechanism to implement one of the key strategies of HSMP.

Technical sustainability will be achieved in avoiding the establishment of separate vertical programs and using the existing structures as well as through institutionalization and implementation of project recommendation and lesson learned. Evidence from project implementation will be used for advocacy to expand the delivery of integrated maternal and child health services at the national level. Previous experience, in Mongolia, had demonstrated that incorporation of pilot models into the health government policy is an effective tool for ensuring the sustainability of results achieved with the pilot projects.

The GAVI HSS project also intends to introduce the use of performance-based incentives for primary health care providers. It is also planned to incorporate a policy on the use of performance-based incentives into the National Human Resource Policy, which will be revised in 2010 (refer to document number23, Annex 1).

MoH and the Mongolian Association of Family Clinics are - in the near future- planning to introduce a comprehensive integrated primary health care database. The GAVI HSS project will coordinate and interact with this initiative in order to share and gain information.

On top of that in February 2009, the first ever online Civil Registration System in Mongolia was launched. The system which will collect and generate accurate statistics on births, deaths, migration, citizenship and naturalization was established at the Civil Registration Information Centre with the support of the UNDP project "Pilot project to support the National Poverty and MDG Monitoring and Assessment System". All 21 provinces and 9 districts of Ulaanbaatar city are connected to the system. The online registration system will improve efficiency, accuracy of civil information data and transparency of service delivery and will contribute to better coordination between government and agencies. Therefore the GAVI HSS project will interact as a provider of data of un-registered people from the project sites.

5.2: Major Activities and Implementation Schedule

Objectives	Outputs	Activities	Year 1 (2010)				Year 2 (2011)				Year 3 (2012)			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas.	1.1 Multidisciplinary project management team is established and management capacity of province/city district ISPT and MPMT is built.	1.1.1 Establish by order of the Health Minister a multi-disciplinary project management team (MPMT) with detailed TOR under ICC for Immunization including officers of maternal and child health care.	X											
		1.1.2 Conduct quarterly meetings of MPMT.	X	X	X	X								
		1.1.3 Establish by the resolution of the local governor an inter-sectoral service provision team (ISPT) in project sites including province/city district social protection department, civil registration unit, police department and nonformal education center.	X											
		1.1.4 Conduct monthly meetings of ISPT.	X	X	X	X	X	X	X	X	X	X	X	X
		1.1.5 Organize project planning seminars with the involvement of key stakeholders and media.	X				X				X			
		1.1.6 Organize project management orientation trainings for MPMT and ISPT members.	X	X			X				X			
		1.1.7 Organize trainings on leadership, team building and interpersonal communication skills for MPMT and ISPT members.		X				X				X		
		1.1.8 Conduct annual progress review meeting.				X				X				X
		1.1.9 Submit APR to GAVI Alliance and Foreign Aid Coordination Committee of MoH.					X				X			
	1.2 Mapping of target population in project sites is completed and regularly revised on an annual basis, and microplans with health facilities are developed, costed, implemented and monitored.	1.2.1 Train ISPT members on mapping of unreached or difficult to reach population and microplanning on integrated delivery of maternal and child health services in project sites.		X										
		1.2.2 Conduct mapping, microplanning and costing exercise by ISPT.		X	X									
		1.2.3 Revise mapping and microplans on an annual basis.				X				X				X

Objectives	Outputs	Activities	Year 1 (2010)				Year 2 (2011)				Year 3 (2012)			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	1.3 **Package[5] of essential maternal and child** health services and delivery mechanism are discussed and agreed upon.	1.3.1 Discuss and agree the integrated package of essential maternal and child health services in consultation with key stakeholders, MPMT and ISPT.	X											
		1.3.2 Provide the integrated package of essential maternal and child health services	X	X	X	X	X	X	X	X	X	X	X	X
		1.3.3 Identify delivery mechanism and develop & approve guidelines for delivery of integrated package of essential maternal and child health services.	X											
		1.3.4 Revise integrated package of essential maternal and child health services and its delivery mechanism on an annual basis.				X				X				X
	1.4 Capitation method is reviewed to reflect cost implications of service (routine and outreach) provision to unregistered residents.	1.4.1 Develop methodology for geographical targeting to reflect cost implications of service provision to unregistered residents at primary health care facilities.		X				X				X		
		1.4.2 Revise capitation payment method to include geographical targeting and cost of outreach services.				X				X				X
		1.4.3 Approve the revised methodology for capitation payment by joint order of Minister of Finance and Minister of Health.												X
2. By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas.	2.1 In-service and refresher trainings for health care providers conducted.	2.1.1 Develop, publish and distribute guidelines and handbooks on integrated delivery of essential package of maternal and child health service.	X	X				X				X		
		2.1.2 Identify items to be included in kit for essential maternal and child health services	X											
		2.1.3 Train primary health care and service providers on integrated delivery of essential package of maternal and child health services.		X				X	X			X		
		2.1.4 Provide kits for essential maternal and child health services to mobile teams.	X	X			X		X		X		X	
		2.1.5 Report to province/city district MPMT by mobile team on a monthly basis.	X	X	X	X	X	X	X	X	X	X	X	X

[5] The main project activities will allow to create and HSS and to deliver an integrated package of maternal and child services which have been defined as follow: **Health Service:** (1) Routine immunisation for all children under 16 years of age, (2) active home visits of children under 1 year of age, (3) ante and postnatal care to women in reproductive age, (4) micronutrients and vitamins, (5) IMCI; **Health Support Service:** (1) Civil registration (ID and documents), (2) Social welfare services, (3) IEC including health education and civil registration information.

Objectives	Outputs	Activities	Year 1 (2010)				Year 2 (2011)				Year 3 (2012)			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	2.2 Integrated package of health services is delivered to all mothers and children in project areas and BCC is included into integrated package of maternal and child health services.	2.2.1 Establish mobile team by resolution of local governor for integrated provision of health and social protection services to hard to reach and unregistered population in project areas.		X								X		
		2.2.2 Conduct bi-monthly outreach visits by mobile team.	X	X	X	X	X	X	X	X	X	X	X	X
3. By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.	3.1 Effective community partnership model established and tested.	3.1.1 Identify through open bidding and contract partner CSOs to deliver community partnership and IEC/BCC activities (detailed TOR to be included in contract).		X			X				X			
		3.1.2 Select and train community volunteers to assist in improving the communication between community members and project implementation team.		X			X				X			
		3.1.3 Develop and publish communication kit for community volunteers		X			X				X			
		3.1.4 Report regularly (monthly) to mobile team by volunteers.	X	X	X	X	X	X	X	X	X	X	X	X
		3.1.5 Organize quarterly community volunteer networking meetings	X	X	X	X	X	X	X	X	X	X	X	X
	3.2 CSOs are involved in public awareness raising and social mobilization activities.	3.2.1 Develop IEC/BCC plan in project areas by CSO.		X			X				X			
		3.2.2 Conduct media advocacy on maternal and child health issues.	X	X	X	X	X	X	X	X	X	X	X	X
		3.2.3 Select and contract media for project IEC/BCC.		X										
		3.2.4 Report regularly (monthly) to MPMT by media.	X	X	X	X	X	X	X	X	X	X	X	X
		3.2.5 Develop, pre-test, publish and distribute IEC/BCC materials on maternal and child health for target population	X	X	X	X	X	X	X	X	X	X	X	X
		3.2.6 Conduct BCC campaign through mass media on regular basis with consistent message.		X	X	X	X	X	X	X	X	X	X	X

Objectives	Outputs	Activities	Year 1 (2010)				Year 2 (2011)				Year 3 (2012)			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4. Carry out safe and quality health services in project areas by providing regular on-site training and assistance.	4.1 Supportive supervision tools developed.	4.1.1 Develop and pre-test supportive supervision tool.		X										
		4.1.2 Publish and provide with supportive supervision tools.												
	4.2 Supportive supervision team is established and regular supportive supervision visits conducted.	4.2.1. Establish supportive supervision teams in project sites comprised of chief pediatrician, chief gynecologist, EPI manager, state inspector and NGO.		X			X							
		4.2.2 Train supportive supervision team on use of the tool.		X			X				X			
		4.2.3 Conduct monthly supportive supervision visits to project sites.	X	X	X	X	X	X	X	X	X	X	X	X
		4.2.4. Provide feedback to project implementing team on a monthly basis by national and local MPMT.	X	X	X	X	X	X	X	X	X	X	X	X
	4.3 Preventive maintenance plan is developed based on EVSM assessment.	4.3.1 Conduct EVSM assessment of vaccination units in project sites.			X			X						
		4.3.2 Develop and implement preventive maintenance plan.			X		X				X			
	4.4 Cold chain equipment is provided to project sites	4.4.1 Provide maintenance staff with repair toolkit and train on preventive maintenance.			X			X				X		
		4.4.2 Provide cold chain equipment including temperature monitoring device and solar refrigerator/generator to project sites based on EVSM assessment findings.			X				X				X	
5. Produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies.	5.1 Child health e-database is established in project sites.	5.1.1 Sign multiparty contract between MPMT, province/city district civil registration and social protection offices and local governor on improving civil registration.		X				X				X		
		5.1.2 Contract an IT provider to develop child health e-database software with mapping in project sites.		X				X				X		
		5.1.3 Train primary health care and service providers on the use of e-database software.		X				X				X		
		5.1.4 Produce monthly and feedback reports on child health.	X	X	X	X	X	X	X	X	X	X	X	X
	5.2 Baseline and end of project evaluation survey is performed.	5.2.1 Conduct baseline survey in project sites.	X											
		5.2.2 Perform progress project evaluation survey in project sites.								X				
		5.2.3 Perform end of project evaluation in project sites.												X

Objectives	Outputs	Activities	Year 1 (2010)				Year 2 (2011)				Year 3 (2012)			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	5.3 Evidence from project implementation is used for advocacy to expand to other sites.	5.3.1 Organize national consultative meeting to present final report on project implementation and agree on the expansion of pilot project using incremental approach.												X
		5.3.2 Approve delivery model of the integrated and/or essential package of maternal and child health services by the order of the Minister of Health.												X
		5.3.3. Submit project completion report to Foreign Aid Coordination Committee of MoH and GAVI Alliance.												X

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[6]	Source[7]	Date of Baseline	Target (2 province districts and 2 city districts)	Date for Target
1. National DTP3 coverage (%)	Immunization Coverage Annual Report	96%	Health Indicators	2008	97%	2012
2. Number / % of districts achieving ≥80% DTP3 coverage	Annual Immunization Coverage Report	100%	WHO/UNICEF joint report	2008	100%	2012
3. Under five mortality rate (per 1000)	Health Indicators	22.6	Health Indicators	2008	Decrease[8] district value	2012
4. Percentage of fully immunized children under the age 1	MICS (refer to document No24, Annex 1)	60%	Annual Progress Report	2005	Decrease district value	2012
5. The percentage of pregnant women who attended ANC services 6 and more times	Health Indicators	83.7%	Health Indicators	2007	90%	2012
6. Percentage of stunted children which is and province city district specific figures can be obtained from the	Nutrition Research Center	19.6% national	Nutrition Research Center	2008	Decrease district value	2012

[6] **If baseline data is not available indicate whether baseline data collection is planned and when**
[7] **Important for easy accessing and cross referencing**
[8] During the project inception phase a baseline survey will be implemented in the project sites, which will allow to have more detailed data

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value[9]	Source	Date of Baseline	Target	Date for Target
1. Population coverage with integrated maternal and child health services in project areas.	Number of pregnant and lactating women and children under 5, who received integrated health services during reporting period	Total number of pregnant and lactating women and children under five during reporting period	Annual project progress report	NA	Project Sites	NA	100%	2012
2. Client satisfaction rate	Number of surveyed people satisfied with health services provided by primary health care providers	Total number of people surveyed	Baseline survey and end of project evaluation survey	NA	Project Sites	NA	Increase baseline survey rate by 20%	2012
3. Proportion of unregistered residents in project sites.	Number of registered residents surveyed in project sites	Total number of residents surveyed	Baseline survey and end of project evaluation survey	NA	Project Sites	NA	85%	2012
4. Proportion of mothers with children below age 5 with comprehensive knowledge on IMCI in project sites.	Number of mothers with children below age 5, who have correct knowledge on immunization and management of childhood diarrhoea and ARI.	Total number of mothers surveyed	Baseline survey and end of project evaluation survey	NA	Project Sites	NA	Increase baseline survey rate by 20%.	2012
5. Proportion of children up to age two immunized according to national immunization schedule	Number of children up to age 2 immunized according to national immunization schedule in project sites.	Total number of children up to age 2 in project sites during reporting period.	Annual immunization	NA	Project	NA	95%	2012

in project sites.			report		Sites			

6.3: Process Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value[6]	Source	Date of Baseline	Target	Date for Target
1. Percent of smallest administrative units in project province/districts mapped.	Number of smallest administrative units in project province/districts mapped	Total number of smallest administrative units in project areas	Annual project progress report	0	Project Sites	2009	100%	2012
2. Percentage of outreach sessions conducted versus planned by health facilities in a quarter	Number of outreach sessions conducted by health facilities in a quarter	Number of planned outreach sessions by health facilities in a quarter	Project quarterly reports	NA	Project Sites	NA	100%	2012
3. Percentage of community volunteers who submit timely, complete monthly reports to mobile team	Number of volunteers who submit timely, complete monthly reports to mobile team	Total number of trained community volunteers	Project quarterly reports	NA	Project Sites	NA	90%	2012
4. Percentage of health facilities conducting at least three supportive supervisory visits in a quarter to each of their health facilities versus planned by city district and province health department	Number of health facilities conducting at least 3 supportive supervisory visits in the quarter to each of their health facilities	Total number of health facilities in project sites	Project quarterly reports	NA	Project Sites	NA	100%	2012
3. Percentage of health facilities which submit timely, complete monthly reports to MPMT	Number of health facilities which submit timely, complete monthly reports to MPMT	Total number of health facilities in project sites	Project quarterly reports	NA	Project Sites	NA	90%	2012

6.4: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage rate	Immunization Department, NCCD	NCCD	Data will be used for monitoring and evaluation of project implementation and improvement of immunization services in the country.
2. Number % of districts achieving ≥ 80% DTP3 coverage	Immunization Department, NCCD	NCCD	Data will be used for monitoring and evaluation of project implementation and improvement of immunization services in the country.
3. Under five mortality rate (per 1000)	Health Statistical Department, NCHD	NCHD	The results will be used to inform and improve maternal and child health policies.
4. Percentage of fully immunized children under age 1	Annual Progress Report	NCCD	The results will be used to inform and improve maternal and child health policies.
5. The percentage of pregnant women who attended ANC services six and more times	Annual Progress Report	NCHD	The results will be used to inform and improve maternal and child health policies.
6. Percentage of stunted children	Annual Progress Report	MPMT	The results will be used to inform and improve maternal and child health policies.
Output			
1. Population coverage with integrated maternal and child health services in project areas.	Baseline survey and Annual Project Progress Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services.
2. Client satisfaction rate	Baseline survey and Annual Project Progress Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services.
3. Proportion of unregistered residents in project sites.	Baseline survey and Annual Project Progress Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services.

4. Proportion of mothers with children below age five with comprehensive knowledge on IMCI in project sites.	Baseline survey and Annual Project Progress Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services.
5. Proportion of children up to age 2 immunized according to national immunization schedule in project sites.	Project Quarterly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.
Process			
1. Percent of smallest administrative units in project province/districts mapped.	Project Quarterly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.
2. Percentage of outreach sessions conducted versus planned by health facilities in a quarter	Project Quarterly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.
3. Percentage of community volunteers who submit timely, complete monthly reports to mobile team	Project Monthly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.
4. Percentage of health facilities conducting at least 3 supportive supervisory visits in a quarter to each of their health facilities versus planned by city district and province health department	Project Quarterly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.
5. Percentage of health facilities which submit timely, complete monthly reports to MPMT	Project Monthly Report	MPMT	Data will be used for advocacy to expand delivery of integrated maternal and child health services to other sites.

6.5: Strengthening M&E system

The Monitoring and Evaluation Division at the MoH in collaboration with the project partners will be responsible of the ongoing project monitoring. The mid-term and final evaluation of the project will be implemented by an independent mix team (national & international) to be decided during the inception phase of the project.

The project objective number five states "To produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies". In order to effectively implement this objective a database will be established in the project sites (province and district). This data base will provide information on child nutrition, micronutrients, and illness history as well as immunization status. This initiative will also help to strengthen the health information system, and could be later replicated in other provinces and districts nationwide.

In addition, and in order to implement objective number 4 "To carry out safe good quality health services in project areas by providing regular on-site training and assistance" supportive multidisciplinary supervision teams composed of chief pediatrician, chief gynecologist, EPI manager, state inspector and NGO member will be established. These teams will conduct monthly supportive supervisory visits to the project sites, during which, professional expertise will be shared and provided in order to improve the provided health services throughout the project intervention. The recommendations fed into the quarterly report will be used for the monitoring the activities by local and national level MPMT.

6.6: Operational Research

The project is designed to implement "Reach Every District" international strategy developed by WHO and UNICEF in one city district of UB city (2 sub-districts) and one province (2 districts). The RED strategy addresses common health system bottlenecks in order to increase immunization coverage, improve quality city district planning and health services as well as to improve inadequate monitoring and supervision of health workers. Mongolia introduced RED strategy in 2008 with a small scale UNICEF project in one sub-district of Ulaanbaatar city. The project implementation should provide the fertile ground for several studies to be conducted in order to assess burning health related issues of the present Mongolian health system. Using the opportunity of GAVI HSS funding performance outcomes of the project as well as practical aspects of it as: (i) costing and feasibility to manage and expand the RED strategy nation-wide, (ii) cost effectiveness study to assess effectiveness of the RED strategy, (iii) study on relation between mobile population and health services delivery in remote and rural area, (iv) study on possible innovative methods of tracking mobile population using mobile phone, (v) study of innovative incentive mechanism to motivate health providers in remote and disadvantaged areas should be investigated and analyse for further replication and expansion in other provinces and districts (refer to document No6, Annex 1)

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description

Give details on the management costs and mechanisms (especially if a partner will be managing parts of the GAVI HSS proposal)	Four structures are established to manage and coordinate the implementation of the project. 1. The ICC for Immunization will provide leadership of the GAVI HSS proposal and will be responsible of the overall project management. ICC will meet on a quarterly basis to share and discuss project progress, and provide advocacy for improvement where it is needed. ICC will also discuss and endorse the APR. 2. A Multidisciplinary Project Management Team will be established under the ICC for immunization by the order of Health Minister. The members for MPMT will be drawn from relevant divisions of MoH for maternal and child health, and child nutrition & food safety and Immunization Department of NCCD. The MPMT will take oversight of operational management and coordination of the project activities. The MPMT will have following duties and responsibilities: o Plan, organize and coordinate day-to-day activities of the project o Allocate budget to project sites in accordance to approved operational budget o Provide technical support to ISPT and primary health care facilities in project sites in project matters o Collaborate with project partners at the national level including conducting selection of project partners, contracting and monitoring & evaluation of partners' performance o Write project progress report and report to ICC o Write APR and get endorsed by ICC o Monitor project progress o Conduct regular project site visits A focal point will be appointed inside the MoH, he/she will coordinate day-to-day activities of the project and provide logistical and other support to MPMT. The focal point will also liaise with the project implementation sites, MPMT, ISPT and project partners. He/she will be responsible for organizing national level seminars and will report to the Director of Policy and Planning Division, MoH. 3. An Inter-sectoral Service Provision Team (ISPT) will be established by the local governor at the province and city district health departments of project sites. The Team will be composed by officials from province/city districts, social protection department, civil registration unit, police department and non-formal education centre. The ISPT will take overall management of project implementation in the community and primary health care facilities. The ISPT will conduct supportive supervisory visits to primary health care facilities. The duties and responsibilities will be: o Develop micro plan, organize and coordinate day-to-day activities of the project at local level o Allocate budget to primary health care facilities in accordance to approved operational budget o Provide technical support to mobile team and primary health care facilities in project sites in project matters at local level o Collaborate with project partners at the local level including conducting selection of project partners, contracting and monitoring & evaluation of partners' performance o Write project progress report and report to MPMT o Participate in the monitoring project progress o Collaborate with project partners at the local level including conducting selection of project partners, contracting and o monitoring & evaluation of partners' performance

Give details on the management costs and mechanisms (especially if a partner will be managing parts of the GAVI HSS proposal)	Mobile team comprised of province city district and FGP medical doctor, nurse/vaccinator, social worker and driver to be established by the resolution of local governor for integrated provision of health and social protection services to hard to reach and unregistered population in project areas at primary health care facilities will 4. Provide services to unreached or hard to reach population including unregistered, mobile population and street/homeless children. Mobile team will conduct bi-monthly outreach service visits and report to ISPT on the number of population covered and services provided during the service.
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	The Vice Minister of the MoH is in charge of ICC for Immunization will be responsible for overall management of GAVI HSS implementation and M&E.
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	ICC for Immunization who took overall coordination of GAVI proposal development process will take overall management of project. ICC will meet on a quarterly basis to share and discuss project progress, and provide advocacy for improvement where it is needed. ICC will also discuss and endorse APR. The ICC for Immunization will participate in the project with following responsibilities: o Make any decision related to project implementation o Discuss project progress report o Appoint head of the MPMT and approve selection of members for MPMT o Approve budget allocation for project sites o Provide advocacy and recommendations for the improvement of project implementation o Meet on a quarterly basis for discussion of project activities o Endorse APR o
Mechanism for coordinating GAVI HSS support with other health system strengthening activities and programs	In Bayankhongor province is one of the project sites, where nutrition project is being implemented by the World Vision Mongolia. In Songinokhairkhan City district of capital city, improvement of the nutritional status of children project by The Second Health Sector Development project through ADB support. Improving health services for disadvantaged population in capital city is being implemented by ADB. These projects are implemented to strengthen capacity of primary health care facilities and health provider, and guidelines and training modules of these projects will be reviewed and used for the development of supportive supervision guideline. Best practices of these projects will be incorporated, where it is needed. The existing child and maternal health interventions such as IMCI, continuum-of-care to address maternal and child health, micronutrient deficiency control and water and sanitation at health facility and community level.

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Please list the specific roles and responsibilities of this partner in the GAVI HSS implementation
Vice Minister of Health, Chair of ICC	Ministry of Health	Y	Provide leadership and provide advocacy and endorse APR.
Director of the Policy and Planning Division	Ministry of Health	Y	Provide oversight to the project activities implementation, chair the MPMT, and endorse APR.
Officer in charge of Communicable Disease Control	Ministry of Health	Y	Serve as the member of the MPMT and participate in the project coordination.
Director	Budget Department, MOF	Y	Participate in ICC discussions and endorse APR.
Director	Public Health Institute	Y	Participate in ICC discussions and endorse APR.
Resident Representative	WHO	Y	Provide leadership and provide advocacy to project implementation and endorse APR.
Resident Representative	UNICEF	Y	Participate in ICC discussions and the APR endorsement.
Officer in charge of communicable diseases and EPI	WHO	Y	Serve as the member of the MPMT and participate in the project coordination.
Representative	JICA	Y	Participate in ICC discussions and the APR endorsement.
Planning Coordinator	ADB-supported 2nd HSDP	Y	Serve as the member of the MPMT and participate in the project coordination.
Officer in charge of Nutrition and Food Safety	Ministry of Health	N	Serve as the member of the MPMT and participate in the project coordination.
Officer in charge of Mother and Child health	Ministry of Health	N	Serve as the member of the MPMT and participate in the project coordination.
Health and Nutrition Specialist	UNICEF	N	Serve as the member of the MPMT and participate in the project coordination.
Epidemiologist	EPI, NCCD	N	Serve as the member of the MPMT and participate in the project coordination.

7.3: Funding arrangements

Mechanism / procedure	Status / Description
Has a GAVI FMA been conducted: yes / no	NO
When was the last FMA conducted: mm/yyyy	NA
If yes: Has an Aide Memoire been signed: yes[9] / no (Document Number.....)	NA
If yes: Will the present Aide Memoire govern the financial management of the GAVI HSS funds: yes / no	NA
If no: Reasons for not following all the agreements in the last Aide Memoire	NA
Next FMA scheduled for: mm/yyyy	NA
Has a joint financing mechanism been established for the health sector: yes / no	NO
If yes: Will this joint financing mechanism be used for managing GAVI HSS funds: yes[10] / no (Document Number.....)	NA
If no: Reasons for not using the joint financing mechanism	NA
Please provide a detailed description of the financing mechanism proposed for the management of GAVI HSS funds[11] if all the agreements in the last Aide Memoire is not followed or a FMA has yet to be conducted.	According to the rule of MoH on donor funding, there will be an agreement signed between MoH of Mongolia and GAVI Alliance before the GAVI HSS fund release. The MoH of Mongolia will abide rules of the agreement and once the GAVI HSS funds are released and transferred to the MoH, the authorised financial director of Finance and Investment Department of MoH will provide overall monitoring of the financial management and sign cash release form as per the responsibility.
Title(s) of document(s) governing the annual budgeting process for the use GAVI HSS funds[12] (Document Number.....)	Order No 123 dated May 04, 2005 of the Minister of Finance on the approval of regulations on "Activities of cashier in budget organizations"
Title(s) of document(s) governing the financial management (accounting, recording and reporting) of the GAVI HSS funds[13] (Document Number.....)	Law on Accounting of Mongolia (refer to document No25, Annex 1)

[9] Please summit a copy of the Aide Memoire

[10] Please summit a copy of the agreement/memorandum of understanding, which governs the joint financing mechanism and a copy of the document which describes how the joint financing mechanism is currently functioning.

[11] Please note that the mechanism selected must comply with the minimum requirements of GAVI's Transparency & Accountability Policy

[12] Please summit a copy of the procedures and legislation, which applies to the annual budgeting process for the use of GAVI HSS funds and documentation, which describes how the budgeting process for GAVI HSS funds would be conducted

Title(s) of document(s) governing the audit of the GAVI HSS funds[14] (Document Number.....)	Law on Auditing of Mongolia (refer to document No26, Annex 1)
Frequency of internal audits planned for GAVI HSS funds?	GAVI HSS activities and fund will be audited internally 2 times a year.
Frequency of external audit[15] planned for GAVI HSS funds?	The external audit will be purchased one time to conduct auditing.

[13] Please summit a copy of the procedures, which apply to the financial management (accounting, recording and reporting) of GAVI HSS funds and documentation, which describes how the financial management of GAVI HSS funds would be functioning.
[14] Please summit a copy of the procedures, which apply to the external audit of GAVI HSS funds and documentation, which describes how the external audit of GAVI HSS funds would be conducted
[15] "External audit" defined as the audit conducted by the Government's Supreme Auditing Agency.

7.4: Reporting arrangements

The mobile team, the smallest unit of the project to be established at the primary health care facilities, will provide their outreach services reports to ISPT on a monthly basis. The ISPT will conduct regular supportive supervisory visits on a monthly basis to primary health care facilities and upon return will write reports of activities to MPMT at province/city district level.

Province/city district MPMT will report project activities implementation to national level MPMT on a quarterly basis. National level MPMT will conduct supportive supervisory visits to primary health care facilities on a quarterly basis together with province/city district MPMT.

National Focal Point together with MPMT will collect and analyse project progress monthly, quarterly and annual reports and provide feedback to project implementation sites with lessons learnt from the project intervention. National Focal point together with MPMT will compile the Annual Progress Report under direct guidance and support of the Director of the Policy and Planning Division of the MoH, who will provide oversight to the project implementation.

7.5: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)	Anticipated funding source
1. Baseline survey to identify baseline value in the project sites and	1 month[16]	Annually	Competitive tender	GAVI HSS
2. Project progress survey to assess the improvement of the indicators against baseline value.	1 month	Annually	Competitive tender	GAVI HSS
2. Project end survey to assess the improvement of the indicators against baseline value.	1 month	Annually	Competitive tender	GAVI HSS
4. Effective Vaccine Storage Management assessment in 6 Immunization units of the project sites	1 month	Two times (at the start and end of the project)	International consultant	GAVI HSS
5. External Auditing Service	1 month	Annually	MoH	GAVI HSS

[16] One month is intended for the overall four project sites

Section 8: Budgeting and Funding for GAVI HSS supported activities

8.1: Budget for implementing GAVI HSS support

Area for support	Unit cost, if applicable	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	TOTAL COSTS
		2010	2011	2012	
Activity costs		**164,542**	**167,832**	**171,187**	**503,561**
Objective 1: By 2012, institutionalize mechanisms for sustainable delivery of integrated package of maternal and child health services in project areas.					
Output 1. Multidisciplinary project management team is established. **Output 2.** Management capacity of province/city district ISPT and MPMT is built.					
Activity 1.1 Establish by order of Health Minister a multi-disciplinary project management team (MPMT) with detailed TOR under ICC for Immunization.		1,000	–	–	1,000
Activity 1.2 Conduct quarterly meetings of MPMT. (3 MPMT X 4=12 meetings)		2,000	2,000	2,000	6,000

Activity 1.3 Establish by the resolution of the local governor an inter-sectoral service provision team (ISPT) in project sites including province/city district social protection department, civil registration unit, police department and nonformal education center.		1,000	–	–	1,000
Activity 1.4 Conduct monthly meetings of ISPT. (12 times x 200$)		2,400	2,400	2,400	7,200
Activity 1.5 Organize project planning seminars with the involvement of key stakeholders and media. (2 times x 40 person x 8$)+(photocopy, tea break, transportation)		4,000	1,000	1,000	6,000
Activity 1.6 Organize project management orientation trainings for MPMT and ISPT members.		4,000	1,000	1,000	6,000
Activity 1.7 Organize trainings on leadership, team building and interpersonal communication skills for MPMT and ISPT members.		2,000	2,000	2,000	6,000
Activity 1.8 Conduct annual progress review meeting. (transportation + DSA)		3,000	3,500	4,000	10,500
Activity 1.9 Submit APR to GAVI Alliance and Foreign Aid Coordination Committee of MoH.		500	500	500	1500
Sub-Total		**19,900**	**12,400**	**12,900**	**45,200**
Output 1. Mapping of target population in project sites is completed and regularly revised on an annual basis. **Output 2.** Microplans with health facilities are developed, costed, implemented and monitored.					
1. Train ISPT members on mapping of unreached or difficult to reach population and microplanning on integrated delivery of maternal and child health services in project sites.		4,000	4000	4000	12,000
2. Conduct mapping, microplanning and costing exercise by ISPT.		2,000	–	–	2,000

3. Revise mapping and microplans on an annual basis.		-	500	500	1,000
Sub-Total		**6,000**	**4,500**	**4,500**	**15,000**
Output 3. Package of essential maternal and child health services and delivery mechanism are defined and agreed upon.					
1. Define package of essential maternal and child health services in consultation with key stakeholders, MPMT and ISPT.		–	–	–	–
2. Identify and approve guidelines for delivery of integrated package of essential maternal and child health services.		–	–	–	–
3. Revise package of essential maternal and child health services and its delivery mechanism on an annual basis.		–	–	–	–
Sub-Total		–	–	–	–
Objective 2: *By 2012, ensure universal access to integrated package of health services by all mothers and children in project areas.*					
Output 1. Integrated package of health services is delivered to all mothers and children in project areas. **Output** 2. In-service and refresher trainings for health providers conducted. **Output 3.** Behaviour change communication is included into integrated package of maternal and child health services.					
Activity 2.1 Develop, publish and distribute guidelines and handbooks on integrated delivery of essential package of maternal and child health service.		8,000	5,000	3,000	16,000
Activity 2.2 Train primary health care service providers on integrated delivery of essential package of maternal and child health services.		6,000	3,000	3,000	12,000

Activity 2.3 Establish mobile team by resolution of local governor for integrated provision of health and social protection services to hard to reach and unregistered population in project areas.		500	–	–	500
Activity 2.4 Identify items to be included in kit for essential maternal and child health services		–	–	–	–
Activity 2.5 Provide kits for essential maternal and child health services to mobile teams.		16,000	18,000	10,000	44,000
Activity 2.6 Conduct bi-monthly outreach visits by mobile team. (Fuel cost) (mobile team member's DSA)		30,442	35,000	37,000	102,442
Activity 2.7 Report to province/city district MPMT by mobile team on a monthly basis.		–	–	–	–
Sub-Total		**60,942**	**61,000**	**53,000**	**174,942**
***Objective 3* By 2012, identify and test an effective community partnership model to promote and deliver services in project areas.**					
Output 1. Effective community partnership model established and tested					
Activity 3.1 Identify through open bidding and contract partner CSOs to deliver community partnership and IEC/BCC activities (detailed TOR to be included in contract).		500	500	500	1,500
Activity 3.2 Select and train community volunteers to assist in improving the communication between community members and project implementation team.		4,000	4,000	4,000	12,000

Activity 3.3 Develop and publish communication kit for community volunteers		6,000	3,000	3,000	12,000
Activity 3.4 Report regularly (monthly) to mobile team by volunteers		4,000	7,000	7,000	18,000
Activity 3.5 Organize quarterly community volunteer networking meetings		1,000	1,000	1,000	3,000
Sub-Total		**15,500**	**15,500**	**15,500**	**46,500**
Output 2. CSOs are involved in public awareness raising and social mobilization activities.					
1. Develop IEC/BCC plan in project areas.		–	–	–	–
2. Conduct media advocacy on maternal and child health issues.		1,500	2,000	2,500	6,000
3. Select and contract media for project IEC/BCC.		2,000	–	–	2,000
4. Report regularly (monthly) to MPMT by media.		1,000	–	–	1,000
5. Develop, pre-test, publish and distribute IEC/BCC materials on maternal and child health for target population		2,000	4,000	4,000	10,000
6. Conduct BCC campaign through mass media on regular basis with consistent message.		10,000	11,000	11,000	32,000
Sun-Total		**16,500**	**17,000**	**17,500**	**51,000**
Objective 4: Carry out safe good quality health services in project areas by providing regular on-site training and assistance.					

Output 1. Supportive supervision tools developed. **Output 2.** Supportive supervision team comprised of chief paediatrician, chief gynaecologist, EPI manager, state inspector and NGO is established and regular supportive supervision visits conducted.					
Activity 4.1 Establish supportive supervision teams in project sites comprised of chief pediatrician, chief gynecologist, EPI manager, state inspector and NGO.		500	500	500	1,500
Activity 4.2 Develop and pre-test supportive supervision tool.		1,000	–	–	1,000
Activity 4.3 Train supportive supervision team on use of the tool.		4,000	2,000	2,000	8,000
Activity 4.4 Conduct monthly supportive supervision visits to project sites. (transportation cost, DSA)		2,000	2,500	3,000	7,500
Activity 4.5 Provide feedback to project implementing team on a monthly basis.		–	–	–	–
Sub-Total		**7,500**	**5,000**	**5,500**	**18,000**
Output 3. In-service training module for the delivery of integrated maternal and child health services is developed.					
Activity 4.6 Develop in-service training module for the delivery of integrated maternal and child health services.		2,000	1,000	1,000	4,000
Activity 4.7 Develop and publish training materials for the delivery of integrated maternal and child health services.		2,000	1,000	1,000	4,000
Sub-Total		**4,000**	**2,000**	**2,000**	**8,000**
Output 4. Preventive maintenance plan is developed based on EVSM assessment. **Output 5.** Cold chain equipment is provided to project sites.					

Activity 4.8 Conduct EVSM assessment of vaccination units in project sites. (2 province/city district x 2 person x 3 days 25$) + (transportation 150 $x 2 way x 2 person)		1,000	1,500	2,000	4,500
Activity 4.9 Develop and implement preventive maintenance plan. (maintenance visit 4 time x 4 site x 100 $ fuel cost x 2 way x 3 days x 10$)		3,500	4,000	4,500	12,000
Activity 4.10 Provide maintenance staff with repair toolkit and train on preventive maintenance. (2 province/city district x 800)		1,500	1,500	1,500	4,500
Activity 4.11 Provide cold chain equipment including temperature monitoring device and solar refrigerator/generator to project sites based on EVSM assessment findings. (solar refrigerator 2x 600, generator-3x500, TM-device 800)		8,000	20,000	15,000	43,000
Sub-Total		**14,000**	**27,000**	**23,000**	**64,000**
Objective 5: Produce evidence of successful models by rigorous monitoring and evaluation, and use the results to inform and improve maternal and child health policies.					
Output 1. Child health database is established in project sites.					
Activity 5.1 Sign multiparty contract between MPMT, province/city district civil registration and social protection offices and local governor on improving civil registration.		–	–	–	–
Activity 5.2 Contract an IT provider to develop child health e-database with mapping in project sites.		1,000	1,000	1,000	3,000

Activity 5.3 Train primary health service providers on the use of database.		1,000	1,000	1,000	3,000
Activity 5.4 Produce monthly and feedback reports on child health.		1,000	1,000	1,000	3,000
Sub-Total		**3,000**	**3,000**	**3,000**	**9,000**
Output 2. Baseline and end of project evaluation survey is performed. **Output 3.** Evidence from project implementation is used for advocacy to expand delivery of integrated maternal and child health services.					
Activity 5.5 Conduct baseline survey in project sites.		–	–	–	–
Activity 5.6 Perform end of project evaluation in project sites.		–	–	–	
Activity 5.7 Organize national consultative meeting to present final report on project implementation and agree on nationwide expansion of pilot project using incremental approach.		–	–	8,000	8,000
Activity 5.8 Approve by the order of Health Minister a model on integrated delivery of essential package of maternal and child health services.		–	–	–	–
Activity 5.9 Submit project completion report to GAVI Alliance and Foreign Aid Coordination Committee of MoH.		500	500	500	1,500
Sub-Total		**500**	**500**	**8,500**	**9,500**
A.TOTAL Activities		**147,842**	**147,900**	**145,400**	**441,142**
B. Support costs		16,700	19,932	25,787	62,419
B.1. Management costs		**5,700**	**5,700**	**5,700**	**17,100**

B.2. M&E support costs (including operational research)		8,000	12,232	13,087	33,319
B.3. Technical support		3,000	2,000	7,000	12,000
TOTAL COSTS (A+B)		**164,542**	**167,832**	**171,187**	**503,561**

Management Cost

#	Name of cost	Cost Unit	Total for year	Total for the duration of GAVI support	GAVI funding	Government	Total
1	Administrative cost	100U$ month x 12	1,200	3,600	3,600	_	3,600
2	Travel expense		2.500	7,500	7,500		7,500
3	NMPMT	2000U$year	2,000	6,000	6,000		6,000
4	**Total**		**5,700**	**17,100**	**17,100**		**17,100**

Technical assistance cost

#	Name of the cost	Unit cost	Total cost	GAVI HSS support	Anticipated source of funding	Total
1	Baseline survey to identify baseline value in the project sites and	2,000/month	2,000	2,000	GAVI HSS support	2,000
2	2. Project progress survey to assess the improvement of the indicators against baseline value.	1,000/month	1,000	1,000	GAVI HSS support	1,000
3	2. Project end survey/evaluation to assess the improvement of the indicators against baseline value.	6,000	6,000	6,000	GAVI HSS support	6,000
4	4. Effective Vaccine Storage Management assessment in 4 project sites	10,000	10,000	_	UNICEF	10,000
5	External Auditing Service	1000 x 3 times	3,000	3,000	GAVI HSS	3,000
6	**Total**		**22,000**	**12,000**	_	**22,000**

8.2: Calculation of GAVI HSS country allocation (this number should be consistent with data used in other GAVI applications and annual progress reports)

GAVI HSS Allocation (GNI > $365 per capita)	Allocation per year (US$)					
	Base year	Year of GAVI application	Year 1 of implement ation	Year 2 of implement ation	Year 3 of implementation	TOTAL FUNDS
	2008	2009	2010	2011	2012	
Birth cohort (number)	63.262	64.527	65.817	67,133	68.475	
Allocation per newborn ($)	_	_	$2.5	$2.5	$2.5	
Annual allocation ($)	_	_	164,542	167,832	171,187	**503.561**

Birth cohort: 63,262 (Health Indicators 2008, National Centre for Health Development)
GNI: US$ 995 (Statistical Books 2007, National Statistics Office of Mongolia)

8.3: Sources of all expected funding for health systems strengthening activities

Funding Sources	Allocation per year (US$)				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	TOTAL FUNDS
	2009	2010	2011	2012	
GAVI		164,542	167,832	171,187	503,561
Government		3,600	3,600	3,600	10,800
Donor 1. UNICEF		10.000	_	_	10.000
TOTAL FUNDING		**178,142**	**171,432**	**174,787**	**524,361**

Source of information on funding sources:

GAVI: GAVI is requested to fund HSS project activities and majority of management cost and technical assistance cost.

Government: The Government of Mongolia will provide partial funding of management cost.

Donor 1: UNICEF is requested to conduct EVSM assessment second and third level storage in project sites.

Total other:

8.4: Describe how GAVI HSS funding will complement other sources of HSS funding

2nd HSDP funded by ADB has been implemented in the selected sites of this GAVI HSS project. The ADB funds were allocated for human resources and health information system strengthening. GAVI HSS support will be used as a complement those existing resources.

Section 9: Terms and Conditions of GAVI Support

GAVI ALLIANCE
TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application . Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THIS PROPOSAL
The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION
The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application , or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION
The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the government confirm that this proposal is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the Country for any claim or loss relating to the programmes described in this application , including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

Section 10: Endorsement of the Application

To the applicant: sections 4.1, 4.2, 4.3 and 4.4

- *The GAVI HSS proposal cannot be reviewed without the necessary signatures and endorsement from the Minister of Health and Minister of Finance, the Chair and members of the Health Sector Coordinating Committee (HSCC)*
- *All HSCC members should sign the minutes of the meeting where the GAVI HSS application was endorsed. This should be submitted with the application and any issues identified during the meeting that may affect the proposal's implementation or monitoring should be highlighted by HSCC members (numbered and listed in Annex 1).*
- *Please give the name and contact details of the person for GAVI to contact if there are queries.*

Note: The signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.

10.1: Government endorsement

The Government of....Mongolia.....commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Please note that this application will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

Minister of Health:

Name: Lambaa S.

Signature:

Date: Apr 24, 2009

Minister of Finance:

Name: Bayartsogt S.

Signature: T. Odkhuu

Date: apr. 24, 2009

10.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on ....23 April 2009..... The signed minutes are attached as Annex 1.

Chair of HSCC (or equivalent):

Name: Tsolmon

Post / Organisation: Deputy Minister of Health

Signature:

Date: Apr 24, 2009

10.3: Government official to contact in case of programmatic enquiries:

Name: Tugsdelger Sovd

Title: Director of Public Health Policy Coordination Department (formerly: Health Policy and Planning Division), MOH

Tel No: 976-51-262990

Address: Olympic St 2
Ulaanbaatar 210648
Mongolia

Fax No. NA

Email: Tugsdelger.Sovd@moh.mn

10.4: Government official who is the focal point for overseeing the financial management of GAVI HSS funds:

Name: Tumendemberel N.

Title: Director of Finance and Investment Department, MOH

Tel No: 976-51-262901

Address: Olympic St 2
Ulaanbaatar 210648
Mongolia

Fax No. 976-11-320916

Email: tumendemberel@moh.mn

We, the undersigned members of the Inter-Agency Co-ordinating Committee met on 23 April 2009 to review the *GAVI HSS proposal. At that meeting we endorsed this proposal.*

Name/Title	Agency/Organisation	Signature	Date
J. Tsolmon, MD, PhD, Vice Minister of Health	Ministry of Health		April 23, 2009
S. Togsdelger, MD, MPH Director Health Policy and Planning	Ministry of Health		April 23, 2009
D. Nar angerel, MD, MSc,(Officer in charge of Communicable Diseases)	Ministry of Health		April 23, 2009
Mr. J. Oyunbileg, PhD, DSc(biol)	Public Health Institute		April 23, 2009
Mr. G.Tseveendorj, (Officer)	Ministry of Finance and Economy		April 23, 2009
Dr. Wiwat Rojanapithayakorn (Resident Representative)	WHO		April 23, 2009
Dr. D. Sodbayar (EPI in country advisor)	WHO		April 23, 2009
Mr. Bertrand Desmoulins (Resident Representative)	UNICEF		April 23, 2009
Mr. Ishida Yukio (Resident Representative)	JICA		April 23, 2009
Dr. Y. Byanjargal, (Consultant, "Health Sector Development" project)	ADB		April 23, 2009

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application and final checklist

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
Order No91 dated June 2002 of the Minister of Health on the establishment of ICC for Immunization	Yes	2002	No1
Order No107 dated Oct 2008 of the Vice Minister of Health on the establishment of GAVI HSS proposal development working group	Yes	2008	No2
GAVI HSS proposal development working group meeting minutes	Yes	2009	No3.1-3.7
Inter-agency Coordination Committee (ICC) minutes, signed by Chair of ICC (2 meetings)	Yes	2008 & 2009	No4.1-4.2
Stakeholder meeting minute and participants list	Yes	2008 & 2009	No5.1-5.2
Reaching Every District – development and testing of a health micro-planning strategy for reaching difficult to reach populations in Mongolia, Rural and Remote Health 9: 1945. (Online), 2009	Yes	2009	No6
Health indicators - 2007	Yes	2008	No7
Health Sector Strategic Master Plan of Mongolia	Yes	2006-2015	No8
cMYP[17]	Yes	2007-2012	No9
Review on immunization service in Mongolia	Yes	2009	No10
Assessment of Effective Vaccine Storage and Management	Yes	2008	No11
Reaching Every District (RED) strategy and implementation guidelines	Yes	2008	No12
Study of Infant Mortality in Ulaanbaatar and Its Causes	Yes	2008	No13
Situation Analysis of Children and Women in Mongolia	Yes	2007	No14
The Mongolian Health System at a Crossroads: an Incomplete Transition to a Post Semashko Model	Yes	2007	No15
Review of the Integrated Early Childhood Development Policy Implementation	Yes	2007	No16
Socio-economic Situation of Migrants and Their Access to and Need for Social Services	Yes	2007	No17
Short Programme Review for Child Health	Yes	2007	No18
Mongolia: Health system review. Health Systems in Transition. Vol. 9 No.4 2007	Yes	2007	No19
Strategic Analysis for Reaching MDGs 4 and 5 in Mongolia through HSS and Scale-up of Integrated Packages of High Impact and Low Cost Interventions	Yes	2008	No20
Why Mothers Die	Yes	2006	No21
Foreign Aid Coordination Committee of MoH	Yes	2009	No22
National Human Resource Policy for 2004-2013	Yes	2003	No23
Multiple Indicator Cluster Survey	Yes	2005-2006	No24
Law of Mongolia on Accounting	Yes	2001	No25

[17] **If available – and if not, the National Immunisation Plan plus Financial Sustainability Plan**

Law of Mongolia on Auditing	Yes	1997	No26
Law on procurement of goods, works and services by state and local funding	Yes	2005	No27
MTEF18	Yes	2006-2015	No28
PRSP[8]	Yes	.2003-2010	No29

18 if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

ANNEX 2 Banking Form

Note: It cannot be stressed enough that without a banking form that contains complete, accurate banking details (IBAN, SWIFT code, corresponding US bank and account details) it is impossible to transfer funds. Lack of full and correct information in this section WILL cause many unnecessary delays. This needs to be endorsed by UNICEF country representative on letter headed paper.

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	**Banking Form**

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated . . . . . , the Government of . . . Mongolia. hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: *(Account Holder)*	Ministry of Health		
Address:	Olympic Street-2, Ulaanbaatar-210648		
City – Country:	Ulaanbaatar, Mongolia		
Telephone No.:		**Fax No.:**	976-11-323916
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	USD.
For credit to: ***Bank account's title***	MoH-UNICEF FUNDS		
Bank account No.:	40410563 1		
At: ***Bank's name***	TRADE & DEVELOPMENT BANK OF MONGOLIA		

Is the bank account exclusively to be used by this program? **YES ( ) NO (✓)**

By whom is the account audited? State audite office

Signature of Government's authorizing official:

Name:	J. Tsolmon
Title:	Vice minister, MOH
Signature:	
Date:	24, April, 2009

Seal:

FINANCIAL INSTITUTION	CORRESPONDENT BANK (*In the United States*)
Bank Name: TRADE & DEVELOPMENT BANK OF MONGOLIA	1. STANDARD CHARTERED BANK USA N.A, NEW YORK, US, SWIFT: MRMD US 33
Branch Name: ENKHTAIVAN	
Address: 210646 ENKHTAIVAN STREET 114, SUKHBAATAR DISTRICT, UB, MONGOLIA	2. AMERICAN EXPRESS BANK LTD, NEW YORK, USA SWIFT: AEIB US 33
City – ULAANBAATAR **Country:** MONGOLIA	
Swift code: TDBM MN UB	
Sort code:	
ABA No.:	3. CITIBANK N.A, NEW YORK, US SWIFT: CITI US 33
Telephone No.: (976-11) 312679	
Fax No.: (976-11) 312661	

I certify that the account No. 404105631 is held by (*Institution name*) ... M.O.H.-UNICEF.FUNDS .....at this banking institution.

The account is to be signed jointly by at least TWO *(number of signatories)* of the following authorized signatories:	Name of bank's authorizing official:
1 Name: Tumendemberel N. Title: Director of Finance and Investment Department, Ministry of Health	INFORMATION DESK OFFICIER
2 Name: Dolgionsuren S. Title: Chief Accountant, Ministry of Health	Signature:
3 Name: Title:	Date: 24 APR 2009
4 Name: Title:	Seal: TDB Branch-80 Information desk

United Nations Children's Fund
UN House 2
United Nations Street 12
Sukhbaatar district, Ulaanbaatar

Telephone 976 11 312185
Facsimile 976 11 327313
www.unicef.org/mongolia

GAVI Alliance Secretariat,
Att. Dr Julian Lob-Levyt
Executive Secretary
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

On the ....27 April 2009.... I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	***J. Tsolmon***	***Vice Minister, MoH Mongolia***
Bank's authorizing official	***Ts. Baatar***	***Information Desk Officer***

Signature of UNICEF Representative:

Name ***Dr. Bertrand Desmoulins***

Signature

Date ***27 April 2009***