DEVELOPMENT ASSISTANCE, AID COORDINATION AND HEALTH SYSTEMS STRENGTHENING: A CASE STUDY IN POST-SOVIET MONGOLIA

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Doctor of Medicine

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The School of Public Health
Abstract

Background and Aim: Despite the increasing amounts of donor funding over many years, development assistance initiatives in health have not always resulted in their intended outcomes. In fact, significant negative outcomes have been reported in donor countries: development assistance has created fragmentation of country health systems, competing priorities, increased administrative burdens as a result of parallel structures, and unsustainable outcomes. As a result, both donors and recipients have concluded that there is a need for a change in the aid modalities and approaches in order to support country Health Systems Strengthening (HSS). The Mongolian Ministry of Health, having the comparative advantage of a relatively well-established health infrastructure and workforce inherited from the Soviet period, has recognized the need for better coordinated development assistance in order to optimize its performance.

During the decade from 1990-2000, Mongolia experienced the various development challenges of countries in transition, as it emerged from a socialist economy under the influence of the Soviet Union to a democratic market economy. With the collapse of the Soviet Union in 1991, Mongolia suffered economically, suddenly needing support from new development partners to replace decades of Soviet support. In 1999, Mongolia was one of the four most aid dependent countries, when aid constituted more than 25% of Gross National Income (GNI). During these early years of development assistance, the aid provided was primarily humanitarian relief, both in cash and kind, essential for its failing health system. However, as the country moved from transition to early development, this type of support proved to be less effective, as it did not promote capacity building and sustainable and equitable health outcomes. There was now an inevitable need to shift support into HSS in Mongolia. This research examines development aid and coordination in Mongolia; its contribution to HSS, and their relationships to global and local development policy agendas and their drivers.

Approach and Methods: The research is guided by the Walt and Gilson’s policy triangle framework, which highlights the importance of context, processes and actors in studying the content of health policy. The research uses qualitative methods, including in-depth interviews with key informants, participant observation and reflective field notes. These are triangulated with an extensive literature review to examine the contribution of different aid modalities and aid coordination approaches to strengthening the Mongolian health system. A mix of thematic and narrative analysis has been used to analyse the research findings.
Findings and Conclusion: Four interrelated key themes emerge from the research, confirming the complexity and interdependency of global and local health policy and processes.

- **Theme One** presents the unique characteristics of health sector aid engagement in Mongolia and similar Central Asian Post-Soviet countries. These contexts have received limited research attention since the break-up of the Soviet Union. In these critical years, Mongolia has engaged relatively few, but important, development partners, creating distinctive challenges and outcomes. Despite the limited numbers of donors and relatively low proportion of aid to overall health expenditure, aid coordination has remained important, largely because of the key role of donors in health reform and innovative programmes on health insurance, public-private partnership and institutional capacity building.

- **Theme Two** focuses on the importance of aid coordination, highlighting the role of the Mongolian Health Sector Strategic Master Plan (HSSMP) 2006-2015 in increasing the awareness of systems challenges, identifying specific health systems gaps and providing a structure for coordinating donor support towards HSS. The theme also emphasises the importance of a systemic approach in aid coordination—the Sector-wide approach (SWAp)—to achieving Universal Health Coverage (UHC)—with its focus on country leadership and donor collaboration around a comprehensive sectoral policy package.

- **Theme Three** explores the global norms and local adaptation of HSS, different perceptions and approaches to HSS by different actors in health sector, examining the influences of those differences on development assistance. This thesis argues that the variance in approaching HSS interventions is one of the factors contributing to the limited collective contribution of partners towards health systems strengthening, as measured against the Mongolian HSSMP framework.

- In **Theme Four**, the tensions between key actors’ perceived needs and priorities for HSS and the extent of the actual allocation of their support to HSS are uncovered. The thesis concludes that both government and development partners in Mongolia recognise the importance of HSS. Yet, despite enduring rhetorical commitment to the Paris Principles for Development Assistance and the sectoral plan provided by the HSSMP, donors continue to prioritise service support over broader HSS interventions, and the early promise of governance and resource management capacities shown by the Ministry of Health in the HSSMP have not been sustained. As a result, improvements in health systems performance have stagnated. There is a need for coordinated promotion of HSS, harnessing the resources of both government and development partners to achieve the key targets identified in the HSSMP which serves as a national health policy framework.
Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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Publications during candidature


Editorials:

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Ulikpan A, Narula I, Hill P. Shifting the driver’s seat: Health Sector Strategic Master Plan in Mongolia, World Health Care Networks Conference, Cairns Convention Centre 26-28 July 2012

Poster presentations

Ulikpan A, Malik A, Hill P. Donor’s contribution to Health System Strengthening in Mongolia: Differences between thinking and doing, Third Global Symposium on Health Systems Research, Cape Town, South Africa, 30 Sep-3 October, 2014
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**Publications included in this thesis**


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Data collection (interview conduct) (100%)  
Data interpretation and analysis (80 %)  
Drafting and writing (85%) |
| Mirzoev T       | Data interpretation (10%)                                                                   |
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| Malik A         | Conceptualisation and design (20 %)  
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Drafting and writing (10%) |
| Hill P          | Conceptualisation and design (10 %)  
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| Narula I        | Data interpretation and analysis (5%)                                                    |
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| Hill P          | Conceptualisation and design (10 %)  
Data interpretation and analysis (10 %)  
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Editorials:


For my editorials listed in 2-4, I was 100% responsible for conceptualisation, critical review and analysis, drafting and writing. For the first editorial listed above, I was responsible for 90% of the conceptualisation and critical review and analysis; 80% of the drafting and writing. Muratova N and Suvanbekov A were responsible for 10% of the conception and critical review and analysis; 20% of the drafting and writing.
Contributions by others to the thesis

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Statement of parts of the thesis submitted to qualify for the award of another degree

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**Note:** The following terms referring to providers of international development assistance have been used interchangeably in the thesis due to differing use by different partners: *donors, partners, international partners, development actors, development partners*. This change in usage reflects the evolution in the use of the terms during the last two decades, as the focus of aid effectiveness has shifted towards development effectiveness (1).
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<th>Full Form</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AusAid</td>
<td>Australian Agency for International Development</td>
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<td>BCC</td>
<td>Behaviour Change and Communication</td>
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<tr>
<td>BRICS</td>
<td>Brazil Russia India China South Africa</td>
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<td>CAPS</td>
<td>Central Asian post-Soviet</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>CRS</td>
<td>Creditor Reporting System</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DAH</td>
<td>Development Assistance for Health</td>
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<td>DALYs</td>
<td>Disability-adjusted Life Years</td>
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<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>GBS</td>
<td>General Budget Support</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GF</td>
<td>Global Fund</td>
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<td>GHI</td>
<td>Global Health Initiatives</td>
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<td>GIZ</td>
<td>German Technical Development Agency</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>GPPPps</td>
<td>Global Public Private Partnerships</td>
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<td>HF</td>
<td>Health Financing</td>
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<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<td>HMIS</td>
<td>Health Management and Information System</td>
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<td>HR</td>
<td>Human Resource</td>
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<td>Human Resources for Health</td>
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<td>Health Sector Development Programme</td>
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<td>Health Systems Strengthening</td>
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<td>HSSMP</td>
<td>Health Sector Strategic Master Plan</td>
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<td>Institutional Development</td>
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IHME Institute for Health Metrics and Evaluation
IHP+ International Health Partnership Plus
INGO International Non-government Organisation
JICA Japanese International Cooperation Agency
JICWELS Japanese International Corporation of Welfare Services
KII Key Informant Interview
LMICs Low-income and Middle-income Countries
M&E Monitoring and Evaluation
MAP Multi-country AIDS Programme
MCA Millennium Challenge Account
MDG Millennium Development Goal
MIC Middle-income Country
MoF Ministry of Finance
MoH Ministry of Health
MSF Médecins sans Frontières (Doctors without Borders)
NCD Non-communicable Disease
NGO Non-government Organisation
NHA National Health Account
NLM Norwegian Lutheran Mission
ODA Official Development Assistance
ODI Official Development Institute
OECD Organisation for Economic Cooperation and Development
PBA Programme-based Approach
PEPFAR President’s Emergency Plan for AIDS Relief
PFM Public Financial Management
PHC Primary Health Care
PPP Public Private Partnership
PRSP Poverty Reduction Strategic Paper
PSS Pharmaceuticals and Support Service
QoC Quality of Care
RH Reproductive Health
SDC Swiss Agency for Development and Cooperation
SIDA Swedish International Development Cooperation Agency
SIPs Sector Investment Programmes
SWAp Sector-wide Approach
TB  Tuberculosis
UHC  Universal Health Coverage
UN  United Nations
UNAIDS  United Nations Programme on HIV/AIDS
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
UNICEF  United Nations Children's Fund
USAID  United States Agency for International Development
VSO  Voluntary Service Overseas
WB  World Bank
WHO  World Health Organisation
WHR  World Health Report
WV  World Vision
CHAPTER 1: INTRODUCTION: DEVELOPMENT ASSISTANCE IN POST-SOVIET MONGOLIA

1.1 Introduction to the thesis

This thesis documents development assistance and aid coordination in Mongolia in over two decades of significant global change: from the collapse of the Soviet Union, on which Mongolia was politically, economically and socially dependent through the economic and political transformations that have made it an emerging middle income democracy. In development assistance for the health sector, it analyses the transition from high levels of aid dependency though the successive attempts to coordinate development partners, to its current policy leadership and development partnerships. But global changes in development policy have also been substantial over this period, with a shift from project based vertical approaches to more programmatic and integrated approaches. There has been universal recognition—though not always observance—that developing country governments must maintain overall leadership if effective Health Systems Strengthening (HSS) is to be achieved and that aid must be coordinated and aligned with government policy.

As a case-study, Mongolia offers specific policy experience that provides local lessons for application but that also cast light on broader global developments. As a Central Asian Post-Soviet state, its politics and characteristics are a product of its unusual historical context, and under-researched. Having inherited a reasonable health infrastructure and workforce from its Soviet modelled health system, it was well prepared to benefit early from health sector policy initiatives, given its inclination towards democratic reforms, and well positioned to move towards Universal Health Coverage. With limited numbers of donor partners, and a strong desire to map out its own policy framework, consensus has been easier to achieve than in some developing countries. Yet despite this, Mongolia has faced a volatile political history, and the resultant administrative unpredictability. These factors, combined with the limited flexibility of some donors, have amplified the issues of governance in its transition from aid-dependent, low-income, developing-country style governance to autonomous governance. This makes Mongolia’s history both distinctive and unique, and powerfully instructive as a case-study in development for health.

This thesis explores that history—and its consequences—in depth.
1.2 Background

During the decade of 1990-2000, Mongolia experienced the various development challenges of countries in transition, as it emerged from a socialist economy under the influence of the Soviet Union to a democratic market economy. With the collapse of the Soviet Union in 1991, Mongolia was hard hit, suddenly needing support from new development partners to replace decades of Soviet support. The country was one of the four most aid dependent countries in 1999, when aid constituted more than 25% of Gross National Income (GNI). During early years of development assistance, the aid provided was primarily humanitarian relief; both in cash and kind. This was essential for its then failing health system. However, as the country moved from transition to early development, this type of support proved to be ineffective, as it did not promote capacity building and sustainable and equitable health outcomes. With the economic urgency of aid dependence past, there was now a need to shift support from health service provision into HSS in Mongolia. This important transition of development assistance in a country undergoing rapid economic and political change has not been extensively explored. The tensions for donors in adapting their investment from disease-oriented vertical investments into more comprehensive health systems approaches is globally problematic. In the unique post-Soviet context of Mongolia’s health system, there are additional and significant challenges to examine.

Mongolia is a former socialist country that is landlocked in Central Asia bordering with China to the south and Russia to the north (Figure 1-1). Mongolia’s population of 2.8 million (2), and vast territory of 1,566,460 km² makes the country one of the least densely populated (1.5 persons/km²) countries in the world. Mongolia’s economy is one of the fastest growing economies in the world because of its natural resources and booming mining sector. Gross Domestic Product (GDP) per capita went up from US$471.5 in 2000 to US$2250 in 2010 (3). GDP annual growth has been between 3.6 and 4.2 during 2005-10 except during 2009, when it fell to 2.3 (3) because of the impact of the global financial crisis and falling commodity prices. Although Mongolia’s economy is growing, the dominance of the minerals sector places the Mongolian economy in a context that is heavily dependent on mining and makes the country’s economy highly vulnerable to external financial shocks and volatile commodity prices (4, 5).
Although the country has never been officially part of Soviet bloc states, as a satellite, it has a similar context to former Soviet states. All aspects of government management and organizational structure, function and culture have been greatly dominated by the influence of the Soviet Union. At its height, Soviet assistance was providing one-third of Mongolia’s GDP, making the country solely dependent on the Union of Soviet Socialist Republics (USSR) (6). However, this assistance ended when the Soviet Union collapsed in 1991. Since then, Mongolia has experienced dramatic changes and development challenges, as 70 years of a one-party state with its centrally planned economy and support from the former Soviet Union also collapsed (6-8). A need for engagement with various international donors has become a necessity to overcome transition challenges.

During the early 2000s, Mongolia remained heavily aid dependent (9). In 2003, Mongolia was the sixth most aid-dependent country in the world measured as a percentage of GNI (10). However, as a result of a rapidly growing economy mainly due to natural resources, the country officially entered Middle-income Country (MIC) status in 2011 (11). Despite the country’s growing economy, the poverty rate remains high, reaching 35.2% in 2008, almost the same level as it was in 1995, when it was estimated at 36.3% (3). There is a persistent inequity in the distribution of resources and opportunity, despite the growing economy, which further reinforces the need to have a better resource management system. The potential impact of development assistance now needs to shift:
improving aid effectiveness and channelling aid towards strengthening the country’s systems has become more critical.

The main bilateral donors providing grants in Mongolia and the share of their contributions in 2009 are captured in Chart 1-1. The United States and Japan alone occupy more than 50% of the total aid (12). United Nations (UN) assistance and international Non-Government Organizations (NGOs) are not included in the graph, but provide a limited proportion of overall development assistance.

Chart 1-1: Main bilateral donors providing grants and their overall contribution (2009)

Source: Ministry of Finance, Mongolia (12)

But in the context of the Fourth High Level Forum on Aid Effectiveness at Busan (1), what this graph does not point to is the potential contribution of trade in supporting growth across government sectors. With a growing mining sector, there are expectations that this sector will provide resources not only in mining and related industrial sectors, but also in the health and education sectors through Public-Private Partnership (PPP) arrangements currently being negotiated (13-15).
1.2.1 Overview of Mongolia’s socio-economic and health status

Mongolia’s Socio-economic Transition

Mongolia’s transition from a socialist system to a market economy presents both political and economic transition challenges. The country’s rapid economic changes and the consequent interventions over a relatively short time, have been referred to by Tsilaajav et al as “shock therapy” (16): the impact on the economy has been a dramatic roller-coaster since 1991. Sudden withdrawal of Soviet aid caused inevitable challenges in all aspects of social and economic life. The mineral resource-led economic growth experienced during the early 2000’s and recently in 2012 is still highly vulnerable to external situations such as the global financial crisis and fluctuations in world commodity prices (4).

On a positive note, notable progress has been achieved in key health indicators and in meeting Millennium Development Goals (Table 1-1). However, equitable distribution of progress achieved remains a challenge.

Table 1-1: Key socio-economic and health indicator, Mongolia (1990–2010)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1990</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (in million)</td>
<td>2.1</td>
<td>2.3</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>GDP per capita (current US$)</td>
<td>630</td>
<td>474</td>
<td>998</td>
<td>2285</td>
</tr>
<tr>
<td>GDP annual growth rate (%)</td>
<td>6.3</td>
<td>1.1</td>
<td>7.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Net ODA received (per capita, US%)</td>
<td>n/a</td>
<td>87</td>
<td>112</td>
<td>n/a</td>
</tr>
<tr>
<td>Poverty rate (headcount index, %)</td>
<td>36.3</td>
<td>35.6</td>
<td>61.1</td>
<td>35.2</td>
</tr>
<tr>
<td>Life expectancy at birth, total (years)</td>
<td>63.7</td>
<td>63.2</td>
<td>65.2</td>
<td>68.1</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>205</td>
<td>158</td>
<td>93</td>
<td>45</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>63</td>
<td>31</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Under- 5 mortality rate (per 1000 live births)</td>
<td>87.5</td>
<td>41</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: World bank databank, Health Indicators, Ministry of Health Mongolia (17, 18)
Overall, Mongolia faces a positive economic outlook due to the recent mining boom; however management and absorptive capacity remains a huge challenge. The persistent high poverty rate despite the economic growth indicates poor resource management capacity and inequity (4, 14). In fact, the key issue is not the lack of resources, but the capacity to direct this into structural change that benefits the population’s social development and health aspect in an equitable and effective manner.

**Mongolia’s Health Transition**

The country is experiencing a double-burden of continuing infectious diseases, and increasing non-communicable disease (13, 16), coupled with a persistently high rate of poverty and resource inequity. Health sector capacity to address key health challenges revealed weaknesses of the health system and management capacity (13, 14, 16). Despite the need for systems change, the focus of the majority of the donors have been more on the vertical disease-specific projects in the area of maternal and child health, communicable and non-communicable diseases, HIV/AIDS and TB. A very few donors have focused on HSS through supporting national capacity building and good governance.

The achievements obtained in health outcomes have been largely attributable to the technical and financial support provided by external partners in achieving the MDGs (19). Mongolia fully achieved the following MDGs in 2013: a four-fold reduction in the mortality rate for children under-five years and the maternal mortality rate; and limiting and preventing the spread of HIV/AIDS (19). However, sustaining and maintaining the continued achievement in health outcomes beyond that MDGs support is now the key task, further reinforcing the importance of strengthening country’s own system through promoting ownership and capacity building.

1.2.2 **Health sector aid and its coordination**

Similar to other post-Soviet countries, Mongolia is relatively new to multi-actor aid relationships, with its 70-year history of a centrally-planned economy, and dependence on Soviet support. Multilateral and bilateral donors became a significant presence in the country from the 1990s, as a result of the Soviet Union’s collapse. At the beginning the support was mainly relief aid; however, as the country progressed in its development, the type and nature of aid has changed (5, 20).
The annual total health expenditure has been approximately US$170–250 million during 2008–12, with the external aid contribution estimated to equate to 10% of the total health expenditure (21). This figure does not capture all external inputs, suggesting that the official reporting of external aid to the health sector is lower than the actual contribution. For example, the 2008 report of the Mongolian health sector indicates that external aid provided 8.8% (US$17.14 million) of the total health expenditure of the country (17), and does not capture the total amount of aid coming to the health sector. However, much of the official development assistance (ODA) to the health sector is off budget and outside of the official financial management and accounting functions of the Ministry of Health (MoH), and therefore not reported (13, 20). While the reporting criteria were changed for the 2009 report, it captured only the biggest donors such as the Asian Development Bank (ADB), United States Agency for International Development (USAID), United Nation (UN) agencies, Global Fund (GF) and Global Alliance for Vaccines and Immunization (GAVI), and only those that used the national treasury for disbursing their funds. The contributions from international NGOs and parallel projects which use their own financial and procurement procedures are not captured in the data, and it is therefore not clear to what extent they contribute to the health sector (20).

The MoH mapping of donors made in 2011 (Table 1-2) provides an indication of key health donors’ focus and contribution for the period of 2007–13. The figures recorded, however, vary—in some cases measuring amounts committed, and in others funds actually disbursed, without distinguishing between them. The main players in the health sector as reported by MoH mapping are ADB, USAID -Millennium Challenge Account (MCA) project, GF, UNICEF, UNFPA, Luxembourg Government, UN-Trust Fund for Human Security, World Vision and the World Health Organization (WHO). The choice of time-frame ignores the contribution of Japan, historically a main donor in the health sector, and one of the biggest donors to Mongolia. Japan had been the key player in health from early 2000; only after 2006 has its involvement in health become minimal, though it remains the main donor in urban development and infrastructure. Even with MoH commitment to tracking donor assistance in health, there are clear limits in aid data reporting and archiving, with resultant poor institutional memory, and inconsistent recording of donor assistance provided during the 1990s and early 2000s.
Table 1-2: Donor contributions to health, Mongolia (2007–13) (21)

<table>
<thead>
<tr>
<th>Donor</th>
<th>Project focus</th>
<th>Budget year</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Vision</td>
<td>Child care</td>
<td>2010–11</td>
<td>2 million</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Nutrition</td>
<td>2010–11</td>
<td>2.5 million</td>
</tr>
<tr>
<td></td>
<td>Child care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Fund</td>
<td>TB care</td>
<td>2008–14</td>
<td>10 million</td>
</tr>
<tr>
<td>Global Fund</td>
<td>HIV/AIDS</td>
<td>2008–14</td>
<td>9 million</td>
</tr>
<tr>
<td>Global Fund</td>
<td>TB-DOTS</td>
<td>2010–16</td>
<td>9.2 million</td>
</tr>
<tr>
<td>Global Fund</td>
<td>HIV/AIDS high risk group</td>
<td>2008–13</td>
<td>3.3 million</td>
</tr>
<tr>
<td>Global Fund</td>
<td>National lab network</td>
<td>2010–12</td>
<td>4 million</td>
</tr>
<tr>
<td></td>
<td>Blood safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>Disaster relief</td>
<td>2010–11</td>
<td>276,000</td>
</tr>
<tr>
<td></td>
<td>Reproductive health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>HIV/AIDS prevention in border areas</td>
<td>2009–11</td>
<td>160,000</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Global Programme</td>
<td>2008–11</td>
<td>3.1 million</td>
</tr>
<tr>
<td></td>
<td>Reproductive Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commodity Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UN-Trust fund for human security</td>
<td>Human security through</td>
<td>2010–12</td>
<td>319,400</td>
</tr>
<tr>
<td></td>
<td>Integrated and prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>approaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA</td>
<td>RH service capacity and commodity supply</td>
<td>2007–11</td>
<td>2.1 million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA</td>
<td>RH quality of care</td>
<td>2010–11</td>
<td>139,000</td>
</tr>
<tr>
<td>UNFPA &amp; Luxembourg joint project</td>
<td>Telemedicine network</td>
<td>2007–10</td>
<td>1.5 million</td>
</tr>
<tr>
<td>WHO</td>
<td>Environmental health</td>
<td>2010–11</td>
<td>169,500</td>
</tr>
<tr>
<td>WHO</td>
<td>New and re-emerging disease</td>
<td>2010–11</td>
<td>560,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>106.3 million</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Mongolia 2011 (21)

While this initiative to collect aid-related data is an important first step in aid coordination, the range of partners included is limited, and hence distorts our knowledge of donor participation in health. With the expanded understanding of development effectiveness brought through the Busan High Level Forum on Aid Effectiveness in 2011 (1), non-traditional donors, NGOs and private sector contributions need to be included to get a comprehensive picture. The other significant limitation of this analysis is its failure to explore if aid is aligned with health sector priorities determined by the MoH, or how much of aid committed is actually disbursed.
The development of the Health Sector Strategic Master Plan (HSSMP) played an important role in channelling aid towards health system reform and in providing a basis for coordination for the donor investments in the health sector (13, 22). The HSSMP and the national health programmes give directions and provide strategies in the priority areas of the health sector. In 2005 the MoH adopted a strategic objective to move towards a Sector-wide Approach (SWAp) (20) as a means to improve aid effectiveness. Although a SWAp has not been supported by all partners in health, the increasing support towards the components of a SWAp played an important role in promoting MoH ownership and alignment, bringing partners under a single sector plan defined in the HSSMP (23). The government itself took the initiative to coordinate aid and promote the SWAp, and assumed ownership over the process of development of its strategic plan. However, the frequent turnover of senior level staff and dominance of political agendas in establishing priorities has undermined some of the MoH’s effectiveness in realizing its strategies as outlined in the HSSMP. Nevertheless, there is again evidence of growing development partner interest in promoting development aid and a programme-based approach, including in the health sector.

1.2.3 Aid coordination capacity

Currently aid coordination in the MoH is limited to an administrative arrangement for collating and documenting the contributions of key bilateral donors and development banks, rather than strategically directing donor aid towards strengthening the health system. The challenges of donor coordination have been highlighted in a series of reviews and sector analyses. The Joint Sector Review conducted with the assistance of Japanese International Corporation of Welfare Services (JICWELS) in 2009, confirmed the need for improving ownership and good governance, not only for improved aid effectiveness but for overall development effectiveness (13).

The WHO country cooperation strategy 2010-15 also emphasized partner coordination as a key challenge to be addressed in the MoH (24). They recommended an exploration of the approaches to delivering aid in the Mongolian health sector and improving aid coordination in order to support the health system. The sector itself is committed to improve its partner coordination and health systems capacity, as indicated in the MoH response.

Mongolia is not alone in needing to address the issues of development effectiveness and donor coordination. A series of key global agendas on aid effectiveness have reiterated this claim,
progressively refining the concepts from the 2005 Paris Declaration on Aid Effectiveness (25), through its monitoring in the 2008 Accra Action Agenda (26, 27), to the redefining as development effectiveness at Busan in 2011 (1) and its interpretation in health through the creation of the International Health Partnership (IHP+) (28). Each of these have progressively built on improving aid coordination through strengthening government ownership, alignment and harmonisation, managing for results and mutual accountability and the development of each country’s own system in order to bring sustainable development outcomes (29).

But the reality is that donor roles in strengthening a country’s health system remain ambiguous and poorly documented. In Mongolia, this has led to the need to conduct this research and explore aid coordination models in Mongolia and similar post-Soviet countries.

1.3 Research aim and questions

The research aims to analyse the role of development assistance, its coordination and contribution to health system strengthening in Mongolia through exploring global aid policies, aid coordination approaches and the roles of aid partners in the health system.

The ultimate goal is to inform the coordination and alignment of development assistance so that it is supportive of health systems in developing countries.

The contribution of development assistance to HSS, and its coordination have never been critically assessed in the Mongolian health sector. While there have been health sector reviews, this research will be the first of its kind to independently explore the following research questions:

1. What changes have occurred recently in global aid agendas, aid modalities and global aid policies?

2. How has understanding health systems and HSS developed?

3. What is the extent and type of aid engagement in Central Asian Post-Soviet countries, and Mongolia in particular?
4. What aid coordination mechanisms and aid modalities are operational in Mongolia in supporting HSS?

5. How do government and development partners in the health sector understand HSS?

6. To what extent do the current development partners’ programmes and projects support HSS?

7. How must aid approaches and aid coordination mechanisms change in order to strengthen the country’s health system?

The issues implicit in these questions have been focused into the following objectives, which respond to the research questions above. This thesis seeks to:

1. Explore current global aid policies, modalities and coordination mechanisms in the context of HSS

2. Analyse the current health sector aid coordination, mechanisms and capacity in the Central Asian post-Soviet states, with a particular focus on Mongolia

3. Document and analyse government and donor perspectives and priorities for HSS in Mongolia

4. Critically examine partners’ contribution to HSS and determine the areas that need more support in order to achieve a sustainable health system

5. Identify mechanisms and approaches through which government and development partners might collaborate effectively to strengthen the health system

This research is very timely, as many developing countries and donors are aiming to channel aid into strengthening national health system capacity to bring about sustainable health outcomes. This has been a key agenda of recent international polices and health systems research calls (30-33). Examples of effective integration of external aid into HSS are very limited, indicating a clear need for a greater investment in the area of applied health systems research in low-income and middle-income countries (LMIC) (34). Mongolia, an example of a host country willing to improve its own capacity and take ownership of the development processes, provides a useful case-study for finding the ways in which government and development partners can collaborate to improve the health system. This is critical for sustainable development.
1.4 Outline of thesis Structure

The thesis explores its objectives using documentary and policy analysis, reflexive commentary and qualitative research methods, concluding with a synthesis of the findings and the implications for aid coordination and health systems strengthening in Mongolia and its application to other emerging economies. The introduction (Chapter 1) describes the general background of the Mongolian health sector, aid engagement and the need for effective aid coordination. It also provides research justification, establishes the objectives of the research and introduces the structure of the thesis.

A reflexive commentary on “Development for whom and for what?” further clarifies my reason and passion for doing this PhD research.

The literature review (Chapter 2) uses documentary and policy analysis to explore the two content elements of the research: the first examining overall aid modalities, global aid policies and recent shifts in approaches; the second defining Health Systems and Health Systems Strengthening, and comparing the application of various health systems frameworks.

A further commentary examines progressive shifts in global aid agendas and my perception of the relevance of Paris Declaration.

The methodology section (Chapter 3) presents the theoretical framework and knowledge paradigm that guided the research and a reflective analysis of health policy research complexities followed by research design, data collection and analysis methods.

In Chapter 4, I analyse aid engagement in selected Central Asian Post-Soviet (CAPS) countries, locating Mongolia in its unique socio-political context, and drawing key lessons for aid coordination in Post-Soviet countries.

As an actor in the health policy analysis exercise, especially within the context of post-Soviet health systems, I have reacted to the recent international health systems research call funded by WHO Alliance for Health Policy and Systems Research. My peer colleagues from similar contexts have joined the voice to express their challenges of getting successfully involved in the call. It also raises broader aspects of positioning post-Soviet health systems researchers in a field of global health systems and policy research.
The structures for aid coordination in health examined in Chapter 5 presents two subthemes. The first explores Mongolian health sector aid coordination mechanisms, and the role of the Health System Strategic Master plan (HSSMP) in providing a policy envelope for promoting aid coordination. The second further investigates if the choice of a Sector-wide Approach (SWAp)—as a specific aid modality—can advance the achievement of broader health systems goals such as Universal Health Coverage.

My last reflection examines the current Mongolian resource sector-led development and its implications for the health sector. It attempts to raise an awareness of potential risks of the resource abundance “curse”, to which the health sector is highly vulnerable.

Chapter 6 presents global norms and frameworks for identifying HSS and the process of developing a context-specific Health Systems Strengthening (HSS) framework. Analytical review of national health and development polices has been conducted to identify local strengths and challenges for achieving HSS objectives.

Chapter 7 further explores if stakeholders understanding of HSS matches with local definition of HSS as stipulated in the national HSSMP. Commonalities identified between HSSMP and the Building Blocks frameworks have proven to be superficial and the differences are unpacked to explore more context-specific HSS areas and interventions. The chapter further reinforced context specific nature of the health systems issues and challenges.

In Chapter 8, the research aims to track Official Development Assistance (ODA) contributions to HSS in Mongolia and identify the linkages between donors’ approach and contribution in supporting HSS. In doing so, it revealed inconsistent classification of ODA across different data sources and amongst various donors. Tension between rhetoric and actual practice to support HSS interventions by different partners indicated a need for a shift in HSS investments.

The Chapter 9 synthesises key research findings of the entire research and highlights the key issues and challenges in aid approaches towards supporting HSS. It also draws out key lessons learned in defining context-specific health systems interventions and the broader implications for donors’ contributions in achieving country health systems priorities.

The policy analyst is not only a researcher. Because of the nature of the research and the policy analyst’s positioning in relation to change, the analyst is also an actor in both the policy and research processes (35). The policy analyst’s voice is not the disinterested and ‘objective’ voice of
research; the voice of the policy analyst takes a position resulting from their research and actively advocates for change. Therefore, in an attempt to give insight into this other dynamic of my policy analysis, I have included examples of my own voice in the field of development relationships in the health sector. These take the form of reflections posted as editorials in the International Health Policies Newsletter, a web-based weekly digest of global health systems and policy research provided through the Institute of Tropical Medicine in Antwerp (36). These reflections, that give insight into my broader policy role, are included as separate documents between the Chapters 1-2; Chapters 2-3; Chapters 4-5; and Chapter 5-6.
The policy analyst as actor I: Shaping development agenda: differing positions of the donor and recipient countries

My commentary on development assistance, posted in International Health Polices Newsletter, examines development relationship between donor and recipient country and how other factors such as value systems and culture shape the understanding of development and its effectiveness.
This post is one of the two introductions to this week's international health policies newsletter.

No country is completely independent in today's globalized world. When it comes to health and development, that is even more the case. Interdependence, like biodiversity, is necessary and essential despite the inevitable disadvantages. Drawing on my experience at the Mongolian Ministry of Health and with various international agency funded projects (knowing both sides of the fence, so to speak) I want to share some of my thoughts and observations on the relationship between donors and recipient countries and their approaches in working together for health. However, the more I learn about current development relationships, health and development, the more new questions seem to pop up rather than answers found.

Globally, a number of initiatives and strategies such as Sector-wide Approach (SWAp), IHP+, Health 8 (H8) have been introduced in recent years in order to improve the effectiveness of development aid. These initiatives are all mainly based on (or inspired by) the Paris Declaration (or vice versa) despite their differences in name, origin and signatory parties. However, these donor initiatives are often limited by set time frames and focuses, while Governments must constantly look at a health system as whole. They don't have the privilege of focusing on only their areas of comparative advantage like donor agencies do. How to find the right balance and approach to arrive at a win-win situation? How can they work together, as eventually equal partners for development, and thus go beyond the typical ‘Donor and Recipient’ relationship?

We may need to take some distance first and look at how development is interpreted in different nations. Obviously, understanding country or community values is very important to grasp what development could mean for particular countries or communities.

Asian values are often defined in line with Mahathir and Lee's views, rulers of Malaysia and Singapore respectively. In their view, Asian values emphasize the community rather than the individual, prefer order and stability to personal freedom, insist on hard work and respect for political leaders, and hold the belief that government and business need not necessarily be natural adversaries. Lee even claims that (too much) freedom and civil rights can hamper economic growth. Asian values, defined this way, conflict to some extent with Western values, especially with those that seem to put excessive emphasis on the individual rather than the community, or display a lack of social discipline and great tolerance for eccentricity and abnormality in social behaviour. As a newly emerging democratic country, Mongolia sits somewhere on the fence, in between the two values systems: transiting from collectivism to individualism; from authoritarianism to democracy. Therefore, Mongolia often faces development dilemmas resulting from the co-existence of differing value systems. How often do donors take these invisible but essential domestic values really into account when developing their strategy, styles and approaches in exchanges and negotiations with developing countries? Hard to say. At the same time though, we don't want to fall into the trap of ‘culture relativism', whereby some human rights risk to get trampled upon under the banner of ‘local values'. A balance has to be found, but often this turns out to be a difficult exercise.

If development is to be “owned” it will also need sufficient time and space. Donors should never underestimate the appropriate time and process needed for institutional change. Development is not something that can be donated or borrowed but it is typically generated locally, something that takes
time, and evolves through its patchy ways of challenges, failures, lessons and successes. My Mongolian experience allowed me to see the development relationship through the lens of a recipient country. I noticed that if external partners push too much, the very essence of ownership risks to get lost somewhere along the way. Moreover, there is a danger that the reform process will be seen as a burden rather than being owned and led by the Government itself. The question should always be: what is our ultimate goal? To meet donors' timeframes and expectations or to meet our own people's health expectations?

Nevertheless, it is to be applauded that currently high importance is given to country ownership and sustainable development. It is reported that IHP+ and SWAp countries are showing progress in terms of ownership and support for a national health plan based on a country's own priorities (rather than donor initiated agendas). These new approaches also brought donors together under a single umbrella called “national health plans” and promote cooperation rather than competition amongst different donors which used to be the case in the past. Can the current momentum be sustained, even if some of these initiatives cease to exist in the future?

I hope to find some of the answers in Busan.

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2 CHAPTER 2: THE EVOLUTION OF DEVELOPMENT APPROACHES IN HEALTH: AID MODALITIES AND HEALTH SYSTEMS STRENGTHENING

2.1 Overview

This chapter consists of an extensive literature review and documentary analysis conducted in two main parts: part one explores overall aid modalities and their engagement with the health system, and global aid policies and shifts in aid coordination in terms of supporting country ownership and health systems; part two investigates the complexities of understanding health systems, HSS and various health systems frameworks. Based on the study of the frameworks, I propose a framework to be used in my research. The chapter as a whole addresses Objective 1 of the thesis: To explore current global aid polices modalities and coordination mechanisms in the context of HSS.

2.2 PART ONE: A. Aid modalities and their engagement with the health system

Donors use different approaches in delivering aid, in part reflecting the different agendas and positions of bilateral donors, multilateral organizations, NGOs and public-private partnerships. The emergence of non-traditional donors, civil society, and the private sector in aid relationships has added further complexity to aid coordination. This section will describe the different types of aid modalities and their advantages and disadvantages in terms of contributions to strengthening a country’s health system. The preferred choices of aid modalities for development partners, and the perceived appropriate mix of approaches for strengthening health systems have evolved over time. The evolution of the different types of aid modalities in itself is an indication of global efforts to bring better results in aid effectiveness, reflected in the progress documented by the Organisation for Economic Co-operation and Development’s (OECD) High Level Forums on Aid Effectiveness from Rome Declaration on Harmonisation (2003), Paris Declaration on Aid Effectiveness (2005), Accra Agenda for Action (2008) to Busan Partnership for Effective Development Cooperation (2011) (1, 25, 27, 37). However, different types of aid may operate simultaneously within a single country, and not only between different country contexts, revealing the complexities for making a choice between these aid types. The type of approach ideally depends on the partner country’s needs and priorities, the consensus on policies, the capacity for implementation, and specific donor objectives and constraints (38, 39).
There are three main aid modalities for development assistance in health globally. The most common form is a *disease-specific vertical project*; however, this modality is increasingly criticised for creating fragmentation and administrative burdens for local authorities. Since 2005, the Global Fund (GF) and the GAVI Alliance are increasingly moving towards integrating their disease focused programmes into country health systems, promoting *disease-specific programmatic approaches* (40).

**A Sector-wide approach (SWAp)** is another type of aid modality which advocates country leadership and collaborative donor support of a whole sector policy envelope, strengthening national systems and capacity (41). Lastly, *direct budget support*, the transfer of resources from an external financing agency to the partner government’s national treasury provides the most direct modality of development assistance, allowing the recipient government to coordinate donor funds to support their country’s strategies (42, 43). These different aid modalities will be discussed in detail in the subsequent sections.

### 2.2.1 Disease-specific vertical projects

Historically, in project funding, a development agency usually funds specific activities based on an agreement with the recipient government. Typically, projects have had their own standalone management arrangements, including project documentation and work plans, project managers and implementation units, reporting formats and rules and arrangements for expenditure (including procurement). The activities to be funded can be readily influenced by the funding agency (44-46). While project-type support can improve many areas in the health sector such as vaccination, child health, and infectious disease; in the long run, the project format for development assistance has had noticeable negative health systems effects, contributing to the fragmentation of the MoH into vertical fiefdoms based on specific diseases or programmes and resulting in the weakening of the system (47, 48). As resources (mainly human resources) have been diverted from routine operations to serve those projects funded by donors (49), and to meet the required conditionalities for finite time periods; the basic infrastructure, the coordination and regulatory functions of the MOH have been neglected. This has produced outcomes where the “part” is being improved while the “whole” is being neglected.
In a landmark summit signalling the limitations of project aid, the G8 Toyako summit report acknowledged that while vertical programmes have been successful in combating certain communicable diseases globally, they have created three major problems (50):

- Selective financing of certain areas often leads to distortion of the health systems, as better-funded vertical programmes deprive other parts of the system by draining them of qualified staff and resources.
- Vertical programmes make it difficult for countries to plan the development of integrated health service delivery.
- Vertical programmes do not always benefit from the synergies of the integrated service as they have parallel and therefore divisive structures.

Discontent by governments and donors with the way these vertical programme problems exacerbated fragmentation and contributed to inefficient resource management has lead both to recognise the necessity of initiating new approaches in aid delivery. However, there are contexts and conditions which enable project aid to work more effectively, especially in fragile and conflict-affected countries, or in countries where there is less transparency and accountability, where the most feasible form of aid may be vertical programmes managed by donor agencies (51).

2.2.2 Disease specific programmatic approaches: Global Health Initiatives (GHIs)

Disease specific programmatic approaches were introduced to overcome the structural and efficiency challenges of the vertical projects that often created multiple project implementation units and repetition of activity areas. Global Health Initiatives (GHIs) are an example of programmatic approaches implemented on a global scale. These initiatives have been introduced as a response to an increasing number of lethal global diseases such as HIV/AIDS, TB and Malaria in low and middle income countries. The increasing number of GHIs indicate the increased involvement of the private sector, philanthropic trusts and civil society in health care, and also reflect the desire by bilateral donors to target particular issues in the hope of achieving greater outcomes (52). GHIs include global Public Private Partnerships (PPPs) in health such as the Global Fund (GF) to fight AIDS, Tuberculosis and Malaria the Global Alliance for Vaccines and Immunization (GAVI), addressing the growing global crisis of HIV/AIDS, Malaria, TB and other major diseases (53). The GHIs model has extended from global PPPs to bilateral agencies—in particular the US President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Bank’s
Multi-Country AIDS Programme (MAP) (52). In both of these cases, collaboration with the private and non-government sectors has been a prominent element.

Currently there exist about 100 GHIs, provided by partnership arrangements and bilateral and international donors (29). GHIs have become a very important and substantial part of international aid. Three GHIs—GF, PEPFAR and the World Bank’s MAP—contribute more than two-thirds of all external funding to control HIV/AIDS and malaria in resource poor countries (52). GHIs also play a substantial role in improving access and availability of services for these targeted infectious diseases in developing countries and, as a result, have attracted significantly more funds over the years. The GF support alone has been increased from 230 million in 2002 to 3.9 billion in 2013, and approximately 15% of the fund was allocated to HSS activities (54).

However, GHIs, especially global PPPs have their own challenges in their governance, equity in voice and participation, working in harmony with host country governments and contributing to the country’s health system (55). GHIs have been criticised for not contributing to strengthening the country’s health system and in some places even weakening the system (56, 57). Even the International Monetary Fund (IMF)—historically, a strong promoter of vertical programming—has been critical of vertical programmes’ sustainability, bureaucratic requirements and management burdens on a country’s system (58). Malawi is an example of one country that has triggered change in the al Fund, as the GF in Malawi was earmarked only for drugs and laboratory tests, with no regard to investing in the human resources or health systems that would enable their delivery. Besides, the GF’s actions in Malawi were in tension with the SWAp adopted by the government (58). Under the SWAp, the Malawi Government claimed the prerogative to decide on the allocation of donations by its various partners. This was not the preferred relationship for the GF, which arranged local governance through a Country Coordination Mechanism, where the MoH is only one of several stakeholders in decision making. However, the increasing recognition within the GF and other GHIs that they should invest in a country’s health system in order to bring about more sustainable outcomes, influenced change. This resulted in the GF package being integrated into Malawi’s SWAp funding matrix with an additional $40 million in Round 5 of the GF (58). This was used to recruit more health workers to Malawi’s Essential Health Package programme that covers not only GF targeted diseases but other illnesses as well (58).

Starting from its Round 4 in 2004, the GF has increasingly promoted HSS through supporting various components of the building blocks of health systems and following GAVI in trialling a health systems specific window, followed by short lived negotiations around a collaborative health
systems funding platform. By 2008, Ooms et al. were proposing a “diagonal approach” to development assistance for health, in which health system constraints to achieving outcomes related to malaria, TB, or HIV/AIDS were targeted by interventions that strove to combine specific health outcomes and positive system-wide effects (40). Julio Frenk, Dean of the Harvard School of Public Health, argued that: “In a diagonal approach, specific priorities that will drive the health system are laid out, which in turn creates a system that can respond to revolving health priorities. This way, health systems can be planned with a list of priorities.” (59). The recognition that system-wide problems impact on further progress in achieving disease specific targets has influenced the design of development programmes for both GAVI and GF. The awareness of the importance of focusing on HSS to improve the effectiveness of the GHIs has significantly increased over time, and specific HSS initiatives have been implemented (30, 52). GAVI and GF started to engage in HSS and a M&E framework for the health systems building blocks was developed and applied. Early studies of GHIs’ interaction with country health systems have shown positive effects on scaling up HIV/AIDS service delivery, broader stakeholder participation and channelling of funds through NGOs and faith-based organizations (33, 60). There were also negative effects such as distortion of recipient countries’ national policies and re-verticalisation of the planning and M&E systems (61, 62). However, it must be acknowledged that health systems efforts take time to achieve their desired outcomes. In order to secure funding for the HSS the Health Systems Funding Platform was established in 2009 on the recommendation of the High Level Task Force on Innovative International Financing for Health Systems (63). However, the future of the HSS effort of the GHIs is uncertain with recent suspension of Round 11, and the freezing of GF engagement in the Health Systems Funding Platform, and of HSS components in the transition mechanisms, due to delays in the availability of donor pledges. For both GAVI and the GF, HSS initiatives have been confined to those activities that can be demonstrably linked to outcomes for their own targeted programme mandates. That in itself indicates the vulnerability of health systems initiatives in the current aid climate.

2.2.3 Locally managed development partnerships: the Sector-wide approach (SWAp)

The perceived limitations of the effectiveness of vertical programmes that subsequently drove the GHIs in the 1990s had driven the development of the SWAp. The SWAp proposed more comprehensive solutions to the problem of fragmentation caused by aid assistance through vertical
programmes, offering a mechanism for engaging various stakeholders under a single government policy framework, with pooled financial resources and common administrative processes.

By the late 1980s, experience had shown that the project-based or vertical approaches in development cooperation did not fulfil government and donor expectations in areas of effectiveness, sustainability and capacity-building (48, 58, 64). Moreover, dealing with various donors, and using the different, standalone financial and reporting procedures imposed by them, overloaded their national counterparts. Project-based aid caused fragmentation, burdens to the country health systems, increased transaction costs and was often driven by donors’ agendas rather than a country’s needs and priorities (65, 66). Consequently, SWAp emerged as a measured response to the limitations of vertical project approaches and has been seen as one promising way of attempting to address the challenges (48). The World Bank’s role in initiating Sector Investment Programmes (SIPs) has played an important role in SWAp’s development. The SIP initially originated in non-health sectors and was seen as an operational instrument for implementing the broad sector approach to investment lending (67). Then later in the health sector it became known as the sector-wide approach to health development and evolved as a process to promote a country’s ownership and capacity building, and institutional development (41).

SWAp definitions vary from those that are focused, country-contextualized to those that are broad, hypothetical and principle-based; and often vary between situations and partners (41, 66, 68, 69). In fact the variations on the definition may be explained by SWAp’s non-prescriptive but more process-oriented nature.

Cassels’s (1997) definition is comprehensive but probably more aspirational. It defines a SWAp as: “A sustained partnership, led by national authorities, involving different arms of government, groups in civil society and donor agencies in the context of a coherent sector policy” (p11) (41). Country ownership and aligning with national policy were core principles in SWAp, and have subsequently been adopted as key principles of the Paris Declaration on Aid Effectiveness (25). This will be explored in detail in Section 2.3.

The Figure 2-1 below captures the elements of a SWAp that have to be instituted as part of the SWAp’s development. However, there are core elements to be in place prior to implementing a SWAp in order for it to be optimally successful. These are: coherent sector policy, an effective mechanism for dialogue and coordination led by the government, and a sector expenditure framework (23). These core elements are in place in the Mongolian health sector but have varied in their depth of development.
Progress in developing the elements of a SWAp is synergetic with producing the components of an effective health system: harmonisation, improvements in the monitoring system, and stakeholder consultation. All are keys for a better functioning health system. This suggests that effective implementation of a SWAP can be a catalyst for strengthening the health system.

2.2.3.1 A SWAp in practice

In practice, and given its later definitions as being progress towards an end, not all SWAp elements have to be in place at the same time. The process can start with the operationalisation of core principles and elements that eventually evolve into fully-fledged SWAps. A stable macroeconomic situation, and sufficient commitment to common goals by government and key partners, also create an enabling environment for implementation of a SWAp.

There is no specific presumption as to how a SWAp should be financed: it is often a mix of projects, pooled funding and sector budget support. However, it is implicitly assumed that over time an increasing share should be provided in the form of untied budget support, rather than earmarked aid, as a means of reducing transaction costs and supporting a country’s priorities.

Starting from early-mid 1990s, many countries were enthusiastic about trying out SWAps, as governments saw it as an opportunity to improve the management of the health sector. In a SWAp,
local stakeholders must be at the heart of the process firmly promoting ownership and local capacity building (67). Therefore, compared to project aid, a SWAp can be much more supportive of a country’s health system, if interpreted and implemented properly.

While SWAp initiatives assume a certain level of aid dependence, and have historically mainly been implemented in the social sectors, over time they have expanded to other sectors and to less aid dependent countries (73). The continued value of a SWAp beyond aid dependency, suggests that SWAps are not only effective as an aid coordination mechanism but also offer an approach to consolidate the development of a country’s home-grown capacity to coordinate resources through encouraging ownership, harmonisation and accountability.

The assessment of the SWAp’s impact on health sector development has been mixed so far, mainly because the starting conditions and the evolutionary paths of different SWAps have been so varied, making it impossible to say what health impacts should be expected and when, particularly when measured against the fluctuations in health status indicators (74). A review of the literature around SWAps, shows that the optimism about SWAps has declined starting from mid-2000, when the International Health Partnership Plus compact offered countries an alternative donor coordinating mechanism.

A SWAp has its own limits, but a number of assessments (69, 75, 76) have revealed that a SWAp showed better performance than other traditional aid modalities in aligning with a recipient country’s priorities and reducing transaction costs. Assessments argued that the SWAp was also directed more towards strengthening public policy and the systems of recipient countries, and that supply-driven technical assistance projects have been greatly reduced, and joint donor funding arrangements for capacity building have been initiated.

The feasibility assessment for implementation of a SWAp in the Mongolian health sector revealed that the main SWAp elements are in place: a comprehensive sector policy, expenditure framework and process for dialogue with partners (23). Mongolia’s Health Sector Strategic Master Plan (2006-2015) clearly states its objective to move towards a SWAp; and dialogues around the process of introducing a SWAp in the health sector have been initiated (20, 24). Major donors in the country have, in the main, been supportive of SWAp developments, but recent political changes and the consequent senior-level staff turnover have disrupted MoH institutional memory and continuity of policy commitment and weakened government leadership capacity to oversee the process of aid coordination (13, 77).
2.2.4 Budget support

Budget support is the transfer of resources from an external financing agency to the partner-government’s national treasury: untied budget support allows the recipient government to use the funds as it sees fit; tied budget support earmarks resources for a specific programme, often ensuring greater levels of accountability and transparency for the donor (42). While the SWAp is confined to a single sector strategy, budget support may enable coordination of donor funds to support whole of government strategies such as the Poverty Reduction Strategic Paper, offering support across sectoral boundaries (78). Both SWAps and budget support are intended to reduce transaction costs and increase the use of recipient country systems and procedures for allocating and managing the funds. But budget support may also operate at programme level, within a sector. Depending on the quantum of aid given and the extent to which assistance is directed towards a specific programme, tied budget support may also be considered as a Programme-Based Approach (PBA) which is defined as coordinated donor support for a comprehensive programme.

The reason for the emergence of budget support is also because of concerns about the effectiveness and sustainability of the traditional approaches, and an implicit expectation of the government eventually assuming total responsibility for the areas currently supported through budget support. Parallel systems outside the government’s budgetary framework, low disbursement rates and limited impact on a country’s public financial-management systems were main concerns. Increasingly, donors are moving away from supporting specific projects and toward more strategic medium-term assistance and are exploring budget support as a mode of effective aid delivery (79, 80). Direct budget support benefits both donors and recipient countries alike, as it allows increased scope for scaling up development assistance, reducing transaction costs, strengthening country ownership, and achieving greater development effectiveness when compared with traditional modes of aid delivery (79-81). Along with the evolution of the external assistance, some donors are increasingly expressing a preference for direct budget support to a country’s budget (81). In a number of countries in Africa, it already accounts for 20–40% of the government budget (78, 82). Several major donors such as the World Bank and the European Commission have indicated a firm intention to scale-up their aid programmes relying primarily on budget support (82, 83).
2.2.4.1 Budget support in practice

In practice, budget support has had a varied effect on the host country’s system. In Tanzania budget support was provided by 14 donors and it contributed significantly to the open dialogue on strategic issues of economic management and design of policy (81, 83). It also contributed to aid alignment and harmonisation, given the increased financial control of government on the total funding package. The key to this progress was the capable and strong Ministry of Finance and internal political commitment to bring about changes. Despite the challenges in its budgetary process both in technical and political matters, Tanzania has made gains in efficiency in public spending and empowerment of the government which would not have been so effectively facilitated by any other aid modality (81).

Williamson (78) developed the framework (Figure 2-2) to assess potential effects of General Budget Support (GBS) to Public Financial Management (PFM) and applied it in the cases of Uganda and Tanzania.

Figure 2-2: Potential effects of GBS on PFM outcomes

Both countries had shown improved macroeconomic management and strategic resource allocation. In Uganda, public expenditure as a whole has become more efficient and transaction costs have been reduced by 30% as a result of the reduced parallel projects. However, the same positive
outcomes have not been as evident in Tanzania because of the weak budget formulation process. Nevertheless, both countries showed evidence that the recipient’s budget is likely to be more efficient with budget support than with any other forms of aid (78).

But budget support is not without its risks, both to donors and recipient countries (82, 83). In some countries, variations between commitments and disbursements create greater volatility in budget support funds compared to other aid modalities, especially in the initial stages of budget support (79). With individual project-based support, governments are able to compensate for withdrawals by one donor through seeking support from another. With budget support, the loss of anticipated funding from a donor who does not honour their commitment is not so easily replaced. The main reasons for these variations between pledges and disbursements may include complicated internal donor procedures, misalignment of the budget cycles of donors and recipients, obscure disbursement conditions, complex fiduciary requirements, politically motivated commitments, or weak alignment of the budget process with the Poverty Reduction Strategic Paper (PRSP) on which support may have been premised (79). For donors, fungibility—where governments take advantage of donor commitments to specific areas of the budget to reduce their own contributions, redirecting these to other priorities—is another reason that they are reluctant to provide aid in the form of GBS (79). In budget support the impact on state budgets is amplified because of the resultant lack of predictability of funding; with donor pledges now incorporated into state budgets, the impact of delays or variations is experienced across the budget, rather than affecting only a limited sectoral or project component, as with project aid.

Overall, while direct budget support can serve as an effective tool to promote the recipient country’s fiscal management capacity and strategic resource allocation, and better harmonisation and alignment; poor governance and accountability, political instability, and lack of good information systems to monitor fiscal performance impedes the optimal achievement of budget support (78, 79, 81, 82).

2.3 PART ONE: B. Global aid agendas and shifts in aid coordination

In the previous section we have looked at the evolution of aid modalities and their implications for a country’s health system. This section will explore various aid agendas and coordination efforts, their evolution and overall impact on a country’s health system. Evolving aid coordination agendas
from Rome (2003) and Paris Declarations (2005) to the Busan Partnership agreement in 2011 (1, 84) and their implications to the strengthening of the health systems are also explored.

There have been swings in aid coordination from vertical-horizontal-diagonal and back to the combination of both vertical and horizontal approaches (Figure 2-3). It might be seen as oversimplification of complex international policy evolution, and in reality it is not as linear and occurred sequentially. It is more a coexisting tension, with a pendulum like change in dominance. Different policies introduced overtime co-existed in various contexts. Different types of aid modalities discussed in the previous section reflect the changes that have occurred in aid coordination agendas over time.

**Figure 2-3: Shifts in aid coordination**

The shifts also indicate an evolution in international health policy approaches, which play an important role in shaping agendas of development cooperation. Maciocco & Stefanini (2008) and Merson et al. (2006) traced the evolution of international health policies (simplified in Table 2-1), starting from the Alma-Ata conference to the setting up of the GF (58, 85). Understanding the evolutionary process in international health policy helps reveal the shifts that have occurred in aid approaches over recent years.

The Alma-Ata Declaration of Integrated Primary Health Care was very comprehensive and it included non-health issues such as water and sanitation, and health education. Community and intersectoral participation was accorded a high priority (58). However, the implementation of an all-inclusive integrated primary health care began to be challenged by health ministries and specialists committed to specific medical disciplines and diseases. They argued that comprehensive primary health care cannot be achieved given the low resources available, and that a more selective strategy was needed to address the priority diseases able to be targeted with available “low cost” drugs and technologies (86). International organisations, in particular UNICEF, adopted “Selective PHC” (Primary Health Care) as their strategy, initially focusing on their GOBI strategy—growth monitoring of children, oral rehydration salts for management of diarrhoea, breast feeding and
immunisation. This was later expanded to include the 3Fs: female education, family planning, and feeding (nutrition strategies).

Table 2-1: Evolution of international health policy and related aid approaches

<table>
<thead>
<tr>
<th>Year</th>
<th>International policy</th>
<th>Dominant approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>Alma-Ata Declaration</td>
<td>Integrated/horizontal: It declared the importance of a comprehensive approach that addresses issues related to education, water and sanitation, and population well-being.</td>
</tr>
<tr>
<td>1980s</td>
<td>Selective Primary Healthcare (SPH)</td>
<td>Selective/vertical: World Bank introduced the SPH approach to address priority cost-efficient interventions such as vaccinations, breast feeding and oral rehydration etc. (86) supporting SPH started this vertical approach (58). However, it is considered as counter-evolution by a number of academicians and researchers (58).</td>
</tr>
</tbody>
</table>
| Mid-1980s | Bamako initiatives – Drug Revolving Fund  
|          | Community financing schemes by UNICEF  
|          | Introduction of user fees by World Bank  
|          | Promotion of private insurance                                                     | Selective/vertical: Further initiatives by UNICEF and the World Bank were also supportive of the vertical approach and focused on creating market-based interventions in health, which have had some negative impact especially on poor households as it imposed unaffordable cost burdens for them (87, 88). |
| 1990s  | SWAp  
|        | World Bank investing in health (1993)  
|        | International Conference on Population and Development (1994)                      | The horizontal approach was a dominant form of the initiatives introduced during the 1990s, especially with the prominence of SWAp and the rebirth of a comprehensive approach which was promoted by a number of donor agencies and recipient countries. However, the World Bank report of 1993 has supported a disease-specific approach as it used disability-adjusted life years (DALYs) as the justification for funding; hence later it served as a start of big GHIs. |
| Since 2000 | GHIs  
|          | World Health Report (WHR) 2000–health systems performance  
|          | WHO- burden of disease control                                                     | A mix of vertical and horizontal approaches was promoted by various agencies. GHIs focus on addressing HIV/AIDS, TB, and Malaria, and re-introduced selective vertical disease-control programmes; whereas WHR 2000 focuses on performance and the systems approach towards healthcare. |
| Since mid-2000 | GHIs with health systems component                                                  | Diagonal\(^1\): However, despite the intention to support countries’ health systems, GHIs, to date, have not been as effective in targeting underlying health systems issues (62, 89). |

Source: Adapted from Merson et al. and Maciocco & Stefanini (58, 85)

\(^1\) combines the strengths of both horizontal and vertical approaches
The advocacy of selective health care divided the development community: while some agencies such as the World Bank were in favour of the approach, a number of academics opposed the idea. According to the late Professor K.W. Newell, from the Liverpool School of Tropical Medicine: “Selective PHC is a threat and must be considered as a counter-revolution. It is a form of health feudalism that is destructive rather than an alternative. Attractive to professionals, financing agencies and governments that are seeking results in the short term, but a pure illusion.” (p.906) (90)

The economic recession of the eighties led to the “structural adjustment” recipe devised by the World Bank, the IMF and the US Treasury for the “recovery” of the poorest and most indebted countries, without predicting the catastrophic effects of impairing programmes in health and education (58). In 1993 the World Bank published its annual World Development Report focusing on the health sector and investing in health (91), which identified four major problems of international health care systems as follows:

- misallocation of funds to less cost-effective interventions
- inefficient use of funds
- inequity in access to basic health care
- increase of health care costs that are outpacing the growth of income.

Using the DALY as a unit that enabled calculation of the economic cost of disease and comparison of burdens of disease, the World Bank was able to assess interventions on the basis of their cost-effectiveness in reducing DALYs lost to disease. Policy recommendations of the report included shifting the focus of government investment from costly tertiary-level curative care towards public health in what superficially appeared to be a return to the horizontal comprehensive approaches of Alma Ata. They recommended the introduction of social or private insurance plans to prevent catastrophic health expenditures and to foster competition in the delivery of health services (85). But the interventions that were prioritised were linked to vertical disease interventions, and reinforced targeted vertical approaches to limit costs. Most donors supported the recommendations in general and have started shifting their focus towards such initiatives.

The International Conference on Population and Development held in Cairo in 1994 evokes many of the themes of Alma-Ata. For the first time, WHO included NGOs in significant numbers in the development of the agenda, with NGOs prominent in advocating new approaches to address the issues pertaining to reproductive health, and in particular, asserting a rights-based approach. This
focused on individual choice for women over their own bodies, including contraception and abortion, as opposed to the earlier focus on the collective family and population control focus.

In the mid-1990s the rhetoric of SWAp became very prominent. It was seen as a tool to overcome the inefficiency of vertical projects, and the duplication of interventions delivered by donors without consultation with the MoH. This coordination and integration was to be accomplished through promoting government ownership and capability building to coordinate and manage the sector. SWAp was seen as a mechanism for enhancing good governance and accountability with a strong emphasis on improving national coordination and strengthening the development of a comprehensive and integrated health system.

The debate about comprehensive (horizontal) approaches versus selective (vertical) approaches was the major debate in global health during the 1980s and 1990s, with few programmes bridging the gap. Most policy analysts and funding agencies saw this as an either/or choice until early in the 2000s, when providers of disease-targeted programmes began to realise that health systems obstacles were impacting on their capacity to reach their targets. By the late 2000s, a theoretical shift to combine the strengths of both approaches was introduced and the use of HSS strategies within selective programmes was advocated, with a view to gradually strengthening health systems to enable them to deliver more comprehensive care. This has been called the diagonal approach.

Aid coordination agendas have been shaped by these shifts in international health policy. In February 2003, leaders of the major multilateral development banks, international and bilateral organisations, and donor and recipient country representatives gathered in Rome for the First High-Level Forum, which focused on harmonisation of development assistance for greater effectiveness. The main emphasis of the resultant Rome Declaration was to harmonise the operational policies, procedures, and practices of the international development partners with those of other development agencies and partner country systems to improve the effectiveness of development assistance; thereby contributing to achievement of the MDGs. The Rome Declaration was further reinforced by the Paris Declaration on Aid Effectiveness in 2005, promoting ownership, alignment, and harmonisation; and managing for results and mutual responsibility as the key elements for achieving development effectiveness. In 2008, following a disappointing assessment of the implementation of the Paris Principles, the Accra Agenda for Action was put forward to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness, encouraging the private sector to contribute to an effective country-led development processes. The application
of those agendas was intended to help countries to move towards development results while improving their country’s own system (72, 93). By the next round of high level forums, it was clear that the paradigm of development which underpinned these forums no longer held in the current era of development.

As a result of these changes in the agenda, the theoretical framing of development has become more complex, and the polarising debate about vertical versus horizontal approaches has been recognised as unproductive. Even among GHIs, the focus is moving away from the disease-specific towards systems for improving efforts in meeting both vertical programme targets and globally agreed benchmarks (94). A number of efforts to improve aid efficiency through shifting the emphasis from the vertical project approach to a horizontal or systems approach have been made in the last two decades. Balabanova et al. (2010) have provided a comprehensive overview of the GHIs to explore if these initiatives are assisting in the strengthening of country health systems (29). They noted 18 signed agreements and processes at global level (this includes Paris and Accra, International Health Partnership+ etc.) and 6 initiatives at national level (including SWAp, Country Coordinating Mechanism of Global Fund) since 2003. At the heart of these attempts is the improvement of country ownership, alignment and harmonisation which are also emphasised in the Paris Principles. However, the study found a persisting need for government capacity to manage and deliver services in accordance with national strategies and to coordinate external aid with local resources. Also, performance monitoring, accountability and acting on the evidence of what works under what circumstances were needed for improving GHIs contribution to health systems. All these are applicable to the Mongolian health sector. The WHO Maximising Positive Synergies Collaborative Group study also focused on the extent that these global initiatives actually have succeeded in improving national health systems: global versus strictly national responsibilities for health and optimisation of GHI funding to take advantage of opportunities for synergies (52). The study contributed to putting an end to the debate on ‘vertical versus horizontal’ approaches to health, as it promoted synergy of these two differing approaches.

The recent Fourth High Level Forum on Aid Effectiveness held in December 2011 in Busan (1) questioned donors’ ability to implement the Paris Declaration. At a global level, only one indicator (strengthened capacity by coordinated support) has been met since 2005. The slow progress raised doubts about how well the declaration had been adapted, interpreted, applied and even measured (76, 95, 96). Partner countries expressed their views on the need for differentiation of approaches between fragile states, Middle-Income Countries (MICs) and Lower-Income Countries (LICs) (1). They also recognised that the largest number of the world’s poor now live in MICs and should not
be ignored, and that recent intentions to withdraw assistance from these countries by the developing partners should be re-considered while encouraging greater domestic responsibility for the poor.

The arrival of new donors, new forms of cooperation and an increasing demand for results, has challenged the application, inclusiveness, and sustainability of the Paris Declaration after Busan. As a response to these changing circumstances, the Busan Partnership for Effective Development Co-operation was signed by ministers of developed and developing nations, emerging economies, providers of South-South and triangular co-operation and civil society (1). This declaration, for the first time, established an agreed framework for development cooperation that includes traditional donors, South-South cooperation, the BRICS\(^2\), Civil Society Organisations (CSO) and private funders; and encourages public-private partnerships. This was an important step in shaping global aid architecture with more actors, more sources of financing and diverse modalities and partnership arrangements. However, the mechanisms of including these new members into existing coordination and reporting procedures still need to be worked out (1). The diagonal approach that supports health systems while achieving the targets of the selective programmes remains high on the agenda of aid coordination. But the irony is that donors, while supporting the rhetoric of HSS, are reluctant to commit to its development. Now we have more donors, but more explicit reluctance.

2.4 PART TWO: Complexity of health systems, health systems frameworks and HSS

Both global partners and recipient countries unanimously agreed on the importance of supporting a country’s health system in order to bring about sustainable health outcomes. Over the past decade, numerous global health agendas, policies, and strategies have emphasised the importance of a strong health system as central to discussions on how to achieve significant progress toward meeting the next set of global health goals such as Universal Health Coverage (UHC). With this increasing awareness of the importance of contributing to health systems, it is essential to be clear about what constitutes a health system and what actions would strengthen it. This subsection explores the definitions of a health system and HSS, and the differences between supporting and strengthening health systems. It also explores various health systems frameworks and identifies

\(^2\) Brazil, Russia, India, China, South Africa-BRICS-it is an abbreviation for newly emerging donor countries.
common and operational elements for HSS frameworks to explore implications of systems thinking on HSS.

2.4.1 Definitions of a health system

The health system is a very complex and dynamic system that involves many actors, different administrative levels and varies greatly from country to country, depending on the political system, socio-economic situation and social values and norms. Therefore, it is hard to establish a single, agreed definition of a health system that applies universally— the very nature of these systems is that they are continually evolving and context specific. The diversity is reflected in the variety of health systems frameworks that have been developed to assist in defining health systems.

The World Health Report 2000 Health Systems: Improving Performance defined a health system as: “(i) all activities whose primary purpose is to promote, restore or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.” (p.5) (97).

This definition is very comprehensive, as it captures all the functions, actors and policies of an established system, together with an acknowledgement of the expectations of the population, financial risk protection and the goal of improving health. In reality, there are very few health systems that comprehensively meet this definition, especially when it comes to ‘responding to people’s legitimate expectations and protecting them against the cost of ill health’. Yet the recognition that the health system is responsible not only for improving health for the whole population, but also for protecting them from the financial threats implicit in disease and the search for health, is integral to all understanding of health systems since the World Health Report 2000: Health Systems: Improving Performance. The WHO (97) report acknowledges the complexity of the health systems, and because of this complexity it is not easy to say exactly what a health system is, what it consists of, and where it begins and ends.

Later in 2008 in the Tallinn Charter from the 2008 WHO European Ministerial Conference on Health Systems, a health system is defined as “the ensemble of all public and private organizations,
institutions and resources mandated to improve, maintain or restore health…which encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health." (p.1) (98)

As seen from the definition, the boundaries of the health system are difficult to circumscribe, as many of the activities that contribute to health lie beyond the health sector—protection from conflict, adequate housing, safety in travel, food security, education for women—all have direct impacts on health but do not lie within the control of the health sector. Besides, the health system and its surrounding context are linked bi-directionally, with interaction from each affecting the other. Changes in politics, laws and the economy affect the components of the health system and, in turn, health systems interventions affect the broader context (99).

As the previous section has shown, global-development assistance trends swing between prioritising specific disease interventions and working comprehensively across the health system. The recent proposal for the health goal within the Sustainable Development Goals (SDGs) includes elements of both: functioning health systems are seen to be necessary to deliver an expanded communicable and non-communicable disease agenda (100). With the increasing emphasis on approaches to strengthening health systems by both global actors and national governments in the last few years, HSS has developed as a development focus in its own right, with considerable debate around what it is and how to achieve it.

2.4.2 Defining Health Systems Strengthening (HSS)

There is now a strong consensus between key donors and recipient countries about the need for channelling aid towards HSS, though there is some persisting caution among certain actors, in particular Bill Gates (38, 101). But the lack of consensus on what HSS means and consequently on how it should be done and evaluated remains a challenge (52, 102). Understanding HSS also reflects the complexity of defining health systems.

According to WHO, HSS is defined as “…the process of identifying and implementing the changes in policy and practice in a country’s health system, so that the country can respond better to its health and health system challenges” (103).
WHO also defines a good health system as follows “A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies” (104).

These definitions place an emphasis on improving the core elements of the system—financing, human resource, information and logistics management—and making changes in policy and practice in order to make the system responsive to population health needs and expectations.

Chee et al. also place emphasis on performance drivers (105, 106), such as policies and regulations, organisational structure and behaviour, which mainly focus on process elements rather than systems inputs; hence have a more holistic nature and encourage HSS. But defining HSS is very context specific—the history and evolution of each health system produces distinctive characteristics and structures. As a result, it is important to choose an applicable framework, or to adapt and combine several frameworks for a given context. Shakarishvili et al. also highlighted the complexity and multiplicity of HSS frameworks (107). Recognising the challenge of choosing an appropriate approach to HSS at the country level, Shakarishvili et al. proposed a converged conceptual framework (Figure 2-4) that focuses on identifying practical approaches to collective actions to strengthen health systems (108).
This framework is not meant to add additional dimensions in explaining what a health system is, but rather is a tool to translate concepts into actions for improving health systems in developing countries. This translational framework emphasises the importance of context specificity, and consistency in the application of a common approach to make HSS workable. It serves as an effective tool to translate concepts into actions for improving health systems in developing countries. I have used the same approach used in the translational framework in my research to identify Mongolia specific HSS interventions, and to develop my own framework for analysis.
2.4.3 Health systems frameworks

In the past three decades, health systems frameworks have been developed by multiple authors with a view to improving health systems and health outcomes, through better understanding of the complexities of health systems (109). Because a health system is dynamic by its nature, seeking to clarify the relationship between a health system’s functions and the ultimate objectives of a health system is an important element in defining it. Hence, many researchers prefer to use health systems frameworks that illustrate the complexities of the system, the relationship between the surrounding context and components of the health systems, eventual health outcomes and impacts. The existence of multiple frameworks indicates that a health system is complex and may be understood differently by different people, disciplines and geographical regions; and changes in understanding may also occur over time (109).

The evolution of health systems frameworks over time provides an overall view of how health systems understanding and focus have been changed. Analysing the changes over time shows how these frameworks have influenced—and have been influenced by—the global health systems agenda, and consequently their influence on a country’s health system. Figure 2-5 below illustrates those frameworks that have reflected paradigm shifts in the evolution of systems understanding over the course of time. The key shift between the frameworks of the 1980s and 1990s has been the introduction of an emphasis on the interrelationships of systems components. Frameworks after 2000 have emphasised health systems functions, performance and performance drivers in relation to health system outcomes and goals.

Although the emphasis on health systems and HSS has become more prominent since 2000, it has been on the agenda of international health discourse since the mid-1960s (110). Global health agendas shape the fundamentals of the health systems framework. For example, the frameworks developed in the early 1980s such as the Actors Framework derived its systems and holistic nature from the influence of a horizontal view of the Alma-Ata declaration “Health for All” released in 1978.
Figure 2-5: Key health systems frameworks evolved during 1981-2011

Kleczkowski et al. framework (1984) - components of health system infrastructure:
- Development of health resources
- Arrangement of health resources
- Health service delivery
- Economic support
- Management

Roemer’s framework (1993)
- Management
- Organization of programmes
- Delivery of services
- Economic support

Control knobs (Roberts 2004)

WHO Building blocks (2007)

Reform framework (Frenk 1994) interrelationships between five different actors:
- providers
- population
- state as collective mediator
- organizations generating resources
- Other sectors

Shakarishvili et al framework to assess HSS contributions (2011)

Source: adapted from Van Olmen, 2012
The purpose of the frameworks has changed over time; earlier frameworks such as the Actors Framework by Evans, and Kleczkowski et al.’s and Roemer’s frameworks tended more towards conceptualising and describing health systems in order to establish a clear understanding of the system (109, 111). Later frameworks such as the Performance Framework (97), Control Knobs (112) and Systems Thinking frameworks (113) are more analytic, and allow health planners and managers to examine interactions between the functions, objectives and goals of the system. Systems Thinking, developed by De Savigny and Adam (113) brought another new and very important dimension to HSS as it advocates a holistic and comprehensive approach. The evolution of these frameworks is indicative of the changing perspectives on health systems and is reflected in both the global and Mongolian health policies. Because of their importance in the development of my own framework for analysis, I have briefly presented the key frameworks that have brought paradigm shifts in understanding and exploring health systems in some detail, presenting them chronologically. Together these have allowed me to reflect on my own understandings of health systems and have set the stage for exploring Mongolian HSS efforts and the necessary systems framework to do this.

Performance Framework

The World Health report of 2000 introduced the Performance Framework which has been one of the key frameworks for understanding and studying health systems. The following schematic diagram (Figure 2-6) by WHO (97) illustrates the relationships between the functions and objectives of health systems.

It defines the four main functions of the systems in order to achieve an equitable and responsive health system to improve population health: service delivery (sets of interventions); resources (what financial and non-financial resources are needed to deliver the interventions); financing (how to collect funds for the services, developing a payment system and a fair allocation of the funds); stewardship (who is responsible for overseeing the delivery of the services).
Murray and Frenk (114) emphasised that by investigating these four functions, the understanding of the proximate determinants of health system performance become more clear, and as a result, it becomes apparent which major policy issues and interventions need to be considered. Hence, these four functions of the systems have consistently been part of the main components in many frameworks developed over time by different researchers.

**The “Control Knobs” framework**

The World Bank uses a ‘Control Knobs’ framework in its Flagship Programme on Health Sector Reform and Sustainable Financing. The framework was developed by Roberts *et al.* at Harvard University, and it aims to understand challenges and roadblocks to improving health outcomes, and to formulate strategies for system strengthening through fixing errors in each of the control knobs. The framework assists in defining the range of processes affecting the components of a health system (five control knobs), and explores policy instruments to influence them (107, 112). The five control knobs are:

- financing
• payment
• regulation
• organisation
• behaviour.

The five control knobs are linked to key policy instruments and enable policymakers to know which policy instrument would allow them to achieve desired outcomes in what ways (108, 115). Most importantly, this model of health systems was developed based on the many years of experience of consultants and academics working in developing countries.

**The “Building Blocks” framework**

WHO defined six building blocks of a health system (Figure 2-7) in the WHO publication “Everybody’s business: Strengthening health systems to improve health outcomes” (116). Identifying six blocks works as a “check-list” to ensure all dimensions of a health system are considered, and allows analysts to clarify how each block can contribute to the aims of the whole system.

It is important to have a clear understanding of the main components of a health system and their sub-components, interrelatedness and dynamic nature as these can have a major influence on the systems’ overall goals. Also, a thorough understanding of the system can assist in channelling external assistances into HSS. Although defining the system is complex and requires a thorough understanding of the interactions of various components of the system, some simplification is necessary for understanding what kind of investment is needed to provide better access, coverage, quality, and safety, resulting in improved health and equity (116, 117).

The Building Blocks framework, although it is in many ways a reductionist conceptualisation, simplifying a complex system into what are really interrelated parts, has enabled a common understanding of the health system among various partners in health (118).
The “LIST” framework for health systems performance

The reasons for variations in performance by different health systems even at the same level of economic performance and same level of per capita health expenditure is explained by Julio Frenk in terms of health systems performance. Using the acronym LIST, Frenk identified the main determinants that influence health system performance in decreasing order of complexity (30).

- **Leadership**: Without good leaders even the best systems fail and this is probably the most complex challenge in health systems.
- **Institution**: For health systems, the crucial institution is the MoH and building capacity within institutions requires long-term investment.
- Systems Design: Quality service delivery can only be achieved through well designed, well interrelated human, financial and technological resources.

- Technology: This is the most studied priority area where many funding agencies direct their investment, but without having good system design it is not going to improve overall performance on its own.

Frenk’s LIST Framework also emphasises the greater interrelatedness of each determinant of the system, encouraging the understanding of health systems as a dynamic model, and the development of a holistic approach towards systems strengthening.

**Systems Thinking for HSS**

Systems Thinking for HSS by De Savigny and Adam (113) further advanced Building Blocks by adding interactions both between the health system components and actors, and within the various component elements (Figure 2-8). This has complemented the shortfalls of the Building Blocks framework, which had the original intention of guiding the investment of resources for HSS. Unfortunately, to some extent the Building Blocks framework risked the creation of another type of fragmentation and verticalisation by encouraging investment in specific blocks in isolation,(118, 119) and not clarifying the varied weighting and interactions between the blocks. Without an understanding of the interplays between blocks, its application for assessing contributions to HSS has been limited (118).

A Systems Thinking perspective is needed for bringing innovation and transformational change in all aspects of health systems—in health practice, education, research and policy (99, 120)—and hence, has been highly promoted by health systems researchers, globally. As a holistic approach “systems thinking demands a deeper understanding of the linkages, relationships, interactions and behaviors among the elements that characterize the entire system” (p.33) (113). It has a number of commonalities with other frameworks and reinforces the importance of key systems elements. But more importantly, it brings an understanding of system-level interventions, such as improved financial instruments or providers’ behaviour and communication skills, which can have a profound effect on addressing systems issues and challenges.
2.4.4 The functions of health systems frameworks

Currently, there is no shortage of frameworks to explore health systems, though the application of these frameworks is challenging as various frameworks have different functions and offer different approaches to HSS. Numerous efforts have been made to analyse the available range of health systems frameworks (108, 114, 121-124). Hoffman et al.’s (109) categorisation of health systems frameworks (Table 2-2) allows a comprehensive analysis of the frameworks available in the literature and identification of their conceptual differences and similarities.
Table 2-2: Categorisation of health systems frameworks

<table>
<thead>
<tr>
<th>Goal</th>
<th>Sub-framework</th>
<th>System-framework</th>
<th>Supra-framework</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WHO, 2007, <em>Building Blocks</em></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Global Fund, 2008, <em>Understanding health systems components</em>†</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Naidkelson-Lopez, et al., 2010, <em>Understanding governance parameters of WHO Building blocks</em>†</td>
<td></td>
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<tr>
<td></td>
<td>Feldstein &amp; Friedman, 1976, <em>Comparing effects of national health insurance plans</em>†</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Nixon &amp; Uzawa, 2006, <em>Health spending and health outcomes</em>†</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mills &amp; Ramson, 2001, <em>Informing change in health systems reform for LMIC</em>†</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Commonwealth Fund, 2006, <em>Informing change in performance improvement</em>†</td>
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<tr>
<td></td>
<td></td>
<td>Van Olmea, et al., 2010, <em>Health systems dynamic Framework</em>†</td>
<td></td>
</tr>
<tr>
<td>Note:</td>
<td>*indicates a descriptive framework; † indicates an interactive framework added by authors</td>
<td>International Health Partnership, 2008, <em>Evaluating changes in health systems</em>†</td>
<td></td>
</tr>
</tbody>
</table>

Hoffman et al.’s analysis covers 41 systems frameworks indicating the variety of ways in which health systems are understood by different researchers, disciplines and regions, and how this
understanding has changed over time (109). They have clustered current health systems frameworks according to three dimensions:

- **Scope/Level** of frameworks: sub-frameworks, system frameworks and supra-frameworks
- **Goal** of frameworks: understanding, comparing, informing change and evaluating
- **Nature**: descriptive and interactive.

Defining the scope of a framework helps to identify whether the analysis focuses on particular components of the system (sub-frameworks), the entire system (system-framework) or includes interactions with other systems (supra-framework). A sub-frameworks’ focus has the advantage of addressing both systems issues and vertical programme needs (121), but may distort analysis by excluding contextual factors such as governance, politics, and social and cultural aspects which highly influence the effectiveness of the system (125). The system-framework focuses on the whole health system and effectively addresses less-complex systems issues. A complex analysis is best undertaken using supra-frameworks, addressing not only the health system under analysis in isolation but also its linkages to other systems. While this abundance of frameworks provides a better ground to explore health systems using multi-dimensional perspectives, the challenge is to decide which one is relevant for the given purpose of the systems research. The scope and goal of the frameworks chosen must serve the same purpose as the research, and the use of a single framework is inadequate to explore a health system in a holistic way.

But despite these overall trends towards complex, holistic and context specific frameworks and understandings of HSS, more atomised approaches persist. USAID, for example, defines HSS as “any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency” (126). This definition points to the composite activities that each contribute to the health system, but is in tension with systems thinking perspectives. Fragmenting health systems by their components and principally supporting one or more functions of the health system does not necessarily strengthen the health system, particularly where that intervention cannot address underlying systems issues. In many ways this confuses individual activities that support health systems and a more synergistic systems approach. Health systems researchers Chee and Gilson (106, 127) have distinguished between health systems support and HSS in order to improve systems strengthening.
2.4.5 Distinguishing health systems support and HSS

It has been recognised that despite many years of financial and technical effort to improve health outcomes, these have not been achieved as expected in many LIMCs. Analyses point to their weak health systems as a likely cause of this disappointing progress (106, 128). Over the past decade, there has been an increasing recognition of systems thinking and the importance of contributing to HSS by both governments and donors (128). The differentiation between HSS that creates sustainable systems change with a systems wide impact and other contributions that provide health system support has become more crucial in order to achieve sustainable health outcomes. Chee et al. explain:

“Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs. Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services” (p.1) (106).

The approaches that focus dominantly on input elements rather than performance drivers (Figure 2-9), are more likely to relate to health systems support, and do not necessarily contribute to sustainable systems change and continuing health outcomes. However, as I have shown, interpretation of what is health systems support compared to what is health systems strengthening varies widely according to different actors (106), with a clear consensus position on HSS still developing.
Over the last decade, a number of global health institutions and researchers have attempted to clarify distinctions between the disease specific or health systems support and systems strengthening interventions. The Alliance for Health Policy and Systems Research based at the WHO; the World Bank; the Health Systems Funding Platform; the Global Fund; High Level Forums on Aid Effectiveness and their outcomes, such as the Paris Declaration; the G8 Forum held in Japan; the High-Level Forum on the Health Millennium Development Goals; and private foundations such as the Rockefeller and Doris-Duke Foundations all strongly emphasised a need for contributing to HSS (31), although the challenges on “how-to” remain an issue. Identification of what is HSS and what is not HSS is the first step towards better contributions to systems strengthening. However, it is not to say that system support intervention is less important, as it helps to fix problems in a relatively short time, while systems strengthening takes longer and is more complicated, though it has a more positive long-term impact on the system. A synthesis of the understandings of HSS developed by Gilson, Travis et al., Shakarishvilli et al. and Chee et al. (106, 107, 127, 128) provides concrete examples that differentiate disease specific systems support and HSS responses to health systems issues, as shown in the Table 2-3 below.
Table 2-3: Examples of distinctions in response to health systems issues between disease specific systems support and HSS interventions

<table>
<thead>
<tr>
<th>Systems problems (by health systems components)</th>
<th>Disease specific response or system support</th>
<th>HSS intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical inaccessibility: distance to facility</td>
<td>Outreach for focal diseases</td>
<td>Reconsideration of long-term plan for capital investment and siting of facilities</td>
</tr>
<tr>
<td>Poor quality care amongst private sector providers</td>
<td>Training for private sector providers</td>
<td>Development of accreditation and regulation systems</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Human resources:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriately skilled staff</td>
<td>Continuous education and training workshops to develop skills in focal diseases</td>
<td>Review of basic medical and nursing training curricula to ensure that appropriate skills included in basic training</td>
</tr>
<tr>
<td>Poorly motivated staff</td>
<td>Financial incentives to reward delivery of particular priority services</td>
<td>Institution of proper performance review systems, creating greater clarity of roles and expectations regarding performance of roles, review of salary structures and promotion procedures</td>
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<td>Human resources:</td>
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<td></td>
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<tr>
<td>Health financing:</td>
<td></td>
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<tr>
<td>Financial inaccessibility: inability to pay, informal fees</td>
<td>Exemptions/reduced prices for focal diseases</td>
<td>Development of risk-pooling strategies</td>
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<td></td>
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<tr>
<td>Governance and leadership: Lack of inter sectoral action and partnership</td>
<td>Creation of special disease-focused cross-sectoral committees and task forces at national level</td>
<td>Building systems of local government that incorporate representatives from health, education, agriculture, and promote accountability of local governance structures to the people</td>
</tr>
<tr>
<td>Weak planning and management</td>
<td>Continuous education and training workshops to develop skills in planning and management</td>
<td>Restructuring ministries of health, recruitment and development of cadre of dedicated managers</td>
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<td></td>
<td></td>
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<tr>
<td>Health information systems:</td>
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<td></td>
</tr>
<tr>
<td>Weak data collection, analysis, and reporting</td>
<td>Training to develop skills in data collection, analysis, and reporting</td>
<td>Developing data collection, analysis and reporting system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implementing data collection, analysis, reporting and dissemination</td>
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<tr>
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<tr>
<td>Medical products and technologies:</td>
<td></td>
<td></td>
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<tr>
<td>Shortage of medicine and supplies</td>
<td>Increasing expenditures on medicines and other consumables</td>
<td>Development of procurement regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Development of supply-chain management system</td>
</tr>
</tbody>
</table>

Source: Adapted and synthesised from Biesma, 2009; Shakarishvili 2011; Travis 2004 (61, 107, 128)

Approaches that focus dominantly on providing inputs such as staff, medicines, technology and other resources tend to be disease-specific or health systems support rather than HSS, and do not necessarily contribute to sustainable health outcomes. Certain forms of health systems support,
similar to disease-specific programmes, may create verticalisation of the system, thus limiting systems thinking and the development of a holistic approach. In contrast, investing in the process elements or performance drivers is more likely to develop sustainability, and systemic and related strategic approaches—key aspects of HSS.

A number of studies have evaluated the HSS funding allocated by the GAVI and GF HSS funding windows, to explore if these funds were actually contributing to HSS (33, 61, 62, 89); however, very few studies have looked at overall donor assistance contributions to the HSS. The studies found that GAVI HSS interventions were mostly supportive of service delivery of immunisation and maternal and child health services rather than supporting sector-wide or systemic change (18). A lack of proper understanding of HSS can also potentially lead to a less than comprehensive assessment of a HSS intervention’s effects across multiple health systems building blocks (102), hence the risk of undervaluing the positive impact of the actual HSS interventions on health systems outcomes as a whole. Goeman et al.’s analysis of GAVI HSS funding pointed out that country proposals focus on “short-term solutions to systemic problems, rather than advocating longer term systemic responses, raises concerns regarding sustainability of interventions” (129). These findings suggest the importance of a clear understanding of what is considered as health systems or disease-specific support and what is considered as HSS interventions in order to improve the effectiveness of the contributions supportive of each type of intervention.

Having examined health systems and HSS definitions, and clarified the difference between health systems support and health systems strengthening, I have attempted to apply these lessons to developing a conceptual framework to be used in exploring the Mongolian health system and the role of donors for HSS in Mongolia.

2.4.6 Conceptual framework for exploring the health system in Mongolia

Based on the extensive study of health systems frameworks and concepts, the common dimensions of the health system, system components and cross-cutting components have become clear, despite the variations and differing emphasis of the frameworks. For my analysis, several key frameworks have informed and provided a basis for developing my analytical systems outline, illustrated in Table 2-4 below: WHO Performance framework, Control Knobs framework by Roberts et al., LIST framework by Frenk and Building Blocks and Systems Thinking for HSS (30, 97, 112, 113, 116).
Overall I have identified three key dimensions to explore the health system: input, process and outcome, and each has different components (Table 2-4). Supporting differing dimensions of the health system brings different outcomes. Support to input will improve the health system through providing staff, resources and commodity support; however, it will not necessarily bring sustainability and a strong health system unless underlying health systems issues—such as the human resource management system, procurement and payment systems and the maintenance system—are tackled. The latter can be supported through contributing to the component elements that support the processes/functions of the health system. Until recently the support to inputs has been dominant in development assistance to Mongolia, rather than support to process elements that look at the system as a whole and facilitate system thinking and development effectiveness (72, 106).

Table 2-4: Dimensions and components of Mongolia’s health system

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Components</th>
<th>Cross-cutting components</th>
<th>Surrounding policy and economic environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inputs</td>
<td>• Staff&lt;br&gt;• Resource&lt;br&gt;• Technology and medicine&lt;br&gt;• Data and information</td>
<td>• Governance/leadership&lt;br&gt;• Institution capacity&lt;br&gt;• Behaviour</td>
<td>• Politics&lt;br&gt;• Economy&lt;br&gt;• Actors&lt;br&gt;• International and regional polices&lt;br&gt;• National policies and strategies&lt;br&gt;• Culture&lt;br&gt;• Values and principles of society&lt;br&gt;• Demography&lt;br&gt;• Openness and transparency</td>
</tr>
<tr>
<td>Functions/Processes</td>
<td>• Human resource management&lt;br&gt;• Financial management&lt;br&gt;• Supply and maintenance system&lt;br&gt;• Monitoring and evaluation system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>• Sustainable health outcome&lt;br&gt;• Increased responsiveness&lt;br&gt;• Social and financial protection ensured&lt;br&gt;• Improved efficiency</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Adapted and synthesised from different frameworks by WHO, Roberts et al, Frenk and De Savigny (30, 97, 112, 113, 116).*

The health system components are dependent on multiple actors and the surrounding policy and economic environments; therefore, these factors should be studied together, too. The social...
construction, politics, economy, culture and values of the society have had a significant role in shaping power and relationships in health systems (111, 130, 131). As development assistance crosses cultural constructions of health and governance, the fundamental differences between Asian and Western value systems need to be considered, otherwise these differences could limit sharing of experiences and lessons in undertaking some policy measures (132, 133). Mills and Ranson (2006) argue that each country’s health system is influenced by different factors, including those external to health (131). The social, cultural and economic dynamics in society, the history of the country and its health system, and the power of the actors with different interests make the development of each health system very context specific. However, despite this complexity, they acknowledge that it is possible to identify common features of the system and to use increasing knowledge of which design results in which outcomes, thus allowing cross-country learning. The process of identifying these commonalities may be facilitated by the choice of health systems framework used for internal or comparative analysis. As discussed, there have been many attempts to make the concept of health systems clear and having these various views provides an opportunity to identify appropriate approaches towards HSS in a given context (38, 108).

Based on the literature review, I have mapped out the key dimensions to explore health systems and developed the following conceptual framework (Figure 2-10). This has been used as a guiding framework to explore HSS interventions in my research. I did not find any single framework adequate for exploring a complex health system like the Mongolian system, transiting from Soviet-style governance to democratic governance but with poor leadership capacity to coordinate the various stakeholders in health. Therefore, my framework needed to derive its basis from the synthesis and analysis of the currently available frameworks and components and principles of the operational health system. It includes both external and internal elements of the health system and their interaction with both process and actors; hence can be named an Interactive exploratory framework for HSS. The synthesis of health systems frameworks and the policy triangle model by Walt and Gilson (35) were adopted in the framework. These are largely accepted frameworks and frequently used in health policy analysis. But the combination of the frameworks is derived from the need for exploring both process and content elements of health sector aid and its interaction with the overall health system and the context it is operating in.
The health sector is highly vulnerable to both external (politics, the economy, and international policies, etc.) and internal factors (client and provider needs and demands, health insurance policy, etc.). Therefore, it cannot be studied in isolation. The outer oval in my framework contains the contextual factors that need to be considered in conducting my analysis and making potential recommendations. The inner oval includes the categories of health systems components: input, process and outcomes, which will be used in studying external aid contributions to the HSS. However, my study will primarily examine the extent of the aid channelled into input and process elements only without going deeply into aid impact on health outcomes. While changes in health outcomes will be outlined, it is difficult to establish direct causal links between external aid and improved health outcomes due to a larger proportion of domestic funding on health in Mongolia.
and the number of confounding factors. These include the country’s policy and politics, a rapidly changing economic landscape and people’s health-seeking behaviour and culture and beliefs. Actors, both external and internal to health, are an essential part of the policy research; hence they are positioned at the heart of the research.

The framework is comprehensive for the purpose of my research as it covers the three key elements of my research—health systems, actors, and context—and allows me to explore their interactions in the context of the Mongolian health sector. It also allows a basis for analysis of donor’s contributions to HSS and suggests what areas need more focus in achieving a better performing health system. The support to process elements is not as straightforward as supporting inputs. In some cases, input support to health systems’ components continue to be mistakenly labelled as a HSS intervention (106). This reinforces the need for further exploring the difference in contributing between a disease-specific response and health systems support and HSS.

2.5 Summary

Changes in aid modalities over time reflect the evolution of global aid and development policies. The various aid modalities have evolved over time in order to improve aid effectiveness, country ownership and capacity building, which in turn will eventually lead to strong country systems. The development of the Global Health Initiatives—targeted responses to specific disease challenges—have more recently engaged elements of a systems approach, though in the main this tends to be limited to HSS components that directly support their limited mandate. SWAp and budget support, demonstrate a development of aid modalities that are supportive of the Paris Principles of government ownership, donor harmonisation and alignment. In Mongolia and other developing countries, these are in various stages of development and have proven to be susceptible to many other external-to-health sector factors, such as politics, history, and the socioeconomic condition of the country.

There is no lack of definitions for health systems and HSS. An abundance of frameworks for exploring health systems increases the complexity of health systems research. The interpretation of health system support and HSS is not always clear, and needs to be explicitly understood in terms of the conceptual and operational principles of local health systems. Over time, an in-depth exploration of various health systems frameworks and their evolutionary development has made the importance of understanding key components of a health system—input, process and outcomes—
clear. Furthermore, developing an overall guide to choosing the right framework that suits the research purpose offers an opportunity to inform evidence-based effective HSS interventions in a given setting. It benefits not only the Mongolian health system in transition, but may also be applicable to many other post-Soviet countries. As the context of the research and conceptual framework becomes clear the next stages would be clarifying research methods (Chapter 3); studying health system aid coordination and its development in post-Soviet countries’ and in Mongolia (Chapters 4 and 5) and identifying country-specific HSS frameworks and examining donors’ contribution to the implementation of the health systems interventions (Chapters 6-8).
The policy analyst as actor II: Changing global aid polices and the relevance of the Paris Declaration

The Paris Declaration has been at the heart of the aid effectiveness agenda ever since it was introduced. However, after two rounds of monitoring and evaluation of the Declaration, slow progress towards indicators has led to questioning of the relevance and the very nature of the Declaration. Indicators are to track progress made against targets— in terms of “how much” or “how far” they have been achieved. But, they do not necessarily investigate fundamental reasons and factors that worked for and against achieving better results. My brief commentary will present the reasons why I see the Paris Declaration remaining effective.
A changing aid environment marked by the arrival of new donors, new forms of cooperation and an increasing demand for results has challenged the application, generalizability and sustainability of the Paris Declaration after Busan. While it is important to welcome new approaches, it is also worth remembering that “a new thing is often a somewhat forgotten old one”.

The Paris Declaration, by its very nature and intent, aims to be a catalyst of real development. It focuses on systems and sustainability through promoting transparency and accountability. Changing a system and tackling the root causes of chronic problems are complex tasks. They require more time than the supply of commodities. In my opinion, many “unmets” of the Paris Declaration targets are thus acceptable and expected, as the targets aim to build system and local capacity. The fact that some progress in indicators, although slow, can be noticed indicates that the Declaration is doable.

Development cooperation must be directed towards the reduction of the rapidly increasing gaps between the rich and the poor in developing countries. Resistance by BRIC countries towards the Paris Principles poses a danger of potential corruption and further aggravation of inequity. Adherence to agreed norms and standards of better practice and partnership is increasingly becoming the norm rather than complying with rules set as a result of the Declaration. This positive trend and dynamic should not change with the arrival of new donors and a so called “new” agenda for aid effectiveness after Busan.

The IHP+ initiative that applies the Paris Declaration principles in the health sector provides good practices and experiences that can be shared with other sectors. Inevitably, implementing the Paris Declaration in the new aid era poses many challenges, but these should not be seen as reasons to get rid of the Declaration nor to exclude new donors. They are not mutually exclusive.

Finally, we must acknowledge that it is not the Paris Declaration itself that is to blame for the slow progress of development results. It is the way the Declaration is being adapted, interpreted, applied and even measured that tends to make all the difference.

Anar Ulikpan

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3 CHAPTER 3: METHODOLOGY

3.1 Overview

In the previous chapter I have extensively explored current international development policy and health systems frameworks to analyse shifts in the policy agendas towards building stronger health systems in developing countries. Also, I have developed an interactive exploratory framework to be used in my research for exploring aid contributions to health systems strengthening. Here, in Chapter 3 I will present the knowledge paradigm and methodological tools and approaches that I have used in the research.

The research uses a case study design to explore the contribution of development assistance to HSS in Mongolia. The thesis incorporates descriptive research in framing the case study, using documentary and policy analysis of development assistance and HSS in Central Asian Post-Soviet States with particular reference to the Mongolian health sector. As exploratory research—using documentary and policy analysis, key informant interviews and participant observation—it examines aid modalities and coordination mechanisms, exploring the use of the Health Sector Strategic Master Plan, and the less successful progress towards a SWAp as coordinating mechanisms. The extent of development assistance contribution to HSS has been further explored through key informant interviews and the analysis of donor financial reporting, comparing donor project data against the health systems priorities identified in the national health plan.

The chapter introduces i) the knowledge paradigm and theoretical frameworks used in Health Policy and Systems Research (HPSR), ii) the policy triangle framework used for the research, and iii) an overall methodology through which the research was conducted.

3.2 Knowledge paradigm for health policy and systems research

Social and political science uses descriptive, exploratory and applied research (134). Descriptive and exploratory research is often undertaken in order to extend the current stock of knowledge in a particular field, and is driven by the interest and expertise of the researcher. It is distinguished from applied research, which is designed to be problem solving, and expected to have an outcome with immediate relevance to the context being researched (134-136). This research employs both descriptive and exploratory approaches to shape theoretical aspects and principles in the current
development of donor assistance and HSS, with the impact of the research expected to be more incremental in shaping change over the longer term. An exploratory approach was used in investigating stakeholders’ understanding of health systems priorities, and the contribution development assistance to HSS in the context of the Mongolian health sector.

Researchers use knowledge paradigms to frame their understanding of reality and the functions and nature of research (137). Perspectives used in HPSR embrace a wider range of understandings of social and political reality compared to most health research, which often uses positivist perspectives, in which standardised and repeatable methodologies are commonly used, studying people and physical things using similar analyses (127, 137). Relativist social science perspectives are needed to investigate health policies and systems as these present complex social and political phenomena constructed by human action, rather than natural occurrence (137, 138). Table 3-1 below illustrates these three different research paradigms applied in HPSR based on the work of key HPSR researchers (127, 137, 139, 140). The key features illustrated in Table 3-1 position critical realism between the extremes of positivism and relativism, clarifying the key differences between these two differing views used in HPSR. I have adapted a table by Gilson (127) by adding definitions and the main features of these three distinctive research paradigms, as well as listing the disciplines related to each research paradigm from Gilson et al., and Cohen and Crabtree (137, 141).

The positivist approach is often used in biomedical and epidemiological research and operates on the basis that phenomena or issues of investigation of research exist independently of how they are understood and seen by people (127, 134). It often starts with hypothesis and uses a deductive approach, hence it would not be appropriate for my research with its more complex focus and inductive approach. The critical realist approach, which shares features of both objectivist and subjectivist paradigms, suits my research purpose well, as it has enough flexibility for new themes to emerge while being guided by the conceptual framework of the research.
Table 3-1: Research paradigms applied in Health Policy and Systems Research

<table>
<thead>
<tr>
<th>Knowledge paradigm</th>
<th>Positivism</th>
<th>Critical realism</th>
<th>Relativism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Positivists see a real world of objects apart from people and understand that the phenomena or issues comprise a set of facts that can be observed and measured</td>
<td>Critical realists understand that a real world exists apart from people but acknowledge that researchers can only know reality from their perspective of it</td>
<td>Relativists view phenomena as not existing independently of social actors, and reality as being in fact a social construction</td>
</tr>
<tr>
<td><strong>Types of questions addressed</strong></td>
<td>Is the policy-intervention cost-effective?</td>
<td>What works for whom under which conditions?</td>
<td>How do actors experience and understand different type of policies?</td>
</tr>
<tr>
<td><strong>Main features</strong></td>
<td>Often uses standardised and repeatable methodologies; applying mainly quantitative methods to the study of both people and physical things. Positivists mainly use quantitative methods</td>
<td>Generates theories that explain the social world and identifies the mechanisms that explain the outcomes of interventions. It uses both qualitative and quantitative methods.</td>
<td>Based on the interpretation of the interactions and the social meaning that people assign to their interactions. It mainly uses qualitative methods.</td>
</tr>
<tr>
<td><strong>Related disciplinary perspectives</strong></td>
<td>Epidemiology Welfare economics Political sciences and evaluation</td>
<td>Policy analysis Organisational studies Philosophy, social sciences</td>
<td>Linguistics Philosophy, literary criticism Political science Anthropology</td>
</tr>
<tr>
<td><strong>Key research approaches used</strong></td>
<td>Deductive-hypothesis driven Statistical analysis</td>
<td>Deductive and inductive</td>
<td>Inductive—theory building</td>
</tr>
</tbody>
</table>

Source: adapted from Gilson, Gilson et al., Cohen and Crabtree (127, 137, 141)

Based on the examination of the main features and application of the different paradigms, I have identified critical realism as appropriate for my research approach. Critical realists see the objects of research as discrete and measureable, but acknowledge that researchers can only know reality from their own perspective. The relativists takes this further, arguing that researcher’s values are implicit throughout the research, and that objectivity is not a realistic construct (141). Critical realism believes that we cannot separate ourselves from what we know, and is placed between the two paradigms and effectively used in policy analysis (127). As it answers the question “what works for whom under which conditions?” taking the surrounding context into consideration, it allows me to
investigate the current aid approaches and their contribution to health systems along with their operational conditions. Actors in aid and health systems, despite their influence on the policy and system, work within defined theoretical frameworks. As a result, a number of scholars advise the use of critical realism in public policy and health policy analysis (127, 142, 143) rather than relativism.

### 3.3 Theoretical framework for health policy and systems research

Theory is at the heart of qualitative research and the choice of theoretical approach to be used depends on the research question and the methodology chosen (134, 144). The theoretical framework will then shape the data collection and data analysis methods (134, 145). For this research, the key questions explore the intersection of three key issues: current global aid policies, aid modalities and coordination mechanisms; government and donor perspectives on HSS; and the extent of donors’ contribution to strengthening the health system. In addressing these questions, I accept the normative premise articulated in the Paris Principles that country ownership, leadership and coordination of development assistance enhance the relevance and effectiveness of the targeted aid and the health system more generally. But I also acknowledge that in this complex environment, OECD listed donors are not the only significant partners in development, and that much development activity does not take the form of aid – as pointed out by Severino and Ray (146) and during the Busan 4th High Level Forum on Aid Effectiveness (1). These recognitions highlight the need for a research framework that allows exploring the health policy process and content along with the surrounding context and actors involved. The policy triangle framework by Walt and Gilson et al. (147) is an appropriate theoretical framework, able to accommodate not only content but also actors, process and the surrounding context (Figure 3-1). This well-respected and commonly used framework allows flexibility in health policy analysis, defining the complex set of interrelationships in policy, and providing a generic framework onto which other dimensions and interrelations could be grafted (148).
Figure 3-1: Conceptual framework for exploring development partners’ contribution to Health Systems Strengthening (HSS)

Source: adapted from a model for health policy analysis by Walt and Gilson (35)

The interdependence of these four policy elements is essential for policy analysis: the actors are influenced by the context; the context is affected by factors such as values, societal principles, and political views; the process is influenced by the position and power of the actors; and the content of the policy reflects some or all of these dimensions (147, 148). This chain of linkages needs to be considered in every stage of policy analysis; from setting up research design and methods to actual data collection, analysis and the proposing of policy interventions and recommendations.

In development assistance in health, actors play a very important role. Actors referred to in this thesis include WHO, other UN agencies, development banks, bilateral and multilateral organisations, partners in GHIs, international NGOs, private sector and governments and sub-national authorities at the national level. The process of policy making is as important as those who are involved in policy development: how issues get onto the policy agenda; who is consulted in the formulation and design of policy; and how policies are communicated, implemented, regulated, assessed and evaluated (85, 148). In this research, I examine the process of development of the national Health Sector Strategic Master Plan (HSSMP), aid coordination and moves towards a
SWAp to health development; and the evolution of donor partners’ policies collectively through the Paris Principles, and individually in terms of their health aid commitments. Context is the environment within which policies are developed: it therefore shapes and is shaped by external stimuli such as the dynamic political and economic factors that impact on the Mongolian economy and its development (85, 149). Content refers to the object of policy and policy analysis (148, 150) and in this research case-study refers both to donors’ development assistance policies and the government’s policy on aid coordination and the health system.

Under the overall umbrella of the policy triangle framework, each component has its own theories or frameworks that guide the in-depth exploration of the theme. Table 3-2 shows the specific frameworks or theories/agendas that assist in exploring details of each of the policy triangle components. Health systems definitions, donor aid policies and trends that lead to HSS in the context of post-Soviet economies will underpin the theory used in the research.

Table 3-2: Theoretical frameworks corresponding to policy triangle components

<table>
<thead>
<tr>
<th>Policy triangle component</th>
<th>Specific research framework/theories/agendas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context:</strong> Drivers of health aid policies</td>
<td>Paris Principles, and High Level Panels on Aid Effectiveness</td>
</tr>
<tr>
<td></td>
<td>Global and national health aid governance and delivery system</td>
</tr>
<tr>
<td></td>
<td>Health sector reform</td>
</tr>
<tr>
<td><strong>Actors:</strong> Partners’ position and role for supporting HSS</td>
<td>Partners’ aid focus and approaches</td>
</tr>
<tr>
<td></td>
<td>Power relationship between various partners in supporting HSS</td>
</tr>
<tr>
<td></td>
<td>Partners’ perception of health system priorities</td>
</tr>
<tr>
<td><strong>Process:</strong> Exploring government and partners’ understandings of health systems priorities and planning</td>
<td>Health systems frameworks</td>
</tr>
<tr>
<td></td>
<td>Context specific HSS framework</td>
</tr>
<tr>
<td></td>
<td>Development of HSSMP and SWAp</td>
</tr>
<tr>
<td><strong>Content:</strong> Aid policies and modalities and country health system</td>
<td>Aid coordination mechanism</td>
</tr>
<tr>
<td></td>
<td>HSSMP</td>
</tr>
<tr>
<td></td>
<td>Donors development policy</td>
</tr>
</tbody>
</table>

Health systems definitions, donor aid policies and trends that lead to HSS in the context of post-Soviet economies will underpin the theory used in the research.
3.4 Methodological challenges in health policy research

The research design of this project has had to address the methodological challenges that are common to health policy research. There is limited methodological guidance on how to conduct policy analysis, and what research designs, framework or theories should best inform policy analysis (147, 148). The complex and dynamic nature of the health policy and system, coupled with context-specific features of policy issues, further complicate methodological difficulties (127, 151, 152). Nevertheless, recent initiatives in assisting health policy and systems research address these challenges. The Methodology Reader supported by the WHO Alliance for HPSR has been a useful guide for researchers in the area, especially those from LMICs (127). Also, three series of articles by key senior experts in the area of HPSR, commissioned by PLoS Medicine—Gilson, Hanson, Sheikh, Agyepong, Ssengooba and Bennett—critically explore current challenges in the health policy and research area and identify strategies and interventions needed to support local capacity in the area and support policy development and HSS (137, 138, 153). The first paper raises the need for multiple foci of enquiry and types of research questions, and a wide spectrum of methodological approaches in conducting HPSR (138). The subsequent papers highlight the importance of establishing an understanding across disciplinary boundaries and removing structural barriers that currently prevent the development of the HPSR capacities (137, 153). The key considerations for health policy research such as the danger of “disciplinary capture” and importance of multiple perspectives (138) have been kept in mind throughout the design, conduct and analysis of this research.

While conducting the literature review, I learnt that there is a lack of a common understanding about the different types of theoretical frameworks and research methods in the field of HPSR. This can lead to potentially inappropriate evaluations of research proposals, contradictory reviews of the same research paper and delays in the dissemination of the results. This has been documented in Bennett et al.’s article suggesting an agenda for action in building capacity and innovative approaches for conducting HPSR (153). I have attempted to overcome these methodological challenges through triangulating various methods (review of global and national health policy documents, key informant interviews, primary data collection and participant observation) and engaging relativist social science perspectives for identifying context-specific health systems framework and applying it to the study of donors’ contribution to HSS.

The majority of current HPSR has been funded by international agencies, hence there is a risk of a bias towards research driven by funding agency agendas rather than actual local need (153) which
may mislead health policy and systems research priorities. Policy research, unlike biomedical research, often requires longer timeframes, and rarely offers discrete interventions, but rather raises awareness of the complexities faced, with policy recommendations that will continue to need monitoring for impact. Being unaware of the nature of policy research can build unrealistic expectations from both researchers and funding agencies, with the resulting inaccurate expectations diminishing the importance and value of HPSR.

Lastly, there is continuing debate as to where any form of generalisation is possible from qualitative data generated in specific places and times (154, 155). While the findings of health policy analysis across different contexts may not be generalizable, nevertheless, their significance lies in their potential to inform similar contexts, with lessons learned being readily applicable.

3.5 Research design

This research is a health development policy case study, based on the Mongolian health sector with potential for lesson learning for similar post-Soviet contexts. The case-study approach allows a clear focus to inform health policy (156) on aid modalities, coordination and their contribution to HSS, recognising that this may reflect on wider health and development policy processes (157-159) particularly given the evolving role of aid and its coordination, and its interface with the overall management of information and resources in Mongolia.

3.5.1 Research methods

Exploratory qualitative research methods have been employed as they offer an opportunity to study the complex interrelationships between the donor and government and their interaction in supporting HSS.

The following Table 3-3 illustrates the logical relationship between the research questions, research objectives, methods to achieve the objectives, and rationale for choosing the methods selected.
### Table 3-3: Summary of research methods

<table>
<thead>
<tr>
<th>Research question</th>
<th>Objectives</th>
<th>Methods</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What changes have occurred recently in global aid agendas, aid modalities and global aid policies? 2. How have understandings of the health system and HSS developed?</td>
<td><strong>Objective 1:</strong> To explore current global aid polices, modalities and coordination mechanisms in the context of HSS (Chapter 2)</td>
<td>Extensive <em>documentary reviews</em> on aid coordination mechanisms and aid modalities in health and global aid policy shifts in supporting country health systems.</td>
<td>Documentary review offers an opportunity to explore and compare available peer-reviewed literature on aid modalities and coordination mechanisms and global aid policies. The critical analysis of non-peer reviewed documents improves the visibility of neglected or under-researched contexts and assists in minimising publication bias.</td>
</tr>
</tbody>
</table>
| 3. What is the extent and type of aid engagement in Central Asian Post-Soviet countries, and Mongolia in particular? 4. What aid coordination mechanism and aid modalities are operational in Mongolia in supporting HSS? | **Objective 2:** To analyse the current health sector aid coordination, mechanisms and capacity in the Central Asian Post-Soviet states, with a particular focus on Mongolia (Chapters 4 and 5) | *Documentary review and policy analysis* of relevant peer-reviewed and non-peer reviewed “grey” literature: health sector aid evaluation reports, Paris Declaration evaluation result at country level, project reports on the accomplishment of system performance, government-donor meeting minutes, joint sector review reports.  
**In depth interviews with key informants:** Government senior officials and key donors with experience of working in post-Soviet contexts have been interviewed to identify various aid modalities and aid coordination mechanisms and their contribution to the health system  
**Stakeholder analysis** clarifies stakeholder positions, approaches and activities in improving aid coordination and types of aid modalities  
**Participant Observation** through attending the aid coordination committee meetings and project launching and | Critical review of current peer-reviewed and non-peer reviewed “grey” literature contributes evidence to triangulate stakeholder accounts of aid contributions to HSS.  
Semi-structured key informant interviews provide access to stakeholder’s complex understandings of aid relations, aid governance and partners’ commitment and behaviour, complementing the limited published material on Mongolia and other Central Asian Post-Soviet states.  
Stakeholder analysis provides insight into donors and partners’ positions, power and behaviour in relation to aid coordination mechanisms and HSS.  
My previous experience working with the Mongolian MoH has allowed easier access to varied, relevant and current information, key |
| 5. How do government and development partners in health understand HSS? | **Objective 3:** To document and analyse government and donor perspectives and priorities for HSS in Mongolia (Chapters 6 and 7) | **Document review analysis**  
**In depth interviews** with government officials and key donors to find out how HSS is understood and supported | Literature review of global and local policy documents shaping national health systems strategies  
Semi-structured in-depth interviews with key informants allowed me to understand context-specific health systems priorities and challenges |
|---|---|---|---|
| 6. To what extent do the current development partners’ programmes and projects support HSS? | **Objective 4:** To critically examine partners’ contribution to HSS and determine the areas that need more support in order to achieve sustainable health system; (Chapter 8) | **Document review:** Review of various sources (IHME, WHO, NHA) of aid data, project completion reports, consultancy reports, and sector review  
**Analysis of project financial data:** Externally funded project data between 2000-2010 were collected and analysed against HSS framework identified  
**Analytical matrix** based on the HSSMP key areas has been used to examine donor project contributions to HSS | Project financial data had to be critically examined for its completeness, consistency and reporting format to enable comparison and triangulation with stakeholder interview data and my own participant observation |
| 7. How must aid approaches and aid coordination mechanisms change in order to strengthen the country health system? | **Objective 5:** Identify mechanisms and approaches through which government and development partners might collaborate effectively to strengthen the health system (Chapter 9) | Reflective policy analysis to suggest the most appropriate mechanism for government and development partners to collaborate to improve the health system | Synthesis and in-depth analysis of the findings of both global and local practices of aid coordination in relation to its broader socio-economic and political context enables feasible recommendations for effective collaboration between government and development partners |
Data for analysis has been collected through the methods listed in Table 3-3 above: documentary review and analysis, key informant interviews, stakeholder analysis and participant observation. The research has been facilitated by my previous eight years of experience working in Mongolia during 2003–2011, with the MoH and two key donor agencies: the Japanese International Corporation of Welfare Services (JICWELS) and the Asian Development Bank (ADB). The experience provided me with insight into the evolution of policy, and ensured easier access to information needed from policy elites and key stakeholders.

**Documentary Review:** This has consisted of a review of existing documents, both international and national studies, related to aid coordination, aid modalities, efforts to improve aid contribution to the health systems, and approaches and agendas for improving aid in order to improve its impact on HSS. The review has not been limited to sources published in English only; it included documents published in Mongolian and Russian as well. A total of seven sources (a mix of journal articles and reports) published in Russian and 11 sources (reports and hearings) published in Mongolian were used in the thesis.

The information obtained from the literature review has been used for i) formulating and refining research questions and objectives, research design and method; theoretical framework, and developing interview guides, and ii) responding to the research questions and objectives and comparing and analysing research data.

The literature review has been organised around two main categories of inquiry:

1. International experience in aid coordination, aid modalities and global aid agendas in supporting country health systems
2. Aid coordination and health systems in Mongolian and post-Soviet countries

Information on international experience in development assistance in health was retrieved by using the search databases Pubmed, Scopus, Web of Science, and Google scholar. The main key words used were ‘aid coordination’ ‘aid effectiveness’ ‘sector-wide approach’ ‘global health initiatives’ ‘vertical programmes’ ‘post-soviet countries’ ‘health systems’ ‘health systems strengthening’ ‘health policy’ ‘developing countries’ and the possible synonyms and various combinations of these words using ‘and’ ‘or’ were used. Also browsing aid organisations and event websites such as Organisation for Economic Co-operation and Development (OECD), Swiss Tropical Institute (STI),
Canadian International Development Agency (CIDA), Royal Tropical Institute, Netherlands, Eldis and Official Development Institute (ODI), Institution for Health Sector Development (HLSP), the High Level Forum on Aid Effectiveness provided extensive up-to-date sources of information. In addition to the overall literature review chapter (Chapter 2) that provides an overall global picture on development assistance and HSS, each thematic chapter (Chapter 4–8) has its own documentary review specific to the respective sub-themes of the research.

Given the limited data available from the peer-reviewed scientific literature, much of the specific information on aid in Mongolia and post-Soviet states was obtained through my personal contacts with colleagues from the MoH, donor organisations, consultancy reports and from government websites of the study countries, World Health Organisation (WHO), UN agency, bilateral donors and key NGOs’ country office websites. These included websites of the MoH and Ministry of Finance (MoF) of the Central Asian Post-Soviet (CAPS) countries, the National Center for Health Development of Mongolia, CAPS country office websites of WHO, World Bank (WB), Asian Development Bank (ADB), UNICEF and UNFPA and websites of the Open Society Forum and World Vision.

**Key informant interviews:** Semi-structured interviews were conducted with key informants including policy elites such as directors of the various departments of the MoH, MoF, resident and assistant representatives of the WHO, UN agencies and key donor agencies in health in Mongolia. Semi-structured interviews, by definition, are aimed at obtaining in-depth information on a particular issue from individuals (160, 161). The elite interview provides rich qualitative data about policy contexts that are not openly documented or accessible and gives privileged access to data interpreted through the eyes of the respective interviewees (162, 163). Open-ended questions formulated to address the research objectives of the study were used to guide the interviews.

Two different rounds of interviews were conducted. The first round of interviews was focused on collecting data regarding post-Soviet countries’ aid experience in health. The participants (n = 11) included purposively selected key informants with experience of working in the health sectors of Kyrgyzstan, Mongolia, and Uzbekistan; however, all were based in Ulaanbaatar, Mongolia at the time of interview. More details are provided in Chapter 4.

The second round of interviews had two purposes: i) to find out the role of the HSSMP in aid coordination, and ii) to identify context-specific HSS frameworks and donor contributions to HSS. The second set of interviews had 26 participants in total. Eleven of these interviewees had detailed
HSSMP experience, and they were interviewed specifically around the role of the HSSMP for aid coordination in Mongolia. Detailed information of key informants selected for these two purposes of the research has been provided in Chapter 5 and 7 respectively. Key informant interviews were done during the field work conducted between September to December 2012. Semi-structured interviews were chosen because these are generally more useful than quantitative surveys in eliciting information of a more sensitive nature (160, 161, 164). Aid coordination and donor-government relationship issues are sensitive, and need to be handled appropriately. Interview planning has important significance to the research findings. Planned approaches to identifying and gaining access to suitable candidates; agreeing on the interview location; obtaining consent for recording and transcription; following the interview guide and considering safety issues have been strictly followed.

All the study participants agreed to one-on-one interviews, and gave consent to audio recording and interview notes. Informed consent was obtained verbally at the beginning of each interview, following the format shown in the Annex 1. Signatures were sought from the respondents on the informed consent form. The majority of the interviews (n = 21) were conducted in interviewees’ offices and completed in a single sitting. Three interviews with international partners were conducted in non-work environments at their request and two interviews were conducted through Skype as the informants were travelling. Although an interview guide (Annex 2) was used to steer these semi-structured in-depth interviews, the mix of questions in each particular interview was prioritised according to the nature of the respondent’s involvement in the aid coordination process, and the time available for the interview. The interview time was 40–50 minutes. I conducted and transcribed all interviews. The interviews with the local officers (n = 13) were conducted in the local language Mongolian, with the remainder (n = 13) in English. All interviews were audio recorded and were translated into English. Both notes and records were brought to Australia for further analysis and record keeping.

My previous experience in elite interviewing gained through my previous employment in Government and donor organisations during 2003-11 was an advantage. The use of open ended semi-structured interviews allowed flexibility and new themes to emerge without losing the focus of the discussion. Specific concerns about how the results might be used and caution around being politically correct were taken into account during interviewing by ensuring anonymity of the interviewees and assurances that I was not engaged with any political and government organisations in Mongolia, and that findings would not be used for other than academic purposes.
A stakeholder analysis for the policy analysis (148, 165), was done through mapping out both active and passive actors engaged in health reform processes in Mongolia. It assisted in identifying the main actors in aid coordination in the Mongolian health sector and exploring their roles in formulating and implementing the aid coordination policy. Actors are not only limited by the current active donors but also by past donors and civil society members. The initial plan to include the private sector was no longer relevant following international private partners’ withdrawal from the health sector due to the changes made in the government law on external investors.

Donor project data: Major and key donors (N = 21) health data and reports produced between 2000-13 were collected and analysed in terms of its contribution to HSS. Inconsistencies in the various donors project reporting and data caused difficulties in categorising their contribution according to the health system components. However, the use of a HSS framework and classification and, where possible the disaggregation by areas of support and the amount of funding spent in different areas in supporting the health system, made it possible to draw some conclusions regarding partners’ input to HSS.

Participant observation: Participant observation complemented my other techniques, adding detailed information and insight about context and settings. My previous experience of participant observation was helpful for building rapport, breaking down distinctions between researcher and researched and obtaining insider perspectives (166). However, observation has its own limitations such as observer dependency, and the risk of misinterpretation of events. During my data collection period from September to December 2012, I attended health reform technical advisory group meetings (N = 2) and project review meetings (N = 3), which provided up-to-date information regarding government and partners’ relationships in managing their programmes and donor coordination. Observed events were not audio-recorded; notes were taken during the meetings, written up within 24 hours and subsequently analysed. Minutes of these meetings were obtained and supplemented the documentary review.

3.5.2 Positionality
My past experience working both with the MoH Mongolia and donor agencies, (JICWELS³ and Asian Development Bank) put me in an ambiguous position, both as an ‘insider’ and ‘outsider’. My proposal originated from an insider’s perspective; however, over four years of doctoral study at UQ, increasingly influenced by more global perspectives, my view has increasingly become that of an outsider. The advantage for this research is that I have an insider’s perspective and a deeper understanding of the Mongolian health system, but I was not seen as a total insider by the interviewees. As a former insider, but now removed from the immediate policy context, I was able to ask more complex and sensitive questions, yet I was able to recognise verbal and non-verbal clues as a cultural insider, which improved the accuracy of my research findings. On the other hand, because I have also worked as an outsider to the government, representing donor agencies, I had a fair understanding of donor strategies and behaviour when dealing with government officials, which helped to reduce the bias inherent to the insider position (147).

Nevertheless, aware of my potential insider bias due to my previous experience in aid coordination in the Mongolian health sector, I have made a conscious effort to explore and acknowledge my presumptions. Gilson and Raphaely (151) have shown that publication around health policy in LMICs is small, and often dominated by authors based in northern organisations: my insider’s perspective offers a balancing perspective on the few studies available around aid coordination effectiveness.

### 3.5.3 Sampling

Qualitative studies seek to better understand complex human, social or political issues, drawing lessons and experience from these, rather than generalising the results found (144, 167-169). Therefore, the number of research participants will vary for different research questions, and sample size is determined by the adequateness of the answers for the research question rather than the number of the respondents (167, 168). This adequateness is determined by purposive identification of informants, and observational scenarios, and the data saturation point where one finds that the emergence of new themes and explanations has stopped (167, 169, 170). However, in my study, key informants were selected purposively because of the particular contribution that they have to make. In these circumstances, data saturation point is less useful as an indicator, but adequateness of the answers for the research questions was a key to determine sampling.

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³ Japanese International Corporation of Welfare Services- Implementing agency of the Japanese Ministry of Health
The sampling strategies available to the qualitative study include (167, 169):

- Convenience sample: This sampling takes advantage of informants who are readily available, rather than seeking individuals more difficult to engage. It is least costly but may result in poor quality data as its selection is limited.

- Purposive sampling: Sampling that is based on criteria and the proportion of people from a given background. Used quite often in qualitative research.

- Opportunistic sampling: Sampling criteria are less strictly followed, with the identification of informants secondary to other considerations.

- Network/snowball sampling:
  - referral through study participants
  - may limit the diversity of respondents
  - strategic response: increases the number of sources.

- Theoretical sampling: A form of purposive sampling informed by data analysis, developing theoretical insights of the research problem, consciously choosing respondents to be included.

These methods are not mutually exclusive, rather they can be seen as complementary (167, 169, 170).

**Purposive sampling** is one of the distinctive methods of sampling in qualitative research (167, 170) and “aims at identifying and including in the study those information-rich cases that will provide a full and sophisticated understanding of the phenomena under study” (164). I have used purposive sampling as the main sampling method for my research. The criteria to select key informants were linked directly to the research questions and objectives. The selection of key informants for each objective was further explored during field work to allow more accurate selection of participants.

Nevertheless, the common **inclusion criteria** that have been applied in choosing participants are as follows:

- Representatives from all levels of health system: The hierarchical structure of the Mongolian health system was used to choose respondents as it allows having a voice from all levels

- The sample allows different perspectives and views: Public sector, private sector and civil society representatives
• The sample allows involvement of actors with both past and current experience: both long-established and new development partners have been included in the sampling

• The sample ensures adequate representation of all major donors active in the health sector.

In qualitative research, data collection and analysis are not sequential tasks but occur at the same time (160, 171) allowing the researcher to judge the sufficiency of data retrieved to address research questions, with the option of follow up interviews or extending the sample.

3.6 Data analysis

The qualitative research is rich, and a range of approaches and methods are available, depending on the focus and essential purpose of analysis (172). Data analysis options are dependent on the theoretical framework used, and need to be tailored to the method and research objectives being explored (172) (Table 3-4).

Table 3-4: Four main methods used in qualitative data analysis

<table>
<thead>
<tr>
<th>Methods</th>
<th>Features</th>
<th>Use in policy analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content analysis</td>
<td>Focuses literally on content by counting the occurrences of events or phrases used.</td>
<td>Less commonly used in policy analysis. It began as a statistical research method to count the number of certain words or phrases used.</td>
</tr>
<tr>
<td>Thematic analysis</td>
<td>Identifies themes in the data (173). It is seen as a foundational method for qualitative analysis. Divided into two main types: 1. Inductive thematic analysis (often used with grounded theory) 2. Theoretical thematic analysis.</td>
<td>Commonly used in sociology and policy analysis. However, because policy researchers are often bound (although this is context dependent) to certain frameworks, inductive thematic analysis may not often be as appropriate. But theoretical thematic analysis allows pre-established theories to drive the analysis hence effectively using both deductive and inductive approaches. This was used in my research in responding to Objective 2.</td>
</tr>
<tr>
<td>Narrative analysis</td>
<td>Interested in finding discovers how the essential ‘story’ provides insights about one’s experience in the social and political realm.</td>
<td>Commonly used in policy analysis, especially by experienced researchers. The narrative analysis has been used in analysing findings related to the research Objective 3 on government and donor perspectives for HSS in Mongolia.</td>
</tr>
<tr>
<td>Discourse analysis</td>
<td>Examines the way themes and narratives developed in this research interface with other social or ideological discourses and influences.</td>
<td>Commonly used in policy analysis. Elements of discourse analysis for example, interdisciplinary and problem-oriented approaches have been used throughout the research.</td>
</tr>
</tbody>
</table>

Source: adapted from Hansen, 2006 (172)
I have used theoretical thematic analysis, narrative analysis and some elements of discourse analysis in this research. Thematic analysis was chosen because it provides a required amount of boundaries such as context specific health systems framework in the case of my research. Discourse and narrative analysis provide a degree of flexibility (174) (147, 172, 175) needed for the policy analysis, allowing the emergence of new themes and interpretation of interactions between content, context and actors, which has been an important aspect of my research.

I have followed Pope et al. in their stages for qualitative data analysis as shown in Table 3-5 (171).

Table 3-5: Stages of the qualitative data analysis

<table>
<thead>
<tr>
<th>Stages</th>
<th>Data analysis process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarisation</td>
<td>Transcribing data</td>
</tr>
<tr>
<td></td>
<td>Reading transcripts</td>
</tr>
<tr>
<td></td>
<td>Reading field-notes, noting down initial ideas</td>
</tr>
<tr>
<td>Generating initial codes</td>
<td>Coding interesting features emerging from the data; collating data relevant to each code</td>
</tr>
<tr>
<td>Searching for themes</td>
<td>Collating codes into emerging themes; grouping the potential theme by the components of study themes using the guiding research framework (aid modalities and health systems frameworks are used in the case of my research)</td>
</tr>
<tr>
<td>Reviewing themes</td>
<td>Checking if the themes are working in relation to the coded extracts and the entire data set; Generating a thematic ‘map’ of the analysis</td>
</tr>
<tr>
<td>Defining and naming themes</td>
<td>Refining each theme by doing ongoing analysis</td>
</tr>
<tr>
<td></td>
<td>Refining overall story derived from the analysis</td>
</tr>
<tr>
<td></td>
<td>Generating clear definitions and names for each themes</td>
</tr>
<tr>
<td>Producing the report</td>
<td>Selecting vivid and compelling extracts that exemplify the analysis</td>
</tr>
<tr>
<td></td>
<td>Triangulation of analysis findings across the different sources of data, in this case literature review, key informant interviews, observation data and primary data</td>
</tr>
<tr>
<td></td>
<td>Produce scholarly report</td>
</tr>
</tbody>
</table>


While every effort was made to follow these steps to make the analysis process more accurate, comprehensive and manageable, in the actual setting the analysis was not as linear a process as described in the table. Rather, it was a reiterative process that needed critical thinking, revisiting coding decisions in the light of evolving patterns in the data.

Rather than use NVIVO data analysis software, I decided early in the analysis process to code and analyse manually. This has enabled me to retain my sense of the complexity of the data, avoiding
loss of nuanced meaning and “mechanistic” analysis of the data. Given that I was both responsible for the interviews themselves, their translation and transcription and subsequent analysis, it was more time-efficient for me to manage this data manually as the choice of NVIVO is dependent on the size of the study, funds and time available (176, 177).

Interviews held in Mongolian were translated into English and transcribed. I translated and transcribed all interviews while undertaking the data collection process. Interview findings were categorised according to the levels of participants within organisations (policy level, coordination level, and implementation level), type of organisations (Government agency, bilateral, multilateral, development banks), and topic (aid modalities and coordination approaches, ownership, harmonisation, contribution to the health systems frameworks, needs and suggestions for improvement). Coding and analysis were performed manually by mapping out the stakeholders and a matrix for emerging categories and themes in accordance with the generic conceptual framework used in the study.

Data from each theme or category were identified and analysed using the constant comparative method. Individual key informant interviews representing different types of donor agencies and government agencies were separately compared and contrasted with each other.

3.7 Research validity

Establishing trustworthy criteria for designing rigorous qualitative research is not straightforward and is diverse within the qualitative research domain. The aim of qualitative research is to gather ‘authentic’ understanding of people’s behaviour and experiences, and is dependent on the quality of the data, and the coverage of appropriate informants, rather than on the size of the sample (164, 178). In this study, a range of perspectives were explored and applied to ensure the validity of the study. I paid particular attention to the criteria proposed by Lincoln and Guba (179) for rigor in qualitative research:

- Credibility (internal consistency between the findings and interpretations): preliminary findings of the document review and anecdotal evidences were tested against the findings of the key informant interviews for consistency.
• Reliability (suitability of the methods; transparency of methods and analysis): A wide-range of similar types of studies and their choice of methods were explored. My own position has been clearly defined to allow others to judge if the study is confirmable. Each stage of the data collection and analysis has been presented in detail.

• Transferability: A clear outline of the study context, methods, sampling, data analysis and reports has been provided to allow the reader to decide if the findings can be transferred to other contexts.

In addition to these, I have ensured the representativeness of the sample by purposively selecting a range of actors from different organisational levels; recorded data comprehensibly, using audio recording and prompt transcription; examined any deviant findings inductively to understand how they triangulate with other sources; and ensured consistency in my data analysis to produce systematic and accurate findings (178).

In a complex study such as this, triangulation has been critical to establishing rigor. Triangulation is defined as “using multiple methods, researchers, theories or data sources for the purpose of confirmation or validation” (164). Two types of triangulation have been used in this study: triangulation of methods through obtaining similar data using different data collection methods (document review, observation and key informant interviews) and triangulation of sources through confirmation of results by different sources selected from different levels of the health system, and from international and government sources, and consultation with policy analysts experienced in the Mongolian health system.

3.8 Limitations

The research is mainly relied on the international experience of improving aid coordination and modalities in their contribution to HSS. There are a very limited number of publications and articles on external aid in Mongolia or similar post-Soviet health contexts and, as a result, the documentary analysis for this research relies on broader international experiences of aid coordination and modalities, and their contribution to HSS. The lack of studies and quality articles on the Mongolian health sector has limited the documentary evidence to compare past and current situations around
aid coordination. Also, poor records of aid data in Mongolia, especially lack of reporting the data prior to 2005, have served as a constraint for conducting comparative aid analysis. However, this study is an opportunity to fill the gap in health sector aid research and the insufficiency of such research reinforces the rationale and need for conducting research in the area.

3.9 Ethical considerations

Formal ethical approval and permission has been obtained from The School of Population Health Research Ethics Committee of the University of Queensland (Annex 6) in accordance with the National Health and Medical Research Council’s guidelines, and with the Ministry of Health, Mongolia before commencing the field work. The Ministry of Health provided full support and permission for the conduct of the research and the Vice Minister of Health issued a letter to support data access for conduct of the research (Annex 7).

Participant interview consent (Annex 1) was sought before the interviews, after briefing participants on the purpose of the study. Confidentiality and anonymity were strictly followed. Participants were reassured that their rights would not be affected by either participation or refusal to do so. No incentives were offered for compliance with the interview process.

3.10 Dissemination of findings

To influence policy and practice in the area of aid coordination and development effectiveness in Mongolia, the findings, conclusions and recommendations resulting from the research will be disseminated through reports and meetings with the key stakeholders such as development agencies, government officials, programme coordinators and policy makers. Initial results of the study sub-themes have been published in relevant peer reviewed journals. Findings have also been presented at international conferences.
3.11 Summary

The chapter has provided an overview of the knowledge paradigm for HPSR and the theoretical framework used for the research. The methodological challenges faced in conducting health policy research were presented. The study design and the details of data collection and analysis have been outlined; more detailed information about methods used for various parts of the research subcomponents are provided in the respective chapters (Chapter 4–8).

The overall conceptual framework, which was followed in exploring aid contributions to HSS, was derived from the literature review. Under the analytic framework of the policy analysis triangle described by Walt and Gilson (35), the study of context, content, and actors and process was examined.

The study employed qualitative research methods: document review, key informant interviews and participant observation as key methods for data collection. I have also used primary aid data collected during the fieldwork for triangulation of data findings obtained from different methods and data sources.

Data analysis has used a systematic approach which improves research accuracy and validity. Reflection and acknowledgement of potential bias and my perspective also contributes to the rigor of the study.

The following chapter turns to the one of the four sub-research themes of the thesis, analysing aid engagement in Mongolia and selected Central Asian Post-Soviet (CAPS) states.
CHAPTER 4: LOCATING MONGOLIA IN ITS DEVELOPMENT CONTEXT: CENTRAL ASIAN POST-SOVIET HEALTH SYSTEMS IN TRANSITION

4.1 Overview

The previous chapter introduced methodological tools and approaches applied in the research. Chapters 4 and 5 will introduce key research findings in the context of health sector aid in Mongolia and related post-Soviet countries and their policy implications on aid effectiveness. A comprehensive mapping of the key stakeholders in the health sectors of post-Soviet Central Asian countries was performed. The issues and challenges in development aid in health are best understood through exploration within their broader historical and socio-political context. For Mongolia, this has proved difficult. While it is part of the WHO Western Pacific Region, it has limited commonalities with Asian and Pacific states: its political and economic history is integrally linked to the former Soviet Union—its closest parallels are with the Central Asian Post-Soviet (CAPS) states. In this part of the thesis, I have identified the distinctive challenges that are unique to CAPS countries, and explored the modalities and pathways for aid development that have evolved as these countries have progressed towards democratic engagement. Given their history, and the highly centralised command economy of the former Soviet Union, the CAPS countries’ economies have been integrally linked to the Soviet economy, and until the 1990s, isolated from international linkages. Their health systems have similarly been shielded from analysis and interaction, and there is very limited health systems research available from the CAPS countries. Multi-actor relationships in health and development are also a new phenomenon in Mongolia and similar post-Soviet countries. Yet from a common social and political base, the CAPS countries have developed in quite distinct patterns, reflecting their relationship with the broader development process and their engagement with democratic processes. This research compares the broader socio-economic and political context, and the health sector challenges experienced by these countries during their transition; and has identified important factors that have resulted in two distinctive development trajectories evident over the past two decades. For Mongolia, its rapid economic growth, its commitment to democratic processes and governance, and its engagement with the development community have substantially shaped the development of its health system.

The research argues the importance of having a favourable political environment and good governance as a catalyst for improved development effectiveness. The analysis contributes to the
current research gap in the study and documentation of development aid and health system challenges experienced by CAPS countries, and offers some lessons and recommendations for improving development effectiveness for better health systems outcomes.

The chapter addresses the first part of Objective 2 which aimed to analyse the current health sector aid coordination, mechanisms and capacity in the CAPS states, with a particular focus on Mongolia. The chapter concludes with my reflection on the funded research call for LMIC researchers and its feasibility for post-Soviet countries’ researchers.

4.2 Central Asian Post-Soviet health systems in transition: has different aid engagement produced different outcomes?

Central Asian Post-Soviet health systems in transition: has different aid engagement produced different outcomes?

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Background: The collapse of the Soviet Union in 1991 resulted in a transition from centrally planned socialist systems to largely free-market systems for post-Soviet states. The health systems of Central Asian Post-Soviet (CAPS) countries (Kyrgyzstan, Mongolia, Tajikistan, Turkmenistan, and Uzbekistan) have undergone a profound revolution. External development partners have been crucial to this reorientation through financial and technical support, though both relationships and outcomes have varied. This research provides a comparative review of the development assistance provided in the health systems of CAPS countries and proposes future policy options to improve the effectiveness of development.

Design: Extensive documentary review was conducted using Pubmed, Medline/Ovid, Scopus, and Google scholar search engines, local websites, donor reports, and grey literature. The review was supplemented by key informant interviews and participant observation.

Findings: The collapse of the Soviet dominance of the region brought many health system challenges. Donors have played an essential role in the reform of health systems. However, as new aid beneficiaries, neither CAPS countries’ governments nor the donors had the experience of development collaboration in this context. The scale of development assistance for health in CAPS countries has been limited compared to other countries with similar income, partly due to their limited history with the donor community, lack of experience in managing donors, and a limited history of transparency in international dealings. Despite commonalities at the start, two distinctive trajectories formed in CAPS countries, due to their differing politics and governance context.

Conclusions: The influence of donors, both financially and technically, remains crucial to health sector reform, despite their relatively small contribution to overall health budgets. Kyrgyzstan, Mongolia, and Tajikistan have demonstrated more effective development cooperation and improved health outcomes; arguably, Uzbekistan and Turkmenistan have made slower progress in their health and socio-economic indices because of their resistance to open and accountable development relationships.

Keywords: aid effectiveness; health sector; Central Asian Post-Soviet countries; donor aid

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In 1991, 2 years after the fall of the Berlin Wall, the collapse of the Soviet Union radically transformed the political and the economic context in the Central Asian states previously dependent on the Soviet Union’s economy: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. Mongolia was similarly affected. Although not a member of the Post-Soviet Commonwealth of Independent States, it shares the same socio-political and economic history. The Union of Soviet Socialist Republics (USSR) provided one-third of Mongolia’s gross domestic product (GDP) prior to the collapse, and dominated Mongolian political decision making (1).

All former Soviet countries were hit hard; these countries experienced declines between 33 and 60% of GDP from 1989 levels reaching their lowest point in 1995–96. Uzbekistan had the lowest fall of 15% in GDP (2, 3). Public health spending as a proportion of GDP declined sharply for most Central Asian Post-Soviet (CAPS) countries, falling to between 2.1 and 3.5% of GDP during 1991–1996.
Tajikistan experienced the most precipitous decline in GDP because of its civil war, with health funding dropping from 6% of GDP in 1991 to only 1.1% in 1996 (4). Mongolia’s decline in health expenditure was less dramatic, falling from 5.7 to 4.4% of GDP in the same period (5), cushioned by inputs from external donors, who contributed nearly one-third of the GDP at that time (6).

Under such constrained circumstances, the provision of health services became challenging. Although the CAPS countries mirrored each other in many aspects of socio-economic development, institutional arrangements of health, education, and social-welfare systems (4, 7), early differences among these newly post-Soviet states were becoming apparent, especially in their relationships with donors. For all CAPS countries, the economic vacuum left by the withdrawal of Soviet support needed to be urgently replaced. Donor relationships expanded to include Western European and Nordic countries, Japan, the United States, and South Korea, and cooperation with the major multilateral agencies and development banks was established (4, 8, 9).

One of the factors that distinguished the different trajectories of health outcomes in these states since 1991 appears to be their engagement with these new donors. After 70 years of Soviet domination, CAPS countries did not have the experience to enter into collaboration and negotiation with multiple donors, and the capacity to do so was inextricably linked to their political transitions (4). Donors also needed time and expertise to adapt their development assistance portfolios to this new development challenge, engaging these hierarchical and less-transparent post-Soviet states. Early donor interventions included ad-hoc relief aid, humanitarian assistance, and small pilot projects (4, 10, 11). These multiple and uncoordinated projects increasingly created an administrative burden on the fledgling health ministries, causing an acute need for coordination (12–14). Limited local capacity resulted in international partners trying to drive health sector reforms and manage development coordination (15), though this was constrained by their differing agendas, incompatible financial and reporting forms and procedures. Without effective coordination, donors competed between themselves and with recipient governments over the human and financial resources (16, 17). The international advocacy for local ownership, harmonisation, and alignment that would be encoded in the Paris Principles on Aid Effectiveness (18) contrasted with the deeply centralised Semashko health systems model inherited from the Soviet Union, with its bureaucratic inertia, centralised management, and lack of transparency and accountability. The Semashko model had been established in the 1920s and was in operation throughout the Soviet Union until the early 1990s (19).

The model was characterized by its centralised planning and administration, government financing and provision of services through publicly owned health care providers, which were universally accessible and free at the point of delivery’ (19, p. 421). While the model ensured population coverage with basic health care, issues of efficiency and quality of care were not addressed. The model was largely curative in its focus with massive infrastructure costs that made it too ‘inappropriate and inefficient’ to meet the changing health needs of the population or the market economies of these emerging post-Soviet democracies (9, 12, 20–22).

Despite huge social and political changes, and the significant accompanying reforms in the health sector, research in these post-Soviet states has been neglected. This is reflected in the paucity of recent publications on health systems in these states, and the limited access of the international community to Russian language publications (15, 23, 24). In an analysis that compares publications to population size as a gauge of significance, CAPS countries’ health sector have been ranked as ‘least studied’ with only 0.16–1.71 publications per 100,000 population (24). We found no studies comparing the influence of development assistance on CAPS countries possibly because of these countries’ less aid experience. This research provides an analysis of the transition period from central control to democratic economies in selected low middle-income CAPS countries (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, and Mongolia), examining the role of development assistance in health since the Soviet Union collapse.

Methods

A multi-case study design (25) was used to examine development assistance in health in CAPS countries in relation to their broader socio-economic and political contexts. Three research methods were used: 1) extensive document review 2) key stakeholder interviews for in-depth understanding of both donors’ and governments position in aid coordination and its effectiveness; 3) participant observation based on the two authors’ (AU and TM) 10–15 years of experiences of working in health system reform projects in Mongolia and Tajikistan, respectively. The criteria for selection included their socio-political history as post-Soviet states, and shared regional Central Asian status. The comparability of their socio-economic and health indicators, disease burdens, types of health system, and political regimes at the point of the collapse of the Soviet Union provides a common base from which to observe changes in their socio-economic and political development, and their engagement with development assistance. Kazakhstan has been excluded from the analysis because of its prospering economy, limited requirement for development assistance, and early transition to upper-middle-income status.


Document review
Pubmed, Medline/Ovid Scopus and Google scholar search engines were used for peer-reviewed journals in English, Russian, and Mongolian using a combination of key words: ‘development assistance’, ‘external aid’, ‘donor assistance’, ‘aid effectiveness’, ‘sector-wide approach’, and ‘health sector’. The terms ‘Soviet countries’, ‘Central Asian countries’, and names of each country acted as a further filter.

Websites of international development institutions, public health research institutes, and ministries of health of each study country were also explored to examine various indicators, including those related to health status and other factors directly relevant to aid effectiveness and donor coordination such as the control of corruption, ease of doing business index, and geopolitical and economic influence. The country health reports and health sector strategies that documented these countries’ socio-economic change and health sector performance over the past two decades are mostly in Russian and Mongolian, and were accessed by AU, who is fluent in Russian, and a native Mongolian speaker, and TM, a native Russian speaker. In total, over 100 references published in English, Russian, and Mongolian were reviewed; out of these, 92 references were cited in the final review, comprising 78 in English, 7 in Russian, 7 in Mongolian. Data analysis and the writing of the manuscript were done in English.

Interviews
In-depth interviews were conducted with 11 purposively selected key informants with experience in Kyrgyzstan, Mongolia, and Uzbekistan. Informants were selected for their depth of experience across CAPS country health sector reform processes. This complemented the authors’ direct experience of Tajikistan (TM) and Mongolia (AU, PSH). A profile of key informant experience is provided in Annex 1.

All the interviews were face-to-face, with informed consent, and held in Ulaanbaatar, Mongolia, with two interviews conducted in Mongolian and the remainder in English.

Participant observation
Two authors (AU and TM) participated at the policy making level in the health sectors of Tajikistan and Mongolia from 1998 to 2011, providing direct experience of the changes that occurred during the transition period. Their involvement in donor-funded projects in health allowed the observation of project implementation challenges and the changes that occurred over time. Their engagement with government and donor projects, and their roles as both participants as well as researchers, has given them both ‘insider’ and ‘outsider’ perspectives, depending on the context (26).

Data analysis
Comparison of the quantum of development assistance in CAPS countries was undertaken using the proportion of aid compared to the burden of disease and the amount of Overseas Development Assistance (ODA) received per capita. Other comparative analyses included key socio-economic and health indicators; Paris Declaration indicators for aid effectiveness (Table 4); key informants’ interviews on CAPS countries’ health sector and role of the external aid and the use of the framework to explore evolutionary stages for donor coordination (Table 5).

Limitations
The limited published literature – even including Russian language sources – has constrained the depth of cross-country comparisons. Moreover, data for development assistance for health in CAPS countries are patchy and limited. Nevertheless, this has been compensated through triangulation with interviews and other sources of information (country reports, consultants’ reviews, OECD reports, donors’ evaluation reports, and government documents).

Findings and discussion
We begin with an overview of the socio-economic and health status since collapse of the Soviet Union. The significance of development assistance and aid delivery approaches is critically reviewed. We then identify the main actors involved and those factors that directly affect aid effectiveness are explored along with these countries’ progress on Paris Declaration indicators. Finally, aid coordination mechanism operations are explored to identify the maturity of the aid coordination in these contexts.

How has socio-economic and health status changed since the Soviet Union collapse?
Poverty has remained a persistent issue among the CAPS countries. As late as 2010, 46.9% of the population in Tajikistan were living below the national poverty line; in Kyrgyzstan, 31.7% fell under the poverty line (27). The IMF Country Report for Uzbekistan reports a poverty rate decline from 26% in 2005 to 20% in 2010 (28), and in Mongolia, despite its growing economy, the poverty rate remained at 39.2% in 2010, marginally increasing from 36.3% in 1995 (27). In Turkmenistan, information is limited, though a study undertaken by USAID indicated that in 2003, 58% of the population in Turkmenistan lived below the national poverty line (29).

Comparison of the quantum of development assistance for health in CAPS countries is patchy and limited. Nevertheless, this has been compensated through triangulation with interviews and other sources of information (country reports, consultants’ reviews, OECD reports, donors’ evaluation reports, and government documents).
shortage and inefficient management (19, 31, 32). Economic growth during 1990–2005 was unstable, with the substantial downturn causing social upheaval and lowering health indicators, and unemployment and poverty rates increased dramatically. External aid was urgently needed but did not immediately flow as needed during the early 90s (32), except in the case of Mongolia (6). Though Mongolia is currently a middle-income country, in 1999 it was one of the four most aid-dependent countries, with aid constituting more than 25% of GNI (6).

The overall pattern in health expenditure in four of the five countries has been similar, increasing slowly between 1995 and 2010, with the exception of Turkmenistan (Fig. 1). Tajikistan has the lowest health expenditure amongst the CAPS countries despite its high demand for investments in health (9). Both domestic and external resources need an increase. Nevertheless, Tajikistan made the highest progress in reducing maternal mortality from 120 to 65 during 2000–2010 (27, 33) even though the country spending on health is about half Turkmenistan’s spending. In contrast, despite its highest per capita health expenditure during 1995–2005, Turkmenistan has the poorest health indicators among CAPS countries.

Tables 1 and 2 compare key health and socio-economic indicators of these countries after two decades of the transition, comparing them with overall averages for low- and middle-income countries.

Overall, health indicators in CAPS countries compare positively with the averages for lower middle-income countries (LMICs) (Table 1), arguably as a result of the extensive health and education infrastructure and adequate human resources established during the socialist period. However, the data accuracy and reliability of post-Soviet information systems has often been questioned (9, 20, 22). Key health indicators have improved in all countries – though at different paces – from 2000 to 2010, with highest progress in the declining Maternal Mortality Rate (MMR) and Under 5 Mortality Rate (U5MR) observed in Tajikistan and Mongolia (27). This has been associated in some analyses with the increased donor aid in these areas and aid coordination efforts (9, 34). However, CAPS countries face major inequalities: the poor and rural populations are most affected (20, 22, 34). Turkmenistan has the second highest MMR and U5MR in this cluster, despite its recent move to upper middle-income country status: economic growth has not significantly benefitted population health. The Government of Turkmenistan has allocated the lowest percentage of GDP to health (2.5%), among the CAPS countries. Other CAPS countries included in the study spent 5.4–6.2% of GDP on health, which meets the WHO Commission on Macroeconomics and Health recommendation (35).

Their similar political and economic histories mean that socio-economic indicators (Table 2) of these CAPS countries do not differ much. Despite the challenges faced in the acute disruptions to their economies, none of the CAPS countries are failed states; in the after-shock, their government functions and services were severely downscaled but still continued (37–39). Unemployment is a relatively new phenomenon; in the Soviet Union, state enterprise guaranteed employment. Unemployment rose

![Fig. 1](https://example.com/fig1.png)

**Fig. 1.** Health expenditure per capita (in US$) in selected CAPS countries and averages of low-income and lower middle-income countries.

after the collapse of the Soviet Union with the closure of many factories and some health and education facilities with the cessation of Soviet funding (40–42). In the past decade, the development of the private sector has contributed to an increase in employment opportunities; nevertheless, unemployment is still quite higher in these countries compared to the LMIC averages (27, 43). Poverty is also disproportionally high in comparison with the unemployment rate. On the positive note, a literacy rate is consistently high in all these countries as a result of universal education policy during the socialist regime.

Among the CAPS countries, DALYs per 1,000 population are lower than LMIC averages, except Turkmenistan, which has slightly higher DALYs compared with upper middle-income country (UMIC) averages. The ‘double-burden’ of disease is present in all these countries with increasing dominance of non-communicable diseases over the last two decades and persisting communicable disease burdens (44). These post-Semashko model health systems continue to maintain higher numbers in their health workforce compared with other LMICs, and cost-effectiveness and quality of services continues to be a concern (15, 32, 45).

How significant has development assistance been?
The amount of ODA received by each of the CAPS countries varies considerably. Compared to other countries with similar levels of child mortality, life expectancy and health expenditure, all former Soviet countries receive very low development assistance for their health sectors (46). Kyrgyzstan, Tajikistan, and Mongolia’s aid per capita is relatively high, yet does not yield corresponding positive health outcomes, needing more effective aid coordination. Uzbekistan and Turkmenistan receive disproportionally low amount of aid compared to their overall burden of disease (27, 47), falling into the Very Low Aid Countries category despite their increasing poverty and evident needs for better performance (48). The remaining CAPS countries meet the Middle-Aid Countries criteria, yet the average external resources for health in these countries is lower than in other countries with similar levels of health indicators (46). The reasons for this are often explained by their political history, less openness and transparency in their organisational management culture. An international consultant reports:

Soviet style management by its nature does not promote information sharing, openness and transparency. When I started my work first time in Mongolia, then in Kyrgyzstan, the challenges I faced were very similar. Officers are afraid to provide health information and especially if it was about what is not working properly, they are extra cautious. It is definitely inherited from their

---

**Table 1. Central Asian Post-Soviet countries: GDP, ODA, and selected health indicators**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tajikistan (LIC)</td>
<td>$935</td>
<td>7.7%</td>
<td>6.1%</td>
<td>6%</td>
<td>63</td>
<td>65</td>
<td>63</td>
</tr>
<tr>
<td>Kyrgyzstan (LIC)</td>
<td>$1,075</td>
<td>8.7%</td>
<td>8.3%</td>
<td>6.2%</td>
<td>69</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Uzbekistan (LIC)</td>
<td>$1,546</td>
<td>10%</td>
<td>5.3%</td>
<td>5.8%</td>
<td>66</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Mongolia (LIC)</td>
<td>$3,056</td>
<td>4.7%</td>
<td>4.3%</td>
<td>5.4%</td>
<td>66</td>
<td>67</td>
<td>66</td>
</tr>
<tr>
<td>Turkmenistan (UMIC)</td>
<td>$4,722</td>
<td>0.8%</td>
<td>0.3%</td>
<td>2.5%</td>
<td>67</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>MIC averageb</td>
<td>$3,732</td>
<td>0.6%</td>
<td>0.2%</td>
<td>5.7%</td>
<td>66</td>
<td>67</td>
<td>66</td>
</tr>
</tbody>
</table>


**Note:** Low-income country (LIC) average; upper middle-income country (UMIC) average; lower middle-income country (LMIC) average; WHO = World Health Organization; WHO = World Health Organization.

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Citation: Glob Health Action 2014, 7: 24978 - http://dx.doi.org/10.3402/gha.v7.24978
**Table 2.** CAPS countries’ key socio-economic and health systems indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Total population (2012, WB)</th>
<th>Unemployment rate % (2010, WB)</th>
<th>Percentage of population living below the national poverty line (2010, WB)</th>
<th>Literacy rate (2010) WHO</th>
<th>DALYs per 1,000 population (total, all causes, all ages 2010, IHME)</th>
<th>Health workforce (2011) per 10,000* WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tajikistan (LIC)</td>
<td>8,000,900</td>
<td>11.6</td>
<td>46.9 (2010)</td>
<td>99.7</td>
<td>352</td>
<td>Physician: 18, Nurse: 44</td>
</tr>
<tr>
<td>Kyrgyzstan (LIC)</td>
<td>5,474,000</td>
<td>8.6</td>
<td>31.7</td>
<td>99.2</td>
<td>386</td>
<td>Physician: 19.6, Nurse: 61.2</td>
</tr>
<tr>
<td>LIC average**</td>
<td>N/A</td>
<td>5</td>
<td>49.1</td>
<td>N/A</td>
<td>599 (2012)</td>
<td>Physician: 2, Nurse: 6</td>
</tr>
<tr>
<td>Uzbekistan (LMIC)</td>
<td>28,541,000</td>
<td>11.4</td>
<td>20</td>
<td>99.4</td>
<td>336</td>
<td>Physician: 25.6, Nurse: 111.5</td>
</tr>
<tr>
<td>Mongolia (LMIC)</td>
<td>2,796,000</td>
<td>6.5</td>
<td>39.2</td>
<td>97.4</td>
<td>400</td>
<td>Physician: 27.6, Nurse: 35</td>
</tr>
<tr>
<td>Turkmenistan (UMIC)</td>
<td>5,173,000</td>
<td>11.4</td>
<td>58.2 (29)</td>
<td>99.6 (2010)</td>
<td>311</td>
<td>Physician: 23.9, Nurse: 44.2</td>
</tr>
<tr>
<td>LMIC/UMIC average**</td>
<td>N/A</td>
<td>5 (LMIC)</td>
<td>28.2 (LMIC)</td>
<td>N/A</td>
<td>454/291 (2012)</td>
<td>LMIC: Physician: 8, Nurse: 18, UMIC: 27/10,000</td>
</tr>
</tbody>
</table>

Sources: World Bank and WHO (27, 36).

*WHO estimates that countries with fewer than 23 physicians, nurses, and midwives per 10,000 population generally fail to achieve adequate coverage rates for selected primary health care interventions.

LIC** = low-income country; LMIC** = lower middle-income country; UMIC** = upper middle-income country.
long-standing culture of punitive management and it works against their effective collaboration with international partners.

Mongolia receives the highest ODA per capita amongst CAPS countries (Fig. 2), much higher than highly aid-dependent countries such as Cambodia and Mozambique with US$37.26 and US$76.82 ODA per capita, respectively (27). Tajikistan and Kyrgyzstan have made efforts to improve their aid coordination in the last few years, and consequently, they are attracting more aid since 2000. The low ODA per capita of US$6.9 USD in Turkmenistan and Uzbekistan is likely to be because of their bureaucratic governance and less open relationship with potential donors (49) rather than their being considered as self-sufficient, since both countries have significant levels of poverty (29).

While external assistance for health is not as high in monetary terms compared to other developing countries, the health reform processes in CAPS countries are highly dependent on the international technical assistance.

**How has aid been delivered?**

Globally, aid modalities have changed from mostly project-based vertical approaches to sector-wide horizontal approaches and budgetary support. These changes have been observed in three CAPS countries: Kyrgyzstan, Mongolia, and Tajikistan. The Paris Declaration principles have played a role in improving development aid practice in both donor and recipient partners.

**Aid modalities**

During early 2000, most of the aid provided to CAPS countries was delivered in project-aid form, important in salvaging failing health systems in the early transition, but less useful in terms of sustainable health systems strengthening. The project aid allowed rapid responses by donors to targeted, disease-specific issues – often with limited consultation with local policymakers. These multiple, short-term, ‘vertical’ disease-specific interventions, while often meeting their immediate objectives, increasingly created fragmentation, conflicting priorities, and additional administrative burdens for local authorities (46). As global trends moved towards more effective ways of delivering aid, more transparent and mutually accountable approaches such as programmatic aid and direct budgetary assistance have been strongly promoted by donors and welcomed in Tajikistan, Kyrgyzstan, and Mongolia. In fact, while these new aid relationships may not have had precedents for either donors or recipients, they have offered fresh opportunities for both to redefine their modes of operation. This has been less the case in Uzbekistan and Turkmenistan, where ‘vertical’ disease control projects, often led by UN agencies and global health initiatives continue to dominate development assistance (29, 50).

With the desire to coordinate development assistance and reduce the duplication and inefficiencies of project-aid, sector-wide approaches (SWAps) have been introduced in many LMICs. SWAps promote country leadership and effective collaboration of partners to support a single sector.

![Fig. 2](image.png)

*Fig. 2.* Net ODA received per capita (in US$) in selected CAPS countries and averages of low-income and lower middle-income countries.

policy envelope, and prioritise the strengthening of local capacity for managing programme implementation, monitoring, and evaluation (51, 52). Tajikistan, Kyrgyzstan, and Mongolia are moving towards a SWAp with varied progress (9, 12, 22, 53). Because of their long-standing culture of centralised administration, the SWAp, with its re-centralising tendency may be well-suited to post-Soviet countries. Informants saw significant advantages to SWAps where CAPS countries had already achieved middle-income status:

These countries should use their relative advantages such as less-dependency, negotiation power and political stability for the benefit of aid effectiveness. These advantages provide favourable environment for an effective SWAp, which is planned to be implemented some of these contexts. (UNICEF officer)

Tajikistan has not yet shown major progress in any of the key elements of SWAp (54) whereas Kyrgyzstan is progressing well, with strong donor coordination through this first health SWAp in a post-Soviet country (22, 55, 56), though parallel projects funded by various agencies also co-exist (22). In Kyrgyzstan, government allocations to health increased steadily since the government’s explicit commitment to a SWAp (27, 57). European Union donors have played a key role in the Kyrgyz health sector: since 2006, funds from key donors have been allocated within the framework of a SWAp. The National Health Reform Programme in Kyrgyzstan has recently been evaluated using the IHP+ framework for their Joint Assessment of National Strategies, facilitating donor collaborations.

The Mongolian health sector has seen the development of a clear national health plan, increased ownership and willingness to coordinate partners under this plan, providing a solid basis for a SWAp (58, 59). However, the SWAp momentum has not been maintained. The frequent turnover of senior Ministry of Health (MoH) staff has definitely slowed down the process, and donors’ reluctance or uncertainty about government procedures has tempered their enthusiasm (60). Interviewees from bilateral donors indicated that unless the government improves the transparency and accountability in its governance and financial management procedures, they will find it hard to commit to a SWAp despite the increasing government leadership and capacity over the process.

Budgetary support has increased in Mongolia from 29% in 2006 to 32% in 2010 (3, 61); in Kyrgyzstan, the baseline increased from 12 to 21% over the same time period, with Tajikistan reporting 8% budgetary support in 2010 (9, 55, 56). All three countries are still far from the OECD’s 66% target by 2010. There were no reports regarding direct budgetary support for Uzbekistan and Turkmenistan.

Who are the donors in health?
CAPS countries have relatively few donors in health [Table 3 (9, 12, 20, 22, 62, 63)] but still maintain their need for effective aid coordination (62, 64). Development assistance is said to be fragmented when there are more than 15 donors, between them providing less than 10% of the country’s programmable aid (65). The fragmentation of health aid causes burden to these health systems in transition and interferes with cohesive health policy process (12, 60, 62, 66). Three CAPS countries fall into this fragmented category: Tajikistan, Kyrgyzstan, and Mongolia. Table 3 shows number and type of health donors involved in CAPS countries.

Key informants were also concerned about some bilateral agencies’ unwillingness to commit to long-term capacity building initiatives such as SWAp. With the exception of some European donors and the German GIZ, bilateral agencies’ engagement in CAPS countries has been ad-hoc and short-term, without the necessary long-term development interest (49). Even where SWAps have been established, these agencies have continued providing project aid in parallel to the SWAp (55, 63, 66, 67). In the case of Mongolia, key supporters of the health SWAp have been ADB, UNFPA, and WHO. Development banks’ efforts have been more influential on policy directions in health. Non-Government Organisations (NGOs) in health are a new phenomenon in Central Asia, and have played a less significant role.

There are two divergent patterns for development assistance in CAPS countries. Tajikistan, Kyrgyzstan, and Mongolia have the higher numbers of various partners (9, 12, 22). Mongolia has been most successful in opening up its relationship with the United States, Japan and, the Western countries because of its earlier concrete political steps to democratisation (1, 68). In 1991, ODA reached its peak amounting to 165% of GDP in Mongolia, more than half of it coming from Japan, the United States, and Germany in the form of grants and soft loans to support infrastructure and social sector, including health (61, 69). Since then, ODA had been gradually decreased down to 18 and 4% of GDP in 2001 and 2009, respectively, in response to the mineral-resource-driven economic growth (61, 69). Nevertheless, the early fuelling of ODA had greatly supported Mongolia to overcome transition challenges.

The spread of aid actors in Uzbekistan and Turkmenistan has been limited. The limited involvement of aid actors in the two countries is, in part, due to their intransigent political regimes and neglect of human rights issues, as well as concerns about corruption (19, 29). The resistance to structural change and limited transparency has been a disincentive for development partners, though these are part of a more complex set of factors at play in development politics.
<table>
<thead>
<tr>
<th>Countries (ordered by income categories from the lowest to the highest)</th>
<th>Number of actors active in health (approximate estimate since 2000)</th>
<th>Bilateral agencies (ordered by relative size of ODA contribution)</th>
<th>Multilateral agencies</th>
<th>International NGOs</th>
<th>Global health initiatives</th>
</tr>
</thead>
</table>
| Tajikistan | 53 partners funded and implemented 97 projects (as of 2006) (62) | - DFID  
- European Union  
- SDC  
- SIDA  
- GTZ  
- DANIDA  
- USAID  
- CIDA  
- Italy  
- The Netherlands | - WHO  
- UNICEF  
- UNAIDS  
- World Bank  
- ADB  
- Agha Khan Foundation  
- European Bank for Reconstruction and Development  
- German Development Bank  
- Islamic development Bank | - Soros Foundation  
- ACT Central Asia  
- OXFAM | - Global Fund |
| Kyrgyzstan | 10–20 (not more than 10 in a given year) | - DFID  
- SDC  
- SIDA  
- USAID  
- GTZ  
- JICA  | - WHO  
- UNFPA  
- German Development Bank  
- UNICEF  
- Agha Khan Foundation  
- UNAIDS | - MSF  
- Red Cross  
- Soros Foundation (SF) | - Global Fund |
| Uzbekistan | Less than 10 since 1990 | - USAID  
- GTZ  
- JICA | - WHO  
- UNICEF  
- UNFPA  
- ADB | N/A | - Global Fund |
| Mongolia | 10–20 (had highest number of donors in the region in early 2000; past 5 years not more than 10 in a given year) | - USAID  
- Luxembourg  
- GTZ  
- Belgium  
- AusAid  
- Switzerland  
- Italy  
- JICA | - WHO  
- UNFPA  
- UNAIDS | - Open Society Forum (former SF)  
- World Vision  
- Norwegian Lutheran Mission (NLM) | - Global Fund, GAVI |
| Turkmenistan | Less than 10 since 1990 | - USAID  
- UNFPA  
- UNICEF | N/A  
| N/A | - Global Fund (TB only)  
- GAVI |

Sources: (9, 12, 20, 22, 62, 63) official websites of JICA, GIZ, DFID, World Bank, ADB, WHO, UN agencies, Agha Khan Foundation, World Vision, Soros Foundation, GF, GAVI.
The geopolitical positioning of the CAPS countries between Russia, China, and India has raised concerns that external donors' interests may be more geopolitical than developmental in motivation, and current political developments in former Soviet states underline this concern (49, 70). The landlocked position of CAPS countries, coupled with their rich mineral resources, make them attractive to the geopolitical interest (71–73) of both traditional and emerging donors. Russia, China and India, three of the BRICS nations have been active in business investment, but they have not contributed to development assistance in health in CAPS countries.

What factors influence aid effectiveness?
Aid is effective only where there is adequate transparency and accountability (74, 75). The extent of democratic reform from a planned economy towards a market economy in post-Soviet countries appears to be one of the key determinants of the levels of external partners' involvement (69, 76, 77), with the control of corruption, and the promotion of voice and accountability, linked to effective aid implementation as suggested in.

In each of the CAPS countries, the percentile ranking of the control of corruption (Fig. 3) has significantly fallen between 1996 and 2010, with the exception of Tajikistan. While Mongolia remains highest among the selected CAPS countries in terms of corruption control, by 2010 its ranking had fallen to almost half its ranking in 1996. Turkmenistan’s ranking has dramatically lowered from 36 to 2, and is now the lowest in terms of corruption control, lower even than Uzbekistan.

A similar tendency has been observed in the voice and accountability indices (Fig. 4); all CAPS countries’ rankings were lowered, except Tajikistan. Turkmenistan and Uzbekistan’s ranking has been persistently low among the selected CAPS countries, reinforcing the findings about the countries’ rather slow transition to democracy and openness.

The Ease of Doing Business index (Fig. 5) also contributes to the assessment of the robustness of aid environment. In 2011, Kyrgyzstan ranked the easiest (at 69) among the group, whereas Uzbekistan’s ranking was very low at 168, indicating the rather difficult environment for doing business in the country which further confirms its limited cooperation with donors. There was no indicator available for Turkmenistan, and no indicators for previous years were identified for the remaining countries.

It is widely acknowledged that quantifying aid effectiveness is challenging, and attributing its contribution to health system outcomes difficult to isolate from the complex of issues that impact broadly on health (78–80). Arguably, the process of development assistance should point towards long-term change, and the OECD has devised indicators against which donor conformity with the Paris Declaration on Aid Effectiveness (Table 4) might be measured. Though these are not confined to the health sector, they reflect the extent to which donors prioritise government leadership and processes, harmonise approaches with each other and align activities with government policy.

Fig. 3. Control of corruption index percentile rank comparison of 1996 and 2010. Source: World Bank databank (27).
All three countries have only 2–3 indicators for alignment and mutual accountability met out of 12 indicators for the Paris Declaration. As for the CAPS country health sectors, arguably these indicators would be slightly different in positive ways: ownership and alignment indicators for the health sector would show progress as preparation for and implementation of a health SWAp has improved MoH ownership and coordination capacity in Mongolia, Kyrgyzstan, and Tajikistan.

**Fig. 4.** Voice and accountability index percentile rank comparison of 1996 and 2010. Source: World Bank databank (27).

**Fig. 5.** Ease of doing business index. Source: World Bank databank (27).
We have extrapolated the current directions of aid coordination, observing a transition from ‘Donor coordination’ to ‘Development Partnerships’ as trade relationships progressively displace aid relationships, while still requiring a level of government coordination. Since the 4th High Level Forum on Aid Effectiveness in Busan (82), the understanding of aid coordination processes has broadened its scope beyond aid promoting country ownership and sustainability (82, 83). The implications of this paradigm change have been progressively reflected in the aid coordination of CAPS countries.

CAPS countries are located across the three evolutionary stages of aid coordination steps articulated by WHO (Table 5) in a framework for aid coordination. In this table adapted from WHO, we envisage a transition into a fourth stage as foreshadowed at Busan Forum.

<table>
<thead>
<tr>
<th>Ownershipa</th>
<th>Operational development strategies</th>
<th>2010 Target</th>
<th>Actual</th>
<th>2010 Target</th>
<th>Actual</th>
<th>2010 Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliable public financial management (PFM) systemsb</td>
<td>3.5</td>
<td>3.5</td>
<td>4.5</td>
<td>4</td>
<td>3.5</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Reliable procurement systemsc</td>
<td>No target</td>
<td>N/A</td>
<td>No target</td>
<td>N/A</td>
<td>No target</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Aid flows are aligned with national priorities (aid on budget)</td>
<td>85%</td>
<td>24%</td>
<td>85%</td>
<td>19%</td>
<td>85%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Strengthen capacity by coordinated support</td>
<td>50%</td>
<td>81%</td>
<td>50%</td>
<td>81%</td>
<td>50%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Use of country PFM systems</td>
<td>35%</td>
<td>32%</td>
<td>66%</td>
<td>27%</td>
<td>No target</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Use of country procurement systems</td>
<td>No target</td>
<td>28%</td>
<td>No target</td>
<td>21%</td>
<td>No target</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Aid is more predictable</td>
<td>83%</td>
<td>44%</td>
<td>74%</td>
<td>30%</td>
<td>No target</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Aid is untied</td>
<td>More than 94%</td>
<td>77%</td>
<td>More than 86%</td>
<td>82%</td>
<td>More than 78%</td>
<td>66%</td>
<td></td>
</tr>
</tbody>
</table>

Harmonisation

| Use of common arrangements or procedures (programme-based approaches – PBAs) | 66% | 21% | 66% | 32% | 66% | 8% |
| Joint missions | 40% | 20% | 40% | 10% | 40% | 22% |
| Joint country analytic work | 66% | 22% | 66% | 21% | 66% | 50% |

Managing for results

| Results-oriented frameworks | B or A | C | B or A | C | B or A | C |

Mutual accountability

| Mutual accountability | Yes | Yes | Yes | Yes | Yes | No |

Note: Mongolia and Kyrgyzstan participated in both surveys conducted in 2006 and 2011. Tajikistan participated in the 2011 survey only, whereas Uzbekistan and Turkmenistan did not participate in the survey. Indicators below two scores of the target achievable are in Red and those achieved or near to achieving are in Green.

Source: OECD (81).

aScored from A to D: A - highest, D - lowest.
bRated on a scale of 1 (low) to 6 (high) in half-point increments (0.5). A score of 1 corresponds to a very weak performance and a score of 6 to a very strong performance.
cNo target – Indicates that the indicator was not included in the previous monitoring survey in 2006.

There is a lack of government-led aid coordination mechanisms in Turkmenistan and Uzbekistan. The UNDP takes the lead in an aid coordination role in Uzbekistan, and in Turkmenistan, the International Technical Assistance Coordination Unit under the Ministry of Finance is responsible for managing EU projects and programmes nationally (86).

Tajikistan, Kyrgyzstan, and Mongolia have had positive outcomes since 2005 in the coordination of donors and allocation of the aid flows (9, 12, 22). In Tajikistan and Mongolia, aid coordination units have been established within the MoH, initially led by the WHO, but progressively shifting to the MoH (54, 62). The most promising fact is that the government itself is actively involved to coordinate aid and promote the SWAs in these countries (54, 58), and contrasting with contexts where development partners have driven the SWAs process, undermining country ownership (87).
**Table 5. Aid coordination stages and their features**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Characteristic</th>
<th>What is the expected outcome?</th>
<th>Dominant form of aid modalities</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage one: Donor coordination</td>
<td>Main drive comes from the donors; government is passive as there are no systems to engage with the donors in policy dialogue.</td>
<td>Improved coordination of development partners</td>
<td>Donor-led projects</td>
<td>Uzbekistan-UNDP takes the lead role in aid coordination and EU is also involved in coordination of technical assistance programmes implemented jointly with other international partners (84) Turkmenistan – EU takes the lead role in aid coordination. Tajikistan: government is increasingly aware of the importance of taking the lead role in aid coordination and is gradually taking the role formerly held by WHO (62).</td>
</tr>
<tr>
<td>Stage two: Aid coordination</td>
<td>Increasing proactive engagement of government counterparts; establishment of aid coordination mechanisms</td>
<td>Improved aid effectiveness</td>
<td>Projects may still be dominant but better aligned with national priorities; initial SWAp steps could be taken; government increasingly takes the role for aid coordination</td>
<td>Mongolia SWAp readiness exists, but without much progress since 2006; MoH has established a structure for coordinating external resources in accordance with its own priorities listed in the HSSMP. HSSMP mid-term review was undertaken using JANS. Kyrgyzstan: Kyrgyz MoH was the first of its kind to implement SWAp in former Soviet countries and demonstrated SWAp’s relevance and success to post-soviet contexts when applied appropriately (55, 66); National Health Reform Programme evaluation was undertaken using JANS. None of the countries has established public-private partnership (PPP) in health. However, in other sectors, mostly in business sectors, public-private partnerships are under discussion in Mongolia and Kyrgyzstan.</td>
</tr>
<tr>
<td>Stage three: Development coordination</td>
<td>Government increasingly takes the initiative in policy dialogue; establishment of effective mechanisms of both government and external resources.</td>
<td>Improved development effectiveness; improved performance of the system</td>
<td>A SWAp; government-led aid coordination mechanism; possibly, budget support</td>
<td></td>
</tr>
<tr>
<td>Stage four: Development partnerships</td>
<td>Private/trade partners share roles and responsibilities.</td>
<td>Improved development effectiveness; trade relationships replace aid; improved governance (transparency and accountability).</td>
<td>Public-private partnership; there is no longer donor-recipient relationship; corporate sector’s role in development still to be determined. (85).</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from WHO (62).
The development of a national health plan under government leadership has played an important role both in Kyrgyzstan and Mongolia in shifting aid from donor-driven aid projects to country-led programme support (55, 60) and in promoting capacity building amongst health policy makers (55, 58). With the development of their national health plan, Manas Taalimi 2006–2010, the Kyrgyz health sector has officially launched a SWAp greatly improving aid coordination (74).

As a result of a successful SWAp in Kyrgyzstan, the alignment and harmonisation with government policies in the health sector has been improved, and use of country systems have been increased from 3% in 2005 to 14% in 2007 (88); the health sector attracted more donor funds than ever (56). One of the key conditions set by external development agencies for disbursing funds within the SWAp framework was an annual increase of 0.6% in the state health budget as a percentage of total state expenditure. Total expenditure on health accounted for 6.4% of GDP in 2008, which meant that Kyrgyzstan was spending a higher share of GDP on health than many other countries of the former USSR (22). Supporting factors such as an inclusive policy process, a changing political environment and efforts to promote good governance were the key not only for success in the SWAp, but also in the overall health system, making the country a regional leader in the health system reform process (55).

In Mongolia, the largest health projects by ADB fully support the implementation of the Health Sector Strategic Master Plan (60). But a need for more effective coordination in CAPS countries still exists; aid coordination should guide donors towards health system's strengthening (60, 89). Early public–private partnerships (PPP) are emerging in Mongolia and Kyrgyzstan, although they are in a very early stage of maturity, and an appropriate legal framework and institutions to attract partners in PPP is needed (90, 91).

Conclusions

Despite commonalities at the start of the post-Soviet era, CAPS countries developed two distinctive trajectories due to their differing politics and governance. Kyrgyzstan, Mongolia, and Tajikistan have demonstrated better prospects for effective development cooperation and improved health outcomes. However, in Uzbekistan and Turkmenistan, their control-oriented management culture and opaque management processes, appear to have discouraged the engagement of effective development partners, and as a result, have hindered development cooperation.

The influence of donors, both financially and technically, remains crucial to health sector reform despite their relatively small contribution to overall health budgets. As a result of the existing health infrastructure and human resources established under the Soviet system, the CAPS countries have had the potential to achieve better health outcomes in a relatively short time, if the right reform processes are undertaken under the right leadership. This will also need the engagement of political elites and partners to improve issues beyond the health sector. The studies of CAPS countries suggest that regardless of current economic status, resistance to developing more open and accountable relationships with the donors can result in systems stagnation, and slow progress to improve health and socio-economic indices. Factors that influence aid effectiveness such as control or corruption, voice and accountability have not shown much progress in the past 10 years, which had been reflected in the slow progress in Paris Declaration indicators. The key lessons from our analysis of the development of aid relationships in health in CAPS countries are that:

1. **New aid relationships could offer new opportunities for both donors and recipients.** Neither governments nor donors had any experience of working together in CAPS countries prior to the collapse of the Soviet Union. The positive outcomes for Tajikistan, Kyrgyzstan, and Mongolia who were quite receptive to the new relationships, have been significant, compared to the less open and transparent Uzbekistan and Turkmenistan.

2. **Fewer partners do not necessarily mean less fragmentation.** Even where there have been limited numbers of donors, overlap and duplication of the projects being implemented, and their parallel management mechanisms, have resulted in administrative and capacity burdens to local systems. With health system reform processes in these countries requiring a paradigm shift at every level of the system, donor coordination is critical, regardless of the number of donors.

3. **Aid modalities chosen must reinforce ownership and sustainability.** While the diversity of donors, policies, and approaches makes it difficult to preference any single aid modality, using local systems, local management, and governance is a key to sustainable development. Where project aid continues, it needs to be aligned with national priorities, and effective coordination by the government is critical to ensuring its contribution to health systems strengthening. Country-led capacity building processes also remain crucial, as was evident in the health sector plan development in Tajikistan, Kyrgyzstan, and Mongolia.

4. **Aid coordination beyond the health sector is needed to bring real development effectiveness for health.** Many factors outside health affect development effectiveness: the broader political context, governance, management culture and capacity indirectly affect health outcomes and systems development.
Development effectiveness requires its own time for in-country capacity building, and the lack of absorptive capacity remains a challenge, especially in contexts such as Mongolia and Turkmenistan, where economic growth has occurred in a relatively short time. In these contexts, capacity shortage, if not resource shortage, remains as an issue, necessitating continued technical assistance.

Conflict of interest and funding

The authors declare no competing interests. This research was conducted as a part of AU’s PhD research funded by Endeavor Awards Program, Australia.

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Annex 1. Representation of the key informants

<table>
<thead>
<tr>
<th>Parent Institution</th>
<th>Kyrgyzstan</th>
<th>Mongolia</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Asian Development Bank</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>UNICEF</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GIZ</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>District Health Centre</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Annex 2. Abbreviations used in Table 2

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AusAid</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>DANIDA</td>
<td>Danish International Development Agency</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
</tr>
<tr>
<td>GTZ</td>
<td>Gesellschaft für Technische Zusammenarbeit (German Technical Development Agency, now renamed as GIZ)</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins sans Frontières (Doctors without Borders)</td>
</tr>
<tr>
<td>NLM</td>
<td>Norwegian Lutheran Mission</td>
</tr>
<tr>
<td>SDC</td>
<td>Swiss Agency for Development and Cooperation</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
The commentary has been written to express my frustrations of locating the CAPS in the broader development context, especially when it comes to health systems research. Lack of relevance and feasibility of the research calls funded by international agencies could serve as an obstacle for generating health systems research within the context of post-Soviet countries, where availability of published research is already so limited.
A week ago, I (AU) received an email from a colleague at the Institute of Tropical Medicine (ITM), Antwerp informing me and other young researchers about a call for implementation research focusing on maternal, newborn and child health in Low and Middle Income Countries (LMIC) issued by WHO's Alliance for Health Policy and Systems Research and UNICEF. It is an appealing call as it intends to address issues affecting maternal, new born and child health, still a huge problem in many developing countries (including Post-Soviet countries, where we come from). Yet, our initial excitement about this very relevant call disappeared as we read through the Eligibility Criteria.

The excerpt is as follows:

ELIGIBILITY CRITERIA

The Principal Investigator must be an individual in a low or middle income country directly or indirectly involved in the implementation of health interventions for maternal, newborn and child health. Program Managers, District Health Officers, front line health workers are typical examples of such individuals. Please note that this condition must be met for the proposal to be eligible for funding.
These “Eligibility criteria” immediately sounded like “Elimination criteria” to us. Just looking at our respective country contexts (Mongolia, Uzbekistan, Kyrgyzstan), we could not think of any person who is working in the field, yet able to write a research proposal in English and work as a Principle Investigator to implement a US$100,000 research project within a period of 12 months. In reality these people are just too overwhelmed by their day-to-day work, both clinical and managerial tasks, seasonal outbreaks etc. Some do not even have the time, nor access or the skills and knowledge to use cyber technology. In most cases, practitioners in LMIC are not researchers and vice versa. We acknowledge the Call encouraged collaboration with local researchers: “Implementers, particularly if they are not trained in research methods, are encouraged to collaborate with researchers from an academic institution or research institute based in the study country.” However, ultimately it is the principal investigator who is expected to run the research, NOT the collaborator. The fact that there will be expert facilitators and a protocol development workshop to help research teams is very encouraging, too. But again, the earlier stages of the process are very challenging, at least for practitioners from post-Soviet countries (before they get to these stages where more support is foreseen).

As mentioned above, I (AU) received the Call announcement from the Emerging Voices email network run by ITM and shared it with my colleagues from the same region. It made me and my colleagues question other issues (especially related to logistic and infrastructure capabilities) as well. How many of the District Health Officers (DHO) or front line health workers in LMIC have access to a Research call announcement? And even if they have access, how many of those from non-English speaking countries will be able to understand English and be able to work as a Principal Investigator? If the Call announcement were disseminated through the local offices of UNICEF and WHO, translated into the local languages, the right people would be able to gain access to it and could respond to the Call in a timely manner.

However, as already mentioned, we acknowledge the Alliance's intention to promote collaboration between practitioners on the field and research institutions. Moreover, the condition stating “...not more than 25% of the total grant value can go to individuals or organizations based in high-income countries” further supports home-grown research capacity building. But the Call's rather prescriptive approach in “appointing” a Principal Investigator somewhat limits many potential research opportunities for Post-Soviet countries. And anyhow, selection and appointment of team members should be an in-country issue, we feel, as local experts know the competences and areas of expertise of their own people better. Instead of being prescriptive about ‘who should do what’, the call should thus have focused more on the content and quality of the research proposal, also with a view on addressing broader system problems such as financing, organising and delivering of MCH services.

The Call may be more applicable to a number of African countries, where the British colonial and educational influence is obvious in the language and ways of operation of the health sector. It is very unlikely, though, that practitioners working in Post-Soviet countries such as Mongolia, Kyrgyzstan and Uzbekistan would succeed to receive a grant from the call. And this is a pity, as these countries definitely have many experiences to offer and lessons to be shared for more effective implementation of existing maternal and child health programs. Unfortunately, as often is the case in health systems research (HSR), these countries will remain ignored. When it comes to HSR, the Post-Soviet region is extremely underrepresented and often overlooked. Hoffman et al confirmed that HSR in the Post-Soviet countries is heavily neglected, by and large. All Central Asian Post-Soviet countries (Kazakhstan, Kyrgyzstan, Mongolia, Tajikistan, Turkmenistan and Uzbekistan) are included in the list of 25 countries with the fewest (0.16-1.71 publications/100.000 population) number of publications in health over the past 15 years (McKee et al., 2012). However, not knowing about the problem does not
mean that the problem does not exist.

As we said before, it would be a pity if research calls from the Alliance/UNICEF or any other health systems research related initiatives left our challenges and experiences unheard, due to a lack of in-depth understanding of the reality on the ground. Post-Soviet countries are part of the (health systems research) world!

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CHAPTER 5: STRUCTURAL MECHANISMS FOR COORDINATION: THE HEALTH SECTOR STRATEGIC MASTER PLAN AND PROGRESS TO A SECTOR-WIDE APPROACH

5.1 Overview

In the previous chapter I have analysed health sector aid and coordination mechanisms, and their impact on the health sector in CAPS states, with a particular focus on Mongolia. The chapter demonstrated the contribution that effective governance brings to better aid coordination and development. This chapter now further explores how the purposive use of a MoH driven planning process—the Health Sector Strategic Master Plan (HSSMP)—served as a mechanism for coordination of donor activities within the health sector in Mongolia. It illustrates the importance of local ownership in the coordination of donor resources and activities, and the alignment of these in health systems strengthening. It then examines the potential role of SWAp, built on government ownership and a comprehensive planning envelope, to achieve health systems goals, and in particular, progress towards Universal Health Coverage (UHC) in Mongolia.

The MoH in Mongolia initiated the process of developing its HSSMP using a comprehensive consultative process, actively managed by the MoH. Among other objectives, the MoH sought to coordinate the disparate and fragmented inputs from key donors through the HSSMP, aligning them with the Master Plan’s structure. The use of working groups headed by experienced MoH personnel was critical to the ownership and sustainability of this plan. The engagement of donors was on the basis of their technical expertise, rather than their political influence, consolidating alignment of their projects. As such, the HSSMP has played an important role in improving aid coordination in Mongolia and there are valuable lessons learned for the wider international development community. The largest and most influential programmes by key donors in the health sector are now largely in line with HSSMP strategies, thus enabling the MoH to use these opportunities to achieve its health sector outcomes. However, challenges remain in maintaining the momentum and effective governance established during the early implementation phase, critical to sustaining the level of motivation and conserving institutional memory. The HSSMP provided a coherent and consistent positioning within the MoH, which is essential in coordinating donors, who, as will be shown in subsequent chapters, are committed to the rhetoric of the Paris Principles, but not always consistent in their application of them.
I then explore the potential contribution of a systemic, coordinated, sectoral strategy—the SWAp—to harness international development assistance in achieving UHC in Mongolia. The analysis focuses on the root factors hindering the achievement of UHC and examines how these affect systems and local capacity critical for achieving UHC. Two principally different approaches, a sector-wide (holistic) approach and a standalone project (fragmented) approach are compared in terms of their contribution to the main indicators of achieving UHC. The SWAp is a promising instrument that promotes a systems-strengthening and capacity-building approach and enables effective aid coordination to achieve a system’s objectives.

This chapter provides a comprehensive analysis of Mongolian health sector aid coordination and the advantages and potential opportunities that coordination offers to improve the country’s health system. Yet this coordination needs a shared understanding of health systems priorities and a shared approach to resource allocation for HSS. The chapter that follows will examine how HSS is understood by various actors in health, and sets the stage for exploring development partners’ contributions to HSS in Mongolia.

5.2 "In the driver's seat": the health sector strategic master plan as an instrument for aid coordination in Mongolia.

“In the driver’s seat”: The Health Sector Strategic Master Plan as an instrument for aid coordination in Mongolia

Anar Ulikpan¹*, Indermohan Narula², Asmat Malik³ and Peter Hill¹

Abstract

In 2005, the Ministry of Health (MoH) in Mongolia initiated the process of developing its Health Sector Strategic Master Plan (HSSMP), using a wide-ranging consultative process, driven by the MoH, and requiring participation from all levels of health facilities, other ministries, donor agencies and NGOs. Among other objectives, the MoH sought to coordinate the disparate inputs from key donors through the HSSMP, aligning them with the Plan’s structure. This research explores the extent to which the HSSMP process served as a mechanism for effective aid coordination while promoting ownership and capacity building and the lessons learned for the wider international development community. The study is based on document review, key-informant interviews and authors’ experience and participation in the MoH planning processes. The HSSMP process improved alignment and harmonisation. It enabled a better local understanding of the benefits of aid coordination, and the recognition that aid coordination as not only a mere administrative task, but a strategic step towards comprehensive management of both domestic and external resources. The process was not challenge free; the fractious political environment, the frequent turnover of key MoH staff, the resistance of some donors towards MoH scrutiny over their programmes and the dismantling of the central coordination and return of seconded staff following completion of the HSSMP, has slowed the pace of reform. Despite the challenges, the approach resulted in positive outcomes in the areas of ownership and better aid coordination, with HSSMP development emphasising ownership and capacity building. This contrasted with the usual outcomes focus, and neglect of the capacity building learning processes and structural and policy changes needed to ensure sustainable change. The largest and most influential programmes in the health sector are now largely aligned with HSSMP strategies, enabling the MoH to utilize these opportunities to optimise the HSSMP outcomes. The lessons for Ministries of Health in similar Post-Soviet countries—or other emerging economies where government capacity and local policy processes are relatively strong—are clear: the development of solid governance and technical infrastructure in terms of planning and evaluation provide a solid structure for donor coordination and insure against local political change.

Background

In 2005, the Paris Declaration on Aid Effectiveness was endorsed by more than 100 signatories—from donor and developing-country governments, multilateral donor agencies, regional development banks and international agencies—with the commitment to improve aid effectiveness and the harmonization of development [1]. The Declaration asserted partner countries’ ownership over their own development policies, alignment, harmonization, results and mutual accountability as working principles for effective aid [1]. But despite the explicit emphasis on local leadership and ownership as prerequisite conditions for aid effectiveness, in most developing countries, the development agenda is frequently driven by donors [2,3]. Global reviews of progress towards the Paris Declaration targets have also highlighted the uneven transition of ownership from donors to partner countries, and concepts of ownership are often interpreted differently by different actors [2,4]. The Accra Agenda for Action sought to address this, urging donors to promote ‘real’ country ownership [5] and ‘walk’ the talk by changing the way aid is delivered [6].
While there is a limited literature on the challenges of aid coordination from the perspectives of developing countries [7-9] no accounts of the aid transition in a post-Soviet health system has been previously documented.

This paper examines government ownership through the development of the Health Sector Strategic Master Plan (HSSMP) as a mechanism for securing donor coordination, based on documentary analysis, key informant interviews and participant observation undertaken within the Mongolian health system.

In 2005, Mongolia, recovering from major socio-economic challenges following the collapse of the Soviet Union, and still transitioning from centrally planned socialism to democracy, released its Health Sector Strategic Master Plan (HSSMP) 2006–2015 [10], asserting its own health sector policy directions. The decision was crucial for the development of the health sector, marking a definitive shift in Ministry of Health (MoH) relationships with donors. Prior to the collapse of the Soviet Union in 1991, Mongolia was dependent solely on the Soviet Union for aid, and had no previous experience working with other donors. To adapt to the democratic transition, Mongolia needed to embark upon reforms in all sectors requiring support from a new range of donors. With the breakdown of the Soviet system, five-year Soviet type plans were discontinued, without any compensatory comprehensive long-term planning mechanism in place for the health sector from 1991 to 2005. In this vacuum, development objectives were determined largely by donors, with development assistance delivered mainly as projects, fragmenting an already fragile health system—still strongly centralized and hospital based following the Semashko model [10]. The Semashko model was established in the 1920s and operated throughout the Soviet Union until early 1990s [11]. “The model was characterized by its centralized planning and administration, government financing and provision of services through publicly owned health care providers, which were universally accessible and free at the point of delivery” (p. 421) [11]. However, with the collapse of the Soviet Union it was too costly to maintain the model as it is considered “inappropriate and inefficient” to meet the changing health needs of the population.

Support from donors between 1991 and 2003 averaged 40% of GDP [12,13]. The multilateral agencies (United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), World Health Organization (WHO) and Asian Development Bank (ADB) along with bilateral partners (Japanese International Cooperation Agency (JICA), German Agency for Development Cooperation (GTZ) (now renamed as German Agency for International Cooperation (GIZ), the European Union) and some international Non-Government Organizations (World Vision, Voluntary Service Overseas) played key roles in health, but using a disparate range of approaches and objectives. Total health sector expenditure over the study period and contributions of the key donors in health and their contributory areas have been provided in Additional file 1 to allow readers to have a better understanding of the aid provided in the Mongolian health sector.

Before 2003, coordination of donors and external resources by the MoH was very fragmented. There was no sector-wide coordinating mechanism within the MoH to provide a consultative forum involving the various departments of the MoH, donors, NGOs and beneficiaries. Different MoH departments presented their perspectives and priorities directly to donors, resulting in duplication of projects being implemented, and the formation of multiple Project Implementation Units and parallel management systems [14]. Project proposals were designed by donors for the MoH’s approval, and were often approved without critical consideration of their relevance and appropriateness, given the government’s chronic funding shortages and imprecise sector priorities [14]. Projects were managed independently by their Project Implementation Units, and were insulated from the rest of the system because of agency accountability requirements. The demand for project management staff diverted limited human resources from the MoH to serve project interests.

Despite the benefits of development assistance, the systemic costs were becoming increasingly evident. Poor information sharing and feedback between the projects, donors, the MoH and beneficiaries highlighted an urgent need for a sectoral approach in planning, resource mobilization and coordination [15]. The MoH recognized that effective coordination—of its own departments as well as the international donors and agencies supporting these disparate initiatives—was a necessary mechanism to promote its health system reforms, and that a strategic sectoral planning process was an appropriate mechanism for achieving this. While the development literature is rich in its rhetoric about local ownership in health, there are limited examples of how putting the government “in the driver’s seat”—has been successfully achieved. In Mozambique, re-orientation of the aid coordination mechanism under government leadership revealed a lack of government capacity to manage the coordination of resources [7]. In the case of Cambodia, despite the growing interest within the Government to facilitate sector-wide management, limited MoH capacity necessitated the extensive participation of WHO and other consultants in the early phases of the reforms [8]. The excessive influence of donors on Ugandan health policy development, potentially threatened national sovereignty and the sustainability of the policy [9]. Having suffered seven decades of Soviet dominance, the Mongolian government was eager to learn from these experiences. This research case-study documents the HSSMP process, specifically examining the ways in
which it was used as a mechanism to build effective aid coordination, while nurturing local ownership and enabling capacity building in planning and management, and the challenges that implementation now faces.

**Methods**

The research uses a health systems case-study approach, examining the evolution of the HSSMP over the decade beginning from 2003, principally using qualitative methods: document review of peer-reviewed journal articles, unpublished studies, government policy and program documents, international agency and institutional reports, progress reports on the implementation of the Paris Principles in Mongolia; semi-structured interviews with 23 key informants, purposively selected to inform on the early and mid-implementation phases of the HSSMP; participant observation of key events [16] by the authors (AU, IN) including participation in implementing health reforms from 2003 to 2010; engaging in preliminary strategic planning, HSSMP development and its implementation processes; the formation of aid coordination committees, and experience of the changes in structure and function of aid coordination responsibilities within the MoH. Rigor within the study was enhanced by triangulation of findings from the three approaches and inclusion of authors with familiarity with the Mongolian health system, but external to the MoH [17].

The Key Informant Interviews were undertaken in 2008 (12 participants), in the early stage of the HSSMP implementation [18] and again in 2012 (11 participants). This allowed researchers to track progress from the strategic planning stage through to implementation and to observe perceptions and paradigm shifts over time, as the dominance of the health sector planning agenda shifted from donors to the MoH. Both sets of interviews included equal representatives of key partners in the health sector: bilateral and multilateral institutions, development banks, international NGOs and government staff working at central and aimag (province) levels.

**Findings and discussion**

The research focuses on two phases of the HSSMP process: the development of the plan and its implementation framework (2003–2006) and its subsequent implementation (2006–2012). The HSSMP development phase was preceded by MoH’s recognition of the need for a strategic direction and coordination of resources using a sectoral planning process, and its commitment to ownership through a ‘unique’ team arrangement. This arrangement differed from previous Project Implementation Units by being located centrally within the MoH, and relying on high levels of MoH staff participation. A participatory situation analysis undertaken by the MoH with international partners was the first challenging step of the HSSMP development process. This collaborative review exposed the reality on the ground of the MoH’s own health system to the scrutiny of donors and other domestic and international stakeholders.

The HSSMP development phase was characterized by three distinct features:

1. process orientation instead of a focus on quick results
2. an implementation framework developed concurrently for the training of the responsible implementers, to ensure capacity building for smooth implementation
3. active management of key donors and development partners through the HSSMP process.

HSSMP implementation reinforced the ownership derived from the HSSMP process, leading to continued commitment of the MoH and the main international partners to the HSSMP. It enabled a better understanding of the benefits of aid coordination, which brought about a “paradigm shift” within the MoH that reframed aid coordination as not only a mere administrative task, but a strategic step towards comprehensive management of both domestic and external resources. The challenges faced during the HSSMP implementation provided lessons learned for future reform processes.

**HSSMP development**

**Commitment to ownership: the ‘unique’ project team arrangement**

In 2001, the MoH Secretary of State and senior bureaucrats took the initiative to begin a strategic planning process. Over a two-year period (2001–2003), a dialogue between the Ministers of Health of Mongolia and Japan established an agreement on the approaches and arrangements for technical assistance for HSSMP development. The choice of partner in this process engaged a strategic regional partner, bypassing other Western bilateral partners with a higher profile interest in health sector reform at the time. Although Japan was Mongolia’s largest current donor, capacity building initiatives that granted ownership to the recipient country were not common in their development assistance practice. Despite this, the Mongolian MoH was able to persuade its counterpart to offer a flexible approach through the Japanese International Corporation for Welfare Services (JICWELS), an implementing agency of the Japanese MoH, that was supportive of capacity building and ownership [19].

Instead of the typical Project Implementation Unit (PIU), insulating project staff and its operations from the MoH, the MoH formed a HSSMP Core Group consisting of 5 technical staff seconded from the MoH and a small JICWELS technical advisory team of three staff (a long-term Technical Advisor, and Technical and Logistics
Officers). This was embedded within the MoH structure, with a counterpart relationship with the Department of Strategic Policy and Planning of the MoH, and reporting to a Steering Committee led by the State Secretary, MoH (Figure 1). The functional nature of this arrangement enabled the integration of the initiative into the planning functions of the MoH, contributing to ownership, capacity building and sustainability within the MoH.

Technical Working Groups (TWGs) were established through ministerial orders to develop strategies for priority areas, which were identified during the situation analysis. The ministerial orders mandated the participation of key senior and mid-level staff in the TWGs in the development of the HSSMP with representation from service delivery facilities, academia, donors and NGOs, establishing the basis for the coordination of partner inputs from the onset of the initiative. The Core Group, in consultation with the key MoH staff, developed a roadmap (Additional file 2) before setting up the TWGs. This roadmap was discussed and endorsed by the key donors allowing the process to be open and transparent from the beginning, but the structure ensured ownership was maintained within the Core Group without being dominated by the donors, with donors invited to participate as members of selected TWGs based on their technical expertise.

**The situation analysis**

The planning process began with a comprehensive situational analysis of the health sector involving both local planners and international actors (multi-laterals, development banks, bilateral donors and NGOs). The review was based on an extensive review of the 192 available reports by consultants and government, grey literature and research findings produced over the 5 years prior the HSSMP process.

The situation analysis was undertaken by the Core Group as the first task of the HSSMP development process overseen by the Steering Committee and supported by the local decision makers and donors in health. Senior MoH management were concerned that without such an analysis there was the risk that the planning process would lead to the reinforcement of existing Semashko model based policies, now recognized as inadequate in responding to the sector’s needs. The analysis further reinforced the need for sectoral reform, and the need to build the capacity of the local leadership, if the MoH, rather than donors, was to retain ownership of the process [14]. However, the process was not challenge free. The MoH commitment to transparency in assessing its own system in collaboration with donors and other stakeholders, pointed to their own weaknesses, while simultaneously identifying the need to move towards a better functioning health system, responsive to the changing socio-economic, demographic and epidemiological circumstances.

The MoH then took primary responsibility for using the development of the HSSMP as the mechanism for building health sector capacity in close collaboration with other ministries and donors, with support from JICWELS [20]. Offers from a key international partner to provide external consultants to draft the HSSMP on behalf of the MoH were declined, despite the promise that this might make the HSSMP more acceptable to broader donors. This courage to reject partners’ offer resulted from previous experience-failed reform initiatives driven by external consultants. Examples of these reforms are decentralisation and health sector privatisation, which were instituted during 1993–1996 along with the introduction of the Public Sector Management and Finance Law (a modified version of Australian Public Sector Management Act 1994) and the implementation of the Health Sector Development Programme-1 by ADB. While technically these reforms addressed issues of governance and significant public policies, the failure of the consultants to understand the politics produced by the rapid transition from a central control
economy to more democratic institutions meant that the necessary local policy ownership was not achieved, and the regulatory changes needed for both reforms were not implemented. Progressive undermining within the administration over several years, and frequent changes in government, resulted in the failure to implement these reforms. The key reasons for the failure were defined as a lack of prior preparation, the absence of well-defined and harmonised guidelines and implementation mechanisms, and inadequate systematic training of the managers at the local government level [14]. In the light of this experience, the MoH aimed to own the process through to implementation, engaging local health planners and allowing them to “learn by doing”. Despite some donor ambivalence around the MoH staff’s capacity to manage this process, support was maintained during this phase. For the MoH, the assertion of leadership enabled a change in their own practices: without externally imposed time constraints or donor conditionals, the MoH was able to place an equal emphasis on the process as well as the results. This was a significant development, as process-orientation and taking ownership in its relationship with the international partners had not been part of the MoH organizational culture, as underscored by many interviewees representing Government agencies: “Traditionally, international partners initiated project planning and set up their own project management and coordinating mechanisms and MoH followed their arrangements. But HSSMP process was different; it switched the “seats”. The Government took a “driving seat” for the first time...” (Senior MoH official).

The process also promoted participation of various actors such as health workers in bagh and soum (peripheral administrative units), aimag, NGOs, other sectors’ representatives and private practitioners, welcoming the fresh inputs and perspectives from these heterogeneous actors.

**HSSMP implementation**

**Implementing the plan and training the implementers**

The concomitant development of the three companion documents of the HSSMP—the Planning and Budgeting, Medium-Term Expenditure and Monitoring and Evaluation Frameworks, supplemented by an Implementation Framework—served as the apparatus for the actual implementation of the Plan at the operational levels. The Implementation Framework formed the basis for the Government’s Action Plan in Health and the Mid-term Plan of the MoH. These companion frameworks provided the necessary guidelines, forms checklists and tools for preparing facility level annual operational plans. Preparation of these plans was managed and facilitated by the MoH, with assistance from the HSSMP Core Group, through a series of participatory training events covering all regions. This enabled the aimag and district facility management teams to develop integrated annual operational plans for all health facilities at each level. These events used a “learning by doing” approach to build the capacity of the health management teams in planning, budgeting, monitoring and evaluation. During the training events, participants recognized that up to this point, the annual planning and budget estimation had not been linked, and that for effective planning, this linkage was vital. Ongoing in-service training, provided by the MoH, would be required if the emerging ability to plan, estimate budgets, implement and monitor the annual work plans was to be institutionalized.

The Implementation Framework was an essential tool to help unpack national level strategies into implementable objectives and activities that could be adapted at the aimag and soum (district) level, while the participatory training methodologies equipped the health management teams with the necessary skills to develop their operational plans and budget estimates. Despite the MoH’s reticence to delegate control of the planning process to donors, the need for donor support for implementation was increasingly self-evident. For the donors, the functional structure emerging from the planning process raised confidence in the HSSMP. Consultation to secure the support of ADB, WHO, GTZ, UNICEF and UNFPA, made the strategic plan amenable for implementation at operational levels. These partners now also adapted their own strategic plans to reflect the HSSMP strategies, providing funding for training in their programme area health facilities at aimag and soum levels.

During the development and implementation process, three national consultative meetings and 16 regional and aimag level consultative meetings were held. These provided additional capacity building opportunities to examine local and sector-wide priority issues and make recommendations. These meetings also enabled consensus building about these priorities and suitable implementation modalities. A number of interviewees from implementation levels positively commented on the ownership aspect of the plan. Their views are represented in the following quote from a Senior health official of the Aimag Health Department “This was the first time the implementation plans were developed by us, the implementers, and not just imposed on us by outsiders or top level MoH and related government agencies as happened often in the past”. Although institutionalizing the planning exercise at the operational level was constrained by the lack of capacity, experience and resources, the shift in mindset brought about by this planning process was significant: the assertion of ownership of the process by the MoH now enabled the evolution of local ownership by aimag and city health departments of these operational plans.
Managing donor participation

With the cabinet approval of the sector strategic plan in 2005, coordination of donors under the MoH leadership became necessary to enable MoH to begin managing the sector. The recent declaration of the Paris Principles provided further impetus for harmonisation of donor planning with that of the MoH. The increasing focus on Health Systems Strengthening as a global shift in development assistance saw some key partners (GTZ, UNFPA, UNICEF) providing funds for HSSMP supported training activities for MoH staff in their project areas. In the health system strengthening components of their plans, this provided evidence of their buy-in into MoH capacity building. Broad acceptance of the importance of host country ownership and capacity building was becoming evident in action plans to direct donor coordination through a Sector-Wide Approach (SWAp) [18]. While a SWAp is conventionally understood as a donor coordination mechanism in which partners, under the leadership of the MoH, align and harmonize all resources and efforts through the collaborative development of a single sector plan [21,22], the experience in Mongolia effectively inverted this sequence. The development of the HSSMP with managed donor input, provided an initial mechanism to assert MoH ownership, and build capacity. Now the HSSMP would serve as a structure to harmonize donors’ (particularly ADB, GIZ and UNFPA) and other stakeholders’ contributions, aligning donors’ agendas with the MoH policy package, and setting the agenda for a future SWAp.

The HSSMP as an ongoing construct for coordination

Given the history of frequently changing priorities in the MoH with each new ministerial regime and its administration, the durability and continuity of the HSSMP had to be carefully considered from the outset.

First, wider acceptance by a broader range of stakeholders was necessary. A process of reviews to build advocacy for approval was planned: a consultative meeting involving all the directors of the aimag health departments, heads of the main tertiary hospitals and heads of the MoH departments was held to endorse and submit a communique, signed by the directors of the aimag health departments, heads of the other MoH departments for feedback to obtain their commitment to collaborate with the MoH in implementation. This part of the review process was required for presentation of the HSSMP to the cabinet for approval. The Cabinet approved the HSSMP and its companion documents, and a Resolution endorsing the HSSMP and authorizing the Minister of Finance to fund the plan with active support from the partners, was signed by the Prime Minister of Mongolia [23]. As in other documented country experience, approval of the strategies at a level higher than the MoH were deemed to be beneficial for achieving better donor coordination and continuity [24]. This was also demonstrated by the Mongolian HSSMP process, and increased the commitment by the MoH-Mongolia to the HSSMP. The process also helped to provide legitimacy so it could continue to serve as the primary umbrella document, despite subsequent changes within the Minister of Health. Consequently, each new Minister has, until now, employed the HSSMP as the basis for developing the Ministry’s work plans.

Second, the Steering Committee appointed by the Minister to oversee the HSSMP process played a central role in safeguarding the continuation of the process of coordination and harmonization beyond the development of the HSSMP. Its members went on to serve as members of the Health Sector Aid Coordinating Committee (HSACC). The HSACC was newly established in 2005, as required by the Ministry of Finance (MoF), following the HSSMP’s approval, as a mechanism for supporting a SWAp. Regular meetings of this committee enabled future donor initiated projects to be in line with the HSSMP strategies and current programmes to be coordinated under the umbrella of HSSMP. During these meetings, progress reports of current projects and new project proposals were presented by the MoH and partners for consultation and approval. Also, project and programme evaluation reports were presented at these meetings and new studies, and initiatives such as the joint sector review were consulted upon and recommended for implementation by the MoH and partners.

The 2008 general elections, however, exposed the potential vulnerability of coordination to political change: the formation of a coalition government resulted in the health portfolio being transferred to the minority coalition partner. As a result, HSACC operations were suspended for about a year. In this interim period, however, the MoH, recognizing the importance of the coordination function, was able to continue the alignment and harmonization of projects with the HSSMP by appointing temporary technical working groups. These efforts were supported by the key international partners in the health sector.

With the support of ADB and WHO, the MoH has regularized the meetings of the HSACC and is now moving towards expanding its role as a Health Sector Coordinating Committee to further support the Health Sector Reform Agenda. Additionally, key partners now operate through the budgetary process approved by MoF. Evaluation of the Paris Declaration activities in Mongolia
indicated that donor use of country public financial management systems has increased from 17% to 27% between 2007–2010, although this is still below the target set for 2010 [25].

**Improved aid coordination**

In practice, HSSMP development enabled harmonization and coordination of external aid earlier than anticipated, as the largest international partners oriented their support towards MoH priorities. Key partners in health increased their support to the health sector, and aligned these with HSSMP priorities [26]. The Third, Fourth and Fifth Health Sector Development Projects (HSDP) funded by Asian Development Bank (17.6 million; 18.15 million and 30 million USD respectively) focus on the key strategies outlined in the HSSMP: improving health insurance system, hospital rationalization, strengthening primary health care, improving postgraduate clinical training, drug safety, blood safety and waste management.

UNICEF and UNFPA budgets doubled between 2006 and 2010 [26]. After four years of inactivity, the WB program contribution to the health sector resumed in 2007. For GIZ, after an absence of 6 years, health support recommenced in 2011. Their support focused on addressing capacity building in management for emerging infectious diseases, and the introduction of social health insurance, which were listed as key strategies in the HSSMP. The US government funded (17 million USD) focus on the key strategies addressed health issues for the first time: the increasing threat of non-communicable disease and road traffic trauma. In interviews, the key informants from bilateral and multilateral agencies unanimously agreed that HSSMP provided a predictable structure for channeling their resources in health in accordance with MoH plans:

".. We are happy to work with MoH as its scope and direction is clear and priorities identified in the Ministry’s long term plan accurately pinpoints areas to be improved in Mongolian health sector...Our ultimate intention is to bring sustainability within the system which thankfully, was also key emphasis in the Ministry’s master plan. The plans often used to be merely a “wish list” in the past”. (Multilateral donor representative)

Following HSSMP approval, unspecified donor funding for health decreased consistently from 40.3% in 2003 to 3.7% in 2007, reflecting alignment with HSSMP priorities [27]. However, alignment was clearly dependent on MoH monitoring: following the 2008 elections and the suspension of the Health Sector Aid Coordination Committee, unspecified funding increased to 19% in 2009. The total health expenditure as a percentage of GDP also increased, from 4.8% in 2006 to 5.5% in 2010 [28]. Progress towards the Millennium Development Goals for health is well on track, with the target for reducing maternal mortality met before 2015 [29,30]. Although these positive contributions may not be solely attributed to the HSSMP, its more targeted and coordinated ways of using health resources have supported development of the health sector and resultant health outcomes.

Three specific examples demonstrate the use of the HSSMP as an instrument for securing donor coordination. As a lower income country moving towards middle-income status, Mongolia continues to be eligible for grants. While the Government had not been heavily involved in the design of grant projects, they now sought to ensure that projects were aligned with HSSMP strategies. Although the original design of the THSDP was highly focused on an external consultancy model, marginalizing local engagement, the MoH insisted that this program and subsequent ADB grants now conform to the HSSMP, under the oversight of the HSACC. The three biggest ADB health projects are currently operated under a single PIU under the HSACC, allowing better harmonization and alignment between the projects and MoH, besides substantially saving management costs. All the funding provided by ADB and WB is now channeled through the Ministry of Finance, rather than off budget.

The second example involved the Millennium Challenge Account-Health project, whose conditions required a demonstrable business orientation as part of the proposal. The resultant proposal promoted the establishment of a quasi-private tertiary level diagnostic and treatment center, designed with the intention of meeting the health needs of the wealthier members of society, and capturing the health funding that they currently expend outside the country. While the rationale targeted economic sustainability, it was clearly regressive, and in its focus on the rich, while neglecting the poor, did not fit with the HSSMP focus. The MoH used its commitment to the HSSMP as its benchmark in continued consultations with donors, eventually resulting in a change in the project’s focus and a redesign to support HSSMP strategies. With non-communicable diseases (NCDs) and injuries identified as priority diseases based on the national epidemiological profile, and highlighted in the HSSMP, the focus of the Millennium Challenge Account proposal was reoriented from building a tertiary level diagnostic and treatment center towards combating NCDs and injuries, consistent with the HSSMP priorities, MoH’s persistence in these negotiations was clear evidence of confident ownership of policy directions.

The third key strategic change was the transfer of responsibilities for implementing a SWAp and aid coordination from MoH’s International Cooperation Division to the Strategic Policy and Planning Department, in 2006, a
year after the HSACC establishment. This was recognition that aid coordination is not merely a fund raising and reporting task as understood previously, but a strategic function to coordinate, channel and oversee external resources to implement MoH objectives. The changes in the MoH organizational structure that followed the approval of the HSSMP were effectively determined by the need to address functions required to implement key HSSMP strategies. Channeling the domestic and external resources through a better-coordinated strategic framework made off-budget funds more accountable and also created an enabling environment for joint assessments of the performance of the public health sector rather than piece-meal and shielded assessments of the various projects. The trend to more effective coordination has been reflected in the joint sector review of HSSMP mid-term implementation, completed in 2012, using the Joint Assessment of National Health Strategies (JANS) initiated by International Health Partnership (IHP).+.

Challenges
The development of the HSSMP and its implementation processes were not challenge free, and key points have demonstrated the potential vulnerability of the local governance that it has created. With the completion of the HSSMP process, the Core Group was disbanded. The responsibilities of the Core Group are now embodied in the HSACC. The seconded staff now confronted difficulties in returning to their former substantive positions, because of politically driven structural changes in the MoH following the appointment of a new Minister. Despite support for the Paris Principles, some donors have not been comfortable with the level of MoH pressure to re-program their projects to conform with the HSSMP. With persisting ambivalence around MoH capacity, they now considered commitment to the MoH-HSSMP placed implementation of their project resources beyond their control, a risk they were reluctant to take. The high staff turnover and frequent changes in the rules and procedures in the MoH provided some justification for their concerns.

The vulnerability of the key senior MoH staff to a fractious political environment has slowed the pace of implementation of HSSMP and reduced the strength of its influence in aid coordination. The joint sector review of mid-term HSSMP implementation, completed in 2012, also highlighted this loss of momentum in the efforts to accelerate progress towards a SWAp. Senior level staff changes, the infrequency of HSACC operations since 2010 and unclear guidance around implementing a SWAp, were cited as concerns [31]. Clearly, the task of maintaining internal consensus around the HSSMP is critical to extending that leadership to donor coordination.

Conclusion
Mongolia’s experience shows that the process of developing a national plan, if carried out meticulously, with wide participation and sufficient time for stakeholder consultations, can provide an opportunity to advance ownership, build capacity and lead to better aid coordination in developing countries. The most important success factor for the sustainability of the plan was the commitment of the Government to lead the process, with support from international donors playing a vital role to facilitate this homegrown initiative. Ownership cannot be conferred but can only be claimed [32] and this HSSMP development process has demonstrated that principle.

The strengths of the HSSMP development process lie in three specific areas:

1. The continuity provided by political durability, despite political instability
The HSSMP has “survived” 6 ministers from the time of its development to the current stage of its implementation. This is due to the participatory nature of its development, with consensus building consultative meetings that enabled the HSSMP to consolidate realistic strategies. Strategies to ensure approval by the Cabinet and authorisation by the Prime Minister, development by the staff of the MoH and key stakeholders, and ownership by operational level facilities, have overcome the consequences of the political instability and the staff turnovers that have occurred.

The HSSMP Core Group have ensured continuity and institutional memory remains within the MoH. The choice of a select team of long-term technical advisors maintained continuity and nurtured capacity building in ways that previous short-term technical assistance had not.

2. The use of the HSSMP to ensure the cohesion of MoH-led donor alignment
The MoH used the HSSMP as a clear framework to align partner projects with its priorities and strategies. Donor alignment initiative arose from the strategic plan, rather than being driven by the donors themselves. This was quite a shift, challenging donors’ assumptions about the lack of Government capacity and its commitment to lead donor coordination. The contemporaneous signing of the Paris Declaration by the Mongolian Government, and the development of the HSSMP has had synergies in promoting adherence to the principles of aid effectiveness in the health sector.

3. The value of process orientation and participatory approach to building capacity
The HSSMP development process preferentially used the “learning by doing” approach as a mechanism for creating an enabling environment for increasing MoH
ownership and capacity. Participation of domestic and international stakeholders was enabled from the outset and sustained throughout the process through widespread and systematic consultations. The Core Group, embedded in the MoH and consisting of seconded staff, supported the emerging ownership within the Government.

The lessons for Ministries of Health in similar Post-Soviet countries—or other emerging economies where government capacity and local policy processes are relatively strong—are clear: the development of solid governance and technical infrastructure in terms of planning and evaluation provide a solid structure for donor coordination and insure against local political change. The development of a comprehensive policy package—in this case the HSSMP—provides a concrete framework against which donor contributions can be matched. But the governance to maintain this infrastructure is crucial. The disbanding of the Core Group has increased the risk of competing interests within the MoH; the temporary loss of the surveillance provided by the suspension of the HSACC saw unspecified donor funding balloon. Despite the patchy compliance with the Paris Principles [32], donors are sensitive to peer monitoring of their performance; a more structured approach to tracking aid effectiveness through the Paris declaration indicators will enable the gains secured through planning processes to be monitored.

But as important as effective donor coordination is the MoH’s capacity to effectively coordinate its own domestic resources, and to harness the growing contributions of the private not-for-profit and for-profit sector, as well as the emerging public-private partnerships that have resulted from early exploitation of its mineral wealth. As Mongolia’s economic standing increases, and the proportion of donor support decreases, these lessons of coordination will be critical to implementing the MoH’s vision for health.

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Additional files


Additional file 2: Roadmap for developing Health Sector Strategic Master Plan.

Competing interests
The authors declare no competing interests.

Authors’ contributions
AU conducted the document review, interviews and observation. PH and IN provided the study design and all authors participated in the narrative analysis. AU and AM developed the first draft and led on its further development. PH and IN provided further inputs and revisions throughout the manuscript development process. All authors read and approved the final manuscript.


Additional file 2: Roadmap for developing Health Sector Strategic Master Plan.

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5.3 Can a Sector-Wide Approach Underpin and Advance Universal Health Coverage?

BRIEF COMMUNICATION

Can a Sector-Wide Approach Underpin and Advance Universal Health Coverage?

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Fragmented management approach makes the provision of comprehensive health care for achieving universal health coverage very unlikely. This article aims to explore the potential contribution of a systemic approach—the sector-wide approach (SWAp)—to achieving universal health coverage (UHC), using the Mongolian context as an example. The paper describes UHC and factors that hinder its achievement in developing countries, based on the Mongolian experience. The analysis focuses on the root factors hindering the achievement of UHC and examines how these affect system and local capacity critical for achieving UHC. Two principally different approaches, a sector-wide (holistic) approach and a standalone project (fragmented) approach are compared in terms of their contribution to the main indicators of achieving UHC. The current stage of the Mongolian health SWAp is identified and early rewards of a SWAp are presented. The paper proposes a SWAp as a potential approach to tackle these root factors to help in achieving UHC, because it is a promising instrument that promotes a systems-strengthening and capacity-building approach to enable effective coordination of standalone projects in alignment with the national priorities.

Keywords holistic approach; sector-wide approach; systems approach; universal health coverage

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Acknowledgment: This paper was developed as a part of Emerging voices’ essay competition and granted a winner’s award. It can be classified as ‘perspectives’ or ‘communication’ as it is to share and explore potential opportunity to improve Universal health coverage through employing Sector-Wide Approach. The main author has an interest on Sector-wide Approach and its impact on the systems’ development. As such, she had done her Master’s research work on assessing Mongolia’s health sector preparedness to move towards SWAp and the thesis got published in Asian Social Work and Policy Review 2 (2008) 111–125. The current paper can serve as a continuation of the previous paper as it covers the earlier rewards and potential opportunities of SWAp implementation in Mongolia in regards to achieving Universal Health Coverage. We acknowledge support from the ‘Emerging Voices for Global Health’ venture at the Institute of Tropical Medicine (ITM), Antwerp, Belgium. The Emerging voices endeavour started as an essay competition in April 2010 and was financed by the Framework Agreement between ITM and the Belgian Development Cooperation (DGD). More detail on the Emerging voices project, winners and coaching process can be found on the following website: http://www.itm.eu/colloq2010.
The significant problems we face today cannot be solved at the same level of thinking we were at when we created them.—Albert Einstein

Universal health coverage in Mongolia and factors hindering its achievement

UHC is a constitutionally defined entitlement in Mongolia and is understood as having timely access to health facilities, availability, affordability, equity, and sustainability of essential health services (Core Group, 2005). According to the World Health Report 2010, UHC is enabling people’s access to health services—a mix of promotion, prevention, treatment, and rehabilitation without incurring financial hardship (World Health Organization, 2010a). The report also gives importance to the right balance between the proportion of the population covered, the range of services included, and the costs to be covered when providing UHC. To date, UHC in Mongolia has been more focused on the proportion of the population covered (breadth), rather than the range and quality of the services (depth) provided through the essential care package. As a result, statistics reporting based on coverage may present quite positive findings about UHC in Mongolia, without addressing the realities of the type and quality of services and the responsiveness of the system.

The challenges that act as bottlenecks to achieving UHC in Mongolia include a number of factors, the key ones being financing, staff competence and attitudes, management skills and styles compounded by silo-like operations of the various departments of the Ministry of Health (MoH). An insularity of the operations of the hospitals at various levels and a historical separation of the curative and public health services result from fragmented management style and processes.

Health managers often complain about inadequate funding in the system. However, besides a lack of funding there is a definite “lack of efficient and effective management of the available resources that affects the provision of quality health services,” as noted in the World Bank report on the Mongolian health system (World Bank, 2007), and poor coordination and cooperation within the Ministry departments which operate their departments instead of working together to manage the sector as a whole (Bolormaa et al., 2007). Over the last decade, Mongolia has been able to keep its health spending as a percentage of GDP (4% on average) at a level higher than most other transition countries (Department of Health Mongolia, 2009). The traditional method of merely increasing funding to solve operational problems without efficient management resource allocation and a sector orientation has not improved equity. Resources need to be more targeted and based on the needs of the sector and shifted to locally defined priorities. There is a pressing need and an emerging demand from the population to improve management capacity, the operating efficiency, and the sectoral orientation of the system to avoid duplication, reduce wastage, and achieve better outcomes with available finances.

Maternal and child health (MCH) has been a long-standing priority in the Mongolian health sector, with a commitment to improve MCH indicators. The policy of providing free maternal and child health care in Mongolia was intended to enable easy and...
equitable access by the vulnerable target populations to achieve the health Millennium Development Goals 4 and 5. However, maternal health indicators have not improved in line with expectations, despite the high percentage (99%) of births that are attended by skilled health personnel in the country (World Health Organization, 2010b). Poor service quality and a lack of competence of the staff act as the main barriers to quality MCH services and to the provision of UHC.

Service acceptability and service utilization depend on other factors besides technical efficacy. These include factors such as who delivers the service (male or female provider), in what environment (privacy and confidentiality), organizational culture (client-friendly), and how staff behave in their relationships with patients. These can be tackled through improved management and administration of the health facilities. However, the prevalent fragmented style of management of the health facilities does not easily allow these facility managers to see what gaps exist, and where and how these can be remedied.

Underlying causes of all the abovementioned barriers tend to be associated with fragmented management and inability to see the sector as a whole system with interdependent components. Therefore, a holistic approach would contribute to overcoming those barriers.

The need for a paradigm shift to achieve UHC

Years of experience in implementing numerous projects have not brought about the expected result of achieving sustainable UHC in many developing countries. With a reported increase in development assistance provided to low- to middle-income countries for health from $5.6 billion in 1990 to $21.8 billion in 2007 (Nirmala et al., 2009), we need to ask: Are we making a difference with the amount of money provided?

Sridhar points out that, while it is appealing to recognize the donors’ commitment in increasing health resources, the government’s stewardship of its own budget needs to be determined by its own priorities, rather than the priorities of those donors and campaigns that are most successful in mobilizing Overseas Development Assistance funding (Sridhar & Woods, 2010). For example, antiretroviral treatment need not be given priority over addressing Mongolia’s maternal mortality (still lamentably lagging behind among the MDGs) simply because donors have more successfully mobilized funding for HIV/AIDS. The government must decide who should take responsibility for setting its priorities.

There is a need for a paradigm shift: rather than developing government policies that “second guess” what donors will buy into, policies need to be developed to meet the people’s universal health needs and expectations.

Project-type management as a key bottleneck for universal health care

In Mongolia, as in many developing countries, donor agencies still play an overly decisive role in the health sector through implementing standalone projects in their areas of interest. These create challenges for the overloaded and underpaid national planners to find politically complicated ways of ensuring consistency of national priorities from a perspective that will provide the constitutionally and legally mandated full continuum of health
services, despite the distracting cacophony of the donors who have the luxury of focusing on a few agency priorities.

A “Ministry of Health Projects” to implement donor projects cannot provide universal health care in an integrated and unified way. Universal coverage requires a systems/holistic approach. Understanding part of a system and tweaking only that part (project) so that it functions better contributes to uneven development, fragments the sector, and reinforces the fragmented management style. Fragmented management makes the provision of integrated health care to achieve UHC very unlikely.

Bilateral donors, preoccupied with attribution to justify their aid budgets to skeptical parliaments, are especially prone to funding disease-specific standalone projects and skew health financing towards their funding interests, especially in donor-dependent countries (Sridhar & Woods, 2010). Short-term projects cannot substitute for long-term efforts to achieve universal coverage. They can be complementary but, without their concurrent integration that strengthens the host system processes, structures and financing that support universal coverage, such short-term pilot projects are unlikely to overcome the inequalities generated by socioeconomic stratification and exclusion (World Health Organization, 2008).

The Mongolian experience showed that, in the absence of a government-led overarching sector-coordination framework, there has been a vacuum which the donors have used to impose their agendas and funding interests on the MoH. This had led to overlapping projects and duplication, resulting in wastage and inefficient use of scarce resources. Often donors, amongst themselves, do not coordinate their inputs because of attribution, status, and protocol-related reasons. In such circumstances, donors end up coercively instigating similar projects, which an operationally resource-starved MoH with its poorly paid staff is unable to refuse, even though these projects do not conform to national priorities (Core Group, 2004). However, the development of a Health Sector Strategic Master Plan (HSMP) in Mongolia started playing an important role to guide, facilitate, and coordinate international assistance in health. While the HSMP still serves as a common strategy within which all actors in health work in a harmonized way and their programmes and projects are aligned with the national priorities, experience so far has shown that it requires additional efforts especially at the central level (where there is very high turnover of senior staff) to develop a better coordination mechanism that is spearheaded and operated by the government.

How a system is managed matters more than just the availability of human resources, finances, infrastructure, and technology. Although projects provide substantial resources and achieve positive outcomes in specific areas, focusing on short-term results should not be at the expense of long-term capacity building, essential for providing sustainable universal health care (De Renzio, 2007). A sector-wide approach (SWAp) could offer an alternative mechanism for managing a system to achieve universal health coverage.

A SWAp is no longer only an aid-coordination instrument. As defined by Ellen van Reesch (2008), “The sector-wide approach is a process in which funding for the sector, whether internal or from donors, supports a single policy under government leadership, and adopting common approaches across the sector … a sector-wide approach should
ideally involve broad stakeholder consultation in the design and implementation of a coherent sector programme.” Moreover, we need to move beyond the aid delivery focus of SWAp and embrace the SWAp as an approach to effective sector development (Boesen & Dietvorst, 2007).

Table 1 compares the two principally different approaches: a sector-wide (holistic) approach and a standalone project (fragmented) approach. Criteria such as accessibility, availability, sustainability, affordability, and equity are used to compare how each approach could help achieve universal health care coverage in the Mongolian context.

Table 1 Comparing sectoral and project-based approaches based on Mongolian health sector experience (Narula, 2009)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sector-wide approach</th>
<th>Project-based approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Encourages provision of and access to integrated comprehensive health care supporting continuity of health care along the health care continuum</td>
<td>Does not usually support continuity of health care as the project design and management are predicated on agency priorities and specific services targeting selected population groups</td>
</tr>
<tr>
<td>Availability</td>
<td>Supports the provision of a full range of health services available for all segments of the catchment population using a public private mix</td>
<td>Supports certain vertical programmes for target groups during the project timeframe only, thus creating availability differentials</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Helps create an enabling environment for strengthening the system and its institutions through building local capacity</td>
<td>Short-term disbursements and success of projects; often tends to create unsustainable “islands of excellence” (Cassels &amp; Janovsky, 1998)</td>
</tr>
<tr>
<td>Affordability</td>
<td>Supports priority-based resource allocation; thus priority/essential services are often subsidized especially for the poor and vulnerable</td>
<td>Subsidization may not necessarily be for essential services as donor-imposed projects often do not conform to local priorities</td>
</tr>
<tr>
<td>Equity</td>
<td>Holistic approach helps address horizontal and some vertical equity issues in the delivery of services</td>
<td>Horizontal equity is neglected as standalone projects tend to address vertical equity and are not easily accountable for equity in the whole system</td>
</tr>
<tr>
<td>Health outcome</td>
<td>Allows the measurement of performance in terms of the process indicators in the short term but also allows sustainable positive impact on the main health status indicators over the long term</td>
<td>Tends to achieve immediate intermediate results in the project areas but their sustainability and direct longer term impact on health status indicators is controversial</td>
</tr>
</tbody>
</table>

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It can be seen that a SWAp has great potential to strengthen the very system that is responsible for providing UHC through improving access, availability, and affordability of services.

**Synergy between SWAps and provision of UHC**

SWAps allow the system and the interrelatedness of its various sub-systems to be investigated. Moreover, a SWAp is a process, based on a sector plan in which universal health coverage is the top-level priority of all the sub-systems.

Universal health coverage cannot be achieved without effective inter-sectoral collaboration, partnerships, community involvement, and stakeholder participation. Since these elements are also essential for implementing a SWAp, there is great synergy between SWAp and UHC. However, a lot depends on the way the SWAp is employed. An appropriate and effective SWAp can be asserted and is more likely to address system issues such as health inequality, poor access to basic health services, and uneven resource allocation, concomitantly strengthening institutional capacity. It focuses on effectively managing standalone projects in the sector in an integrated way under a single-sector strategic plan.

**At what stage is the Mongolian health SWAp?**

The Mongolian health SWAp is evolving slowly but noticeably, compared to its own context during the mid 2000s. However, it is still not mature enough to be classified as an “intermediate SWAp” as outlined in Table 2. The paper published in 2008 (Ulikpan, Mirzoev, & Narula, 2008) assessed the readiness of the Mongolian health sector for a SWAp using the same staging outlined in Table 2. Early SWAp characteristics identified then have evolved to the next stage, and are more in depth rather than in breadth since then.

The Mongolian health SWAp is somewhere between early SWAp and intermediate SWAp. Therefore, we created another stage known as “pre-intermediate” and outlined the characteristics of the current Mongolian health SWAp. The Mongolian health SWAp evolved in its own context-specific ways. Its experience shows that a SWAp preparation and evolution can be slower and more challenging than was expected. However, the returns from addressing these challenges and slow progress can be both rewarding and long lasting. The returns thus obtained are as follows:

- A SWAp has brought some tangible results, such as various partners namely, GTZ, UNFPA, and UNICEF providing funds for HSMP-initiated training activities as evidence of their buy-in into the integration of the capacity-building activities for implementing the health system strengthening components of their plans. This collaboration also served as an example of converting the competitive tendency amongst donors into cooperative synchronization to reach the common goals if the right process to enable such cooperation is in place.
- A SWAp preparation process brought increased ownership to the Mongolian public health sector. The MoH has started managing the donors in accordance with its own
Table 2  Mongolian health sector’s SWAP stages and characteristics

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Mongolia context</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWAp not under consideration</td>
<td>Limited government reform and leadership&lt;br&gt;Limited donor presence&lt;br&gt;Weak civil society&lt;br&gt;Health service requires vertical programs</td>
<td>These characteristics were present during mid 1990s until early 2000</td>
</tr>
<tr>
<td>Preliminary informal SWAp discussion</td>
<td>Significant donor presence but limited coordination&lt;br&gt;Increased awareness of need for sector coordination by donors; donor “push” and external TA; design of SWAp components&lt;br&gt;Advanced discussion initiated between donors and government&lt;br&gt;Loss of momentum may occur between discussions, hence delaying the process</td>
<td>These characteristics were present in the Mongolian health sector during 2000–2005</td>
</tr>
<tr>
<td>Early SWAp</td>
<td>Formal recognition by government and partners&lt;br&gt;Increased momentum&lt;br&gt;Government “pull” emerging but still strong donor “push”&lt;br&gt;SWAp components addressed on paper but not in practice&lt;br&gt;No pooled funding arrangements in place</td>
<td>These characteristics were present in the Mongolian health sector during 2005–2009</td>
</tr>
<tr>
<td>Pre-intermediate SWAp †</td>
<td>Ideal characteristics of this stage were not given as the initial classification by IHSD did not include this staging.</td>
<td>2009–2012 (current stage)&lt;br&gt;Increased government ownership of the decisions for the channeling of external aid&lt;br&gt;Better harmonization and alignment of external aid&lt;br&gt;Targeting of resource allocation to agreed priorities&lt;br&gt;Donor coordination mechanisms in place, though operational effectiveness needs to be improved&lt;brPooling of funds not a target in the design of Mongolian health SWAp</td>
</tr>
</tbody>
</table>
needs and priorities and is not managed by them under their agendas, as it was often the case in the past. This ownership obtained also made initiation of the SWAp possible without necessarily requiring a formal SWAp structure (donor-managed pooled funds, etc.) to be in place in advance.

- Government capacity to negotiate and channel donors’ aid according to its priority areas and emphasis on local capacity building has notably increased. The Strategic Planning Department of the MoH is leading the SWAp process along with the technical assistance provided by ADB-funded Third Health Sector Development Programme.

- A SWAp-enabled harmonization and coordination of the external aid mechanism was established earlier than anticipated under the umbrella of the HSMP. As a result, ADB, the largest international partner, supported MoH priorities. For example, the Third and Fourth Health Sector Development Projects funded by Asian Development Bank (amounting to $17.6 million and $14 million, respectively) and the Millennium Challenge Account-Health project ($42 million) are in line with the strategies outlined in the HSMP, illustrating the vital role the projects are playing in the achievement of the sector performances and the MDGs. The UNICEF and UNFPA Master Plans of Operations and WHO Country Strategy Paper were based on the HSMP. The UNDAF process in health was also influenced by the HSMP.

### Conclusions

UHC can be achieved only when a country’s own health system is strengthened and targeted to the country’s priorities, rather than donor-induced priorities. External assistance

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**Table 2 (Continued)**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Mongolia context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate SWAp</td>
<td>One cycle/one review &lt;br&gt; Further system development and harmonization required &lt;br&gt; Donor coordination, M&amp;E mechanism in place but needs refining &lt;br&gt; Some pooled funding</td>
<td>Projected to happen during 2012–2016</td>
</tr>
<tr>
<td>Mature SWAp</td>
<td>All SWAp components in place &lt;br&gt; Two or more planning cycles undertaken &lt;br&gt; Government-led process &lt;br&gt; Pooled funding mechanism operational for all or part of sector</td>
<td>Expected to be achieved by 2016 as projected in the strategic plan of the MoH</td>
</tr>
</tbody>
</table>

*Note: Adapted from IHSD (2005), cited in World Health Organization (WHO, 2006). †This stage was created by the authors and adapted to IHSD SWAp table. ‡Renamed as HLSP Institute in 2006.*
should provide support to contribute to UHC in an integrated, complementary, and coherent way and not to hinder or further fragment the system that delivers it. A comprehensive approach such as SWAp offers a viable alternative that permits and enables all partners to work under a single-sector strategic plan channeling both domestic and external efforts to the accomplishment of the Ministry’s Sector Plan by strengthening the management of the host country’s health delivery system and enabling coordination and integration of its management. The SWAp in the Mongolian health sector is surely evolving, though slowly. Despite its slow progress in certain areas, there are already some early rewards, such as increased government ownership of the decisions for channeling of external aid, concrete efforts to improve governance with the concomitant improvement of management capabilities and style, the targeting of resource allocation to agreed priorities, and leading and refining the mechanism for better coordination of projects and programmes. Although, it may seem premature at this stage to draw conclusions that the newly evolving Mongolian SWAp is significantly contributing to UHC, there is early evidence that its implementation is improving accessibility, availability, and sustainability of health care services through effectively targeting the resources to the most needed areas and integrating and defragmenting the management of these resources.

References


The policy analyst as actor iv: Is this the “development we wanted?”

Mongolia’s recent economic growth led by mineral resources made me question the cost and implications of this ‘development’, especially, the implications for health and well-being of the population which need to be highlighted as we face the ‘paradox of plenty’.
Is this the “development” we wanted?

By Anar Ulikpan (EV 2010 & 2012, currently PhD Candidate at the School of Population Health, The University of Queensland, Australia)

Mongolia is a former socialist country that has been experiencing major socio-economic changes since the collapse of the Soviet Union. The country has been transitioning from a centrally planned socialist country to a market economy and multiparty democracy over the last two decades. Mongolia is now classified as a lower middle income country and nicknamed “Minegolia” because of recent rapid economic growth driven by mining. According to the World Bank, the share of mining in GDP now stands at 20 percent, twice the proportion of a decade ago. The economy grew by 17.3 percent in 2011, compared to 6.4 percent GDP growth in 2010. Also in the next five years growth is expected to continue at a double digit rate. Significant progress has been made in achieving several Millennium Development Goals at the national level. This all sounds very promising! But, to what extent do these burgeoning results impact the everyday realities for the majority of Mongolians? Moreover, what are the implications for people’s health?

Unfortunately, the response from ordinary people in Mongolia to the above question is not very positive. There are increasing disparities between the rich and poor, both in cities and in rural areas, especially in health, education and social services, and close to 30% of Mongolia’s population is below the national poverty line, raising serious concerns about who is actually benefiting from this rapid growth. How sustainable and inclusive is this growth? The growing interest of wealthy multinational investors in this relatively unknown, very sparsely populated (2.8 mln, 2011), landlocked country sandwiched between the two giants Russia and China has suddenly made my country economic headline news. The people of Mongolia have begun to realize the importance of their country (but not necessarily of the country’s inhabitants) to the rest of the world.

Let me show the view from the ground on the implications of this mineral wealth on health. First and foremost is the danger to the health and safety of the communities adjacent to the mining operations, despite the safety programs run by a few mining companies. Local health services are overstretched due to increased road traffic accidents caused by the increased volume of vehicles, industrial accidents during the mine construction and dust induced respiratory and eye infections. Injury and respiratory infections are amongst the top five causes of morbidity and mortality in the population in the mining areas. Besides, access to health services by the transient population is uncertain as local health facilities receive their budget based on the
number of locally registered people. The rapid influx of workers also contributes to increasing sexually transmitted infections and a higher risk of contracting HIV/AIDS.

Mongolians are proud to be one of the last nomadic people in the world. Sadly, mining might end this pride. Extensive and potentially permanent devastation of land and forests, and increased dust cover over large pastoral areas, are already contaminating pasture and water sources, threatening nomadic life. In the last five years more and more nomadic families have moved to urban areas because of their inability to adapt to their rapidly changing circumstances. Today, not even a quarter of the population lives in the traditional way. The high influx of migrant workers (Mongolian and international) and consequent overpopulation in the capital city poses a number of public health challenges: lack of proper housing, an increase in infectious and respiratory diseases, inaccessible health and welfare services for the unregistered population, etc. People who have moved into the city tend to reside in the outskirts of the city, living in felt covered tent-like gers (moveable dwellings). They burn low quality coal to keep warm during winter making Ulaanbaatar one of the most polluted capital cities in the world. Consequently, respiratory disease is one of the top five causes of death. Poor sanitation and limited access to safe drinking water is increasingly becoming a key cause of illnesses in poor people living in these expanding slum districts on the outskirts of Ulaanbaatar.

Although the biggest mining companies such as Rio Tinto and Ivanhoe Mines are endeavoring to mitigate mining related risks, they are not operating within a broader planning framework, nor are they coordinating with each other and with other government social sector services. Many of the smaller and local mining companies are adopting a “take what you can and damn the consequences” approach, which unfortunately is often aided and abetted by local politicians eager to get their share of riches as quickly as possible. If this attitude prevails, Mongolia will face the “paradox of plenty” with widespread non-salutary impact on the health and safety of the people and on their environment.

A number of civil movements led by local people have been quite active in demanding responsible mining with potential positive impacts on average people’s life in Mongolia in the first few years of the mining operations. Unfortunately many of them have lost their original vision and motivation, partly because both of the main parties made “attractive” promises for one time cash transfers of the wealth from mining (approx. 1150 USD) to each citizen (Cash handouts did indeed materialize, but far below what had been promised). On the other hand, in the media, pundits (often also working as mining company advisors) are asking “How long do you want to be called a beggar, by outsiders, while you are sitting on the gold”? Even if not all Mongolians are convinced, they have quite some influence over public opinion.

The country must not forget its own recent (and bitter) lessons of being heavily dependent upon the mining sector. The unpredictability of the market prices of gold and copper will continue to threaten economic stability and hence development sustainability. In 2005-2006 Mongolia enjoyed fast economic growth when world copper prices almost tripled. However, in 2008, when the copper price dropped by half, the country experienced an economic “bust” and recognized its
lack of strategic investment planning for the development of other sectors during the “boom” period. Learning to better allocate mining resource revenues and investing in health and social services and infrastructure whenever a “boom” occurs is a must.

Still, if getting “rich” as a nation increases disparities and comes at the expense of our people’s health and safety, erodes their heritage and culture, negatively impacts the poor and vulnerable, it is safe to say that this is not the “development” our people had in mind.

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CHAPTER 6: UNDERSTANDING HEALTH SYSTEMS STRENGTHENING: GLOBAL NORMS AND THE POLICY FRAMEWORK IN MONGOLIA

6.1 Overview

Since the 1978 Conference on Primary Health Care in Alma-Ata, there have been successive waves of attention to health systems for low and middle-income countries, with a recent focus on HSS. In the context of WHO’s global goal of UHC—securing access for the whole population, extending the services available and containing the financial risk of health care (63)—this has become increasingly important. But as we have detailed in Chapter 2, definitions and frameworks for health systems vary widely, and the process of coordination of national and donor resources to achieve UHC requires a shared understanding of what activities are considered as HSS interventions in any given context.

In this chapter, I present two nested policy analyses of HSS: a documentary analysis examining the global norms around HSS; a policy analysis exploring the development of HSS within the context of the Mongolian health sector. These provide a policy and documentary framing for the qualitative research that follows in the next chapter: the perceptions of HSS from the perspectives of donor and government actors. The first documentary analysis is an extension of the literature review of Chapter 2, and relies on recent international literature—both peer reviewed and other literature (web-based, WHO reports, commentaries, etc.)—as it has developed to shape health systems with a view to UHC. The second policy analysis builds on this, examining national health and development policy documents and local political constructions of HSS in the specific context of Mongolia.

These analyses of the current health policy reform processes have provided me with a basis for developing a context-specific HSS framework for my research. The framework permits the diagnosis of the ills in the health system at the policy and operational levels, and points to context specific issues for their improvement. It has given me a structure to explore the interrelationships between health systems inputs, processes and outcomes, and has served to help raise the level of awareness among policymakers of the importance of focusing on HSS.
Overall, the key challenges and issues for the Mongolian health systems appear to share globally recognised health systems challenges, and common needs for health systems reform. However, closely examining the commonalities identified between the HSSMP and the building blocks framework suggests that these apparent commonalities are superficial. Unpacking the differences between global frameworks and the local specificities of the Mongolian health system has allowed me to explore more context-specific HSS areas and interventions. Despite the lessons that need to be adopted from global health and development policy, the types of interventions and approaches needed for achieving HSS priorities, which have emerged as a result of the study, have a number of dimensions that are unique to Mongolia.

6.2 HSS: defining global norms for health systems development

In Chapter 2, I examined the competing health systems frameworks for understanding health systems and the resultant implications for HSS. This analysis builds on that literature in very practical ways, examining the normative assumptions around what HSS interventions should consist of, especially in the LMIC settings. HSS is a complex intervention that requires multidisciplinary and multi-actor cooperation (113, 180) as I showed in Chapter 2. Health system researchers have begun to acknowledge that, while structural models of health systems such as the WHO Building Blocks are useful in deconstructing the health sector, HSS interventions need to be understood as a process, and that process must be adapted to the context-specific situation of each country—its political and socio-economic circumstances, its social values and norm, and its national leadership.

This progressive understanding is evident in the chronologically listed analytical summary of the key studies (see Table 6-1 below) looking at characteristics of HSS interventions. These studies represent the authority and agendas of key agencies working towards supporting HSS: WHO, World Bank, USAID; and reputable academic institutions (London School of Hygiene and Tropical Medicine, London, UK) and key authors; and are published in prominent peer-reviewed journals such as the Lancet and New England Journal of Medicine. As such they set compelling global norms for understanding HSS in development for health in LMICs.
Table 6-1: Key studies identifying characteristics of HSS interventions

<table>
<thead>
<tr>
<th>Author and study/report</th>
<th>What should a HSS intervention look like?</th>
</tr>
</thead>
</table>
| Mills A (2014); Health Care Systems in Low- and Middle-Income Countries (181) | • provides a long-term strategic focus  
• considers constraints imposed by history and previous decisions  
• encourages societal level consensus building and synergies among sectors and actors  
• considers both broader governance and socioeconomic context and local culture and population preferences  
• allows flexibility and autonomy in decision-making  
• creates resilient interventions, learning from experience, and feeding back into the policy cycle  
• demonstrates openness to dialogue and collaboration between public and private sectors, with effective government oversight |
| Balabanova *et al* (2013). Good health at low cost 25 years on: lessons for the future of health systems strengthening (182) | • promotes good governance and strategic investment  
• preserves institutional memory  
• ensures sensitivity to the context  
• innovates and adapts to resource limitations  
• responds to population needs  
• requires reliable infrastructure  
• includes female empowerment and education |
| D. Smith, R., & Hanson K. (2012). Health Systems in Low- and Middle-Income Countries: An economic and policy perspective (183). | • ensures context-feasibility  
• considers not only health system components but also *relationships* among parts, feedback loops, process of learning, and adaptation over time.  
• delivers politically adaptable/workable interventions |
| Gilson, L. (Ed.). (2012). Health Policy and Systems Research: A Methodology Reader (127) | • impacts on the micro, meso, and macro levels  
• considers interactions and interrelationships  
• focuses on the hardware of the systems (HR, HF, Information) and also the software (policy, governance, behaviour)  
• focuses on the long term and sustainable strategies |
<table>
<thead>
<tr>
<th>Source</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| J Sundewall *et al* (2011) Health-systems strengthening: current and future activities (38) | - involves civil society and community-based organisations  
  - focuses on retention and optimum use of human resources for health  
  - promotes health-systems governance and intersectoral collaborations  
  - promotes capacity of health-information systems for evidence-based systems interventions  
  - ensures the health system is responsive to demographic change, ageing populations, chronic diseases, and emerging infections (holistic view)  
  - builds capacity among senior health-systems stewards  
  - ensures sustainable and efficient funding mechanisms |
  - supports the principles and values of primary health care: fairness, social justice, participation and intersectoral collaboration  
  - considers system’s thinking elements such as system’s networks, dynamics, organisation and knowledge |
| Takemi, K., & Reich, M. R. (2009). The G8 and Global Health: Emerging Architecture from the Toyako Summit (115) | - deals primarily with:  
  o health workforce  
  o health financing  
  o health information |
| World Bank (2007) Healthy development: the World Bank strategy for health, nutrition, and population results (184) | - interventions include:  
  o health financing innovations  
  o public and private health service provision  
  o incentives for health workers  
  o logistical and financial management  
  o governance of health systems  
  o decentralisation  
  o sector-wide strategic planning; |
| USAID (2007) health systems assessment approach (126) | - WHO’s six building blocks and their interaction  
  - interventions that promote equity, access, quality, efficiency and sustainability |
There is a considerable degree of consistency between these studies in determining what is appropriate in HSS interventions. These studies all highlight the importance of system-wide perspectives, good governance, capacity building and interaction with the broader political context in supporting HSS. But while earlier studies were more focused around the hard components of key health systems such as health financing, human resource and information; more recent analyses look at health system values and principles, the surrounding context, interrelationships between and within the system, the role of civil society and other sectors such as education and welfare; as well as historical features that influence the system, and intangible factors such as capacity building and good governance.

Downs and Larson (185) underline this in their description of complexity and dynamicity of health systems: “...We must also place the health systems model in its relevant, health-centered political, socio-cultural, economic and ecological contexts: a ‘model within models’. For example, a model of the political context explains how power is distributed within the society, how health and development policy decisions are made, and the relationships among stakeholders, and is fundamental to effective intervention. A socio-cultural perspective is needed that describes gender dynamics, youth–adult relations, tribal and ethnic dynamics. Social drivers of health that result from these contexts and dynamics need special attention in a systems model. (p,150)

The complexity and interrelatedness of the health systems perspectives has also been reinforced in the above-mentioned (Table 6-1) key studies. Contextual factors which serve as cross-cutting elements across different areas of health systems such as the socio-economic context, politics, governance and institutional capacity have been identified as important factors for effective HSS.

Clearly, HSS needs to be understood as a complex process, and as a means to the end rather than simply the output itself. In my analysis of the Mongolian context, I have used the three elements which I identified in the conceptual framework (Figure 2-10) as follows.

- input elements or hardware components
- process elements
- cross-cutting elements or contextual factors.

These elements of health systems served as a basis for determining an effective and feasible HSS framework appropriate for Mongolia. Effective health systems need all these elements functioning effectively as they form key structure (input), functions (process) and drivers (contextual factors) of the health sector, enabling it to achieve equitable, affordable and sustainable health outcomes.
Mongolian health system reforms often had a more concentrated focus on improving input elements only, with little consideration for improving process elements such as financial management and regular monitoring and evaluation that feeds into the policy development process. Also, contextual factors require more importance than ever, especially as the country gradually transits since early 2000 from a centralised and autocratic management type to a more decentralised, democratic and participatory style of management.

6.3 HSS in Mongolia: examining its context-specific application

The health systems conceptual framework (Figure 2-10) highlights the influence of the surrounding context and politics in identifying effective HSS in any given environment. The application of the converging health systems framework by Shakarishvili et al. (108) is useful for informing developing understandings of context-specific HSS in Mongolia, particularly with its attention to the external-to-health factors and their influence in defining HSS. The Mongolian health system has been dramatically affected, both positively and negatively, by a series of external factors: broad socio-economic issues, dramatic transitions in history, unpredictable politics, and a dramatically changing policy and legal environment. This policy analysis examines the key factors and national health and development policy documents that have shaped local definition of HSS.

6.3.1 Socio-economic and historic influences on HSS

The social choices that have determined the radical changes in health system organisation, priorities, and performance, have themselves been influenced by dramatic historical, political and economic changes. With the collapse of the Soviet Union in the 1990s, the health system of Mongolia began its transition from the centralised, public provider Semashko model to a more decentralised, mixed provider system (186). During this transition period, the health sector of Mongolia has been heavily dependent on aid provided and directed by various donors (187). As Mongolia’s market orientation and political governance have stabilised, the development of a long-term health sector strategy has become inevitable, and within that the coordination of these diverse, unaligned and project-oriented donor aid initiatives.
As highlighted in previous chapters, in the early years of donor aid, donor support focused more on relief aid, with cash and in-kind support providing inputs for service delivery. As the country transitioned to early development, input-focused support was no longer as effective or desired, as it did not directly contribute to the capacity building and sustainability of the sector (188). Realising these weaknesses, the MoH initiated the development of the HSSMP to oversee long-term development of the health sector and direct partners’ support according to the country’s needs and priorities (13, 189). The HSSMP was the first-ever comprehensive long-term strategic document in the sector, developed using local participation, capacity building and systems thinking.

6.3.2 HSS and the politics of health in Mongolia

Health system decisions such as resource allocation, licencing and regulations are subject to government decision making, and the influence of a range of social and economic stakeholders. As such, the system is explicitly political (183). It is also very vulnerable to political volatility as the health agenda is often used as powerful popular electoral tool for politicians. Although this may positively impact the health sector in terms of increasing health sector revenues, populist political activities do not necessarily bring positive health outcomes as these politically driven health agendas are often short-lived, unable to promote the necessary capacity building and systems strengthening, which require long-term effort and commitment. In fact, too much politicisation in health has a negative impact (190). In Mongolia, establishing new district hospitals, reducing out-of-pocket payments and strengthening the health insurance scheme have been the key health issues in both of the main parties’ policy agendas from 2007–2008. Establishing new hospitals has been more attractive in terms of winning votes, but is not necessarily supportive of comprehensive HSS. In its joint health sector reviews (13) there has been a consistent recommendation that health policy in Mongolia needs a shift from its current hospital and curative focus to a more preventive and public health approach, and this has been highlighted in the HSSMP. Reducing out-of-pocket expenditure and strengthening the health insurance scheme are both initiatives that complement the directions of the HSSMP, but the implementation mechanisms need a more step-by-step approach and effective collaboration with the social welfare sector in order to bring sustainable health outcomes (16, 20, 77).
6.3.3 HSS: Progressive policy and legislation in Mongolia

Mongolia has been the one of the most successful post-Soviet countries in transitioning from a socialist system to a democratic and decentralised system over the last two decades (6, 191). The country inaugurated its new Constitution in 1992, in which it is clearly stated that: "The fundamental purpose of state activity is the assurance of democracy, justice, freedom, equality, and national unity and respect of law." (Article 1.2-Mongolian Constitution (192)) The very nature of the statement confirms the country’s aspirations to adopt a just and democratic system. But the actual transition to this new value system has not fully occurred, as the country has been experiencing growing inequity in all aspects of social life in the last two decades.

The key government policy documents and national development strategies have aimed to ensure sustainable and equitable development; and as a result, the principles and values of these development goals are reflected also in the health sector policy documents. In my review of Mongolian Government development and health policy documents, I have identified the extent to which health systems issues are reflected in both non-health and health policy documents and their implications for HSS. The analysis shows that to quite an extent, these documents are reflective of current health systems thinking and strategies internationally, and their implementation in Mongolia is fairly consistent with global trends.

Table 6-2 below summarises this analysis, providing a comprehensive picture of key health and non-health policy documents developed in the last two decades, and what their implications are for the health system. This will be followed by a more in-depth study of how a local key health policy document—the HSSMP— is consistent with globally recognised health systems frameworks and agendas, in addition to its being relevant and responsive to local issues.

The policy documents are listed from the most influential in terms of their impact on the health sector.
Table 6-2: Key health and non-health documents and initiatives and their implications for HSS

<table>
<thead>
<tr>
<th>Policy/strategy</th>
<th>Aim/purpose (relevant to health)</th>
<th>Key health system components influenced</th>
<th>Implications for HSS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government policy documents and initiatives that impacted the health sector (since 1996)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Improve maternal and child health, HIV/AIDS programmes, and safe water supply.  
- Improve health financing mechanism.  
- Provide population with safe and quality-tested medicaments and medical tools, introduce proper medical technology and develop health infrastructure. | Health care technology  
Human resource: hardship allowance  
Service delivery  
Health financing  
Infrastructure and pharmacy | Key areas of health systems are covered. However, the use of MDGs as the core metrics somewhat encouraged vertical programmes for maternal and child health and HIV/AIDS. Nevertheless, it serves as an overarching high level document to support the health system which ensures political and technical support to the areas outlined. |
Governance  
Health Management Information System (HMIS) | The law was intended to support performance-based budgeting; however, in practice it created mismanagement of funding and irrational resource allocation, further worsening inequity because of poor financial management capacity and a weak monitoring and evaluation system. Hence, it was abolished in 2012. |
<p>| Law on Foreign Loans and Grant Aid (2003) | - To harmonise and align partners’ aid programmes with the government priorities, regulations and procedures. | Governance and accountability | The law encouraged collective contribution to support the health sector and reduce duplication of projects and programmes. Also, it promoted strengthening of the government regulations and procedures; and served as an action to support Paris Declaration principles. |</p>
<table>
<thead>
<tr>
<th>Establishment of a licensing and accreditation system (1998-2002)</th>
<th>Licensing and accreditation of health facilities.</th>
<th>Quality of care</th>
<th>It aimed to serve as an incentive to improve quality of care. However, actual practice of licencing and accreditation did not adequately serve its purpose, especially in district public hospitals because of the inevitable need to provide services to the local population regardless of the hospital being accredited.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Service Law (2002; amended in 2008 and 2011)</td>
<td>To mandate civil servants to be non-partisan and free from any political activities.</td>
<td>Governance and accountability</td>
<td>Unfortunately the law had more cosmetic effect rather than actual change of practice. However, at least the awareness of accountability and responsibility, good governance and anti-corruption initiatives has been increased amongst the population.</td>
</tr>
<tr>
<td>State and Local Government Properties Law (1996; amended in 2005)</td>
<td>First initiative to implement decentralisation and semi-privatisation.</td>
<td>Governance and management</td>
<td>The process has been centrally driven and implemented without prior preparation; and thus so far incomplete due to the lack of institutional, managerial and technical capacity at all levels. It also revealed poor financial management capacity at a local level.</td>
</tr>
<tr>
<td>Programme for privatisation of state property and service (1997)</td>
<td>Piloting health sector privatisation.</td>
<td>Quality of care/service delivery</td>
<td>Intention to improve quality and range of services through promoting private health sector did not work as intended because of poor regulation. Instead, it created poorly coordinated questionable private health services.</td>
</tr>
<tr>
<td>Gender Law (2011)</td>
<td>To ensure gender equity in all aspects of social relations.</td>
<td>Ensuring gender equity in health sector is included Gender specific health needs are addressed Reproductive health rights of both men and women and adolescents are highlighted.</td>
<td>Increased the emphasis on reproductive health and special health needs of men and women, but the implementation and monitoring mechanism has not been developed clearly, hence did not have much systematic impact.</td>
</tr>
</tbody>
</table>

**Health sector key policy documents and initiatives (since 2001)**
| Health Sector Strategic Master Plan 2006-2015 | - Reduce maternal and child mortality  
- Increase access to quality health services especially for the poor and vulnerable  
- Increase coverage of basic sanitation and safe water supply  
- Reduce household health expenditure especially for catastrophic illnesses  
- Support more effective, efficient and decentralised health system  
- Implement sector-wide approach  
- Promote optimum public private mix. | Health service delivery  
Pharmaceutical and support services  
Behavioural change and communication  
Quality of care  
Human resource development  
Health financing  
Institutional development & sector-wide management | The plan development promoted capacity building. The plan itself provided as an umbrella document to look at the sector as whole with an interaction with other sectors promoting systems thinking. HS areas identified in the plan are similar to health systems components in other HS frameworks such as building blocks and control knobs. The plan implementation and monitoring requires well-designed HMIS. |
| Human Resource Development Policy of the health sector (2010-2014) | - To provide guidance for staffing of the health services and the training of health service personnel. | The policy also highlighted the limitations of workforce planning in the current policy environment | The policy highlighted the importance of intersectoral collaboration in developing human resources in health and supported the establishment of the high level intersectoral committee on HRH |
| Health Financing Strategy 2010-2014 | - To provide financial protection for individuals and ensure accessible and quality health care for everyone | Efficient payment mechanism  
Rational resource allocation  
Use financial instrument as an incentive to improve quality of care | The policy highlighted the importance of provision of equitable, efficient and quality care with special emphasis on keeping out of pocket payments at less than 25 percent of total health expenditure. Gaps between the policy priorities and actual resource allocation were highlighted and ways to address these gaps have been introduced (193). |
| Establishment of Health Promotion Fund (2010) | - To create alternative source of funding for health through introducing special tax on tobacco and alcohol. | Revenue generation in health  
Support to the health promoting behaviour | It contributed to the increased social responsibility of alcohol and tobacco producers (22) |
| Revision of the key health Acts (2011) | - Health Law  
- Citizen’s Health Insurance Law | Health service effectiveness and efficiency  
Access and availability of health service  
Affordable and quality health service | Service accessibility and affordability was a key element to be promoted  
Social health insurance reform further highlighted a need for better functioning payment mechanism and good information and data management |
| Policy on public and private partnership in health sector (2011) | - Encourage private sector investment to quality health services and infrastructure  
- Support development of the private health sector to encourage competitive and quality services  
- Develop effective and long-term PPP in health. | Access and availability of quality health services  
Quality of care  
Health infrastructure  
Health financing (revenue generation)  
Effective financial management | Range and quality of the services provided through PPP is highlighted  
Also reinforced the importance of other systems elements such as well-functioning licensing and accreditation system, HMIS. |
|---|---|---|---|
| National Health Accounts (NHA) (2002) | - To create a reliable data base for the development of strategies and policies in health care financing. | Health care financing  
Data management (HMIS) | It provided detailed and disaggregated data about national health expenditure assisting the development of the Health care financing policy. But NHA is still not fully appreciated or adopted by the policy-makers (14). |
| Sector-wide Approach (SWAp) (introduced 2005) | - To strengthen multi- and bilateral cooperation and coordination;  
- To improve management and coordination of both external and domestic resources to progress the sectoral performance. | Health financing  
Resource generation and rational allocation  
Capacity building  
Ownership | Promoted systems thinking and capacity building.  
Supported effective planning and management and rational resource allocation.  
Improved harmonisation and alignment of the programmes implemented in the health sector, although was not appreciated by all donors in health and some key government officials, hence stagnated since 2011. |
| Law on Drugs (2005) | - Approve essential drug list;  
- Promote equity, accessibility and quality of pharmacies. | Pharmaceuticals  
Drug procurement  
Drug safety  
Rational drug use | It emphasised rational drug use and proper prescription usage, though change in practice in rather slow.  
Regulation of drug procurement and manufacturing system was highlighted. |
Per capita payment mechanism | It revealed a need for strengthening capacity at PHC level.  
Administrative and financial management capacity has been improved at FGP level. |
| State Policy on Public Health, 2001 (SPPH) | To combat common diseases based on the epidemiological profile on the country;  
To reduce risk factors causing illnesses;  
Involvement of Government and NGOs, family and community to encourage healthy behaviour was a key. | Behaviour change and communication areas are covered.  
Involvement of Government and NGOs, family and community to encourage healthy behaviour was a key. | Despite its best intention to support preventive medicine, it created many vertical standalone programmes that caused administrative burden on health providers.  
Programmes operated in isolation which prevented from having collective and effective health outcome. |
An analytical review of these current polices and strategies suggests that there has been a definite paradigm shift in policy, moving from a curative, provider-oriented health care system towards a preventive and client-centred system; from vertical and fragmented approaches to a more holistic systems approach; from centralised management to decentralised and participatory management and decision-making approach (14, 16, 77, 187, 194, 195). Key health system components reflected in the strategies that are documented in both health and non-health policy documents include both Input (staff, resource, and infrastructure) and Process (financial management, human resource management, and the M&E system) elements. Health financing, human resources, governance and capacity building, service delivery and quality, behaviour change are the key health systems components highlighted in a number of health policies and reform initiatives (13, 195, 196). These have been followed by the Health Management and Information System (HMIS), medical equipment, infrastructure, and pharmaceuticals. Global health and development approaches such as a SWAp and public-private partnerships are also effectively reflected in the local policies (15, 24). Good governance, accountability and transparency are increasingly on the agenda.

But the implications for HSS have been varied. There has been an increased awareness of the importance of local capacity building and a good information management system in order to build a strong health system. Ambitious health systems policy interventions have been initiated: decentralisation, private sector regulation, and public-private partnerships. But despite the best intentions, in some cases, these reform strategies have not worked due to a lack of preparatory work for the reform, or a lack of support in the political environment beyond the health sector. For instance, decentralisation has been an essential reform from which the health sector could substantially benefit, providing more financial authority to the local level, and encouraging participatory planning and budgeting. However, more than 70 years of centrally-controlled economic management means that health authorities at regional and district level were not prepared to manage the devolved responsibilities. Despite higher level political changes, they continued to look to the top for direction, and have been reluctant to take ownership over their planning and budgeting (13, 187). Given their historical positioning, they could not feel confident to negotiate with the district government authorities, and to defend their plan and budget.

Similarly, privatisation did not bring the intended positive outcomes such as increased range and quality of services through creating competition, client-friendly services; instead it created chaos where some health facilities were turned into unregulated pharmacies, while some provided profit-oriented services that were irrelevant to the population health needs. These failures in early policy
implementation revealed the need for greater prior preparation; effective government coordination through proper licensing and accreditation systems, and a well-managed information and data management system (187).

6.3.4 HSS: using the HSSMP to map HSS

The HSSMP, which has served as a key health policy document since its completion in 2005, has defined seven key areas of work (20) that are largely consistent with the WHO building blocks. The fact that the HSSMP was developed before the introduction of the six building blocks, shows both the originality of the HSSMP structure, reflecting local health needs and priorities, and its conformity with global health systems’ thinking as crystallised in the WHO definition of health systems for HSS. However, implementing the policy framework outlined by the HSSMP in such a way that it targets HSS in Mongolia requires clear mechanisms and a supportive policy and governance environment. The highly participatory nature of the development of the HSSMP has ensured that it is the most widely accepted policy framework document in health in Mongolia, and is seen as most relevant to local needs and priorities (189, 197). For this reason, I have further examined how HSS is defined in this key planning document—the HSSMP.

The Mongolian Government approved its HSSMP 2006-2015 in 2005. The goal of the HSSMP is defined as “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-centred and quality services.” (p. 37) (20). Mother’s and children’s health has been given more importance in the plan as maternal and child mortality indicators have been fluctuating, despite their overall improvement in the last 10 years (77).

The HSSMP identified seven areas as key components of the health system to be improved. These are:

- health service delivery
- pharmaceutical and support services
- behavioural change and communication
- quality of care
- human resource development
• health financing
• institutional development and sector-wide management.

A brief definition of each area will provide some guidance of for what constitutes local defining of the Mongolian health system and indicates how these could be approached for strengthening.

**Health service delivery** strategies are intended to improve *coverage and accessibility of services* at all levels of health service without neglecting equity and creating a gap between urban and rural populations. The area also covers linkages between levels of the health system through an *effective patient referral system*.

**Pharmaceuticals and support services** strategies streamline and systematise the *logistics management system* including ordering, procurement, storage, distribution and monitoring of the performance of the drug and medical supplies system at all levels. The other task within pharmaceuticals and support services is the integration and unification of the regulatory and quality assurance functions of the MoH for drugs, bio-preparations, food supplements and bioactive substances.

**Behavioural change and communication** is a new area of the health system that has been identified as a key area to improve health outcomes. It has been identified as a separate component because of its contribution to health through providing appropriate and *effective health education programmes, mobilising community and campaign activities* and increasing awareness and sensitisation about health hazards among the general population. It also includes promoting improvement of the *inter-personal communications skills of providers* and encouraging consumers to adopt appropriate *health seeking behaviours*, avoiding risky behaviours and self-medication. Providers’ poor interpersonal communication skills have been identified as one of the key barriers to accessing health services, especially amongst the poor.

**Quality of care** has been identified as a component with the intention of establishing integrated decentralised quality management and monitoring mechanisms at all levels for on-going quality improvement. The emphasis is placed on enabling the emergence of a *quality management culture* through increased participation of professional associations and interested stakeholders in quality of care improvement. Development and enforcement of the quality standards
application guidelines and conducting related training programmes are identified as key interventions to improve the quality of care.

**Human resource development** covers the reform of the current *HR planning and management system*. Rational distribution of health workers, retention of rural health workers and regulation of overproduction of specialists are the key issues to be addressed. Also, implementing a sector-wide system to provide access to ongoing and relevant continuing education to meet the re-licensing requirements would be a key strategy.

**Health financing** strategies cover reform of the current *health insurance system* through separation of the purchaser and provider functions. Also, increasing financial resources to the health sector, fair allocation of resources across levels of care and introduction of *performance-based payment mechanisms* and the institutionalisation of the National Health Accounts would be the key strategies of the area.

**Institutional development and sector wide management** covers a number of key health systems reform issues related with *managerial and institutional capacity building* of the health administrative organisations; strengthening management, *governance and leadership* in the MoH; enabling *effective cooperation with intersectoral agencies* and external partners; effective private sector regulation; and implementation of an *effective Health Management and Information System (HMIS)* that contributes to the evidence-based decision making at the policy level.

It has been observed that there are some similarities between the seven key areas identified in the HSSMP in 2005, and the WHO health systems’ building blocks which followed in 2007 (Table 6-3). HSSMP covers all six of the WHO building blocks (116), and adds additional areas: Quality of care, and behavioural change and communication. However, when the HSSMP is explored in greater depth, the extent to which this strategic plan shows signs of its local emergence, and the specific application of global approaches becomes apparent.
Table 6-3: Comparison between HSSMP and of building blocks

<table>
<thead>
<tr>
<th>HSSMP key areas</th>
<th>WHO building blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service delivery</td>
<td>Service delivery</td>
</tr>
<tr>
<td>Human resource development</td>
<td>Health workforce</td>
</tr>
<tr>
<td>Institutional development and sector-wide Management (This has a component that deals with information management and leadership and governance.)</td>
<td>Information Leadership and governance</td>
</tr>
<tr>
<td>Pharmaceuticals and support service</td>
<td>Medical products, vaccines and technologies</td>
</tr>
<tr>
<td>Health financing.</td>
<td>Financing</td>
</tr>
<tr>
<td><strong>Quality of care</strong> (This is identified as a standalone reform area in the HSSMP because of required paradigm shift from Soviet-style punitive quality management to more supportive quality management).</td>
<td>Financing</td>
</tr>
<tr>
<td><strong>Behavioural change and communication</strong> (This is a new area that has been identified as essential to improve population health in Mongolia.)</td>
<td>Financing</td>
</tr>
</tbody>
</table>

These key areas identified in the HSSMP were based on the extensive situation analysis of the Mongolian health sector issues and challenges; therefore, it forms a health systems model constructed from within the system and tailored to meeting the system’s needs. Areas of quality of care and behavioural change and communication are not specifically addressed in WHO building blocks, but, behavioural change and communication has been considered as a performance driver in the control knobs framework (112). Other areas, such as health financing, human resource development, service delivery and components of the institutional development and capacity building areas are reflected in the WHO building blocks, and this congruence has led to easy support by the key stakeholders in health: ADB, WHO, UNFPA and GTZ.

However, it must be noted that despite these superficial similarities between the HSSMP areas and the WHO building blocks, and with other global and regional policy documents, the Mongolian health systems interventions identified for each key area of the HSSMP are substantially and qualitatively different. My analysis, based on stakeholder interviews, which will be discussed in the following chapter, suggests that the HSS interventions are interpreted differently by different actors.
in different settings, and that the stakeholder context is the key to the understanding of a framework. For example, while the focus of key HSS interventions in the area of human resources is usually on the number of health workers trained, in the case of Mongolia, it is the quality of workers trained, the equitable distribution of workers across the system, and systematic development of quality training programmes that are considered as the most important HSS interventions, with direct links to achieving better health outcomes (13, 22, 77, 187).

The development of the HSSMP highlighted critical systems problems and its structure and strategies readily enabled HSS interventions. The inclusive and participatory nature of the HSSMP development allowed multi-dimensional perspectives and pragmatic approaches to identify and address underlying systems issues of the health sector challenges. As defined in the HSSMP strategies, the following interventions are considered as HSS interventions when using systems thinking and holistic approach based on the analysis of the key studies identifying HSS characteristics (Table 6-1). These interventions are to:

- improve accessibility and affordability of health services
- streamline and systematise the drug and medical supplies procurement system
- increase awareness and sensitisation about health hazards among the general population through improving health education
- improve provider and client interpersonal communication skills
- enforce quality standards application guidelines and conduct related training programmes
- support the rational distribution of health workers and retention of rural health workers
- establish continuing education programmes for health workers
- promote the fair allocation of resources and the introduction of performance-based payment mechanisms
- support an effective health management and information system
- develop managerial and institutional capacity and governance and leadership in the MoH.

All these are supportive of Process elements within the health systems framework used in the research; hence these potentially bring systematic changes and sustainable health outcomes. However, the implementation of the plan requires governance capacity and continued political will (77) to maintain the momentum gained during the development process of the HSSMP.
6.4 Summary

The chapter presented both global and national norms and frameworks to identify HSS. An extensive review and analysis of globally recognised studies defining HSS has provided theoretical basis and justifications of effective HSS perspectives and strategies. As a result of this analytical exercise of global norms and perspectives for HSS, a structure to explore the interrelationships between health systems inputs, processes and outcomes has become clear. It also raised the awareness of the importance of focusing on contextual factors such as politics and socio-economic drivers that influence HSS. Building on this, comprehensive review and analysis of national health and development policy documents and local political constructions of HSS have been conducted.

Overall, the clear identification of what needs to be done in supporting HSS has been well presented in current policy documents, especially in the HSSMP. The HSSMP provides an overall umbrella within which other health programmes and projects can be aligned and contribute to the implementation of the plan. The principles of effective health systems, such as accountability and transparency, equity, participatory approach, sustainability and ownership, are consistently emphasised in the HSSMP. But how actual HSS interventions are understood and supported by key stakeholders in health remains unclear. This has been explored in key informant interviews with both domestic and international actors, which will be discussed in the next subsection.
7 CHAPTER 7: HEALTH SYSTEMS STAKEHOLDER PERCEPTIONS OF HEALTH SYSTEMS STRENGTHENING IN MONGOLIA

7.1 Overview

The previous chapter has shown how global norms and frameworks for HSS have been adapted locally in identifying effective health systems strategies and that the HSSMP has served as a strong local template. This chapter will further investigate if this local adaptation of HSS as outlined in the HSSMP is consistent with key stakeholders’ perceptions of HSS strategies feasible to Mongolia. Key-informant interviews with policy elites form the basis of the analysis of the stakeholders’ understanding and approaches of working towards HSS.

As outlined in Walt and Gilson’s policy triangle framework (Figure 3-1) (35) the position and power of the actors are important in defining HSS in specific context. With HSS becoming the growing focus of global health and sustainable development, it is important to look at how this common broad goal is understood and approached by different partners in the context of Mongolia. This part of the research responds to the research question 5 which reads: “How do government and development partners in health understand health systems strengthening?” While global and regional agendas on HSS provide broad approaches to strengthening the health system, it is important that, at the country level, different partners share a similar understanding of HSS, in order to respond to the country’s specific health system’s needs, and to coordinate collective inputs into the country with a view to enhanced outcomes. These key informant interviews—with both domestic and international partners working in health— not only complement the previous documentary and policy analysis on HSS in Mongolia but also provide another new dimension about why partners consider HSSMP as a basis for supporting HSS and the reasons they approach supporting HSS in Mongolia differently.

7.2 Methods

The interviews were conducted with 26 participants (Chapter 3) during my fieldwork held between September and December in 2012 in Ulaanbaatar, Mongolia. The elite interview method was chosen to understand HSS perspectives of key stakeholders as it provides rich qualitative data (162,
The pre-prepared interview guide (Annex 1) was only used in staying focused on the overall focus of the research but did not limit the emergence of new themes. Interview questions were open-ended on purpose to prevent my pre-established ideas of HSS dominating interviewee’s perspectives.

Interviewees were selected by purposive sampling method, based on their extensive knowledge and experience related to the health systems reforms in Mongolia. Twenty-six key informant interviewees were selected for semi-structured in-depth interviews. Twenty-four interviews were done individually in face-to-face meetings, and two interviews with international partner representatives were done through Skype calls. Criteria for the participants were to have representation from key international partners in health; to have both policy making and implementation level representation; government health and non-health officials with at least 10 years of working experience in public sector. All key donors including bilateral and multilaterals (UN agencies and development banks) agencies, and some representatives of international NGOs working in health were interviewed. Details of the key informants are shown in Annex 3.

I, myself conducted and transcribed all interviews. The interviews with the local officers (n = 13) were conducted in the local language Mongolian, with the remainder (n = 13) in English. All interviews are audio recorded and were translated into English. All notes, transcriptions and records were brought to Australia for further analysis and recording.

The relatively manageable data size and my expertise and skills in manual analysis of qualitative data made me decide to use a manual data analysis method rather than NVIVO—a computer-assisted qualitative data analysis programme. The decision taken was more time-efficient and feasible because I single-handedly undertook the data collection and analysis; consequently, I had a closeness and familiarity with the data acquired during the process of data collection, transcription and analysis.

7.2.1 Data analysis

As planned, the data transcription and analysis process began simultaneously during the data collection process. Notes (memos) were taken both during interviews and transcription as new or repeating categories emerged. Gibbs’ definition (198) for coding was applied to the emergence of
new categories and codes. It reads “..Coding is the process of combing the data for themes, ideas and categories and then marking similar passages of text with a code label so that they can easily be retrieved at a later stage for further comparison and analysis ”.

Coding began to emerge after the fourth interview transcription. Emergence of categories and codes were colour coded on a word processor. A combination of number of techniques to identify themes and codes (199) were used; looking for word repetitions, key-words-in-context/passage; searching for missing information and comparing and contrasting within and between interviewees opinions. Both descriptive and analytic type coding emerged. Descriptive coding simply describes what is in the data whereas analytic coding aims to explain ‘why what is occurring in the data might be happening’ (198, 200). Key informants’ opinion regarding what is HSS and their ranking of HSS priorities required mainly descriptive coding. However, information responding to why they see it as HSS and why various donors approach HSS interventions differently required an analytic type of coding. Memos written during data collection assisted in clarifying respondents’ reasons for the opinion provided.

The interview analysis table (Annex 5) was used to assist organising, collating and highlighting the key themes that emerged from the coding exercise. The analysis table allowed me to see a pattern to how the various levels and types of organisations understood HSS.

The following categories and themes (Table 7-1) emerged from the analysis of the key informant interviews.
Table 7-1: Categories and themes for HSS understanding

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Category 2:</th>
<th>Category 3:</th>
<th>Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HSS is not only a health sector issue</td>
<td>1. HSSMP is a key health system reform document</td>
<td>1. Project design and delivery vary between partners</td>
<td>1. Ownership and government leadership is important for successful HSS</td>
</tr>
<tr>
<td>2. Political disruption affects the health system negatively</td>
<td>2. WHO HSS building blocks are complementary with HSSMP</td>
<td>2. Different aid modalities support HSS in different ways</td>
<td>2. Financial and institutional capacity is key for HSS</td>
</tr>
<tr>
<td>3. Effective inter-sectoral collaboration is lacking</td>
<td>3. HSSMP areas include HSS interventions</td>
<td>3. Isolated projects and parallel implementation units do not support long term capacity building</td>
<td>3. A good monitoring and evaluation system is required for effective HSS</td>
</tr>
<tr>
<td>4. Paris Declaration indicators are relevant for HSS</td>
<td>4. HSSMP areas need to be prioritised</td>
<td>- Seven key areas of HSSMP have been prioritised</td>
<td>4. HSS strategies need implementation support</td>
</tr>
<tr>
<td>5. Aid coordination capacity affects the impact of aid projects on the health system</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Theme 1: Contextual factors are important for successful implementation of HSS interventions |
| Theme 2: The HSSMP key areas serve as the basis for HSS in Mongolia |
| Theme 3: HSS interventions are understood and supported differently by different actors |
| Theme 4: Governance and management capacity is important for successful HSS |

**Key statement/overall theme:** An implementation of HSS strategies requires a holistic and systems approach that involves context, actor and content specific factors.

The interview findings have been classified into four main categories and themes. Each theme is now discussed in more detail with supporting evidence from the interviews.

### 7.2.2 Theme 1: Contextual factors are important for successful implementation of HSS interventions

The HSSMP area of *Institutional Development and Sector-wide management* is a specific site where inter-sectoral collaboration, overall management and institutional capacity are highlighted, and this has been identified by stakeholders as an important element for effective HSS. Multilateral donor partners were particularly aware of the impact of political and social factors such as internal migration, poverty, governance and institutional culture on a stronger health system, with other international partners and government officials working at operational levels confirming this position:
“MDGs achievement is not even, especially when you look at population groups. Internal migration has been increased in the last 10–15 years. Now almost more than half of the population lives in the capital city without access to basic needs, food, water and sanitation etc. Health indicators of this migrant population are very poor but aggregated data would not show these. Without being aware of these broader social issues and needs, we cannot sustainably develop health sector and systems strengthening” (UNICEF officer).

Effective inter-sectoral collaboration and a supporting legal and socio-economic environment are also commonly understood to be as important as strengthening the system components themselves. HSS cannot be considered in isolation; it is necessarily integral to the development of state capacity as a whole:

“…When one talks about health systems strengthening this is not only about health systems; for example organising better quality hospitals we need to look at a good financing mechanism, insurance system, well qualified doctors, education, good information monitoring system, etc. So, it is a systems and inter-systems issue.” (Development Bank representative)

The frequent changes of staff working at central level were listed among the key challenges to strengthening the health system. Senior ministry positions are particularly susceptible to changes in government, but also as a result of ministerial reshuffles within the same government coalition. The development banks and UN agencies particularly expressed their concerns about the high levels of politicisation, sudden changes in staff composition, and the resultant loss of institutional memory within the MoH, with subsequent significant negative impact on HSS:

“Over the last 15 years this instability chronically existed making the systems inefficient. There is a need for some systemic response to stop this as these things have very bad effect on the people and the system. It kills motivation and sincerity of people working in the government” (UN agency representative).

The Asian Development Bank representative strongly felt that systems should not be dependent on the change of personnel; the continuity of policies and strategies must be preserved regardless of staff changes. And the respondent emphasised HSSMP’s role in ensuring the continuation of health system reforms and coordination of donor resources, though coordination capacity still needs to be strengthened and should include broader participation.
Overall, there was a consensus between both donor and government stakeholders that HSS should not only address the technical aspects of health services but also the broader socio-economic, cultural, governance or managerial issues to be able to achieve sustainable health outcomes. This necessarily requires governance beyond the MoH itself, and strong whole of government support. Good working relationships between the research community and policy makers was another important aspect that was consistently mentioned as a key for health systems development, as it promotes evidence use and knowledge translation that in turn, contribute to HSS.

7.2.3 Theme 2: HSSMP key areas serve as the basis for HSS in Mongolia

In the interviews with key stakeholders, six of the seven HSSMP key areas were repeatedly mentioned as key components of the HSS framework in Mongolia. The only area that was not consistently addressed was health service delivery. Analysis of the interviews suggested that improved service delivery is understood to be the outcome of the other key areas such as human resources, financing, institutional arrangement and better use of health information, rather than a systems strengthening component in its own right.

Overall, for the majority of the key informants, the comprehensiveness of the HSSMP was its strength, in terms of defining health systems strategies to be implemented. However, a few interviewees representing international partners would have preferred HSSMP to focus on a few priority areas, targeting narrower areas requiring support, rather than being so all-inclusive. Implicit in this is the recognition that bilateral donors, in particular, may find engagement with specific areas of priority easier than supporting sectoral change as a whole:

“HSSMP is a good plan, but it is somewhat overambitious and has too many strategies that suggest big reforms. This could make the plan unrealistic. Moreover, enforcing international partners to commit to the plan implementation may not be liked by everyone” (Bilateral donor representative)

But despite this qualification, interview respondents prioritised those health systems strategies outlined in the HSSMP in their conceptualisations of HSS: over time the HSSMP has been so institutionalised that HSS is now essentially understood by health stakeholders in Mongolia as the process of supporting one or more components of HSSMP. All key informants (26/26) working at
both policy making and operational level emphasised the following two areas as key HSS components:

1. human resource (26/26)
2. resource/finance/payment (26/26)

The next commonly agreed HSS areas identified were:

3. Health Information System (HIS) / Monitoring and Evaluation (M&E) (20/26)
4. drug and equipment procurement system (18/26)
5. leadership and governance (18/26)
6. behaviour change and communication (15/26)
7. health service delivery (3/26)

The identification of behaviour change and communication as a key component for HSS by 15 of the 26 respondents shows the extent to which the HSSMP has shaped local understandings of what HSS might be. Behaviour change and communication is not listed within the WHO building blocks for HSS, but has a strong presence as a priority in the HSSMP—explaining its inclusion by both government and international development partners. The behaviour change and communication area was distinctive as being the only area not included in the WHO building blocks, and unique to Mongolia’s HSSMP, but identified strongly as essential for HSS. Other areas outside the WHO classification were mentioned by individuals but did not gain consensus support: primary health care strengthening (3/26), service quality, accessibility and availability (3/26) and good medical education system (2/26).

Surprisingly, the two areas from the HSSMP that were least commonly mentioned were service delivery and quality of care, arguably because respondents considered that improved service access and quality are the outcome of the health service interventions improving the more critical components of the system:

“Service delivery is dependent on many other factors such as organisation, financing of the service and skills of the health care workers. So, quality and accessibility of the service would be improved when other areas are effectively in place.” (Development bank official)

All respondents consistently referred to the HSSMP as a guiding policy document in supporting HSS, and expressed their growing use of the plan in designing projects and programmes for the health sector. Despite this common agreement on the HSSMP and support of HSS, however, the
understanding of what it means and approaches employed in supporting HSS vary between different partners, when explored in depth. These divergences between the approaches of the various actors and their commitment to the Paris Declaration and Accra Agenda are not unique to Mongolia (201, 202).

7.2.4 Theme 3: HSS interventions are understood and supported differently by different actors

Despite the common consensus amongst various stakeholders over the context-specific HSS priorities, deeper analysis of their understanding of HSS interventions varied. In other words, a difference between the interventions for health systems support and HSS, which have been discussed in Chapter 2, proved to be understood differently amongst various actors. Consequently, approaches used by different actors towards supporting HSS are varied.

The interviews demonstrated wide divergence between stakeholders’ perceptions of HSS interventions and their approach to HSS, with differences not only between donors, but even among different categories of international partners (NGO, bilateral, multilateral, banks) in supporting HSS. Not only are the areas they support different, but also how they contribute support and the approaches and processes that are employed.

Development bank representatives emphasised in their interviews that HSS needs a focus on using a capacity building approach to strengthen key functions of the system, such as financing, regulation and oversight. Their approach is to generate government ownership and leadership over the reform process through this HSS support:

“It is a key to have strong institution and capable human resources, effective financing mechanism and a good coordination and dialogue mechanism to strengthen the health system in Mongolia... also, you need to be backed by good information system to improve management capacity... All these important “what to dos” are, in a way, already defined in the HSSMP, but the ways and mechanisms of implementation must generate capacity building and ownership to achieve sustainable health outcomes.” (Development bank representative).

Development banks, especially ADB, are supportive of the government’s HSSMP and make every effort to harmonise and align their programmes with the plan. The banks’ focus is on health
systems reform, with special emphasis on human resource capacity building, health insurance reform, primary health care reform, health information systems and E-health, with a view to developing SWAp. ADB’s approach is supportive of government capacity building, prioritising the employment of local consultants, with minimal reliance on international technical assistance.

Bilateral agencies and UN institutions working in Mongolia tend to define HSS as supporting one of the health systems components as identified in the WHO Building Blocks. This is consistent with their development assistance mainly providing support in the training of health workers, procuring vaccines and medical supplies, and infrastructure. While this contributes to the matrix of health systems needs, this targeting of specific components of building blocks makes a limited contribution to the interactive synergies that build HSS (118). Even WHO itself acknowledges that “the building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building” (p.31) (113).

Agency agendas and modes of delivery play a significant role in how they, in turn, define HSS. USAID, JICA, UNICEF, UNFPA tend to use vertical project-based approaches, with a focus on non-communicable diseases, hospital care, maternal and child health and reproductive health. While, they claim that HSS is significant, it tends to be understood in relation to their mandated interests. The UN agencies mainly focus on their commitment to supporting achievement of the MDGs, with the resultant concentration of their inputs around maternal and child health and the relevant MDG disease programmes: HIV/AIDS and tuberculosis.

However, among bilateral agencies, GIZ emphasises a systems/holistic approach and strengthening capacity building within the system. It uses an integrative and capacity building approach by using the existing government administrative structure instead of creating parallel implementation units. GIZ’s capacity building approach has been reflected in their project design and implementation. Their approach towards supporting HSS can be seen from the following quote from their representative:

“Projects should focus on the process as much as they focus on the products or outcomes. Because, the capacity building during the process itself is as important as the outcome. Probably, even more important as it promotes independence and sustainability. Therefore, we often employ learning by doing approach involving local staff in the actual project implementation. I know it is time consuming and challenging, but longer term impacts are beneficial to the system.” (GIZ representative)
The government has been very satisfied with the GIZ approach in supporting HSS, as they do not create parallel administrative structures, but instead use existing structures and functions, and are hence supportive of both staff and institutional capacity building. This contrasts with a more sceptical overall government perception of donor partners’ approaches—as shown in one government official’s comments on development partners’ positions on supporting HSS:

“It is not uncommon that partners pretend that they support HSSMP and systems strengthening, but quite often they would still do what they have planned for us, and not what we need. However, establishment of the aid coordination committee was a progressive step to solve this disintegrative situation, although it still needs some improvement.”

Yet, while government officers legitimately accuse donors of not always adapting their assistance to align with HSS through the HSSMP, the government’s own responsibilities in terms of appropriate governance for HSS have been slow in developing. WHO’s description of elements of their working approach in cooperating with MoH in developing their biannual country programme points to delays and inconsistency within the MoH:

“The ad-hoc style of planning and the absence of a long term plan within the MoH until recently, probably around till 2005, adversely affected effective performance of the MoH, and funding requests for activities that are not consistent with the plan--such as Government officials’ visits to overseas forum and conferences, election campaign funding, etc.—had been problematic, though these requests had become much fewer in the last 8–10 years, as the MoH has been learning to develop a more targeted sense of the multilaterals contribution to HSS.” (WHO official)

As a consequence of the long Soviet political association, there are relatively few international NGOs and professional associations working in health, and their representation at the health policy making level is not as strong or influential as that of bilateral and multilateral donors. Their understanding of HSS is defined as improving the accessibility and affordability of health care services through providing adequate funding to the health facilities and strengthening primary health. There did not seem to be much difference in understandings of HSS among NGO representatives at different levels. Policy making and operational level representatives working in the same agencies had similar understandings of HSS, despite working in different areas. NGOs often work at operational level with district and Aimag (administrative unit equal to district but located in rural area) health facilities, mainly implementing disease-focused standalone projects and providing some funding as requested by these operational-level health facilities. But a lack of
alignment for some NGOs, even at operational level, can cause tensions between the NGO and government counterparts. One district health officer reflected on his perception of the operational culture of one of the largest international NGOs in the country:

“The World Vision project design was not consulted with us prior to its implementation, so quite often it follows their interests and mandate, and not necessarily our needs and priorities... More often, projects actually cause a burden, and our staff are not at their place of duty because of project trainings offered by them. These training activities are not systematic and are ad-hoc. Therefore, it often distracts our routine activities rather than helping us.” (district health officer)

The response of the NGOs and professional associations to these accusations of a lack of consultation or alignment with programmes, was that they had to be more prescriptive and decisive when working with district and Aimag health facilities because of the poor capacity and skills at that level.

However, within the NGO community there are those who take a longer term perspective on HSS. The Norwegian Lutheran Mission (NLM) NGO approach was not in favour of short-term and ad-hoc project-type support, but rather preferred to provide more technical support to promote capacity building and empowering people working at rural and operational levels. But despite their alignment to government policy directions, they found themselves unable to access policy making forums, both locally and at crucial central levels, which hinders their effectiveness at an operational level:

“We, as a NGO try to solve the systems issues at local level, but unfortunately sometimes it goes beyond our strength and capacity. For example: to allow more independence in local level facility management and financial authority there is a need to improve legal regulation, coordination and organisational management which cannot be done at our level. We cannot go beyond current laws and regulation”. (Norwegian Lutheran Mission Representative)

More strategic and effective cooperation between the government and NGOs is under discussion as NGOs current operations are not very supportive of HSS, and do not often yield ownership and sustainable outcomes. While international NGOs’ contributions are respected, government respondents found that there is a tendency for reluctance by international NGOs to conform with MoH strategic priorities, and this perversely affects ownership and innovation at operational level health facilities, where NGOs work.
Overall, there was not much difference in understanding of HSS by levels of operation; policy making and operational level representatives working in the same agencies had a common understanding of HSS. Also, a voice between donor and government has not differed much in defining HSS mainly because of the consensus built during the participatory development of the HSSMP. However, differences in understanding and approaches towards HSS interventions existed by types of organisation represented.

7.2.5 Theme 4: Governance and management capacity is important for successful HSS

Key aspects of governance and management such as capacity, ownership, and good monitoring and evaluation systems are identified as essential areas to be addressed for successful HSS. These areas were repeatedly referred to as important areas for effective functioning of the health system as they can affect other components of the system; hence they emerged as a single theme.

Capacity, especially in policy development, budgetary and financial analysis, monitoring and evaluation and in coordination has been identified as an important aspect for HSS in Mongolia. Building sustainable capacity requires a change in the functions, roles, system and structure (12, 203). Capacity development was frequently mentioned, but understood narrowly, and confined only to staff training. Those respondents representing government agencies often mentioned staff and infrastructure capacity building as their primary understanding of capacity building. However, some international partners—ADB, GIZ and NLM—referred to the importance of developing systems capacity through making functions and roles of the system or institutions clearer. The following quote from an ADB project coordinator explains their concerns around the sustainability of some activities intended to be capacity building:

“For many years donors provided numerous supports in training staff. Yet, we have not seen much change in the system. Why? Because, often these trained people are not in the system, or some trainings are irrelevant, or training quality is not good, etc. There should be organisation and system capacity and policy to retain trained staff, to improve the training institution’s capacity and identifying training needs… there will not be much change unless we see these things in a systematic and holistic manner.” (ADB project coordinator)
Ownership is also another key area for successful HSS. The importance of ownership was articulated clearly in the SWAp initiatives of the 1990s, and extended to all development assistance by the 2005 Paris Declaration on Aid Effectiveness, and further reinforced by the 2008 Accra Agenda for Action (27). Consequently, the major global actors, including development banks, bilateral and multilateral donors and UN agencies have placed country ownership as a main goal of their programming. Despite the variations in the understanding of country ownership, the term generally refers to an expanded role by the affected country in planning, implementation, and financing of health programming (84, 204). But although the Paris Principles have enjoyed strong rhetorical support from both donors and governments, actual operationalisation of the principles has not been adequate because of perceptions of insufficient government financial planning and budgetary capacity and the consequent lack of confidence by donors in using government procedures for procurement and financial management (205).

Further analysis of international partners’ understanding of optimal support towards government capacity building and ownership in Mongolia revealed a tension between government expectations and donors’ actual support to government. The following response from one of the international agency respondents was shared by a number of international partners:

“Frankly speaking donor projects are not responsible for MoH plan implementation and systems capacity as such. It is the MoH responsibility; otherwise ownership will be overtaken by the donors. Donors provide technical assistance according to what they can offer and of course it should be in line with what MoH needs”. (UN representative)

Despite respondents support of the importance of ownership and sustainability in order to strengthen the system, this respondent also strongly felt that the use of host country financial and procurement systems recommended in the Paris Principles is not realistic while the country system is not reliable and transparent, and as a result, risks the misuse of funds.

Lastly, another frequently mentioned capacity area is a Monitoring and Evaluation (M&E) system. It affects all components of the health system and other aspects—ownership and sustainability, too. Government health officers working at central level consistently commented on the importance of operational level ownership for an effective M&E system, but they also acknowledged that making ownership work is difficult to achieve, because of the prescriptive nature of the management style inherited from the Soviet time. Another reason for this is that the current monitoring and performance evaluation approach does not promote self-motivation to improve performance, as it
still employs punitive management rather than supporting staff to overcome challenges. To avoid punishment, the real challenges often cannot be disclosed and discussed openly; hence self-assessment and potential performance improvement are not supported.

Operational level respondents frequently indicated that the current monitoring and evaluation task was still very much directed by funding agencies’ M&E frameworks, instead of integrating them with existing government facility performance indicators’ matrix. Donors use various M&E indicators for their programmes without reference to government HSSMP, which makes it difficult to evaluate their collective contributions and outcomes towards achieving health systems outcomes outlined in the HSSMP. Government needs to provide a common reporting template to donors, which outlines the key areas of the government plan; hence monitoring the contribution of various donors towards implementation of the government plan becomes more systematic and effective.

7.3 Conclusion

This chapter of the research has explored government and donor actors’ perceptions of HSS— one of the key content elements of policy explored in this thesis. Overall, there was a common consensus amongst various stakeholders about the health systems’ priorities identified in the HSSMP. However, more in-depth investigation of stakeholders’ understanding of actual context-specific HSS interventions revealed that these common understanding of HSS priorities are superficial; hence donors’ approaches in supporting country HSS were varied.

HSSMP reflects ‘good practice’ definitions of HSS and is considered as a sensible document of support for the majority of the donors. It addresses not only the input elements of the health system but focuses more on the process elements (such as human resource management and financial management), which are key for HSS. Moreover, conceptually it promotes capacity building, and good governance and ownership, which are known to be important aspects for sustainable development.

However, despite the common understanding in defining HSS, actual approaches and working arrangements towards supporting HSS interventions have varied amongst donors. Especially, the importance of differentiating between health systems support and health systems strengthening—as
emphasised by Chee et al. (106)—did not come out clearly. The majority of the partners understanding of HSS supported one or more elements of the building blocks or HSSMP key areas. Often health systems support is understood as HSS, resulting in differences in approaches towards implementing systems strengthening interventions. UN agencies and bilateral agencies, except GIZ, still use a vertical approach which works well in addressing certain targeted areas such as non-communicable diseases and reproductive health, but does not often encourage collective outcomes because of its isolated working arrangements. Bilateral partners, until recently used predetermined strategies which do not effectively support ownership and capacity building and some of them still use a standalone project approach often pre-decided for local health agencies. However, GIZ’s approach was an exception as they encouraged local participation and involved existing health agencies from the very beginning of the programme design, plan, implementation and monitoring. Nevertheless, on the positive note these agencies, in principle, are all supportive of systems approach and HSS, though their practice relates primarily to their programme and project commitments.

Development banks, especially ADB, make an effort to promote home-grown capacity and involve more local level participation that encourages ownership and sustainability. ADB involves its government counterpart agencies from the very beginning of the project designing and planning. However, the understanding of the ownership overall, is often confined to the government sector only, often neglecting the participation of NGOs and communities. NGOs often work at the operational level with varied approaches towards HSS; however, with right oversight NGOs can contribute to improving HSS as their working approach is quite flexible but requires appropriate guidance and capacity to cooperate with government agencies.

With an increasing emphasis on Sustainable Development Goals (SDGs) –post-2015 development goals, the importance of investing in HSS becomes more prominent. Donor agencies support towards country HSS, using well-known health systems frameworks such as building blocks can be deceptive or inadequate; hence identification of context-specific HSS is a must and both content and context-specific circumstances and actors perceptions of HSS interventions need to be taken into account.

The chapter has shown that donors have been influenced by both global HSS norms and local articulation of this; but to what extent donors actually do what they have preached is explored in the next chapter.
8 CHAPTER 8: THE CONTRIBUTION OF DEVELOPMENT ASSISTANCE TO THE HEALTH SYSTEMS STRENGTHENING IN MONGOLIA: DIFFERENCES BETWEEN PERCEPTION AND PRACTICE

8.1 Overview

In interviews with senior Ministry of Health personnel and donor representatives, it became clear that there is a unanimous agreement on the health system priorities outlined in the HSSMP. This chapter aims to examine external development assistance contributions to HSS and identified priority areas in Mongolia. For these purposes, I draw on both secondary and primary data sources to track development assistance contributions to HSS during 2000-2012. The secondary data sources are the WHO and the Institute for Health Metrics and Evaluation (IHME) databases which both use the OECD Creditor Reporting System (CRS) data, and the Mongolian National Health Account (NHA) data. As discussed in Chapter 3, primary data were collected from 21 donors representing the majority of development partners currently active in Mongolia. These data were then used to map their areas of investment against HSS priorities identified in the HSSMP (Chapter 7).

As a result of donors’ commitment to the Paris Declaration on Aid Effectiveness, health systems and policy support has gradually increased since 2005 both globally and in Mongolia. However, whether this health systems and policy support can be considered actual investment in HSS interventions remains unclear. Global databases, examined for this thesis, revealed inconsistent and incomplete classifications of external assistances, which make it difficult to assess and validate the amount of donor support for health systems and policy. Evidence from donors’ financial reports revealed an existing tension between HSS needs as represented in the Mongolian HSSMP, and the actual interventions provided. There was no consistency in the reporting and classification of HSS expenditure amongst donors. Donors also failed to report against pre-defined categories that aligned with the HSSMP or other HSS frameworks. Such a lack of uniform reporting calls for the adoption of standardised donor reporting forms, which can enable better monitoring of external assistance at a country level.

Overall, I found that ADB has been most supportive of HSS and their investments are largely with the country’s plans. This can be partly explained by the existing relationship between the ADB and the Mongolian government, in which grants and loans are negotiated directly against government
priorities, and where the government has the primary decision making responsibility for resource allocation from these grants and loans. This is in contrast with multilateral and bilateral agencies. With the exception of the German Agency for International Cooperation (GIZ), these agencies prefer to use project approaches, linked to vertical programmes. Nevertheless, donors in health collectively have been successful in achieving health outcomes on maternal and child health, HIV/AIDS and TB, and have assisted Mongolia to meet MDG goals in these areas. Unfortunately, despite an enduring and widespread commitment to a sectoral plan, as documented in the HSSMP, some donors still persist in pursuing their own agendas. Donors claim that there is insufficient evidence of what works for HSS in Mongolia, and this acts as a deterrent for increasing health systems investments by development partners, who continue to prioritise service support over broader HSS interventions. Additionally, the early promise of governance and resource management capacity shown by the MoH in the HSSMP has not been sustained, and as a result improvements in health systems performance have stagnated.

8.2 The assessment of external development assistance contributions to HSS

Measuring and tracking external assistance is a complex task and methods and approaches to assess Official Development assistance (ODA) are continually evolving (206-208). In the past decades a number of efforts have been made to assess donor contributions towards HSS. In particular, WHO, USAID and the GF have been heavily involved in developing tools and methods for monitoring and assessing HSS (29, 33, 52, 60, 61, 101, 209-211). However, these efforts fall short of critically examining the relationship between investments in HSS and health systems outcomes.

Attributing health system outcomes to external assistance is extremely challenging (183). This is partly due to the nature of the health system outcomes, which are highly dependent on many contextual factors such as politics, actors and overall public sector management capacity. Notwithstanding the difficulties in measuring the impact of investments on health system outcomes, various frameworks have been put forward to examine contributions of external assistance for HSS.

In order to examine donors contributions to HSS--specifically who provides HSS support and how much they provide--a common framework that provides some consensus on what constitutes a health system, and which interventions are considered as HSS in a given context is necessary. Such
a consensus is still to be reached. For example, some authors do not consider drug and procurement supply for HIV/AIDS as a HSS intervention, since it contributes to consumables in the control of a single disease, and does not contribute to broader and sustainable health systems strengthening (106, 128). However, others, have argued than these interventions could still be considered as disease-specific HSS, as they are intended to improve the system or sub-system, despite being confined within certain disease specific targets (40, 107).

Bearing in mind the above caveat, various HSS frameworks have been developed by different agencies over time. Table 8-1 below summarises the main frameworks and health system classifications used by different partners for exploring HSS contributions.

As seen from table 8-1 the frameworks that are currently applied in analyses of HSS interventions are largely consistent with the WHO Building Blocks in terms of their broad components, though their application serves two different main purposes. For example, WHO and USAID use their frameworks to assess the outcome and impact of HSS, especially those implemented through the GF and GAVI. Warren et al. (33) and Shakarishvili et al. (107) also use the HSS framework for GF programmes, but with a view to track their HSS investments, not to evaluate their impact. My objective is similar to that of Warren et al and Shakarishvili et al; that is, to track HSS investment, though for all donor health programmes in Mongolia and not only for the GF.
Table 8-1: A summary of key frameworks and their key components used for exploring HSS interventions

<table>
<thead>
<tr>
<th>Component</th>
<th>Function/Indicator</th>
<th>Component</th>
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<th>Component</th>
<th>Function</th>
<th>Component</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure/ICT</td>
<td>Hospital beds per 10,000 population</td>
<td>Health services</td>
<td>Staff, Infrastructure, Operational support systems for health services</td>
<td>Service delivery</td>
<td>Infrastructure, Measures to increase coverage-supply &amp; demand</td>
<td>Service delivery</td>
<td>Organisation of service delivery, referral system, improving access, coverage and utilisation, service quality</td>
</tr>
<tr>
<td>Governance</td>
<td>Support to institutional capacity-building</td>
<td>Stewardship &amp; Governance</td>
<td>Policies and regulation, Planning, research and priority setting</td>
<td>Governance</td>
<td>Capacity building Harmonisation Decentralisation Coordination</td>
<td>Governance</td>
<td>Government responsiveness, Decentralisation Reporting and lobbying Voice and accountability Oversight</td>
</tr>
<tr>
<td>Financing</td>
<td>Total health expenditure as % of GDP Total per capita health expenditure General government expenditure on health</td>
<td>Financing</td>
<td>Financial planning, fund pooling, resource generation, Providers reimbursement system</td>
<td>Financing</td>
<td>Social protection, Resource effectiveness, Financial management</td>
<td>Financing</td>
<td>Revenue collection Fund pooling Purchasing</td>
</tr>
<tr>
<td>Information</td>
<td>Doctors using electronic health records</td>
<td>Health information systems</td>
<td>Data collection, analysis and reporting, Strengthening country M&amp;E system</td>
<td>Information</td>
<td>HIS strengthening Evidence based plans Information accessibility</td>
<td>Health information systems</td>
<td>Processes for data collection, management, and analysis Generating and using Health information</td>
</tr>
<tr>
<td>Health workforce</td>
<td>Doctors per 10,000 population Nurse/midwives per 10,000 population Health graduates per 10,000 population</td>
<td>Human resources</td>
<td>Pre-service training In-service training</td>
<td>Human resources</td>
<td>Pre-service training In-service training</td>
<td>Human resources</td>
<td>Supply and distribution of human resources, Planning and allocation of HR Training</td>
</tr>
<tr>
<td>Supply chain</td>
<td>Tracer medicines availability Median drug price ratio for tracer drugs</td>
<td>Medicine and technology</td>
<td>Rational use of medicines Affordable, quality essential drugs Management of essential drugs</td>
<td>Medicine and technology</td>
<td>Rational use of medicines Affordable, quality essential drugs Management of essential drugs</td>
<td>Medicine and technology</td>
<td>Procurement and supply chain of essential medicines and supplies Quality/safety of pharmaceuticals and medical supplies</td>
</tr>
</tbody>
</table>
The HSS components and the functions outlined in the various frameworks are broadly suggestive of what areas and functions need to be strengthened in order to improve HSS, and so can be used to establish common categories to examine investments in HSS. However various caveats should be noted. First, some broad functions—for example, training and infrastructure—need to be further narrowed down to clarify which specific interventions are included as HSS. The assessment exercise must thus apply clear and explicit inclusion and exclusion criteria for exploring HSS interventions. Second, in each country, the content of the actual interventions will vary according to the local context. What may appear to contribute to HSS in one context may be considered only as support for a targeted programme in another. The capacity to assess local adaptation of interventions under each component is important, and can only be determined with the insight of the relevant partners working in the country. This exercise of clarifying how interventions had been adapted for local implementation would be necessary to differentiate between health systems support and HSS within the specific context. For example, the human resource priorities for Mongolia are more focused on achieving equal distribution of doctors across regions through training, rather than training specific numbers of doctors as a human resources indicator in its own right (13, 20, 22). Vujicic et al’s (89) recent analysis of GAVI, GF and World Bank investments in Human Resources for Health (HRH) in developing countries found that the human resource contributions of these three agencies were mainly focused on short term, in-service training and salary incentives. This failed to address pre-service training needs, which were essential because of shortages of health workers in these countries: while existing health workers were arguably better skilled, the deficit in health workers overall persisted (89). It again reveals the importance of distinguishing between health system support—as in targeted training for specific programs—and HSS that has a more comprehensive systems application. It also implies the need for better coordination of HSS supports between funders that would be the product of applying some existing initiatives, such as the International Health Partnership Plus or donor coordination through a SWAp.

In my research, the local health systems priority areas as defined by key stakeholders in the HSSMP will be used to examine donors’ contributions to the health system since 2000. While the established frameworks discussed have been useful in defining overall HSS understandings and functions, they have not provided enough granularity or detailed judgement to identify HSS interventions in the specific context of the Mongolian health system. As a result, in this analysis I have developed a guide that uses local identification of HSS interventions against the criteria
determined in the light of the HSSMP, using local experience to determine their application as discussed in Chapter 7.

8.3 Overview of data sources

Four data sources were used for tracking external assistance contributions to HSS: i) Institute for Health Metrics and Evaluation (IHME) (IHME: Development Assistance for Health (213); ii) World Health Organisation (WHO) (WHO Global Health Observatory (214); iii) Mongolian National Health Accounts (215); and iv) Primary aid data that I have collected during the fieldwork conducted in 2012.

The IHME databases are based on the OECD Creditor Reporting System (CRS) databases (216), but are complemented by additional data collected from financial reports, annual reports, tax forms, audited financial statements, project databases and correspondence. The WHO database (214) is also based on the OECD and uses its CRS database provided by the Development Assistance Committee (DAC). The CRS database covers approximately 90 percent of all Official Development Assitances (ODA), as reported by registered donors, and shows it by country and focus areas by each donor and recipient country. While ODA does not provide information from donors not registered with the OECD, and records data in the forms provided by donors (183), it represents the best quality overall ODA data available and has been used by researchers (217-219) tracking ODA assistance to various health areas. Development Assistance for Health (DAH) is slightly broader than ODA as it includes funds from other sources such as non-OECD donors, private foundations and NGOs (183). Both Mongolian National Health Account (NHA) data and primary aid data are considered as DAH. However, Mongolian NHA data has not been sustainably produced over time, and the most reliable data available was produced in 2005, and covers aid data from 2002 only. Lastly, primary aid data collected directly from donor project reports, supplemented the findings of the secondary sources. I mapped out 21 donors who have been active during 2000-2013 in the health sector, only excluding international NGOs and ad-hoc private donors who maintain infrequent operations. I was able to meet with 11 donor organisations in person and accessed their project reports, and interviewed the person-in-charge of their health projects. For the remaining 10 donors, I have accessed their project reports through their websites and through MoH aid data. These donors were mainly bilateral donors such as Italy, Australia,
Canada, Belgium, and Luxembourg, who had provided ad hoc or one-time relief support. The data collected have substantially varied in depth and quality. Surprisingly, projects implemented by bilateral partners especially did not always have a good record of annual reporting for interventions funded. Also, pre-2006 data for all partners were aggregated by project duration and key objectives only. Only GF and GAVI data had adequate disaggregation by years and interventions funded.

The lack of annual data, the use of different financial years, the aggregation of data over several years and the well-known volatility of aid flows (220-222) makes it difficult to compare the estimates from the primary data sources with annual estimates obtained from modelled secondary data. Additionally, our data examined do not include charity and small-scale private donations which have resulted in underestimated aid flows. Also, loan aid, with less than a 25% grant component is excluded, which led to the exclusion of the largest ADB projects implemented in Mongolia during 1997-2003.

In this chapter, I will present the available secondary data, largely using the categorisation provided in the original sources. I will then present the data that I have been able to synthesise from these existing databases and from the primary data obtained in interviews and from primary reports. While still encumbered by its limitations, triangulating multiple sources of data has allowed for more robust conclusions to be made in regards to the observed general trends.

8.3.1 Secondary data representations of external resource flows to HSS

The secondary data sources covered a ten year period between 2000-2010, from transition to early development, which also involves important stages in aid evolution in the country. According to the IMF report (223), the years between 1991-2003 are considered as a transition period with an initial painful “transformational recession” before the economy began to recover. Starting from 2003, the period when country’s economy began to recover where the GDP (real) had reverted to the level prior to the transition, is considered as the start of the development phase. At the Mongolia Consultative Group meeting held in Tokyo in 2003, the Prime Minister of Mongolia also declared that Mongolia was in the process of moving from a focus on transition to a focus on longer-term development (224).
Three different sources have been used to track aid flows to the Mongolian health sector.

i) Institute for Health Metrics and Evaluation (IHME)

d) World Health Organisation (WHO)

iii) National Health Account (NHA) 2005

These three sources of data on donor contributions to development use very different schemata of classification to show where development assistance is targeted. With a view to assess the extent to which the alternative data sources can be used for data triangulation, I have assembled in Table 8-2, the aid focus classification across these different sources. It can be seen that IHME and WHO classifications reflect the MDGs and the focused vertical programmes associated with the health goals, while the NHA use budgetary line items consistent with the national health expenditure report. The IHME ‘health sector support’ category includes training personnel and building facilities, while the same type of interventions are classified as ‘other health purposes’ in the WHO database. The ‘other health purposes’ category also includes service delivery, basic health care and nutrition.

Table 8-2 below maps out the different categories of donors’ support according to the various databases.

Table 8-2: Donor’ support classifications in various databases

<table>
<thead>
<tr>
<th>IHME</th>
<th>WHO</th>
<th>NHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Sector (HS) support</td>
<td>Health policy and admin management</td>
<td>Health administration and health insurance</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>MDG 6 (HIV/AIDS, TB and other diseases)</td>
<td>Preventive and public health care service</td>
</tr>
<tr>
<td>MCH</td>
<td>Other health purposes</td>
<td>Capital investment</td>
</tr>
<tr>
<td>NCD</td>
<td>Reproductive health and family planning</td>
<td>Hospital care</td>
</tr>
<tr>
<td>TB</td>
<td></td>
<td>Training of health personnel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmaceuticals and medical equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Research and Development in health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ancillary health care service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation care</td>
</tr>
</tbody>
</table>

Sources: WHO; IHME; MoH-Mongolia (214, 215, 225)
It can be seen that due to the lack of uniformity in the definition, only broad comparisons are feasible, particularly in terms of trends over the study period. Overall, the results from the various sources suggest an increasing trend in health system funding support in Mongolia since 2008.

Graph 8-1 illustrates **IHME data** for ODA in Mongolia by focus areas, derived from the Financing Global Health 2012 report by IHME (225). It can be seen that ODA of the early 2000s was more focused on the disease specific areas, namely, HIV/AIDS, TB and MCH. Non-communicable diseases (NCDs) did not attract a proportionate amount of interest, despite their increasing contribution to the overall disease burden. In Mongolia, NCDs have been the leading cause of morbidity and mortality in the last decade (20, 22, 226).

Health Systems funding shows gradual increases since 2005. This may be explained by partners’ commitments to the Paris Declaration principles, which emphasise alignment of development assistance with government priorities and strengthening of the government system. The limitations of aid reporting prior to 2006 means that health systems support is likely to be inadequately represented in the records. The apparent absence of support to health systems prior to 2006 could then be an artefact of reporting systems, especially as health systems support here includes training personnel and building facilities, which were the important areas for development assistance in the early years. However, a more likely reason is the relatively recent focus on HSS and the lack of a clear definition prior to 2005. The sharp increase in health systems investment observed in 2010 is explained by the GF and GAVI HSS rounds approval in Mongolia.

Graph 8-1: IHME Database- ODA in Mongolia during 2000-2010 by focus area (in USD)

![Graph 8-1: IHME Database- ODA in Mongolia during 2000-2010 by focus area (in USD)](source: IHME ODA Database 2012 (225))
WHO aid data from the country factsheet (227) below (Graph 8-2) shows aid disbursements in the Mongolian health sector by focus areas. It can be seen that notwithstanding some outliers from IHME data, such as relatively higher support in health policy than in MDG6 (HIV/AIDS and TB) during 2000-2005, the broad picture aligns with that from the IHME database shown above. There is also a strong focus on HIV/AIDS, TB and reproductive health and family planning. However, the “other health purposes” category also shows relatively large funds, but this is partly because of the very broad definition used, which includes service delivery, basic health care, nutrition, training and infrastructure. As expected, this will cover the majority of the externally funded projects in the country, but in terms of analysis, the breadth of this category is unhelpful in determining contributions to HSS.

Graph 8-2: WHO Database-ODA disbursements by focus areas in Mongolia, 2000-2010 (in million USD)

Source: WHO (227)

Note: MDG 6 includes support to HIV/AIDS and TB

Despite some observed decreases in 2006-2007, funding health policy and administration management has been gradually increasing over the years, which is a reflection of its prominence in the Mongolian HSSMP, to which all key partners contribute. Importantly, this area represented the
largest allocation in 2010, which is also confirmed in IHME data indicating the highest proportion of ODA going to health systems support in 2010.

With the support of the World Bank, the NHA exercise was carried out for the first time in Mongolia during 2002-2005 (215). The first NHA was more comprehensive than the second NHA conducted in 2009 in terms of covering various sources of financing including external contributions by focus areas. The programme areas used in the NHA are very different from those of IHME and WHO and mainly relied on the line items used in the national planning and budgeting for the health sector. The exercise was also limited to the years 1999-2002 with detailed donor data available only for the year 2002, which makes it difficult the compare with the other two available databases. Overall, DAH constituted 13% of the total expenditure on health (10.5 million USD), though again this figure did not include contributions from small donors and NGOs working at the operational level (215).

Graph 8-3: NHA- DAH by focus areas, 2002 (in USD)

During the transition period, DAH occupied an important space in terms of funding and influencing national health sector reforms. However, because of poor aid coordination capacity there were many overlaps between various external projects (20, 228). This inefficiency is also reflected in the allocation of DAH shown in Graph 8-3, which shows the key focus investment areas identified in

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NHA for 2002. It is seen that health administration funding was very large, partly explained by the very high project administration costs, rather than productive systems contributions. Preventive and Public Health (PPH) services include vertical programmes on MCH, Reproductive health (RH) and communicable disease, basically aligned with the National Public Health programmes. These programmes were mainly funded by external partners. That more than 50% of the donor funding is being spent on two areas only—PPH services and capital investment (infrastructure)—further confirming that the nature of the assistance in early 2000 was more supportive of vertical programmes and commodity supply, rather than providing broader systems support.

In summary, the lack of uniform rules for classification across available datasets and insufficient information on allocation breakdown by type of investment pose challenges to a comparative analysis. Additionally, each dataset has its own limitations and strengths. For example, the CRS used by WHO and IHME databases utilises purpose codes aimed to be uniform across various donors, but they are subject to interpretation and misreporting; and categories are not conceptually mutually exclusive (229). Moreover, the IHME and WHO databases are structured by disease-specific programmes and not by health systems components, which makes it difficult to assess investments in health systems through vertical programmes. On the other hand the NHA was an early attempt by the Mongolian MoH to explore donor contributions by health focus area, but inconsistencies in donors’ reporting, failures to align with the MoH Monitoring and Evaluation (M&E) system and persistent use of donors’ own M&E forms did not allow uniform application of external fund reporting captured in NHA.

Notwithstanding these limitations, it is reassuring to note that by putting together the information available from the various data sources, we can observe a gradual overall shift in DAH since 2008 from input-type support towards health policy and system support. The available data also suggest that the majority of donor support has been mainly structured around MDGs and disease specific vertical programmes.

8.3.2 Primary data on external assistance flows for HSS

Given the limited information available from existing secondary sources, it became necessary to seek primary sources in order to enhance the quality of the overview of external partners’ contributions to HSS since 2000. This necessitated the direct collation of data from donor agencies, derived from their public reports and complemented by interviews with responsible officers that
provided greater clarity in terms of allocation of resources. It also necessitated the development of criteria for standardised classification of HSS interventions.

8.3.2.1 Primary data collection

I personally visited offices of 11 major external partners active in Mongolia and met with the corresponding health and finance officers to collect available financial data to show their contribution to HSS in Mongolia during 2000-2013. A template used to collect the information is included in Annex 4. During the visit I interviewed the respective officers to obtain information regarding i) their health programmes, ii) funds invested in such programmes and iii) their mode of operation in working with local health administrative organisations. The template was left with the interviewed officers, and I later followed up through emails and phone calls.

All data were collected during my fieldwork and were useful for examining the amounts invested in HSS overall. However, the initial data provided were not adequate to track donor support to specific HSS component areas. Firstly, the official reporting templates used by donors did not identify HSS component areas. Secondly, their understanding of HSS component areas was varied. Lastly some donors were not able, or not willing to share disaggregated data. Therefore, after the initial data examination, I contacted project staff again to secure access to their project’s financial and technical reports. Unfortunately, the majority of partners’ reports did not have adequate information that would allow allocating investments to detailed HSS interventions, though broad allocations were feasible. Moreover, about half of the partners were unable to provide disaggregated data for those projects implemented prior to 2006. Therefore, I was able to collect only aggregated figures for the periods in which the corresponding donors were active in country.

In summary, the lack of common categories of recorded interventions, resulting from inconsistency in reporting patterns and different templates, brings additional challenges when seeking to make confident comparisons of the investments made by donors. I should also note that donors were not consistently active during the whole period. For example, USAID has not been active in health until very recently; they have invested in health only during 2008-2013. Therefore with a view to measuring the magnitude of donors’ contributions in Mongolia, I have used the collected data to estimate the number of years in which the donor was active in the country, and their average annual contribution during the period between 2000-2013. In this case, the number of years can be used as
a proxy for the long-term commitment of donors to Mongolia’s health sector, while the average annual investments in the HSS serves as a proxy for the magnitude of their contribution to HSS over the period 2000-2013.

8.4 Understanding the type and focus of health sector donors in Mongolia

The initial product of the process of identifying primary data regarding the contributions of external donors to HSS was a more complex overview of the donors, and their particular engagement with the health sector in Mongolia. Unlike other countries, there are relatively few donors who are active in the health sector in Mongolia. However, they offer varied interest and approaches in the relationship between government and donor organisation.

Five main types of donors (Chart 8-1) have been active in health in Mongolia: UN agencies, GHIs, Development banks, bilateral agencies and international NGOs.

Chart 8-1: Amount of contribution to the health sector by donor types, 2000-2013

<table>
<thead>
<tr>
<th>Type of donors</th>
<th>Amount of contribution (in million USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral agencies</td>
<td>98.2</td>
</tr>
<tr>
<td>Development Banks</td>
<td>69.5</td>
</tr>
<tr>
<td>UN agencies</td>
<td>60.6</td>
</tr>
<tr>
<td>GHIs</td>
<td>47</td>
</tr>
<tr>
<td>International NGOs</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Ministry of Finance, Mongolia (12, 21, 230)
As shown in Chart 8-1, **bilateral agencies** provided nearly one third of the external assistances to the Mongolian health sector over the study period. The types of support provided by bilateral agencies have varied between partners and over time. USAID and Japanese support was dominant; comprising nearly 80% of bilateral agencies’ funding for the Mongolian health sector. Japan’s support commenced in early 2000 and mainly focused on equipment provision to national and regional hospitals. In general, support provided until 2005 was mostly for one-off equipment and service provision. However, JICWELS, a Japanese Government implementing agency for MoH, invested substantially in the development of the HSSMP at the direct request of the MOH, during the period 2003-2009. These investments supported capacity building in planning and budgeting, which was an essential skill gap for health planners and policy makers during the transition towards decentralised system. The investment amounted to only 1.8 million USD, but its impact on improving planning and coordination of various programmes and projects was significant (189, 197). The focus of GIZ investments in early 2000 was on reproductive health services and family planning. Since 2009, GIZ has changed its focus and approach towards supporting systems capacity and sustainability. USAID was dormant in the health sector until the Millennium Challenge Account (MCA) assistance was initiated in 2008. Although the MCA’s main focus was NCD and injury, the project invested substantially in capacity building and NCD management. These interventions are thus considered as disease-specific **process** oriented interventions.

**Development banks** have been supporting reform efforts in the health sector since the early 1990s through grants and loan programmes. Unlike grants, in loan programmes, the government takes more direct control and ownership of these investments, including the thematic areas and regions in which the project will be implemented. While it is encouraging to have stronger government ownership, the risks of political interests driving the agenda, lack of open and transparent management, corruption and limited absorptive capacity pose serious challenges (13, 16, 22). The ADB has been one of the lead aid agencies in Mongolia’s health sector reform. They have worked very closely with the MoH in the HSSMP implementation. ADB has been the most supportive donor in terms of system capacity building especially since the release of the HSSMP. ADB’s Integrated PIU approach and efforts to align their contribution to sector priorities have been fundamental to ensuring a smooth implementation of the HSSMP. They also played a lead role in coordinating the various donors in their collaboration with the government. In contrast, the World Bank involvement has been minimal. Limited technical assistance on health sector privatisation and
rationalisation was provided in the early 2000s, followed by more recent small-scale investments in management of re-emerging diseases.

The United Nations and associated agencies have focused mostly on maternal health and child health and nutrition, reproductive health and HIV/AIDS. UNDP and UNFPA support for improving governance in health and the SWAp has led to improved collaboration between UN agencies and the MoH despite their very minimal amount of funding contribution compared to other vertical programme areas. UNICEF and WHO have also worked very closely with the MoH on developing their mid-term plan and country programmes of work (24), which resulted in better alignment with the HSSMP (197). Notwithstanding these system wide efforts, the actual reporting and indicators used by the UN agencies were still based on vertical programming, which reflects into their observed limited system-wide investments.

Global Health Initiatives (GHI), in particular GF and GAVI, have been active in Mongolia since 2003 and have become the largest source of funding in the field of HIV/AIDS/TB and immunisation. In response to the need for addressing system issues when delivering vertical programmes, round 7 and 10 of GF and GAVI-HSS1 included HSS interventions to deliver HIV/AIDS/TB and immunisation services. Eleven percent of the total GF funding during the study period has been reported by them as allocated to HSS interventions, which is much lower than global cumulative expenditure of 37% that is allocated to the HSS segment (231). GAVI HSS interventions received 8% of the total GAVI funding. Mongolia will be fully graduating from GAVI support in 2016, which poses important challenges and stresses the importance of system capacity strengthening with a view to sustaining the health outcomes achieved in recent years.

The estimated international NGOs support to the health sector is the lowest of external donor assistance, although there are many other small scale NGOs providing ad-hoc support, which have not been captured in the national data. Their key areas of focus are nutrition, public health education and health workers training, with World Vision being the longest operating NGO in the country. NGOs’ focus of work has been on the operational level with the deployment of front-line health workers. However, their mode of operation and approach do not often support capacity building within the existing system (13, 77, 195). NGOs often operate parallel to the existing health services and use their own project implementation units to administer services.
8.4.1 Developing criteria for data standardisation

To gain a more detailed understanding of the contribution of development assistance to HSS, some analysis of the financial resource allocation flows is necessary. With a view of mapping external project funding against HSS priorities, collected data had to be allocated according to standardised categories based on the HSSMP key areas. For these purposes, I drew on current globally known theoretical frameworks of HSS (33, 107) (Table 8-1) and the national HSS priority areas to develop and apply a set of HSS criteria.

Table 8-3 illustrates this process. In the first column, it shows the health system components used to build HSS categories. These are consistent with the HSSMP and stakeholders’ identification of priority HSS areas for Mongolia. Interventions funded by donors were matched to the component of the health system by the criteria provided. The second process of categorisation was to determine whether the intervention was an input intervention—and more likely associated with support of the health system in relation to a single disease programme focus, or was a process intervention, and more likely to contribute to strengthening of the health system as a whole. In distinguishing between these two types of interventions I was guided by principles of the different frameworks by WHO, Roberts et al, Frenk and De Savigny (30, 97, 112, 113, 116) and methodological guides and its applications by Gilson, L (127) and Biesma (61), Shakarishvili (107) and Travis (128) which all collectively assisted me in identifying characteristics of HSS interventions.

- **Input interventions**: these include one-off support to one or more health systems component areas. Examples are: one-off ad hoc commodity and service support to disease specific areas; providing medical equipment, establishing health care facilities etc.
- **Process interventions**: these include interventions that support building a system or sub-system which is embedded in the country health system in accordance with the context-specific HSS areas identified. Examples are: setting up in-service training schemes, cold chain maintenance system etc.
### Table 8-3: Health Systems components and criteria for HSS categorisation of interventions

<table>
<thead>
<tr>
<th>Health systems components</th>
<th>Input interventions</th>
<th>Process interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Delivery (SD)</strong></td>
<td>Commodity, resource and service support for PHC, MCH, RH, immunisation STI/HIV, NCDs, TB, Nutrition, blood transfusion, relief support during disaster</td>
<td>Establishing screening and early prevention system for NCD, strengthening primary health care service, establishing early warning and response system; Integrated and prevention mechanism for HIV/AIDS</td>
</tr>
<tr>
<td><strong>Pharmaceutical and Support Service (PSS)</strong></td>
<td>Communication and IT equipment supply, power supply &amp; water supply of medical facilities, provision of equipment, vaccine and diagnostic reagent</td>
<td>Cold chain system maintenance, waste management, laboratory capacity, laboratory network, telemedicine network/system establishment, improving logistic supply system</td>
</tr>
<tr>
<td><strong>Behavioural Change &amp; Communication (BCC):</strong></td>
<td>Development of posters, brochures, health education sessions, awareness increasing initiatives, CHV campaigns</td>
<td>Establishment of ongoing community health education programme; clearing house for IEC materials</td>
</tr>
<tr>
<td><strong>Quality of Care (QoC)</strong></td>
<td>Development and enforcement of the quality standards, licensing and accreditation, regular update of clinical guidelines</td>
<td></td>
</tr>
<tr>
<td><strong>Human Resource (HR)</strong></td>
<td>One-off trainings in various clinical and non-clinical areas.</td>
<td>Update of training curriculum and programme, strengthening system for continuing education programme</td>
</tr>
<tr>
<td><strong>Health Financing (HF)</strong></td>
<td>Hospital autonomy, financial reporting system, health insurance system reform, health financing reform, payment mechanism, planning and budgeting</td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Development (ID)</strong></td>
<td>Decentralisation, leadership and governance, strategic planning, M&amp;E capacity, Health Information System, research development, aid coordination, programme and project management, institutional capacity building, promotion of intersectoral collaboration</td>
<td></td>
</tr>
</tbody>
</table>
Four areas identified in Table 8-3, namely service delivery, pharmaceutical and support services, behavioural change and communication and human resources are classified into two different types: input support and process oriented support. This classification allowed the clearer representation of donors’ investment in the strengthening of health systems through their interventions in vertical programmes. Assistance provided to the other three areas includes interventions which had more systems effect, and which by nature, were more supportive of HSS. Despite the challenges, the use of HSS categorisation above allowed the exploration of external partners’ support by HSS components and type of interventions. However, resource flows are identified by overall project focus and sub-focus areas, but not by actual interventions that donors have implemented. As a result, it was not always possible to assign the precise monetary value to input and process interventions, given the lack of disaggregated data. However, analysis of the overall project focus and objectives assisted to quantify estimates of the proportion of financial support provided to input and process interventions. Clarification from donor agencies’ staff responsible for these interventions added confidence in these estimates.

8.5 Primary data source representations of external resource flows to HSS

Primary data collected from donors active in the country adds another dimension to the secondary data, by presenting donors’ resource flow to the country-specific HSS priority areas identified by key stakeholders (Chapter 7).

Graph 8-4 shows the number of years donors were actively investing in the health sector in Mongolia and their average annual contribution (in million USDs) over those active investment years. ADB has been reported to be the longest serving partner with the largest contribution in overall, followed by GF and Japan. The amount of the US contribution is the second largest despite their relatively shorter period of time in the country.
Note: ADB and GIZ contribution covers period between 1997-2013

UN institutions including WHO have been active in health ever since they established institutional collaboration with the MoH; but more effective and targeted cooperation towards HSS has begun since the approval of the HSSMP in 2006.

### 8.6 Allocation of funding for HSS interventions – focus areas

Objectives and strategies outlined in the project documents assisted in identifying the primary and secondary focus areas of the project. The criteria for the HSS categorisation table (Table 8-3) has been used to identify project focus areas; definitions for each health system component were used to define the primary focus of each intervention. In some cases, specific interventions within projects had to be categorised differently from the project as a whole. For example, USAID project has key
objectives for improving NCD management, therefore its primary focus has been identified as service delivery; the project has interventions to improve diagnostic equipment and staff skills in NCD area hence, pharmaceuticals and support service and human resource area have been identified as secondary focus areas. But depending on the nature of the support I also determined input and process type support, which is explained in the section 8.4.1.

The following Tables 8-4; 8-5; 8-6 summarise various types of external partners’ areas of contribution by each health systems area. The tables cluster the data for similar agencies to facilitate analysis. Table 8-4 covers bilateral partners; Table 8-5 covers multilateral partners; Table 8-6 covers international NGOs and GHIs. The tables present both the primary and secondary focus of the project, and the total amounts of funding provided for the project. Available data did not always show the funding allocation amounts given to each health system component. Key areas of focus have been determined based on the targets of the project objectives. These have been annotated as: ‘++’ for primary focus areas and colour coded red; and ‘+’ for secondary focus areas. These secondary focus areas have been determined from the project report, and often included supportive interventions that assist the accomplishment of the objectives of the primary focus area.

**Bilateral partners** (Table 8-4) support occupied nearly one third of the total support provided to the health sector by external partners during 2000-2013. The majority of their funding was invested in the service delivery and pharmaceutical and support service areas, consistent with their support of targeted programmes. As an exception to the general trend, Japan and Germany invested in health financing and institutional development, which were identified as priority HSS areas. Almost all bilateral projects—excepting Australian and Canadian projects, which provided relief-type resource support—include significant human resource components designed to support service delivery targeted to various disease specific objectives. Despite this dominating pattern of bilateral health systems support rather than HSS, bilateral project data suggests that the focus of their projects has been shifted more towards process oriented activities since 2006. Arguably, this is due to the HSS focus of the HSSMP locally, and enforcement of global agendas such as SWAps and the Paris Declaration that have highlighted recipient country ownership and the sustainability of the outcomes achieved.
Table 8-4: Summary of the support provided by *bilateral partners* during 2000-2013 by health systems components

<table>
<thead>
<tr>
<th>№</th>
<th>External projects implemented during 2000-2013</th>
<th>Service Delivery</th>
<th>Pharmaceutical and Support Service (PSS)</th>
<th>Behaviour Change and Communication (BCC)</th>
<th>Quality of Care</th>
<th>Human Resources</th>
<th>Health Financing</th>
<th>Institutional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>USAID 2008-2013 42 m USD</td>
<td>++</td>
<td>++</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2.</td>
<td>Japan 2000-2008 34.43 m USD JICWELS 2003-2009 1.8 m</td>
<td>++</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>++</td>
</tr>
<tr>
<td>3.</td>
<td>Germany 1998-2013 8.6 m USD</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>4.</td>
<td>Luxembourg 2009-2010 214.700 USD</td>
<td>++</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>5.</td>
<td>Belgium 2009-2010 6.1 m USD</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td>Italy 2010 7271 USD</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>Australia 2006-2007 5.7m USD</td>
<td>++</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8.</td>
<td>Canada Fund 2010 45.000 USD</td>
<td>++</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total: 98.9 m USD</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Service Delivery is the primary focus for five projects, PSS is for three projects, Finance is for one project, and Institutional Development is for one project. HR is a secondary focus for seven projects; but no project has BCC, Quality of Care and HR areas as a primary focus.
Table 8-5 presents multilateral partners support provided to health during 2000-2013. Again, the initial focus during this period for multilaterals was in service delivery, largely in input areas. Since the approval of the HSSMP, there has been a demonstrable shift in all multilateral partners, with increasing support for process-oriented interventions, though these have often been confined to disease-specific areas. United Nations agencies support has been concentrated around areas linked directly to the MDGs: MCH, RH, HIV/AIDS and TB. HIV/AIDS is funded at a level disproportionate to the local disease burden, mainly because of its global prominence, its investment priority for donors, and its prominence in the MDGs. The UNDP project on good governance in health has been a positive step towards increasing awareness of accountability and transparency in decision making in health, despite its relatively small funding. ADB projects have been largely in line with HSSMP priorities and implemented through a single PIU, which provides consistency and harmonisation between different projects in keeping with principles of efficiency and effectiveness.

Lastly, Table 8-6 shows international NGO and GHIs support to the health sector. Only the three largest INGOs were included in the research as the rest of the INGOs have not worked consistently in health during the last 10-13 years. Besides, there was insufficient data available for small-scale INGOs. World Vision has mainly provided nutrition and commodity support to the operational level health facilities, often cooperating with district health centres. When the criteria for HSS categorisation are applied to their interventions, all reported INGOs investments were input type support, such as service support for delivering primary health care, maternal and child health and reproductive health. However, they have also health education and awareness raising components attached to their projects, and in this sense, are supportive of the behavioural change and communication area of the HSSMP.

GF and GAVI support to HSS is a progressive step towards addressing systems issues. GF HSS components include interventions for i) improving quality of laboratory services for HIV/AIDS, STIs and TB through strengthening the national laboratory network; ii) strengthening capacity for infection prevention and control and iii) improving the quality and use of HMIS for decision making. All three are identified as priority HSS areas (232).
Table 8-5: Summary of the support provided by *multilateral partners* during 2000-2013 by health systems components

<table>
<thead>
<tr>
<th>№</th>
<th>External projects implemented during 2000-2013</th>
<th>Service Delivery</th>
<th>Pharmaceutical and Support Service (PSS)</th>
<th>Behaviour Change and Communication (BCC)</th>
<th>Quality of Care</th>
<th>Human Resources</th>
<th>Health Financing</th>
<th>Institutional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Input</td>
<td>Process</td>
<td>Input</td>
<td>Process</td>
<td>Input</td>
<td>Process</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>WHO 2000-2011 25.3 m USD</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td></td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2</td>
<td>UNICEF 2002-2011 10.3 m USD</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>3</td>
<td>UNDP 290,000 USD</td>
<td>++</td>
<td></td>
<td></td>
<td>++</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>UNAIDS 2007-2011 10.4 m USD</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>5</td>
<td>UNFPA 2002-2011 14 m USD</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>6</td>
<td>UN-Trust fund for human security 2010-2012 319,400 USD</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>7</td>
<td>ADB 1997-2013 64.9 m USD</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>8</td>
<td>World Bank 2009-2013 7.5 mln USD</td>
<td>+</td>
<td>++</td>
<td>**</td>
<td>++</td>
<td>++</td>
<td>+</td>
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<tr>
<td></td>
<td><strong>Total 133 m USD</strong></td>
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</tbody>
</table>

Service delivery is supported as a primary focus area by almost all partners except UNDP. PSS is a primary focus for two projects; Institutional Development for two projects. Health Financing and HR is supported by only ADB as a primary focus; and HR is a secondary focus for seven projects.
Table 8-6: Summary of the support provided by *International NGOs and GHIs* during 2000-2013 by health systems components

<table>
<thead>
<tr>
<th>№</th>
<th>External projects implemented during 2000-2013</th>
<th>Service Delivery</th>
<th>Pharmaceutical and Support Service (PSS)</th>
<th>Behaviour Change and Communication (BCC)</th>
<th>Quality of Care</th>
<th>Human Resources</th>
<th>Health Financing</th>
<th>Institutional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>World Vision 2000-2010</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
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<tr>
<td></td>
<td>Approx 20m USD</td>
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<tr>
<td>18</td>
<td>Norwegian Lutheran Mission (NLM) 2008-2013</td>
<td>++</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>1.5 mln USD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>19</td>
<td>VSO 2000-2010</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>8.5 m USD</td>
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<tr>
<td></td>
<td><strong>Total: 30 mln USD</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Global Health Initiatives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Global Fund 2003-2013</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>41 m USD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>GAVI 2000-2013</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>6 mln USD</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td><strong>Total: 47 m USD</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

INGOs and GHIs’ primary focus areas are Service Delivery and PSS. HSS components of the GHIs are categorised as process-oriented Service Delivery and PSS interventions. All project objectives had a HR component providing one time training amongst health workers in their respective project areas.
The challenge of GHIs’ HSS programme implementation was weak national capacity to implement these interventions and coordinate programme collaboration within and between the sectors. As a result, HSS interventions undertaken by the GHIs could not independently address systems issues adequately, due to needing more support in strengthening technical capacity for sustainable change. GF HSS interventions mainly address systems issues related only to their specific targeted diseases, which tend to be labelled as process-oriented service delivery and pharmaceutical and support service interventions.

During 2010-2013, GAVI HSS support of 504,500USD was invested to address broader systems objectives such as institutionalising mechanisms to ensure universal access to integrated packages of services for maternal and child health (233). However, the majority of the interventions actually implemented were provision of vaccine and supplements to mothers and children and the immunisation service; actual HSS interventions such as costing and funding of the service package and establishment of the e-database for child immunisation suffered delays and implementation challenges due to the required legal and regulatory amendments.

Overall, the majority of all the partners’ primary focus areas were in service delivery and pharmaceutical and support services. Human resources was often a secondary focus area for the majority of the projects. The least supported areas were behavioural change and communication and quality of care. More recently, ADB, GIZ and JICWELS filled the gap with other least supported areas by shifting their main focus on health financing and institutional development, which have been identified as critical areas for HSS in Mongolia.

Notwithstanding the difficulties in obtaining these records, and some concerns identified with the quality and precision of the data, I have been able to demonstrate that pre-2005 assistance was mostly input type support according to the categorisation that we have used in the research (section 8.4.1). Arguably, this was necessary during the crisis: such in-kind and cash support was essential to guarantee continuing provision of health services during the transition period (187). However, as the country moved from transition to early development, process type support, such as that provided by USAID-MCA, GIZ, ADB and JICA-JICWELS gained momentum (16, 77). Funding from UN agencies has also reflected this change as they have become more supportive of disease specific-HSS interventions (19). The new players, the GF and GAVI have also started supporting HSS components since 2010 through supporting disease–specific health systems interventions.

Over time, a few external partners such as ADB, WB and GIZ have increased their use of national systems and their support for national capacity building. Globally, the release of the Systems
Thinking for Health Systems Strengthening report by WHO (113) has played an important role in this shift. In addition, at a country level, the development of the HSSMP shifted the focus from vertical standalone programmes towards a harmonised health systems approach. However, this shift was not observed at subnational level with projects funded by international NGOs and some infrequent bilateral partners.

8.6.1 Service delivery is the most favoured area for donors

A total of 300.3 million USD funding support was provided to the Mongolian health sector during 2000-2013. Although this figure represents the vast majority of external funding to the country, some projects funded in early 2000 and in-kind support were not reported (20, 187). The following pie chart (Chart 8-2) shows the number of external projects implemented during 2000-2010 by distribution of primary focus areas.

Chart 8-2: Number of external projects implemented during 2000-2010 by primary focus areas

As can be seen from the chart, a total of 17 projects had a primary focus on service delivery, though with an increasing amount of projects showing disease-specific systems level interventions since 2006. Pharmaceutical and support service is the second recipient of funding with a similar trend of supporting subsystems such as laboratory networks and equipment maintenance in the last few years. Human resources are supported by almost every project but with interventions mainly related to trainings and study tours. However, only, one project funded by the ADB targets human
resource from a systems point of view by investing in establishing pre-service and in-service training programmes and institutionalising a regular update of training curriculum.

Three projects have focused on Institutional Development as a primary focus area; however, in terms of allocated funding, this area is still under-resourced. Health financing was supported by only two projects initiated by ADB and GIZ, while quality of care and behavioural change and communication were not supported as a primary focus area by any of the projects during 2000-2010, despite these areas being identified as priorities in the HSSMP. However, six projects included behavioural change and communication as a secondary focus area and two projects included quality of care as a secondary focus.

8.7 Tension between perceived need and actual support

Having mapped out in detail the proportional resource allocation by donors to specific HSS priority areas, I have then presented a graphic comparison of the HSS needs as identified by key stakeholders (Chapter 7) with actual donor support to HSS (Figure 8-1). The interviews with key informants clearly articulated donors’ perceptions of HSS and the priorities that need to be addressed by both government and external donors. But, as we have demonstrated in the analysis of donor support to the sector, the actual allocation of resources to the health sector is not consistent with the positions that they had so clearly presented. Despite the rhetoric and their increasing awareness of the importance of HSS, the external health funding flows by donors are predominantly based on disease-specific vertical programmes classification.

This has become particularly evident as I have compared the rankings of priority HSS support needs as observed by key informants with the actual external funding focus to various HSS areas. The results of this analysis are shown in Figure 8-1.
As seen in Figure 8-1, external funding for HSS does not align with the identified priorities: in the most significant case, service delivery, while lowest in the rankings of perceived HSS priorities, it dominates resource allocation for the donors. Service delivery is given the top funding priority, mostly because it is associated with MDG interventions, which have been generously supported by many donors. Notably, human resources, health financing and health information were identified as the top three priority areas for HSS, but they are not demonstrable funding priorities for donors. Pharmaceutical and support services is the second priority for external funding, perhaps because associated interventions are relatively straightforward and demand less political involvement, especially if they are mainly providing equipment, vaccines and medicine, as was the case in Mongolia.

The support for leadership and governance, which includes institutional development and capacity building for health managers, has been collectively aligned with the identified priority ranking because of the substantial financial and technical support provided by ADB and JICWELS to the area. Behaviour change area has been ranked as the second last priority area, which actually reflected in donors’ project funding allocation, too. The support provided to service delivery and
pharmaceuticals and support services needs to be shifted to the more HSS promoting components such as health financing, human resource and health management and information systems in order to meet the needs of the changing system, transiting from centralised management to more decentralised and participatory management, as suggested by documentary review and key informants’ views. The tension observed between the perceived needs for HSS and the actual donor contributions to it is rooted in myriad complex issues. The historical focus of external aid on disease specific targets, reinforced by global commitments to the MDGs, have contributed to aid fungibility by governments, with a recognition that the external pressure to fund these areas reduces government obligation to support these areas. There is a synergy of interests between donors—with their need to divest resources in ways that conform with their mandates—and government, which is reluctant to sacrifice financial benefits, even where they do not exactly coincide with their HSS priorities. The vested interests that accompany commitments to such priority areas bring with them benefits to individual managers and selected clinical clusters: such programmes bring with them training per diems and travel, salary supplantations and incentives for performance resulting in potential distortions of political interest and interference in deciding resource allocations. Besides, global health priorities do not always match national health priorities; HIV/AIDS is undoubtedly a global priority, but not necessarily a competing priority in the case of Mongolia, at least as it stands now. Technical experts in donor agencies often have good motives and an understanding of HSS, but they lack power and persistence to change their organisation’s mandate or the agreements between donor institutions and government. These situations have collectively contributed to the tensions around the allocation of external resources to health in Mongolia.

8.8 Conclusions

There is a gradual shift in the approaches and areas of focus by donors from input focused relief-type support towards more sustainable HSS interventions such as strengthening the health insurance scheme and setting up an in-service training programme. Both primary and secondary sources point to the impact of global and regional agendas promoting HSS into donor programmes. However, there are variations in donors’ commitments to the national health priorities and health systems agendas. United Nations and bilateral agencies--except GIZ--continue to pursue their own priorities rather than those identified as a country’s priorities; whereas development banks and global health initiatives are making a great deal of effort to shift their contributions towards HSS interventions in accordance with national health priorities. The following situations have become clear and it is essential to address them to improve aid effectiveness in health. These are:
**HSSMP has profoundly influenced perceptions of HSS but not investment prioritisation.** For key informants, the definition and understanding of HSS has been greatly influenced by both global and local policies particularly by HSSMP. As a result, the broad HSS areas used for this study were largely consistent with the WHO building blocks, but primarily influenced by the HSSMP key areas. However, different partners adopted different approaches to supporting HSS in Mongolia; hence investment prioritisation was varied. Development banks were more supportive of HSS in its type of support and approach of working with the government. UN agencies and bilateral partners, with the exception of GIZ, continued to rely heavily on vertical projects, although a shift was observed towards increasing support for capacity building.

**Reporting structures remain unharmonised and don’t allow tracking and evaluation of development assistances.** Currently available databases revealed inconsistencies in the external assistance reporting and classification. Existing ODA data templates rely on MDG influenced vertical programmes for classification of funding despite the increasing significance of HSS at conceptual level. This reinforces a need for standardised donor reporting forms to enable better monitoring of external assistances and better guiding of donors’ support towards national health priorities. Existing monitoring and evaluation processes by donors prioritise output indicators targeted to disease-specific programmes, shifting the focus away from process indicators that would demonstrate support for HSS. Common data collection forms and mechanisms for donor projects will allow better tracking of resource flow and ultimately, rational resource allocation.

**The tensions between perceived needs for HSS and actual practice in supporting HSS remain.** Both data sources revealed a tension between perceived HSS needs and actual practice by donors for investing in HSS, despite some positive shifts in supporting HSS. Human resource management and health management and information systems have been underfunded despite their being perceived as a priority areas for HSS. Service delivery has not been identified as a top priority area for HSS but the area attracts the most of the donor funding because of donors’ commitments to support achieving the MDGs. The government needs to take more leadership in setting up the agenda and channelling donor contributions according to the priority HSS areas by regularising and strengthening the function of the aid coordination committee.
CHAPTER 9: ENHANCING THE CONTRIBUTION OF AID TO THE STRENGTHENING OF THE HEALTH SYSTEM

9.1 Overview

This chapter presents a synthesis of the entire research findings and an analysis of the issues and challenges that have been discovered as a result of the research. It examines the lessons learned from the local application of HSS in Mongolia, identifying context-specific health systems interventions and then critically exploring the broader implications for donors’ contributions to achieving country health systems priorities.

My thesis has comprehensively examined the role and contribution of development assistance in strengthening the Mongolian health system through exploring donors’ approaches to working with the Government, and the relevance and importance of donor-funded projects to achieving national health systems objectives. As part of this analysis, I have explored shifts in global health, aid modalities and approaches and their reflection in aid relationships in post-Soviet Central Asian countries. The study reinforced the importance of context, actors and process and their interrelationship in health policy analysis (148): aid relationships in post-Soviet Mongolia and similar CAPS countries cannot be compared with other countries with long histories of aid relationships with multiple donors. By comparison, Mongolia and similar post-Soviet Central Asian countries have engaged with fewer numbers of donors and currently have a relatively low proportion of aid to overall health expenditure. However, what is distinctive in Mongolia and similar post-Soviet states (Tajikistan and Kyrgyzstan) is that despite relatively low levels of development assistance, aid coordination has remained important in these contexts, largely because of the influential role of donors in institutional capacity building and health sector reform, particularly with current innovative programs in health insurance, and public-private partnerships.

The research provides confirmatory evidence for Buse and Walt’s (65, 159, 234) earlier contention that a government owned participatory planning process is critical, not only for managing donors, but also for effectively coordinating all health sector resources--both external and domestic--hence enabling effective health system reform. The Mongolian Health Sector Strategic Master Plan 2006-2015 (HSSMP) development process, driven and owned by the MoH, facilitated harmonisation of various external and domestic health projects. It also has improved donor projects’ relevance and effectiveness through channelling their resources into national health priority areas.
The form of aid modalities chosen by donors in consultation with governments also plays an important role for improving aid effectiveness, and the ultimate effectiveness of the health system (65, 159), though final outcomes are largely dependent on the broader country context. The SWAp, once considered as an optimal choice for improving aid coordination in Mongolia, has become questioned there over the past two years. Economic changes in the country’s context, with Mongolia transitioning in two decades from being an aid dependent low-income country to a rapidly emerging middle-income economy, have greatly reduced the number of donors—but not their importance. As a result, the applicability of SWAp has been reconsidered, with its possible costs outweighing the benefits. But the SWAp’s principles of country ownership, a defined policy envelope, mutual accountability and institutional capacity building remain as important as before. The entire process of progress towards a SWAp, and the re-evaluation of that decision, demonstrates the dynamicity, fluidity and complexity of the health systems issues involved.

This thesis further points to the dissonance between the perceptions of donors and their rhetorical support for policy alignment through HSS, and the varying levels of investment by these same donors in HSS initiatives. At a point where the most significant contribution of donors is to shaping the health system for government control, this inconsistency contributes to constraints on their collective contribution towards HSS. This finding is in some tension with the earlier finding that saw the importance of the presence of external donors linked to their policy advice in health sector reform, as much as in the quantum of their financial and technical support. In the case of Mongolia, the advice of those advisors—often with extensive experience in-country—continues to reflect local values. They have internalised the HSSMP as the appropriate framing for HSS interventions; they support government leadership and ownership; they recognise the need for harmonisation of activities and alignment of policies. But despite recognising the HSSMP as providing the common ground for HSS, the limited mandates of donors, and the historical dependence of government on them for the support of priority programmes, means that donors continue to prioritise service support over broader HSS interventions. Technical advisors within these programmes have limited capacity to shift the overall trajectories of their programmes—HIV/AIDS continues to be funded at a level disproportionate to the local disease burden, for example—even where they are supporting government policy priorities and attempting to align their programmes as far as possible with these. At this point, as an emerging middle-income country, with increasing responsibility for its own health system but a limited history of functioning within modern democratic structures of governance, the Mongolian government is looking to donors for policy support that strengthens the system as a whole. Increasingly it is realising that it may need to invest more of its own funds in programmes that have previously been donor dependent, in order to redirect donor support to other...
HSSMP priorities through the application of criteria that identify context-specific HSS interventions.

9.2 Key findings

The research has shown that country-led aid coordination mechanisms have the potential to improve the implementation of the health system reforms. However, a number of factors related to the context, actors and process need to be carefully examined and addressed in order to improve donor contribution to a country’s HSS. The key findings that have emerged from the research are inter-related, confirming the complexity and interdependency of health policy processes. These are as follows:

1. **Defining Health Systems Strengthening is complex and context specific.** While WHO has developed its building blocks health systems framework as a model for engaging in HSS, debate over the definition of HSS reflects underlying development tensions between those who continue to advocate for comprehensive systems development, and those who seek to justify the contribution of very targeted health interventions to health systems as contributing to HSS. In my research I have observed that debates around HSS can be categorised into the following three differing positions:
   a. HSS does not have a specific defined focus: HSS is any intervention in an area that the government sees as its priority; therefore, if donors are supportive of government priorities, they are supportive of HSS.
   b. HSS can only be achieved through systems-wide approaches: Vertical programmes with HSS components such as GF and GAVI programmes for HIV/AIDS, TB and vaccines cannot be considered as comprehensive systems programmes; these are still vertical programmes with a disease-specific focus. The health systems support that they offer reinforces these systems and may distort the comprehensive approach required for HSS.
   c. HSS and health systems support are different, and need to be distinguished, but are complementary to each other. Health systems support—frequently associated with targeted disease programmes, rather than systems wide programmes—focuses on the input elements whereas HSS focuses on process elements, hence both are supportive of systems issues.
HSS is a global health agenda; but not all donors are comfortable with it. Despite the rhetorical acceptance of the need for strong health systems, the development framework in health acts to shape development assistance towards single issue agendas, often associated with project-based assistance. But the definition of HSS must change from country to country, but also within countries, as the context changes. The HSS needs of post-transition Mongolia are different from today’s Mongolia. My research has highlighted the importance of distinguishing between health systems support and HSS; hence, my research is supportive of the third position above, arguing for both difference and complementarity between HSS and health systems support. Especially in contexts like Mongolia, where the emerging need is no longer in providing infrastructure and commodities but in strengthening good governance and effective financial and human resource management, donor investment priorities need to be shifted towards HSS interventions. The shift in economic status also demands a transition in development relations, with the contribution of financial and material inputs increasingly the responsibility of government, and technical support across health policy priorities a valuable contribution of experienced donors.

2. The health system functions within an evolving and dynamic context, and is itself complex and adaptive. Developing the health system requires distinguishing between Health Systems Strengthening (HSS) and health system support interventions. While in some contexts, especially in fragile and conflict affected states, where basic support elements such as resource, equipment and staff are lacking, distinguishing these two types of interventions may not have high importance as in emerging middle-income countries, because these countries need both types of interventions, simultaneously. However in an evolving context like Mongolia, an emerging middle-income country, support needs to shift primarily towards establishing better governance and better resource management, with focus on building systems more than providing resources and services. This is critical for ensuring the sustainability of the outcomes already achieved. However, it is also important to remember that health systems support and HSS are not contradictory; the acute support does not undermine current and future possibilities for building comprehensive health systems.

3. The politics and governance of aid recipients, and their relationships with both donors and development processes, will produce differing outcomes. Aid engagement in post-Soviet Central Asian countries is a clear example. From a common social and political history, with centrally controlled economies heavily dependent on the Soviet Union, those
countries with relatively open and democratic governments such as Mongolia, Tajikistan and Kyrgyzstan have benefited from better aid relationships, hence better outcomes. But Turkmenistan and Uzbekistan, with their less democratic governance, have not effectively engaged with donors, and health systems challenges persist. The right balance between donor influence and government power needs to be found to avoid fragmentation caused by various donor-funded programmes and the inflexible control of authoritarian governments. The evidence from the research of differing post-Soviet countries’ experiences suggests that both are harmful for effective functioning of the health system.

4. Development of a clear policy envelope under the strong ownership of the Ministry of Health has profoundly influenced perceptions of HSS. For Mongolia, the HSSMP has served as a tool to effectively harmonise health sector resources—both external and domestic. This research shows how the HSSMP influenced donor confidence in the MoH, and how deeply donors have internalised the framework of the HSSMP, as an understanding of HSS.

While the Mongolian HSSMP is superficially consistent with the WHO building blocks framework—an internationally recognised health systems framework—this apparent similarity is deceptive. The HSSMP was developed iteratively from the planning processes within the MoH, and launched well before the WHO framework. It speaks to the development of a framework driven by local perceptions of the needs of the Mongolian health system, rather than the application of an international model on local circumstances. Developing a local framework in the HSSMP has been critical in beginning the process of achieving local health systems objectives, and the identification of context-specific HSS has been important in implementation. But with the rapid evolution of the Mongolian socio-economic context, the HSSMP 2006-2015 will itself require revision, and the successive plans will need to sustain the same level of political will and overarching institutional support if the proposed health systems outcomes are to be achieved.

5. Despite partners’ commitment to the Paris Declaration principles, and their support for the country-owned HSSMP, there is a tension between HSS needs and actual support by donors to HSS. A number of factors have contributed to this. Firstly, the HSSMP has not adequately addressed investment prioritisation, allowing the imbalanced allocation of resources between differing strategic areas outlined in the plan. Secondly, historical investment in global priorities in service delivery have established donor partners’ preferences for service delivery over health systems interventions. Their institutional
mandates frequently tie them to specific disease programmes, and this focus enables them to achieve quick and tangible results through their targeted support of vertical projects. The eagerness of the global community to invest in MDG priority areas—reproductive health, child health, HIV/AIDS, and tuberculosis—has seen substantial external investments in those programmes. This has been a global phenomenon: with the imperative to set “global” goals and targets—through the MDGs, the targeted global health initiatives that aim to achieve these goals, to the post-2015 Sustainable Development Goals—recipient countries have very limited control on how these priorities are set. Despite this, the setting of global goals determines the available pool of development assistance, and the programmes against which global resources can be allocated. This has also been financially convenient for the MoH in Mongolia, reducing its budgetary demands for areas such as maternal and child health and HIV, but locking in continued investment in health services rather than directing a shift in donor development to other HSS priorities. But one of the unintended consequences of this global momentum has been the diminishing health systems focus, and the distortion of financial and human resource allocations. Global goals effectively limit local flexibility, and the capacity of local managers for donor projects to extend their programme into addressing more context-specific systems issues.

6. Mongolia’s transition to an emerging middle-income country brings a critical turning point to the relationship between government and partners/donors. It requires changes in the donor roles and investment priorities in HSS, and a real shift in orientation for donor agencies from a parenting approach to partnering relationships. Power and influence needs to be shifted from donors to national governments without neglecting effective partnership principles. In this changing relationship, the government must accept increasing responsibility for its own essential service provision, and enter a dialogue with donors that sees greater engagement of donors in policy and health systems. At this time, the political instability within the Mongolian health sector due to the election and consequent change in senior administrative capacity within the MoH has both disrupted donor confidence and increased the vulnerability of health systems interventions, as these are often reform initiatives that require long-term political and legal support. The government needs to maintain adequate and consistent leadership in coordinating donor support. With Mongolian aid prospects changing towards more assistance given as loans than grants, it is even more important to promote a process of capacity building and institutional development to enable the sector to function effectively without being dependent on external assistance.
At this point of the transition, revisiting the health systems framework (Figure 2-10) used in the research suggests that the Mongolian health sector now needs more support in its process elements rather than its input elements. Mongolia’s challenges today are now in improving governance, its monitoring and evaluation system, and financial and human resource management, which all support process-elements of the health system as a whole.

9.3 Conclusion

For Mongolia, the continuing importance of effective donor coordination mechanisms should not be underestimated, despite the country’s transition to a middle-income country and consequent relative less-aid dependent status. The Mongolian MoH needs to maintain its leadership in managing donors in accordance with its HSSMP and potential future priorities to be identified. For that, ensuring effective leadership through permanent and functional mechanisms for development coordination and the development of operational tools and instruments, common monitoring and evaluation forms and reporting templates for donor project reports need to be developed. The responsibility for this needs to be vested in the Policy and Planning Division, directly reporting to the Aid Coordination Committee chaired by the Vice Minister of Health, and guidelines for enforcing these tools and instruments need to be operationalised.

In Mongolia overall, HSS enabling factors related to the local context and actors are in place to considerable extent; the process related factors need to be further streamlined and applied consistently. The goals of achieving an effective and responsive health system through better coordination of HSS strategies should not be lost, while working on the operational aspect of improving the subsystems. This will again require the establishment of technical working groups to identify upcoming health systems issues, and the development of mechanisms for involving various partners working at different levels of the system in achieving common health systems objectives. As the current HSSMP is ageing, the next strategic plan with context-specific health systems interventions needs to be developed, and ways of delivering these interventions need to be embedded into current institutions’ functions and responsibilities. All existing and forthcoming projects—both donor and government funded projects—need to be coordinated to achieve system strengthening objectives. A clear distinction between health sector support and HSS needs to be understood and applied, so that health sector resources are channelled into more process elements such as resource management and monitoring and evaluation capacity rather than continue supporting input elements such as staff, equipment and medicine supply. This will require
government leadership in policy, and a willingness to assume greater responsibility for its own inputs while the MoH redirects donor investments toward the emerging challenges of health systems reform.

The particular socio-economic and political history of Mongolia will necessarily require caution in recommending the duplication of HSS programmes that have worked effectively in this setting to another. Health systems issues and challenges need to be identified and processed locally, engaging those working in the system and those affected by the system. But it is my hope that this analysis contributes to the awareness of international experience in the successful implementation of HSS interventions.
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ANNEXES:

ANNEX 1: Participant Interview Consent Form

Research work: “Development assistance and country health system: Does aid contribute to Health Systems Strengthening in Mongolia?”

I (print name), _______________ agree to be interviewed for the research work on “Development assistance and country health system: Does aid contribute to Health Systems Strengthening in Mongolia?”

I have read both sides of the information sheet and understand the purpose of the interview, and what is required of me. All my questions have been answered and I voluntarily agree to participate in this interview.

I understand that I am free to withdraw from the interview at any time without assigning any reason.

I understand that all information collected during the interview will be digitally sound-recorded, transcribed for research analysis, kept under secure conditions and treated in total confidence, and that I am able to have a copy of this transcript if I desire.

I understand that no identifying information about me will be made public in the form of research reports or research papers without obtaining my written consent. Moreover, the access to the thesis material may be restricted to prior permission of the author, if deemed necessary.

I am aware that this study has been cleared by The School of Population Health Research Ethics Committee of The University of Queensland in accordance with the National Health and Medical Research Council’s guidelines. I also know that the Ministry of Health, Mongolia has accorded the departmental approval for this study.

I understand that I can contact Dr Anar Ulikpan at any time on telephone (in Mongolia – 976-99037500 and in Australia +61401943372), and through email (anar.ulikpan@uqconnect.edu.au). I also understand that I can contact the Chair of the Ethics Committee at l.fitzgerald@sph.uq.edu.au

Name: ____________________________ Signature: ____________________________ Date: __________

(Participant) (Participant) (Participant)

Name: _____Anar Ulikpan_ Signature: ____________________________ Date: __________

(Witness) (Participant)

Name: ____________________________ Signature: ____________________________ Date: __________

(Witness) (Witness)
ANNEX 2: Interview Questionnaire Guides

QUESTION BANK FOR IN-DEPTH INTERVIEWS

**Research work:** Development assistance and country health system: Does aid contribute to Health Systems Strengthening in Mongolia?

**Task 1:**
Identifying the current aid coordination mechanisms and aid modalities operational in the Mongolian health sector

1) What kind of aid coordination mechanisms are operational in the health sector?
2) How are the operation of the aid coordination mechanisms financed?
3) Do you think that the current staffing, resources and organizational structure for this aid coordination mechanism is adequate?
4) How aid priority areas are decided? Who decides them?
5) What do you think about the advantages and disadvantages of the current aid coordination mechanisms?
6) Do current aid coordination mechanisms encourage ownership by the Government? If yes, in what ways? If not, why?
7) What is your involvement/role in the current aid coordination?
8) What aid modalities are operational in the health sector?
9) What is your agency’s role in identifying and deciding the resource allocation in the health sector?
10) How do you see the role of the government/donors/NGOs in health sector aid coordination?
11) Does your agency use the government system for financial and procurement procedures? If yes, what are the advantages and disadvantages? If not, why?
12) Is your agency involvement adequate in deciding aid related decisions? Who dominates the decision making?
13) Can current aid coordination mechanism provide required transparency and accountability?
14) Your concerns and difficulties about implementing pooling of funds
15) Is there an agreed framework between international partners and government for reviewing and monitoring of international partner assistance?
16) Do international partners share information with each other on who is doing what to avoid duplication of efforts?
17) Do current aid coordination mechanisms allow the PPP principles to be applied?
18) How to ensure PPP principles are applied in external aid coordination?
19) To what extent do you think current partnerships reflect partnership principles of shared responsibility, shared risk-taking, mutual trust and accountability and transparency?
20) What are the ways to ensure PPP between health and mining sectors are incorporated in current aid coordination mechanisms?
21) To what extent is the government involved in coordinating the effort to develop and implement standardised systems and procedures between the partners as required in the Paris Declaration?

22) Is there an agreement on rules for cooperation between various international partners and government agencies in the areas outlined in the Paris Declaration?

**Task 2:** Identifying the extent the current projects/programmes support Health Sector Master Plan (HSMP) or Health Systems Strengthening (HSS) interventions?

23) What are Health Systems Strengthening (HSS) interventions in your opinion?

24) Why do you see them as HSS interventions?

25) Are current aid coordination mechanisms supportive towards HSS?

26) What are the main challenges in supporting health systems interventions?

27) To what extent does your programme/organisation support the health systems interventions? In what ways?

28) To what extent is aid arranged through coordination mechanisms in support of health systems building blocks?

29) To what extent are health sector master plan objectives incorporated into partners country assistance programmes?

30) How effective is the current mechanism for incorporating HSMP objectives into partner country assistance programmes and projects?

31) How does your agency/programme/project ensure its alignment with HSMP?

32) Is alignment of the external assistances with HSMP adequate to support HSS?

33) How to measure the external assistance role for supporting HSS interventions?

34) Are current indicators used for measuring HSS interventions adequate and reliable?

**Task 3:**

Finding possible ways and suggestions for improving aid coordination and aid modalities that are supportive of health systems and are appropriate in the Mongolian health sector.

35) Governments or partners’ positions and approaches in improving current aid coordination mechanisms?

36) What type of partnerships between the government and international and domestic partners would you recommend for health sector development?

37) What types of aid modalities are more suited and effective in the current Mongolian health sector to be supportive of a strengthened health system? What needs to be done?

38) What recommendations would you like to make to improve the role of international consultants and international-partner technical officers in supporting health systems?
39) What recommendations would you like to make to improve the role of government staff in improving external aid contributions towards HSS?

40) What are the best ways and mechanisms to ensure external assistance is channelled to the strengthening of the health system? How?

41) How to ensure that external assistance is supportive of health systems?
ANNEX 3: List of respondents

<table>
<thead>
<tr>
<th>Institution represented</th>
<th>Level &amp; No. of interviewees</th>
<th>Policy making and coordination level</th>
<th>Implementation level (project/district)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government agencies (total No. 4)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td></td>
<td>2 (local)</td>
<td>1</td>
</tr>
<tr>
<td>District health department</td>
<td></td>
<td></td>
<td>1 (local officer)</td>
</tr>
<tr>
<td><strong>Bilateral agencies/projects (total No. 3)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GIZ</td>
<td></td>
<td>1</td>
<td>1 (local officer)</td>
</tr>
<tr>
<td>JICA</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>EPOS (contractor for US Government funded Millennium challenge account project)</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Multilateral agencies (total No. 10)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNICEF</td>
<td></td>
<td>1</td>
<td>1 (local officer)</td>
</tr>
<tr>
<td>UNFPA</td>
<td></td>
<td></td>
<td>1 (local officer)</td>
</tr>
<tr>
<td>WHO</td>
<td></td>
<td>1</td>
<td>2 (1 local 1 international)</td>
</tr>
<tr>
<td>World Bank</td>
<td></td>
<td>1</td>
<td>1 (international)</td>
</tr>
<tr>
<td>ADB</td>
<td></td>
<td>1</td>
<td>1 (international)</td>
</tr>
<tr>
<td><strong>Global fund (No 2)</strong></td>
<td></td>
<td>1</td>
<td>1 (local officer)</td>
</tr>
<tr>
<td><strong>International NGOs and professional association (total No. 7)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World Vision</td>
<td></td>
<td>1(Int’l coordinator)</td>
<td>2 (local officer)</td>
</tr>
<tr>
<td>Norwegian Lutheran Mission</td>
<td></td>
<td>1(Int’l coordinator)</td>
<td>1 (local officer)</td>
</tr>
<tr>
<td>VSO</td>
<td></td>
<td>1(Int’l coordinator)</td>
<td></td>
</tr>
<tr>
<td>Public Health Professionals association</td>
<td></td>
<td>1 (local officer)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(10 international 3 local officer)</td>
<td>(10 local 3 international)</td>
</tr>
</tbody>
</table>
ANNEX 4 *Template used for donor support mapping in Mongolia* (an example is provided)

<table>
<thead>
<tr>
<th>Donor type/Donor</th>
<th>Field of focus</th>
<th>Timeframe active</th>
<th>Amount invested (US$) (by each components, where available)</th>
<th>Interventions supported and the amount invested by years (USD)</th>
<th>What areas of HSSMP have been supported?</th>
<th>Level of operation</th>
</tr>
</thead>
</table>
| Bilateral: USAID | Improving Non – Communicable disease prevention and management | 2007-2010 | Ex: Human resource- 6 mln  
Equipment provision- 5 mln | 2007-Training-1.5 mln  
2008-Conference-0.05 mln | Human resource  
Pharmaceutical and support service | National and subnational level |
**ANNEX 5 Interview analysis template (example is provided)**

<table>
<thead>
<tr>
<th>Interviewee (I1-I26)</th>
<th>Level of organisation represented</th>
<th>Type of organisation represented</th>
<th>What is HSS?</th>
<th>How do you/your organisation support HSS?</th>
<th>Important elements for effective HSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1</td>
<td>Policy making</td>
<td>Bilateral</td>
<td>Training of health workers Resource management</td>
<td>Supporting government health priorities Human resource</td>
<td>Good governance Management capacity</td>
</tr>
<tr>
<td>I2</td>
<td>Operational level</td>
<td>International NGO</td>
<td>Effective primary health care Accessible and affordable healthcare</td>
<td>Support training of doctors and nurses Donate medicine and equipment</td>
<td>Continuous on-going training Staff motivation</td>
</tr>
<tr>
<td>I3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 6  Letter of approval from the School of Population Health Research Ethics Committee

School of Population Health

Public Health Building
Herston Road, Herston
Brisbane Qld 4006
Telephone +61 7 3365 5345/5280
Facsimile +61 7 3365 5442
Email: Enquiries@sph.uq.edu.au
Website www.sph.uq.edu.au

To  Ms Anar Ulikpan

From  Lisa Fitzgerald
Date  02 August 2012
Re  Ethics Approval AU020812

CC  Associate Professor Peter Hill

Dear Anar
Thank you for your application for ethics approval for your research:

*Development aid and country health system: Does aid contribute to health systems strengthening in Mongolia?*

The School of Population Health Research Ethics Committee has reviewed the materials submitted and ethics approval has been given.

Yours faithfully

Lisa Fitzgerald
Chair, School of Population Health Research Ethics Committee
School of Population Health, University of Queensland
ANNEX 7  Letter of the Vice Minister of Health expressing MoH support to the conduct of the research

(Translation of the letter is provided in the next page)
Ministry of Health, Mongolia

Address: Government Building VIII, Olympic Street.
Sukhbaatar District, Ulaanbaatar 14210
Date: 26 October, 2012; Order N 16/3667

TO: All concerned parties including international partners, managers and officers in charge of the aid and grant funded projects and programmes

Dr U Anar, a PhD researcher based in the University of Queensland, Australia is conducting a health policy research focused on the Mongolian aid coordination and its role on improving health systems strengthening in order to propose policy recommendations on improving health sector aid effectiveness in Mongolia. The research work has been commenced in February, 2011.

Ministry of Health is supportive of the research and I request your and your institutions’ full support for Dr Anar in accessing relevant person in-charge for international health projects and programmes, data and materials required for conducting her research.

Signature (signed and stamped) Vice Minister of Health