REPORT ON THE RAPID APPRAISAL OF EXTERNAL AND DOMESTIC SUPPORT IN THE SUB-NATIONAL HEALTH SYSTEM AT THE TARGET SITES IN MONGOLIA

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Contents

Annexes

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
BCC	Behaviour Change Communication
CHV	Community Health Volunteer
GF	Global Fund against HIV/AIDS, TB and Malaria
FGD	Focus Group Discussion
FHC	Family Health Centre
HIS	Health Information System
MCA	Millennium Challenge Account
MOH	Ministry of Health
MPHPA	Mongolian Public Health Professionals' Association
PHC	Primary Health Care
RDTC	Regional Diagnostic and Treatment Centre
SA	Service Availability
SHC	Soum Health Centre
TOR	Terms of References
UB	Ulaanbaatar City
WHO	World Health Organization
WB	World Bank

1. INTRODUCTION AND BACKGROUND

The Mongolian Public Health Professionals' Association (MPHPA) conducted the Rapid Appraisal Study on external and domestic support provided at the sub-national level of the health care system in Umnugobi aimag and Songinokhairkhan district of Ulaanbaatar City, from 1st November to 10th December, 2013 based on an agreement between the World Health Organization (WHO) Representative Office and MPHPA.

Since 1990, the health sector has been heavily dependent on external aid to provide accessible, affordable and quality health care to the population through both resource provision and improved management of the delivery of health services. With the recent rapid economic growth resulting from the mining boom in the country, the situation has changed and the government expenditure on the health sector has dramatically increased in money terms but not as share of GDP (still less than 3.7% in 2011). During her recent visit to Mongolia (Aug 2013), Dr. Margaret Chan, WHO Director General, strongly emphasized to shift the focus of support and inputs to the sub-national level of the health care system

MPHPA is a non-governmental professional organization that was established in 2003. The mission of the association is to support sustainable development of public health in Mongolia through pooling the skills of professionals, especially its members, and strengthening inter-sectoral collaboration between the various sectors in order to protect and promote the health of the population. As of 2013, more than 170 public health national and international professionals are members of the MPHPA and the organization is actively seeking to grow, at the local and national levels and in the international arena. The, MPHPA has been a member of Euro-Asian Initiative for Patients Safety since 2008, the Asia Pacific Alcohol Policy Alliance and the World Federation of Public Health Associations since 2010.

The preliminary findings and recommendations of the Rapid Appraisal Study were presented at the Health Partners Meeting of the Ministry of Health on the 3rd December 2013 and it was well received by all partner agencies that were present at the meeting (copy of the Power Point presentation is included in Annex 15).

2. PURPOSE AND OBJECTIVES OF THE RAPID APPRAISAL STUDY

The purpose of the Rapid Appraisal Study was to review and document the external support and assistance provided in the health sector (in the selected sites) covering the last four years and to draw conclusions and make recommendations to help in further strengthening the health care system of Mongolia, in particular at the sub-national level. . In order to accomplish this purpose, there were two objectives:

- To conduct an inventory of the external aid and assistance provided in the health sector (in the selected sites) and then study these inputs in terms of health care system

strengthening with particular emphasis at the sub-national levels including health service delivery, improving quality of care, capacity building of health workers and delivering of medical and related equipment and other assets.

- To examine these health related external assistance and aid provided at the selected sites in terms of the areas covered and the amount of funding provided.

In addition to these appraisal study objectives, the scope of work and expected outputs were stated in the Terms of References (ToR) of the Rapid Appraisal study. The ToR is included in Annex 1.

The expected outputs of the Rapid Appraisal Study were the following:

- Inventory of external aid and support provided to the health sector over the last four years will be conducted;
- Areas for which support was provided in the health sector of Mongolia will be mapped along with their geographical location;
- Inputs provided at the national and sub national levels in terms of areas covered and the amount of funding provided will be compared
- The implementation modalities within the context of decentralization and sectoral coordination and management including aid coordination will be described and compared
- Action recommendations made and potential next steps listed.

The appraisal study is expected to cover a period of almost four years starting from 1 January 2010 to and including November 2013 and to conduct an inventory of and examine the external and domestic support provided at the sub-national level of the health care system in the selected sites. The work plan of the appraisal study was to be developed in close consultation with WHO staff.

3. RAPID APPRAISAL STUDY METHODOLOGY

During the Rapid Appraisal Study, data will be collected as follows:

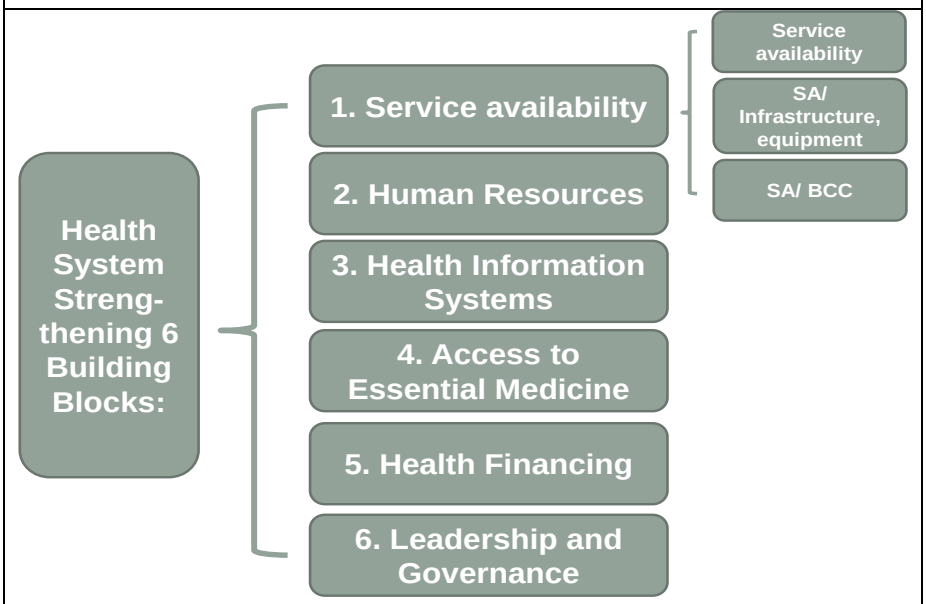
- Individual key informant and group interviews;
- Focus group discussion;
- Matrix developed using and adapting the WHO's HSS 6 Building blocks (illustrated in Figure 1) and SARA questionnaire for a facility assessment, and
- Desk review of relevant project documents, various reports and analyses.

The appraisal tools were developed by the MPHPA team in consultation with WHO staff and mutually agreed to. The mutually agreed tools used for the assessment are included in Annexes 3-5.

The training of the research team on data collection, data processing and analysis went successfully according to the plan. In total, 33 officials in Umnugobi aimag and 15 officials in the Songinokharkhan district of UB city representing local government, health department and health centers participated in the appraisal study.

Additionally, key officers of the various multi- and bilateral international organizations and NGOs were interviewed as key informants to complement and complete the information gathered from the selected sites. The List of participants who were met during the study period is included in Annex 6.

Figure 1. **6 Building Blocks of WHO Health system strengthening**



Source: WHO,

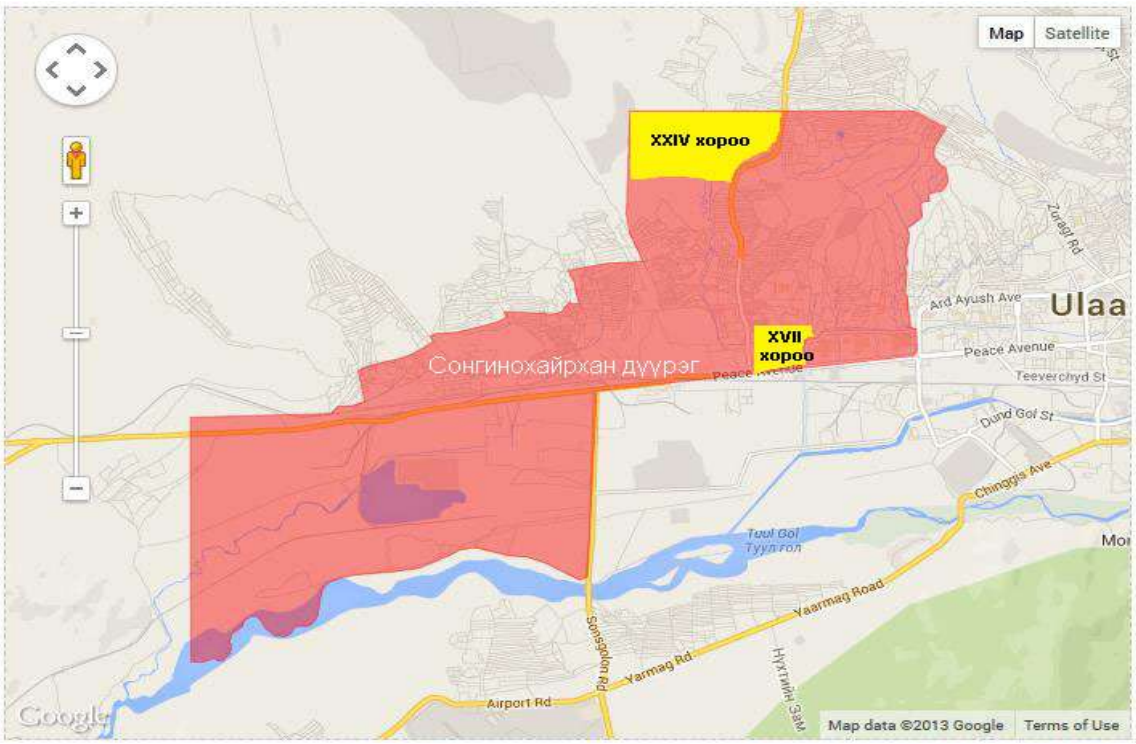
4. PROFILE OF THE SELECTED SITES

For the purpose of the Rapid Appraisal Study, Songino Khairkhan district of Ulaanbaatar city and Umnugobi aimag. 2 khoroos of Songino Khairkhan district and 2 soums of Umnugobi aimag were selected in consultation with WHO to assess the situation at the sub national level including the grass-root level.

4.1 Songino Khairkhan district

Songino Khairkhan district is one of the two largest and most populous districts in UB, and as of 2012, it has population of 262,000. There are 32 khoroos (wards) in the district. Primary and secondary levels of health care services are provided for the district population. Secondary care level hospitals are the District Health Alliance hospital in Khoroo 13 (in the East area), with 138

beds and District Hospital in Khoroo 19 (Central area), which is essentially a pediatric hospital with a 115 beds. Health facilities providing primary level health care include a total of 31 Family Health Centres (FHC), 77 private clinics and 11 private hospitals (inpatient beds). Khoroos #17 and #24 were purposely selected as Khoroo #17 is with apartment blocks and Khoroo #24 is in the ger area and it is one of the newly expanded areas of the district.



The most remote khoroo of Songino Khairkhan district is Khoroo #32 which is located about 20 km from the Central District Office.

Khoroo #17th has population of 5,056 (2012) and it consists of 4 subdivisions. The FHC of the Khoroo has 3 doctors and 3 nurses.

Khoroo #24th is in the ger area and it has population of 10,035 (2012). There are 84 households that have been registered as "poor and vulnerable" totalling 194 "poor and vulnerable" people. The khoroo consists of 10 subdivisions and the FHC employs 3 doctors and 3 nurses. This Khoroo is located adjacent to the Ulaanchuluut garbage landfill. Because it is a new Khoroo, at present there is no school and there is only 1 kindergarten with 180 children attending.

4.2 Umnugobi aimag

Umnugobi aimag, as of 2012, has a registered population of 65,000. However, there is an additional population of approx. 50,000-60,000 mobile/transient persons. The aimag comprises of 15 soums and there are many mining companies operating within the territorial jurisdiction of the aimag. Secondary/Tertiary level of health care is being provided by Regional Diagnostic and Treatment Center (formerly known as the Aimag General Hospital) and primary level care is provided by health facilities that include 11 soum health centers (SHC), 3 inter-soum hospitals and 3 FHCs.

The most remote soum (district) of Umnugobi aimag is Gurvantes and it is located 316 km away from the Aimag centre and it's the most remote bagh (sub district) is 60km away from the soum centre indicating the long distances linked by very poor dirt roads often impassable during severe weather situations

Tsogt-Ovoo and Tsogttsetsii soums of Umnugobi aimag were selected as the study sites for the Rapid appraisal study in consultation with WHO staff. Tsogttsetsii soum has a population of 6,170 (2012) with an additional mobile population of approximately 10,000 persons. The soum consists of 3 baghs and there are 6 public agencies and one of them is an inter-soum hospital operating in the soum and it has 9 doctors. The Mining companies including Tavan Tolgoi LLC and Uhaa Hudag (Energy Resources) LLC are operating in the territorial jurisdiction of the soum.

Tsogt-Ovoo soum has a population 1,635 (2011) and it consists of 3 baghs. There are also 6 public agencies and one of them is a Soum Health Center (SHC). It has 2 doctors.

4.3 Key Health Indicators for the selected sites

Key health indicators of the selected aimag and district are presented in Table 1. The Table is based on the information gathered from the Health Statistics Report of the Umnugobi Aimag HD and Songino Khairkhan District Health Alliance. It should be noted that the Umnugobi Aimag HD produces its monthly and Annual Health Statistics Reports on a regular and timely basis and all Soum Health Centers (SHCs) are able to compare their performance against the other SHCs. This best practice has been operational now almost ten years after being introduced with technical assistance by GIZ Reproductive Health Project. When compared to the national average, the indicator namely the utilization of hospital beds in Songino Khairkhan district is much higher (1705.7) which could be attributed to the large population living in the district. The national average for utilization of hospital beds was 145 in 2012.

Under 5 mortality rates per 1,000 population in Songino Khairkhan district is 2.3 as stated in the statistics report obtained from the District Health Alliance and it could be attributed to the

accuracy of the information recorded and reported instead of showing a very low under 5 mortality rate in the district.

Table 1. **Key health indicators of the selected sites (2012)**

#	Figures	National average	Umnugobi aimag	Songinokhairkhan District
1	Births per 1000 population	26.3	20.2	28.3
2	Deaths per 1000 population	5.9	5.1	6.1
3	Natural increases per 1000 population	20.4	15.1	21.2
4	Under one mortality rate per 1000 live births	20.4	16.9	10.8
5	Under five mortality rate per 1000 live births	18.7	23.1	2.3
6	Utilization of hospital bed	145.0	221.3	1705.7
7	**Morbidity of selected communicable diseases per 1000 population**			
	Hepatitis	24.7	57.4	28.15
	TB	13.9	4.6	21.6
8	**Morbidity of common NCDs per 1000 population**			
	Respiratory diseases	1099.44	1974.08	1277.4
	Diseases of digestive organs	1027.81	1242.25	1554.0
	Urinary tract diseases	764.09	729.51	796.0
	CVDs	817.03	824.54	333.0
	Iinjury and poisoning	502.76	301.4	653.0

Sources: MOH and NHC, Health Statistics Report, 2012, Health Statistics Report, UB City HD, 2012 & Umungobi aimag and Songinokhairkhan district health statistics, 2012

5. RAPID APPRAISAL FINDINGS AND ISSUES

The findings of the rapid appraisal study have been summarized in the inventory and the summary Matrix of findings that was developed by the team. The inventories of health partnerships that were conducted in the selected sites are included in Annexes 7.1 and 7.2 for Songino Khairkhan District and Umnugobi aimag respectively.

The findings from the inventories of health partnerships in the selected sites were further captured and examined in the Summary matrix (Annex 8) to provide a better map of the areas of support and aid that have been provided by partner organizations during 2010-2013. This matrix was organized as follows:

- The ***X axis***, reflected the organisations that provided aid and assistance. Funding organizations are grouped into the following main categories: state budget (central and local budget and funding provided by Member of Parliament of Mongolia), international development partners (multi- and bilateral), NGOs (international and domestic) and business entities (mining and non-mining). Although the main purpose of the Rapid appraisal study is to focus on the extent of external and domestic assistance provided to the health care systems at the sub-national level, it was felt necessary to reveal the support provided by the local government from its local budget., The Umungobi Aimag

Government has been providing great support, especially over the last few years to the health care system at the sub-national level to respond to the increasing demand for health care services and to fill the gaps resulting from the inadequacy of the central government budget.

- The ***Y axis***, reflects the following selected sites:
    - Songino Khairkhan District level;
    - Songino Khairkhan Khoroo level;
    - Umungobi Aimag Health Department;
    - Umungobi Aimag Regional Diagnostic and Treatment Center, and
    - Umungobi Soum level.

External and domestic support and assistance provided in the selected sites have been mapped in accordance with WHO's six building blocks for Health System Strengthening (see Figure 1 on page 7). Many partner organizations have provided support and aid in the areas namely to improve service availability (Building Block #1) and to improve capacity of health workers by delivery of mostly short term (2-5 days) training events (Building Block #2).

In order to better map the external and domestic assistance provided by partners at the sub-national level of the health care system in the selected sites, the appraisal study team has decided to sub divide the Service availability building block (#1) into Infrastructure and Equipment and Behaviour Change Communication (BCC) .

The findings from the Rapid Appraisal Study have been described for each sub-level of the sub-national health care system as follows.

5.1 District level

At the district level, mainly multilateral international partners were active, with World Vision being the only international NGO actively working in Songino Khairkhan District. The focus of these various health partners at the district level was on 4 main areas: Training, Service availability, (Service availability (SA)/Infrastructure & Equipment and SA/BCC). The Building blocks #4, 5 and 6 were not supported during the last four years. It can also be noted that there is no concept of Corporate Social Responsibility among the local business entities in the district as none of the business entities supported or assisted the local health care service facilities. The Summary matrix for Songino Khairkhan District is included in Annex 9.

5.2 Khoroo level

At the khoroo level, it was observed that the main interventions were merely the extension of activities resulting from the district level interventions that had been supported by multilateral international partner organizations through the involvement of the staff at the khoroo level.

NGOs were more active at the khoroo level and they were more likely to work at the khoroo level and therefore were closer to local communities and the people. International NGOs have traditionally been working directly at the khoroo level with no corresponding activities at the District Headquarters (Health Alliance Central Office) level. World Vision, and INGO has especially been working both at the district and khoroo levels.

It can therefore be concluded that multilateral international organizations that have supported khoroos have invariably done so through their liaison with NGOs .

It was noteworthy that a number of domestic NGOs had been working at the khoroo level when compared to Umungobi aimag. However,, many of these domestic NGOs are actively associated with, or belonged to political leaders indicating the possibility of a significant political element in their presence in one of the most populous district in UB.

The Findings of the inventory of the external support provided in the 2 selected khoroos (#17 and #24) is included in Annex 10.1 and 10.2 respectively.

5.3 Aimag level

At the aimag level at the selected site, the Aimag Government, multilateral international partners and business entities were active in providing support and assistance to the health care services at the sub-national level. However, during the last four years no international and domestic NGOs were recorded and noted to have operated at the aimag and soum levels . Only, the NGO from the Czech Republic named "People in Need" had provided on off donation of some medical equipment to the Regional Diagnostic and Treatment Centre (RDTC). This lack of support and aid from international and domestic NGOs may be due to the perception that Umungobi is a comparatively wealthier aimag because of the generation of mining revenues and therefore is no longer a poor aimag requiring their support and assistance.

There were 4 main areas of the health care system in Umungobi aimag that received external support at the sub-national level which were identified as follows:

- SA General including SA/ Infrastructure and SA/ BCC (Building Block #1);
- HR Training (Building Block #2);
- Drugs and commodities (GF, UNFPA) (Building Block #4), and
- Health Information System (HIS) (very minor) (Building Block #3);

Building blocks 5 & 6 were not covered during the last four years in Umungobi aimag. Annex 11 shows the structure and extent of the external and domestic assistance provided at the Umungobi Aimag Health Department level.

The clear relationship between provision of commodities and training in HIS is observed. In particular, the Millennium Challenge Account (MCA) Health project and Global Fund (GF) against HIV/AIDS, TB and Malaria provided training on health statistical reporting as they both

provide equipment and commodities that need to be recorded and accounted for in a transparent way which was required by the funding entities as part of the performance measurement and verification making reporting and documentation a vital part of their project inputs.

Business entities in Umungobi aimag have been providing limited and infrequent support such as equipment and individual scholarships for training.

5.4 Regional Diagnostic and Treatment Centre (RDTC)/Aimag

There is strong support from the Aimag Government for the aimag General Hospital as the local decision makers see the upgrading and strengthening of hospital care is one of the solutions to cope with increased demand for health care services created by the growing mobile population in the aimag. For instance, the Aimag Local government's spending from its local budget (in addition to budget allocated from the national government) for the RDTC only amounted to approximately MNT 1.4 billion over the last 4 years. In 2013, the Aimag Government purchased 3 fully equipped ambulance cars costing approx. 180,000 Euros that would be suitable for use in the rural roads and areas and obtained these directly from Volkswagen, Germany.

The former Aimag General Hospital was upgraded to a RDTC to enable it to cope with the provision of the increased volume of health services. However, it has not been upgraded in terms of the level of care that it should be providing which is from secondary to tertiary level. The assistance provided by health partner organizations has been dominated by provision of equipment as this was constantly emphasized by the health staff at the aimag health department and hospital since its recent establishment/upgrade. Overview of this assistance (mainly various medical equipment) provided to the RDTC is included in Annex 12.

5.5 Soum level

In the two selected soums of Umungobi aimag, mainly multilateral international partners and business entities operating in the territorial jurisdiction of these soums have provided assistance since January 2010. Basically the support was provided to increase health care outreach services to communities through the Training of the Primary Health Care (PHC) workers and Community Health Volunteers (CHV) and the provision of medical equipment.

Business entities have also provided limited assistance to SHCs to help them to accommodate the large number of workers from the Mining companies creating an increased demand for health care services caused by an increased occurrence of more severe injuries and accidents. Mining companies work in shifts while the SHCs are not organized to work 24/7. SHCs, because of lack of funding and HR capacity are unable to provide services 24/7 and this has particularly been observed in Tsogttsetsii soum.

Therefore, in Tsogttsetsii soum, the SHC was upgraded to an inter-soum hospital and this appears to have enabled the SHC to become eligible to more human resources consistent with national HR standards (MNS) for an inter-soum hospital.

The matrices capturing the key areas of assistance along with health partner organizations supporting the soum level are included in Annex 13.1 (Tsogttsetsii soum) and 13.2 (Tsogt-Ovoo soum).

5.6 Financial overview of external and domestic support provided in the selected aimag and district

The ToR for the Rapid Appraisal Study indicates the collecting of information about the overall amount of funding provided as external and domestic assistance at the sub-national level for the health care system at the selected sites. However, it was almost impossible to track and collect information on the amount of funding provided by health partner organizations through the government health agency offices due to various reasons mainly related to lack of information at the various government health agency offices, the long lag time taken by the officers to track down and locate the documentation and conform its accuracy and the lack of ability to collate and organize this information in ways that could be of use for further examination. Turnover of staff, especially at the district level, and poor access to financial data in terms from partners, poor accuracy and retrievability at the local government level became critical factors affecting the timely availability of this financial information.

The Umungobi Aimag HD on the other hand was able to provide the information that is captured in the Table below.

Table 2. **Financial overview of external and domestic aid provided in Umnugobi aimag, 2010-2013**

#	Funding organization	Key areas of support	2010	2011	2012	2013	Total 2010-2013
1	**OT LLC**	Scholarship program for Physicians	5,385,800	3,035,700		9,455,450	**17,876,950**
		Mobile cancer screening		1,585,000	32,035,800		**33,620,800**
		National campaign		3,275,000			**3,275,000**
		Waste equipment			37,389,000		**37,389,000**
		Repair of Training room of HD			10,000,000		**10,000,000**
2	**Energy Res LLC**	Training for affected areas	10,719,165	10,990,600	12,388,000		**34,097,765**
3	**MCA Health**	'Health workplace' project	8,011,280	3,426,365	25,728,240	5,555,400	**42,721,285**
4	WHO	Clean environment for Bulgan and Tsogt-Ovoo			8,245,500	2,618,000	**10,863,500**
		Training at HD			3,922,000		**3,922,000**
5	**UNFPA**	Project in 2 soums				738,290	**738,290**
	TOTAL		29,502,045	30,208,365	221,300,480	30,440,590	**311,451,840**
6	**Aimag total health budget**		2,999,907,700	3,974,760,500	5,941,032,500	6,653,798,300	**19,569,499,000**
	% of external aid on total budget		**1**	**0.76**	**3.72**	**0.46**	**1.59**

Source: Umnugobi Aimag Health Department, November 2013. Total Aimag health expenditure for 2010-2012 and budget for 2013

Similar information at Songino Khairkhan district was not available due to various factors that included:

- High staff turnover and lack of institutional memory;
- Could not retrieve relevant financial and related documentation;
- The records were not easily retrievable or transparent;
- Top-down approach of health partners sharing financial information on a need to know basis
- Local government and health providers are not actively included in project management.

5.7 Issues and Observations

The findings from the Rapid Appraisal Study indicate that capacity building of health human resources is a predominant focus of the external and domestic aid provided during the last 4 years in the selected sites. Projects and programmes based on local needs have been implemented successfully and owned, to some extent, by local people. Unfortunately, the appraisal study team did not come across a single project initiated by local people in any of the selected sites during the period covered.

It needs to be highlighted that in Umnugobi, the Aimag government has provided strong support to the health care system at the sub-national (aimag and soum) level in terms of providing modern medical equipment and capacity building of health workers including training courses in Leadership and English language.

It can also be concluded that MCA and GF projects are service oriented and intensive and have multi-component project designs with a variety of project activities whereas the other international partners like WHO and UNICEF are focusing on a fewer areas such as training of rural health workers and water and sanitation.

Although there are a considerable number of transnational and national mining companies operating in the territory of Umnugobi aimag, the Aimag HD has been informally discouraged from various central level entities from directly approaching the Mining companies for aid and assistance for the health care system. Senior officers have indicated that support, especially from the larger business entities and corporations should be coordinated through a central mechanism so that duplication is avoided and the inputs are not diluted or fragmented. However, it was not clear, from the various consultations with groups and key informants what is this mechanism or what it is supposed to be.

It is also worth highlighting some of the key negative findings relating to the covering of Building block #6 namely Governance and Leadership. These are:

- No institutionalized coordination mechanism(s) for external and domestic aid exist at local government (sub-national) level: no organized and approved sub-national level mechanism(s) for joint policy review and development and comprehensive planning exists and there is also no clearly delineated mechanism(s) for undertaking joint

monitoring and evaluation of the performance of the health care system at the sub-national level;

- Fiscal and activity reporting of project indicators required by external aid agencies contributes to the fragmentation, and depletion of the current HR and institutional capacities rather than contributing to the strengthening of the local health institutions, facilities and staff. It also results in local staff being siphoned off for implementing partner operated projects.

6 CROSS CUTTING ISSUES AND CHALLENGES

The Building blocks # 5 (Health Financing) & #6 (Governance and Leadership) out of 6 building blocks designated for health system strengthening have not been addressed at all in the selected sites. It may help to explain why there is little or no sustainability, poor or absent institutionalization and lack of embedding of project interventions into the routine activities of the health care organizations.

On the other hand, resources allocated to various areas of work by multilateral or other international partner agencies are not necessarily in sync with the WHO's 6 building blocks for health system strengthening.

It could also be concluded that only implementable outcome and output related activities have been carried out at the sub-national level – number of trainees and participants are more important as the targets and goals are written in terms of outputs and outcomes and not in terms of systems built, developed or sustained beyond the life of the project. Hence, peripheral health centers and hospitals are just seen as an arena to carry out goals and plans of various partner organizations (international and domestic) to achieve their targets and to report to these partners and funding agencies. Thus, projects should also include clear activities to build the capacity of the institutions and embed operational processes and procedures especially at the sub-national level

Clearly, there is a lack of ownership of the external assistance provided and many projects appear not to belong to local health authorities and this is gleaned from the respondents' opinions and comments. Deputy Governor of Tsogt-Ovoo soum, Umnugobi aimag, pointed out that "It is very rare that projects supported by international donor organizations provide information on investments and aid given to us and our soum".

One of the significant emerging cross cutting issues is that multilateral international partners have not, generally, been cooperating and collaborating with NGOs at various levels but more particularly at the sub-national level. Multilateral international donor agencies only seem to work with public health centers and public hospitals at least in these selected sites.

Dysfunctional relationship between local government and local NGOs were also noted from the FGDs that result in local NGOs not being actively engaged. In addition, multilateral/bilateral

international partners are also not seen to be collaborating with international NGOs except in a token manner.

At any level in the selected sites, there was no formal clear and operational aid coordination mechanism existing within the local government level (district, khoroo, aimag or soum). Chair of Tsogt-Ovoo Soum Governor's Office shared that the "Coordinating or Steering Committees of different projects are usually set up in accordance with instructions provided by central ministries or higher level decision making bodies. Those committees are functional during implementation of that specific project or programme".

On the basis of the above mentioned cross cutting issues and challenges, the conclusions could be encapsulated and illustrated by an old Indian saying:

"The darkest area is always under the lamp".

UB districts and aimags health care systems almost never systematically benefit from external projects especially in terms of building the health care systems, capacity, sustainability, institutionalization and embedding of project activities into routine work.

7 RECOMMENDATIONS FROM THE RAPID APPRAISAL STUDY

The findings, cross cutting issues and challenges emerging from the Rapid Appraisal Study of the external and domestic support provided to the health care system at the sub-national level in the selected sites over the last four years, help to formulate the following recommendations for consideration action by multilateral and bilateral international partners, INGOs, MoH, local government, and domestic NGOs.

- Enable and institutionalize the participation of and oversight by local government, community organizations and key individuals in the community in all stages of project design and management of implementation and monitoring, supplemented with participative evaluation;
- Engage more effectively with the international and domestic NGOs operating especially at khoroo and aimag and soum levels especially during the situation analysis program/project design, its implementation and during evaluation;
- Expand the role of multilateral and bilateral international partners, especially technical agencies in providing technical support in the areas of governance, program management, participative evaluation and support for option analysis and intervention selection as this is more crucial than ever before (increased state budget cannot always solve the emerging issues because of the new and emerging technical and management related challenges);
- Establish and operationalize a formal, institutionalized and integrated aid coordination mechanism at local government (aimag and district) level with the local governor

chairing the aid coordination mechanism (Paris Declaration: government led) and the head of the health agency/facility as secretary of this coordinating mechanism and all partners (international agencies, INGOs and key/selected domestic NGOs, key community representatives with emphasis on the representation by women) as members;

- Formally integrate the planning, budgeting and monitoring of project interventions at sub-national and local levels promoting decentralization through systematically strengthening local governance and leadership (building block #6) in order to enhance and enable sub national and community level sustainability, ownership and oversight for this assistance and aid provided through projects or through other aid and assistance modalities contributing to institutionalization of these tasks at these levels.

As for the next steps, it is necessary to include here that some critical questions need to be asked by all partners such as:

- What should be the objectives and structure and sequencing of the activities that should be included in project planning process to enable shifting the focus and locus of the health system development support and assistance from the national to sub national levels so that many of the current design, planning, management of implementation of management and oversight weaknesses at the national are not repeated at the sub national level?

- Which type of assistance and aid implementation (project, programme, sector support) modality (ies) would work better at sub-national level that will be in keeping with the Principles of the Paris and subsequent Declarations and building indigenous/local capacity while avoiding the weaknesses that have beleaguered the assistance and aid modalities at the national level?

- What types of capacity building modality(ies) should be built into the project design starting with project identification, design, management and governance, monitoring and evaluation and community participation especially at the sub-national and community levels?

- What sort of decentralization and capacity building activities should be undertaken by the central health authorities,(MoH) supported by the international partners, to enable sub-national health agencies and institutions to undertake health sector development at their level?

8 CONSTRAINTS EXPERIENCED DURING THE RAPID APPRAISAL STUDY

The first of all, the time allocated for such a rapid appraisal study with its expected outcomes as indicated in the ToR was woefully inadequate and the tools developed without participation of public health institutions and staff at the targeted sites were very prescriptive. This was further compounded by a high staff turnover and lack of availability of higher level decision makers,

particularly at the Songino Khairkhan District Government offices which severely impacted on the quality and the adequacy, especially of the fiscal data, for the study. It was a time consuming effort to track the staff to obtain information from primary sources at the district office because of lack of availability of the staff during the study period, poor institutional memory and inadequate and disorganized documentation.

During the data collection stage, the appraisal study team also faced numerous challenges such as the newly assigned government staff who after the several elections during last one and a half years, not being acquainted with the past and current collaborations, assistance and aid provided by the external and domestic partners. This was further compounded by not being able to get appointments (there were repeated cancellations/postponements) with key district government officials severely thwarting the team in obtaining primary data during the study period. In order to overcome these problems, the study team resorted to finding the persons who had been staff members in these positions previously and also seek out and connect with other persons who were well familiar with the situation and issues.

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