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ORIGINAL ARTICLE

Is the Mongolian Health Sector Ready for a Sector-Wide Approach?

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Mongolia has experienced major social and economic changes since the early 1990s. Large-scale reforms have been introduced in all sectors over the last 10 years. Implementing health reforms requires a more coordinated approach and the Mongolian health sector has been exploring an option of implementing a Sector-Wide Approach (SWAp) to the health sector. This article aims to develop and apply an analytical framework for assessing the feasibility of implementing SWAp in the Mongolian health sector. Review of published and unpublished evidence at the national and international levels is undertaken and complemented by semi-structured interviews with key respondents from Mongolian Ministry of Health. A framework for assessing the feasibility of SWAp in Mongolia has been developed which comprises the key elements and stages of development of SWAp in a particular context. This framework has been then applied to assess the feasibility of implementing SWAp in the Mongolian health sector. The main SWAp elements are in place. Emerging central level capacity, increasing donor confidence and willingness to move towards sector-wide management is now becoming more evident in Mongolia. It looks like Mongolia is ready for a national level government-led SWAp with the potential to implement a fully-fledged SWAp in the health sector. The essential ground-work for starting a SWAp is in place, but further capacity strengthening is needed. A framework for implementing health SWAp in Mongolia is suggested. It is important to consider the improvement of existing government systems in future SWAp arrangements to ensure local ownership.

Keywords dialogue; donors; government; harmonisation; health reform; management; MOH; sector policy; Sector-Wide Approach

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Introduction

Mongolia has experienced major social and economic changes since the early 1990s, after the collapse of the Soviet Union, and has moved from a centrally planned communist country, to a democratic regime. Over the last 10 years, the country has embarked on a path of political transformation, liberalization and reform in all sectors, supported by different donors. Consequently, the country is highly aid dependent, and the health sector is no exception. Most of the aid is in project form as determined by the donors, inadvertently fragmenting the health system. This fragmentation has been further aggravated by a weak Ministry of Health (MOH) that only recently, in response to its Master Plan, is beginning to define its new role and responsibilities to adapt to new realities and needs.

Sector-Wide Approaches (SWAp) in the health sector emerged in the mid-1990s as one way of improving effectiveness of external aid in line with host country priorities, and through development of national plans in partnership with donors. Although SWAps are still a relatively recent development, they are becoming the main force to promote home-grown strategic thinking and ownership to reduce inefficiencies in the sector and to encourage donor harmonization (SCIH, 2006). Most importantly, SWAps permit a better understanding of sector development as a holistic, integrated and multidimensional undertaking that should focus on people (Ruger, 2005).

SWAps have been implemented mostly in some of the post-colonial low-income countries in Sub-Saharan Africa and South-East Asia. More recently, attempts have been made to assess the feasibility of this approach in some mid-income countries in Latin America (Seco and Martínez, 2001) and the former Soviet Union (Mirzoev, 2004) but still very little is known regarding whether health SWAps are appropriate in transitional countries such as Mongolia. In this paper an attempt is made to fill in this gap by developing a framework for assessing feasibility of SWAp, based on different countries' experiences of implementing health SWAps and applying this framework to the Mongolian context. The aim is not to produce a detailed plan of actions for the Mongolian Ministry of Health, but rather to attempt to develop a broad framework, which, if accepted, will, with refinement, complement the phased implementation plans.

Methods

The data collection methods included a literature review complemented by semi-structured interviews with key respondents from the National Ministry of Health of Mongolia. The literature review was conducted in 2006. The Web of Science, PubMed and Medline online databases were used to identify published literature with keywords such as "SWAp", "health reform", "developing countries", "health system development" and others. In addition, the websites of the Swiss Tropical Institute (STI), Canadian International Development Agency (CIDA), Royal Tropical Institute, Netherlands, Eldis, Official Development Institute (ODI), and the Institution for Health Sector Development (IHSD) were also browsed and unpublished literature, such as Government policy documents, have been reviewed to ground the feasibility study on locally-available evidence.

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The interview data were collected through initial telephone interviews with eight persons, and were followed up by traditional face-to-face semi-structured interviews. The key respondents included representatives from the key units of the National MOH including officers and deputy directors of the Division of Policy, Planning and Coordination, Division of Monitoring and Evaluation and Department of International Relation and Cooperation. The contents of interviews included their knowledge of coordinated approaches in their field as well as their contribution towards the donor-government coordination together with their recommendations of relevant published and unpublished documents for the study.

A framework for assessing the feasibility of SWAp has been developed which comprises the key elements and stages of the development of a SWAp in a particular context. This framework was then applied to assess feasibility of implementing a SWAp in the Mongolian health sector. The triangulation of data has been performed in order to ensure the validity of results. This was done using two different data collection methods, document reviews and interviews.

This paper is largely based on the experience of one of the authors (AU) in implementing health reforms and managing government–donor coordination in the Mongolian MOH. This study was conducted in 2006 as the basis for the Master of Public Health dissertation of the first author.

Sector-wide approaches – what are they?

Sector-wide approaches emerged as a consequence of an aid environment shifting to focus more on goals, results and partnerships promoting home-grown strategies. Many years of experience with project-type aid have, so far, not contributed in any significant way to host country development and sustainability has still remained as an issue.

Cassels's (1997) definition of SWAp, as follows, provides a comprehensive picture and includes core elements, procedural aspects and ultimate goals.

> A sustained partnership, led by national authorities, involving different arms of government, groups in civil society, and one or more donor agencies with the goal of achieving improvements in people's health and contributing to national human development objectives in the context of a coherent sector, defined by an appropriate institutional structure and national financing programme, through a collaborative programme of work… with established structures for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets

Several key issues emerge from the above definition of SWAp which pose some questions as to how the elements in the above definition would need to be interpreted in the framework for the present paper. Firstly, an overarching goal of a health SWAp is to contribute towards achieving better health for the country's population through sustainable health system's development. Secondly, there are certain prerequisites of a SWAp, which are hardly distinguishable from the objectives of SWAp. For example, an institutional

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framework can be seen as a condition for introducing health SWAp, but it can also be regarded as one of the objectives for capacity development as part of SWAp implementation. Thirdly, in the existing literature the lines between the essential elements or components of a SWAp are blurred and one cannot easily identify what should be a minimum number of essential components that constitute a SWAp. Bearing the above questions in mind, an attempt will be made to develop some explicit criteria for assessing the feasibility of implementing a SWAp in Mongolian health sector.

The SWAp is an approach rather than a blueprint. It is flexible and adaptable to a changing environment. Most programs, even well established ones, are in the process of moving towards broadening support to including all sources of funding thus making the coverage of the sector more comprehensive, bringing ongoing projects in line with the SWAp and developing common management procedures with increased reliance on government mechanisms. This working definition thus focuses on the intended direction of change.

Health sector SWAps reflect a shift from focusing primarily on efforts to coordinate aid to building sector capacity for planning all types of resources and general management. For this to occur, certain prerequisites and conditions, described in terms of SWAp elements have to be instituted.

In practice, not all SWAp elements have to be in place simultaneously. The process can start with the operationalization of a limited number of principles and elements, eventually evolving into fully-fledged SWAps (Land & Hauck, 2003). There is certainly a difference between the SWAp elements perceived as prerequisites for implementing a SWAp within a given context and elements perceived as objectives of SWAp, i.e. being part of the long-term capacity development. There seems to be no clear-cut answer to this question as these two terms are often used interchangeably in the published literature.

The elements of effective health SWAps commonly referred to in the literature include the following (Lister et al., 2005; Peters and Chao, 1998):

- A sound nationally-owned sector policy and strategy.
- A medium-term expenditure program that reflects the sector strategy and the Poverty Reduction Strategy Paper.
- Systematic arrangements for programming the resources that support the sector.
- A performance monitoring and evaluation system that measures progress and strengthens transparency and accountability.
- Broad consultation mechanisms that involve all significant stakeholders.
- A formalized government-led process for aid coordination and dialogue at the sector level.
- Common working arrangements: An agreed process for moving towards harmonized systems for reporting, budgeting, financial management and procurement.

The above elements represent a broad framework which could be deployed for assessing the feasibility of a health SWAp in Mongolia. However, a closer look reveals that there are a number of essential elements that have to be in place before initiating SWAps,

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which, in the authors' opinion constitute the "core" of a health SWAp. These include the following three key elements:

1 A sound sector policy/plan,
2 An effective partnership to implement SWAps
3 An appropriate expenditure framework.

Other conditions, such as a stable macroeconomic situation and sufficient commitment to common goals by government and key partners also create an enabling environment for SWAp implementation (Cassels, 1997) and, although inter-related with some 'core' elements through, for example, providing adequate policy environment, are regarded as the wider contextual factors which can not be easily affected from the health sector.

Different forms of health SWAps

The application of SWAps in different contexts reveal the possibility of its different types in terms of levels, funding mechanisms, management arrangements and coordination mechanisms. Recognition of the different types is, therefore, vital in determining the appropriate type, especially, for those countries that are considering the introduction of health SWAp and do not have all its elements in place (Table 1).

Different types of SWAps originated as variations in different settings; therefore one can expect to have many more types in the future, depending on country-specific circumstances and interpretation of elements as being either prerequisites for, or objectives of, SWAp implementation.

One example of variation in countries' experiences is the coordination under SWAp. It is normally performed through the documents signed between partners (e.g. Memorandums of Understanding) and regular events (most commonly, annual and/or bi-annual meetings) of established coordination units such as in Uganda (Tyson, Feret, Wratten, & Dubois, 2000). However, some countries, such as Cambodia, do not have any formal donor-government joint reviews which is normally the basis for the coordination (Jefferys, Walford, & Pearson, 2003).

The funding mechanisms, another example of SWAp divergence, can vary from a pooled fund as in cases of Uganda and Tanzania; maintaining separate flows of donor and government funds within a district-level SWAp as in case of Zambia; several financing mechanisms in place at the same time, as in the case of Mali, and to the absence of any arrangements for pooling funds, as in cases of Cambodia and Burkina Faso (Jefferys et al., 2003; Mirzoev, 2004; Sundewall and Sahlin-Andersson, 2003).

It is obvious that the management of funds under SWAp also differs depending on what financing arrangements are in place. In most countries funds are mostly managed by the government/MOH. In Bangladesh, however, SWAp-pooled funds were previously managed by the World Bank (White, 2007). This is often regarded as an intermediate stage, as shown in Mozambique, where up to 2004 one of the donors, Swiss Development

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Table 1 SWAp types and divergence in coordination in different settings

<table>
<tr><th colspan="6">Level</th></tr>
<tr><td colspan="2">National level (Ghana, Bangladesh etc)</td><td colspan="2">District level (Zambia)</td><td colspan="2">Programme level (Uganda started SWAp at RH programme level)</td></tr>
<tr><th colspan="6">Funding arrangement</th></tr>
<tr><td>Programme/Project funds managed by each donor in separate accounts (Senegal, Burkina Faso)</td><td>Pooled funds managed by single donor in a separate account (Mozambique, Bangladesh)</td><td>Pooled funds managed by MoF and MoH from a separate account (Ghana-Health fund, Zambia-District fund)</td><td>Sector budget support integrated to MoH normal account with no earmarking (Tanzania, Ghana–EU fund)</td><td>Targeted budget support held by MoF in normal account under specific budget line (Uganda-Poverty Action Fund budget line)</td><td>General budget support held by MoF in normal account – no earmarking (Tanzania-DFID; Mali–EU)</td></tr>
<tr><th colspan="6">Leadership</th></tr>
<tr><td colspan="2">Largely Government driven management (Ghana, Bangladesh)</td><td colspan="2">Largely donor influenced with some government management (Cambodia, Malawi)</td><td colspan="2">Donor driven management (Malawi-strong donor influence especially in the beginning)</td></tr>
<tr><th colspan="6">Coordination and monitoring mechanism</th></tr>
<tr><td colspan="2">Joint Monitoring and Review mechanism by partners and MOH (Ghana, Uganda, Tanzania etc)</td><td colspan="2">Separate donor mechanism without MOH (exists paralleled with joint review in Zambia, Tanzania)</td><td colspan="2">Annual conference (no formal joint review mechanism) for major donors and government (Mali, Burkina Faso)</td></tr>
</table>

DFID, Department for International Development; EU, European Union; MoF, Ministry of Finance; MOH, Ministry of Health.
Source: Adapted from Jefferys et al., 2003, cited in Ulikpan, 2006.

Corporation (SDC), managed two of three pooled funds at national level, and more recently the responsibility has been taken over by the government (Jefferys et al., 2003). These divergences again prove that SWAps are flexible and dynamic processes. Shifts from one type to another can occur even within a single context, e.g. Uganda started with a program SWAp, mainly around a reproductive health program, evolving into a national level SWAp (Jefferys et al., 2003). This possibility of SWAp 'evolution' presents a unique opportunity for the relatively new contexts, such as Mongolia, to change the shape of SWAp arrangement according to the health system's development and stage of government–donor relationships.

Conceptual framework

From the above discussion it appears that the three key elements of health SWAps, namely a sound sector policy and plan, an adequate expenditure framework, a performance monitoring and evaluation system based on effective partnerships, represent a

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Table 2 Conceptual framework for the study

Key element	Composite sub-elements
1. Sector policy/plan	Existence of the policy itself
	Participatory nature of policy development (including local and international actors)
	Adequate institutional framework for policy implementation
2. Effective partnership	Continuous dialogue between the government and international actors such as donors and development banks and agencies
	Adequate means of coordination at all levels of the system through sector coordination committees
	Harmonization of implementation arrangements; appropriate monitoring and evaluation procedures
3. Expenditure framework	Appropriate expenditure framework, existence of medium-term expenditure commitment from the Government
	Integration of sector policy within a wider context (e.g. macroeconomic environment; poverty reduction strategy)

reasonable starting point for assessing the feasibility of a SWAp in a given context as well as the readiness of the country's health sector to implement a health SWAp. In fact, the argument of using the SWAp main elements as a framework for assessing its feasibility is also supported in the literature (Buse & Walt, 1996; Walford, 2003). We will adapt this framework based on the three key SWAp elements for assessing the feasibility of a SWAp in Mongolia.

Each of the three key elements (sector policy, effective partnership and expenditure framework) is rather a complex issue comprising of a number of sub-elements. Consequently in Table 2, more details about each of these three key elements is provided as a basis for the assessment of feasibility of SWAp in the next section.

Where we are now? Progress so far in Mongolia

Mongolia inherited a health care system based on the Semashko model widely used in the former Soviet Union. However, during the last decade, the system has begun shifting from a centralized to a devolved system, with numerous public sector reforms being undertaken. The traditional approach to solving problems by increasing funding, will not significantly improve the health system in Mongolia as it is already absorbing almost 6% of GDP (Borowitz et al., 2005), a figure higher than most transition countries. Therefore, it is more logical to improve the operating efficiency and management capacity of the system, so better outcomes could be achieved with the same or even smaller expenditures.

The Health Sector Strategic Master Plan (HSMP) was developed in 2005 through an extensive consultative process and serves as a comprehensive technical long-term planning document for developing the sector over the next 10 years and as a basis for moving towards a SWAp. It is in line with Mongolia's desire to achieve the

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Millenium Development Goals, as harmonization of the different programs and policies is likely to ensure their accomplishment. The emerging strong and more widespread ownership of the Master Plan by the MOH and involvement of all relevant stakeholders, including international partners, will be crucial in supporting the implementation of the plan.

An appropriate organizational and management structure for the public health sector is essential for successful SWAps. The institutional arrangements for the implementation of the Health Sector Strategic Master Plan have been put in place through the establishment of a Health Sector Coordinating Committee (HSCC) involving different arms of the Government, international partners and non-governmental organizations to oversee and coordinate the implementation of the plan. In this context, a sector-wide management of resources will be essential to create synergies, avoid duplications and steer the development of the sector in the same direction.

Table 3 provides an overview of the current Mongolian context in terms of its readiness towards implementing SWAp. As shown in Table 3, the Mongolian health sector is already experiencing considerable positive receptivity for implementing a SWAp. The critical prerequisites such as sector strategic plan, an expenditure framework, mechanisms and institutions, such as a Health Sector Coordinating Committee, for regular dialogue between the MOH and donors, are already in place and operational. Donors include organizations such as UNFPA, UNICEF, WHO, Global Fund, JICWELS, JICA ADB, WB, GTZ, and other International NGOs active in the health sector on a permanent basis who have a commitment to change. Detailed Terms of References have been developed for the HSCC which provide a clear framework for intra-government coordination and potential for formalizing the SWAp arrangement with the key donors in a Memorandum of Understanding or similar document in the nearest future.

There are also positive signs outside of the health sector. For example, the relatively stable macro-economic indicators have already resulted in an increase in health expenditure to 6% of GDP (Borowitz et al., 2005); HSMP explicitly links the Medium Term Expenditure Framework and Poverty Reduction Strategy Paper and is contributing to improving the government resource allocation system to better target resources to areas of need (Government of Mongolia, 2005).

However, it is clear that because of context-specificity, Mongolia cannot copy a fully-fledged SWAp such as in Uganda, or a combination of its elements as in Bangladesh. There will always be a need to find an appropriate balance between the prerequisites and objectives of SWAp as well as to develop the 'Mongolian' type of SWAp. The most recent classification is developed by the Institute for Health Sector Development (IHSD). It describes five stages based on certain characteristics which reflect the key elements of SWAp. These are shown in Table 4.

Mongolia is progressing well as a candidate for a SWAp in terms of its processes that are essential for the effective implementation of a SWAp. All the characteristics for an early SWAp are already present in the Mongolian health sector. However, more than the mere presence of these elements is needed to successfully implement and sustain a SWAp. Many elements, such as systematic monitoring and evaluation

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Table 3 Feasibility of implementing a health SWAp in Mongolia

Key issues related to implementing SWAp	Ideal scenario	Mongolian context
Sector policy/strategy	Comprehensive and explicit; coherent link with implementation plans	Comprehensive and explicit plan complemented by comprehensive and feasible implementation framework to guide annual planning
Dialogue with donors	Government-led sector dialogue with wide-range involvement of donors and other stakeholders	An enhanced International Cooperation Department under the Planning and Policy Division and liaising with the Monitoring & Evaluation Division has increased technical & management interactions with all donors active in the health sector
Participation of key partners in sector policy	Participation of key partners on formulation of sector policy from the very beginning	HSMP developed using wide-range consultative process involving all key stakeholders Increased trust towards planning capacity of health ministry by some donors
Means of coordination	Government-led with external partners and appropriate in-country coordination mechanisms	Government led Health Sector Coordinating Committee including all donors active in the health sector, relevant international and domestic stakeholders, academia and professional associations appointed and operational
Macro-economic environment and Robust sector expenditure framework	Stable macro-economic conditions MTEF in place that supports PRSP and sector policy	Stable macro-economic indicators HSMP explicitly links the MTEF and PRSP
Institutional framework	Ideally decentralized (devolved) context with involvement of local stakeholders	Devolved context but with varied local capacity Limited involvement of local stakeholders Central level organizational structure needs improvement

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Table 3 (*Continued*)

Key issues related to implementing SWAp	Ideal scenario	Mongolian context
Harmonized implementation mechanisms	Commitment to move to greater reliance on Government financial management and accountability systems that meets donors expectations	An Implementation Framework for joint planning in the sector is in place, however, operational capacity is still lagging behind Donors are not comfortable with current government financial management and accountability systems but the government is moving away from a line item to program-based budgeting in the social sectors
Monitoring and evaluation	Continuous, performed jointly with donors, mainly relying on government capacity	Some improvement in HMIS, but still produces unreliable information; an M&E framework has been finalized based on the sector master pan and its implementation framework to ensure ongoing measurement of the implementation of the sector plan

HMIS, Health Management Information System; HSMP, Health Sector Strategic Master Plan; M&E, Monitoring and Evaluation; MTEF, Medium Term Expenditure Framework; PRSP, Poverty Reduction Strategy Paper; SWAp, Sector-Wide Approach.
Source: Adapted from Ulikpan (2006).

and the expenditure framework, represent areas for further capacity development either as objectives of SWAp implementation or as prerequisites for a health SWAp. Furthermore, much needs to be improved, especially in the fields of establishing common working arrangements and improving the reliability of the current monitoring and evaluation system.

Since the approval of the Sector Master Plan and its Implementation Framework, the Ministry of Health has moved in the broad direction to further develop its capacity to implement the Master Plan within the framework of a SWAp. One indication of that direction is the development of a Planning Manual that provides the guidelines and instruments, supplemented by competency based training materials to use the Implementation Framework to develop Annual Operational Plans and Budget Estimates. A systematic phased nation-wide training program is being designed to train the management teams at all levels including other stakeholders who are working with the health sector.

The other indication of the above-mentioned direction is the formation of the HSCC and the strengthening of the International Cooperation functions of the MOH thus improving its linkages with planning, policy implementation and monitoring and evalua-

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Table 4 SWAp stages and characteristics

Stage	Characteristics
SWAp not under consideration	Limited government reform and leadership Limited donor presence Weak civil society Health service requires vertical programs
Preliminary (informal) SWAp discussion	Significant donor presence but limited coordination Increased awareness of need for sector coordination by donors; donor "push" and external TA; design of SWAp components Advanced discussion initiated between donors and government Loss of momentum may occur between discussion, hence delaying the process
Early SWAp	Formal recognition by government and partners Increased momentum Government "pull" emerging but still strong donor "push" SWAp components addressed on paper but not in practice No pooled funding arrangements in place
Intermediate SWAp	One cycle/one review Further system development and harmonization required Donor coordination, M&E mechanism in place but needs refining Some pooled funding
Mature SWAp	All SWAp components in place 2 or more planning cycles undertaken Government–led process Pooled funding mechanism operational for all or part of sector

M&E, Monitoring and Evaluation; SWAp, Sector-Wide Approach; TA, Technical Assistance.
Source: IHSD (2005), cited in World Health Organization (2006).

tion to enhance the dialogue with the donors and engage them even more in the planning and policy development through Joint Sector and Annual Reviews and the extensive use of working groups and various consultative meetings.

The way forward

It is usually not enough to merely prescribe whether a particular approach is appropriate for a given context; it is always helpful to elaborate practical suggestions on the way forward, even if these are broad policy recommendations. Furthermore, the dynamic nature of SWAps and large-scale reforms introduced in the Mongolian health sector prohibit the possibility of developing a fixed set of recommendations which, if followed, might lead to a SWAp. Therefore, in this section a broad framework is provided for the way forward, and Table 4 summarizes and justifies the broadly proposed SWAp option for Mongolian health sector. This option, while it is the most applicable one in the present context, may evolve to another type as the SWAp develops capacity and secures even

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greater ownership. Therefore, the freedom to move between various options should be afforded.

In practice, SWAp's interactions with other government reforms matter as highly as its management and funding arrangements. In particular, it is very important to bear in mind the large-scale on-going initiatives such as the Millennium Development Goals at the international level and Poverty Reduction Strategy at the national level. Furthermore, global targeted initiatives such as Global Fund for AIDS, Tuberculosis and Malaria or targeted projects from philanthropic institutions such as the Bill and Melinda Gates Foundation may significantly undermine the idea of SWAp in integrating the various efforts in a concerted way.

As demonstrated in Table 5, we suggest the strategy of starting small and considering the possibility of evolution of the health SWAp in the future. A national level SWAp with a mixed type of leadership would be an appropriate way to start the process, as local level capacity is still inadequate. Even at the national level, some capacity-building is needed for the MOH to manage on its own. It is recognized, however, that in order for the SWAp to become a genuinely country-level initiative, adequate capacity at all levels of the health system will need to be developed. It is, therefore, important to build common management arrangements and monitoring mechanisms on existing government systems to encourage ownership while building

Table 5 Suggested framework for implementing a health-SWAp for Mongolia

Main criteria	Option for Mongolia	Justifications
Stage/category	Early SWAp (based on Table 3 by IHSD)	All characteristics for an early SWAp in place
Level	National level	Existing structure and capacity supportive at the national level
Ownership/led by	Largely MOH owned process with some technical assistance	As government capacity develops, there will be more ownership by MOH
Funding arrangement	Program support with no pooled funding but managed by HSCC (jointly) so that could prevent duplication and wastage	It would be unrealistic if MOH expects all donors sign up for pooled fund, so project support will continue coordinated/ managed by HSCC till MOH capacity builds up
Coordination and monitoring mechanism	Joint periodic review meeting through a functioning HSCC and annual joint MOH and partner review as part of the annual operational planning	Current HSCC ToR includes oversight of the SWAp implementation and review processes

HSCC, Health Sector Coordinating Committee; MOH, Ministry of Health; ToR, Terms of Reference.
Source: Adapted from Ulikpan (2006).

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capacity. Since the current management arrangements are of considerable concern to the donors in terms of their transparency and accountability, moving to sector budget support will follow acceptable improvements in MOH management capacities. Otherwise, no donor would blindly commit resources to a basket fund for fear of a major loss of donor funds (Hobbs, 2001).

The efficiency of a SWAp could be measured by its effect on reducing duplication of aid funded service projects, improving harmonization of management procedures and increasing the use of relevant information for resource allocation (Buse & Walt, 1996). Although the sector budget support arrangement is most efficient, it is not feasible in Mongolia today, since Mongolia is not organized for managing such support, and so in the interim, jointly managed program funds could be an appropriate entry point option. Also, an emerging capacity in the sector along with sound health sector strategic plan and improving donor coordination through HSCC allows an enabling environment for the Government-led SWAp with national scale focus. A lot more needs to be done, however, in the area of monitoring and evaluation and financial management systems in an effort to make it more transparent and accountable.

Lastly, in developing the way forward the Mongolian MOH should take into account similar developments across other adjacent social sectors. For example, there may be a possibility of introducing SWAps in other social sectors such as education, which could pose another challenge for Mongolian health policy-makers as to whether there should be a 'social sector SWAp'. In fact, a somewhat similar possibility currently presents itself in the form of a 'Poverty Reduction Strategy Paper' as one model for consideration.

Conclusions

This paper shows that the implementation of a health SWAp is generally feasible and appropriate in the context of transitional countries such as Mongolia. It also raises the question; What are the next steps that the Mongolian health sector should consider in order to effectively manage the introduction of this new framework?

The current context of the Mongolian health sector provides a favorable environment for initiating SWAps. However, a lot more needs to be done to operationalize what is on the paper and sustain the current effort. The success of the SWAp will depend on the commitment and unfailing effort of the government and of the donors to manage the process to achieve the objectives. As mentioned earlier, there is no standard type that can be universally applied. Therefore, the approach proposed for implementation in Mongolia would also require its own contextualized arrangements with prudent and timely adaptation as and when required.

SWAp is a process and as such it is often seen as a continuous set of activities streamlined towards the sustainable health systems development and cannot therefore be a one-off initiative. One can claim that a SWAp can be universally adaptable to almost any

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circumstances. The current experiences in implementing health SWAps show that if the process of institutionalizing a health SWAp is to be ensured, it should be developed and led by local decision-makers. As a conclusion of this paper, three questions are posed for the Mongolian health policy-makers to consider when deciding about SWAp implementation:

1 What should be the balance between the need to adapt the context for implementing health SWAp and the need to adapt the approach itself?
2 How should the prerequisites for SWAp and its objectives be balanced?
3 What type of a health SWAp should the Mongolian MOH eventually aim towards?

In this paper a contribution is made towards a growing body of international research focusing on the feasibility of health SWAps in new contexts, and it is considered that additional research would be needed to assess the feasibility of SWAps to further, as well as monitor, the evolution of SWAps in existing and new contexts. As the country context changes and a SWAp matures, approaches and processes will, most likely, be used more efficiently than at the beginning of the SWAp initiative, with due consideration given to these changing contexts.

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