ASSESSMENT OF THE REACHING EVERY DISTRICT STRATEGY IN MONGOLIA

2010
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EXECUTIVE SUMMARY

Reaching Every District (RED) is a World Health Organization strategy introduced globally in 2002 for building up the capacities of district-level health care services to increase immunization coverage, with a focus on planning and monitoring. One of its main components is the identifying of obstacles to immunization access and ways to improve in order to achieve the global immunization goal of 80 per cent coverage in all districts and 90 per cent nationally by 2010.

Mongolia’s Ministry of Health, with development partners, including UNICEF, adapted the strategy in 2008 to improve access to immunization as well as detecting and responding to the maternal and child health needs in the most-difficult-to-reach populations.

UNICEF requested a rapid assessment of the RED strategy in Mongolia to capture the impact of the RED strategy on health service access in the 13 khorooos (subdistricts) of one district in Ulaanbaatar where it was piloted and as well as look at areas (two districts and one rural area) where it is being considered to generate recommendations for refining and scaling up.

The RED strategy in Mongolia takes a problem-solving approach with the following components: i) health mapping, barrier analysis and micro-planning; ii) community outreach iii) delivery of immunization, maternal and child health (MCH) and related social services; iv) strengthening of partnerships at the community level; monitoring and evaluations. The primary implementers are the family group practice (FGP (health clinic)) nurses and doctors who are supported by district, city and central managers. The FGP is the primary level of care of the Mongolia health system.

The rapid assessment included informant interviews and site visits to Ulaanbaatar’s Bayanzurkh district where the RED strategy was initiated in 2008 (on-the-ground activities started in 2009). Interviews and visits also were made to the two other districts of the capital city and one rural area where a barrier analysis and RED strategy development were undertaken with five FGP clinics.

FINDINGS

The rapid assessment confirms other analysis regarding the current financing and service-delivery models of the Ministry of Health, which although forming a strong foundation for health service access for the majority of the population, are still not working effectively enough for the very poor.
The second conclusion is that sectors of the population in Mongolia are falling 'outside the system', mainly as a result of the recent social transition that has accelerated economic inequities and high levels of internal migration.

The third major finding is that implementing the RED strategy can make improvements in the capacity of the very poor to access health care and some social services. Evidence from Bayanzurkh district and the areas targeted for the RED strategy indicates that it is feasible to pull these populations into the system to some degree through a strategy of 'active search' and 'community social networking', both of which are described in more detail in this report.

Because of the RED strategy, there are increasing numbers of vulnerable populations (children and families) who are now accessing health and social services in these areas (as much as 5 per cent of the total FGP population in those areas). Additional health services provided through the RED strategy include immunization, antenatal care and family planning. According to FGP records, most of the health service needs of the vulnerable population have been delivered. Additional social services provided include civil and health facility registration (which are needed to be counted and to access the services), shelter, emergency nutritional support and employment assistance. According to FGP data, 38 per cent of those social needs have been covered.

Information on additional numbers of community members reached in 2009 in the 13 khoros (of the 24 total) in Bayanzurkh district due to the RED strategy are as follows:
• 219 children immunized
• 2,486 people registered at an FGP clinic
• 508 women received antenatal care
• 1,047 received family planning support
• 515 people received emergency food supply.

The RED target groups are the poorest, which include subcategories of disabled, unregistered, remote and temporary populations, children living in orphanages, single mothers, child labourers and school drop-outs. Through the vulnerability mapping at the start of the pilot, five per cent of the population was targeted as the most vulnerable and to be covered by the strategy’s activity. However, this is not to say that populations beyond this five per cent do not have unmet health needs. According to FGP staff, the five per cent are simply the most vulnerable, living in day-to-day emergency situations.

The civil registration office in Bayanzurkh reports there are up to 500 new civil registrations per day, indicating continuing trends in rapid population growth
that are reportedly due to a range of factors including the 2009-2010 dzud (winter disaster resulting in the large-scale death and debilitation of livestock), socioeconomic pressures and improved access to government financial support and social services through registration.

Through the RED strategy, the principal method for detecting the needs of the vulnerable is by house-to-house contact. Nurses in the FGP clinics are assigned particular areas of the khoroo for monitoring and making the house visits (three days per month). The strategy was implemented in Bayanzurkh district at a cost of 17 million tugrik for one year (US$14,166). Of the total funding, 24 per cent covered training, 15 per cent covered supervision and 66 per cent was used at the service-delivery level for transport and incentives for health staff. Based on the additional numbers of people reached, the interventions proved to be cost effective.

According to the respondents interviewed during the rapid assessment, many of the nurses are undertaking social work in addition to their FGP duties. Some respondents questioned the sustainability of this approach, while others expressed high levels of satisfaction in meeting some of the social needs of the population and being more involved with the community. Overall though, there was overwhelming consensus from stakeholders that unless the basic social needs of the vulnerable populations are met, then health service needs cannot be met. Without prompting, health staff and managers stated that the health situation of the vulnerable population is socially determined, highlighting the need for close partnerships among health and social planners and service providers. There were numerous cases highlighting this finding, some of which are documented in this report.

Findings from the barrier analyses conducted in five non-RED areas suggest high levels of social isolation in the vulnerable groups. There is some evidence that significant minorities of the population are not accessing health and social services. An important conclusion drawn from the case studies is the overwhelming impact of the social determinants of health on the capacity to access health services. The perception of FGP staff in the non-RED areas included in the assessment is that the problem is escalating.

There are limits to the FGP capacity, role and function in relation to the social determinants of health and the expanding populations’ associated health needs due to internal migration and population mobility. This leads to the conclusion that although the FGP can solve only health service issues and some social problems, the FGP has the potential to develop and strengthen social networks for health care that can address some of those social issues. As activities in the RED area
demonstrated, the strategy has the potential to improve health access and raise public and stakeholder awareness about the needs of the vulnerable.

To address the sustainability risks of the strategy, partnership mechanisms need to be strengthened at the district level. As a start, interviewed planners proposed involving social welfare and civil registration managers in the district RED Working Group. At the community level, good practice partnership models for health (partnership mechanisms) and social development are required to build on the early experience of RED (linking efforts of FGPs, khoroo governors’ offices, section leaders and NGOs).

There is a perception among FGP staff and district managers that increases in health resources (human and financial resources) are not keeping pace with the accelerating numbers of urban poor. In one FGP visited, the population had doubled in the past 10 years but the health personnel remained the same. This suggests the health policy is lagging behind social transition.

RECOMMENDATIONS

Policy: Policy flexibility and foresight are needed to address current and prevent future escalating social distress and health inequalities among the urban and rural very poor. Chief among these policy developments should be the reorientation of FGP practices from a primary medical approach (first level of health care) to a primary health care approach – services and strategies across sectors for improving people’s health, including community development, water and sanitation, education and employment changes. This primary health care reorientation will involve establishing partnership mechanisms between health, social and civil society agencies, and a review of financing models to ensure that the FGP clinics are adequately resourced to conduct the active search work and the community outreach to ensure that the very poor access immunization and MCH services.

Operations: In the short to medium terms, the RED strategy should be reinforced in Bayanzurkha district and scaled up in other districts of Ulaanbaatar and in aimags where RED planning or consultations have taken place. The RED scale-up can be supported through UNICEF and other partners in the short to medium terms to provide time to develop needed policy, mobilize resources and refine community-partnership mechanisms and models of health financing for the poor.

Management: In the short to medium terms, capacity-building programmes should be implemented to reorient FGP staff and main stakeholders towards primary health care. Lessons learned on the new mechanisms developed for reaching the poor should be well documented through research and evaluation. In the longer
term, however, efforts should be made to mainstream the RED initiative into the planning and financial management systems of the Ministry of Health.

Options have been identified for this mainstreaming which include the following:

- Integrating RED planning into the annual operational planning system of the MOH.
- Identifying more appropriate pro-poor health financing mechanisms (either through programme-based budgeting or targeted RED funding through the Human Development Fund and the introduction of results-based financing (performance-based incentives) for FGP staff for pro-poor health programming.
- Developing good practice models for district and community partnerships that are adopted into the health policy for scaling up.

CONCLUSION

Whether looking at a short-, medium- or long-term needs, the common conclusion is the need to reorient the FGP clinics away from a primary medical response to a primary health care approach. Policy flexibility is a high priority, notwithstanding the need for adequate legislation and administrative mechanisms and procedures to put appropriate policies and funding models in place. Given the rapid and gathering pace of social transition, there is a shrinking window of opportunity for the health and social policy response.
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**ACRONYMS**

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme for Immunization</td>
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<tr>
<td>FGP</td>
<td>Family group practice</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>HDSP</td>
<td>Health Sector Development Programme</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>NCCD</td>
<td>National Centre for Communicable Diseases</td>
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<tr>
<td>RED</td>
<td>Reaching Every District</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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*Definition: khoroo is a subdistrict and it is divided into 5-6 sections depending on population number*
INTRODUCTION: THE RED STRATEGY AND MONGOLIA’S NEED

Reaching Every District (RED) is a World Health Organization strategy introduced globally in 2002 for building up the capacities of district-level health care services to increase immunization coverage, with a focus on planning and monitoring.\(^1\) One of its main components is the identifying of obstacles to immunization access and ways to improve to achieve the global immunization goal of 80 per cent coverage in all districts and 90 per cent nationally by 2010.

The RED methodology generally involves linking services with communities, outreach vaccination service, supportive supervision, monitoring and use of data for action, and planning and management of resources.

Mongolia’s Ministry of Health, with development partners, including UNICEF, adapted the strategy in 2008 to improve access to immunization as well as detecting and responding to the maternal and child health needs in the most-difficult-to-reach populations.

This report reflects a rapid assessment of the RED strategy in Mongolia to capture the impact on health service access in the 13 khoroo (subdistricts) of one district in Ulaanbaatar where it was piloted and as well as look at areas (two districts and one rural area) where it is being considered to generate recommendations for refining and scaling up the strategy.

HEALTH STATUS AND DEVELOPMENT IN MONGOLIA

There has been significant economic growth in Mongolia, averaging 9 per cent per year over the past five years (2003–2008). The gross domestic product (GDP) per capita has risen, from US$456 in 2000 to $2,111 estimated for 2010.\(^2\) However, the proportion of people living below the national poverty line has remained persistently high over the past 18 years,\(^3\) with the most recent estimate (2008) placing it at 35 per cent.\(^4\) Along with uneven economic growth across social groups, there have been major demographic changes, with the proportion of rural population declining, from 42.8 per cent in 2000 to 38.2 per cent in 2008. The average annual growth rate of Ulaanbaatar’s population during 2003–2006 was around 3.6 per cent, which was triple the total Mongolian population (1.2 per cent) and nearly four and a half times that of the aimag (province) centres (0.8 per cent).\(^5\)

The economic opportunities and inequities have no doubt been a driving force for the high rates of internal migration, which has two main patterns. One is the rural-urban drift, with some respondents in this assessment stating that the proportion of populations residing in ger districts is 70 per cent (that figure was probably
reversed during the socialist period that ended in the early 1990s). The other form of migration is to rural areas for herding and mining purposes.

In terms of health systems and outcomes, there have been gradual improvements in maternal and child mortality in recent years. In the post-socialist era, a public-private model called the family group practice (FGP) was established, with financing through state capitation-based funding models⁶ and health insurance mechanisms. The FGPs are clinic-based services staffed with five to eight doctors and nurses who provide a range of first-line preventive and curative care, including immunization, reproductive health and communicable disease-control services. The FGP also acts as a referral point for more urgent curative care to higher-level facilities. A typical FGP covers a population of 17,000, with a service radius of 5–8 km.

Currently, the investment in health service delivery is 3.2 per cent of GDP; the Ministry of Health is pushing to raise this portion to 5 per cent, which could remain a challenge considering the Government is experiencing a budget deficit. Overall, the Government’s budget investment in health services remains stable at 8 per cent.

A recent assessment of the Asian Development Bank (ADB)-funded Third Health Sector Development Programme (HSDP) highlighted many of the challenges in health sector development in Mongolia, including:⁷

- The FGPs established under the HSDP continue to experience severe challenges in terms of their viability, staffing and quality of services. FGPs, while legally private, are fully dependent on state funding and regulation.
- Most district hospitals lack complete or functioning basic diagnostic equipment, and pharmaceutical supplies appear to be very limited.
- State policies on civil registration constitute a major obstacle to providing the migrant poor with access to health services.(Civil registration legally entitles community members to free health and education services or other social benefits, including state health insurance.)
- Only about 6 per cent of total health funding is spent on capitation payments to FGPs, compared with about 70 per cent of the state health budget on hospitals.

The private medical sector is expanding. But interestingly, despite the high level of democratic openness and administrative trends towards privatization and decentralization, there has been limited development of a health civil society sector.
THE RED APPROACH IN MONGOLIA

A workshop was conducted centrally and in the Bayanzurkh district of Ulaanbaatar in 2008 to develop national guidelines as well as a pilot plan for implementing the RED strategy in Mongolia, which UNICEF subsequently funded in 2009. The implementing plan was designed to reflect the situation in more rural and remote areas of the country. The Reaching Every District: Implementation and Guidelines (draft) categorized the hard-to-reach populations (table 1).

Based on the workshop activity, the RED strategy in Mongolia involves:

- conducting a mapping to identify the hard-to-reach or vulnerable populations
- identifying the barriers they encounter in accessing health care services
- implementing a package of health and social services for the hard-to-reach and vulnerable populations through a house-to-house outreach component
- developing a programme of supportive supervision and community partnerships.

Table 1: Hard-to-reach population classifications in Mongolia

<table>
<thead>
<tr>
<th>Classification</th>
<th>Examples</th>
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<tbody>
<tr>
<td>1. Mobile populations</td>
<td>migrants and temporary residents, herders, travelling business families, informal miners</td>
</tr>
<tr>
<td>2. Remote area populations</td>
<td>traditional ethnic groups, border populations, herders that migrate, remote households in the furthest soums, people living in the mountains</td>
</tr>
<tr>
<td>3. Vulnerable populations</td>
<td>homeless people, resident on waste sites, children in orphanages, disabled people, the very poor, populations with limited education, working children</td>
</tr>
<tr>
<td>4. Unregistered populations</td>
<td>unregistered populations, have registration but live in a different address, those living on the peripheries of Ulaanbaatar</td>
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</table>

The RED strategy in Mongolia was intended to extend beyond immunization to maternal and child health (MCH) and some social services (including assisting with civil and FGP registration) because the determinants for poor access to immunization services are similar to the determinants for poor access for other
maternal and child health care services. In addition, civil and FGP registration is required to access health and other social services. As piloted in Bayanzurkh district, the RED strategy was designed to strengthen the social network within communities (among khoroo governor offices, section leaders, community members, volunteers and NGOs) that enables people who are vulnerable to access the existing health care service. Table 2 reflects the integration of MOH services into the RED approach.

In 2008, UNICEF supported training and development of the RED strategy in five additional aimags, mostly in remote western parts of the country. Due to constraints, financing for the implementation did not become available and extending the RED strategy to those five areas remains on hold.

Following training of FGP staff (including introductory training for district and sub district governors and administrative staff at Bayanzurkh) and the development of the implementing plan, the RED guidelines were adapted by the National Centre for Communicable Diseases (NCCD). The one-year pilot programme began in 2008 in 13 targeted khoroo (subdistricts) of Bayanzurkh.

<table>
<thead>
<tr>
<th>Programme to integrate</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. IMCI</td>
<td>All children younger than 5 years shall be immunized regardless of address or registration.</td>
</tr>
<tr>
<td>2. National Programme on Children Development and Protection</td>
<td>An FGP nurse visits each home with children younger than 16 on the following schedule: every child younger than 2 months: once a week aged 2 months–1 year: once a month aged 1–3 years: once a quarter aged 3–5 years: twice a year. Population registration is renewed twice a year. Home visits on the eve of 10-day vaccination campaigns. Unreached children could be vaccinated during this time.</td>
</tr>
<tr>
<td>3. Prevention of Micronutrients Shortage for Children</td>
<td>aged 6 months–5 years: vitamin A aged 0–2 years: vitamin D aged younger than 5 years: iron supplement aged 6–36 months: mix of micronutrients</td>
</tr>
<tr>
<td>4. Safe Motherhood and Reproductive Health</td>
<td>Prenatal care</td>
</tr>
</tbody>
</table>

Table 2: Package of health and social services, RED Mongolia
### OTHER INITIATIVES AIMED AT THE UNREACHED INFLUENCED BY THE RED STRATEGY

The GAVI Alliance approved funding in 2009 of Mongolia’s strategy to strengthen its health system as a way to reach unreached populations.\(^\text{12}\) That strategy, which is planned for commencement in late 2010 and early 2011, includes many of the components of the RED strategy, with several khoroo in western Ulaanbaatar targeted along with two soums (rural towns) in one aimag where large populations of itinerant mining families live.

In addition, various ADB-supported programmes to improve access of health care for vulnerable populations are being implemented through the Third HSDP. These programmes include improving the primary health care system, strengthening the health finance and financial management systems and building human resource capacity. There are also efforts to improve poor people’s health care access, such as a Human Development Fund to finance activities directed at poverty alleviation, including cash transfers, payment of health insurance premiums and reducing the price of selected essential medicines. Additional funds through taxes on mining profits are planned to be directed to the HDF. The Government is also considering issuing ‘smart cards’ to register all citizens’ health and social services access. The Ministry of Health and Ministry of Social Welfare and Labour are looking at amending the health insurance law to allow the Government to subsidize the contribution expected from people regarded as part of a vulnerable population. Another amendment to that law being considered would provide some level of results-based financing (in the form of bonuses) at the FGP and soum levels.\(^\text{13}\)

Additionally, the Ministry of Health has proposed programme-based budgeting in coming years, which would provide additional opportunities to finance strategies, such as RED, through public health programme budgets.
OBJECTIVES AND METHODOLOGY OF THE RED STRATEGY
RAPID ASSESSMENT

Objectives

UNICEF wanted to assess the progress made so far with the RED strategy, specifically by documenting the numbers of additional children and other clients reached through the Expanded Programme for Immunization (EPI) and other MCH services in one district (Bayanzurkh) and by drawing out lessons learned from planners and health providers that would be useful to guide future implementation. The rapid assessment was to look at the RED activities for the previous 12 months and analyse how they had improved people’s access to EPI and MCH services in areas that are hard to reach.

The rapid assessment was to result in recommendations for scaling up the RED strategy, in partnership with planners at the central and district levels.

Methodology

The rapid assessment was conducted in three stages, the sequence of which is reflected in the structure of this report: i) assessing activities in RED areas, ii) participatory research with district and FGP planners in non-RED areas and iii) analysing the findings from the first two stages to produce the recommendations.

The research involved: i) a review of available literature and programme documentation (RED guidelines, the GAVI proposal, the Bayanzurkh progress report14 and district health information reports and surveillance data), ii) interviews with various informants and iii) group discussions (for the barrier analysis). District team meetings and FGP group discussions and field visits to two FGPs were conducted. An open-ended questionnaire guided the discussions with the planners, implementers, local authorities and community members.

Bayanzurkh was chosen because it is the only district in which the RED strategy has been operational, and two khorooos were selected to concentrate on the activities being conducted. The targeted populations are the vulnerable populations identified in the barrier analysis by the FGP doctors and nurses and confirmed by community visits.

Informant interviewees included policy makers at the central level, planners at the city and district levels and doctors and nurses at the FGP level.

The non-RED areas covered by the rapid assessment included two districts in Ulaanbaatar and one rural location in Uvurkhangai aimag (Uyanga soum). Overall, the sites visited during the assessment:
For the barrier analysis, a one-day training workshop was conducted to prepare five teams of district and FGP assessors to:

- create a map of the hard-to-reach or unreached populations in a FGP catchment area
- define the community impediments to health services (EPI and MCH) access and the health system and programmatic impediments to health services provision
- develop a strategy for improving that access and service delivery for the most vulnerable population, including identifying actual or potential local area health partnerships and activities.

After that process, the FGP assessors presented their findings to the wider plenary of assessors (FGP staff from other locations who participated in the rapid assessment). In some locations, the teams visited the sites of the unreached populations to discuss in detail with the community and resident FGP staff the main issues in health care access for the very poor. Their findings are described in the case studies sprinkled throughout this report.

**Data collection tools**

The main data collection instruments that were used were sourced from the RED strategy guidelines and entail the following:

1. A methodology for barrier analysis, which includes a question outline for assessing community, health system and programme constraints to accessing hard-to-reach populations.

2. Guidelines on supportive supervision, which emphasizes a problem-solving approach to improving performance. These principles of supportive supervision were considered during the training to encourage the FGP assessors to adopt problem-solving and ‘listening’ approaches when undertaking the barrier analysis with the FGP staff.

3. A set of criteria for assessing RED activities (table 3).
4. A questionnaire guideline specifically developed for interviewing informants (annex 2).

**Assessment limitations**

This is an interim assessment. Its primary purpose is formative – it is intended to guide the direction of the RED strategy programme and demonstrate potential for scaling up. It is not a final-term evaluation impact assessment that will influence whether the programme continues or not. That type of assessment requires more rigorous research and evaluation techniques. No sampling strategy was applied for this assessment. Findings cannot be generalized with high levels of confidence. However, sufficient evidence was generated to inform strategic and operational directions in the medium term (next two or three years).

**Report structure**

Section 1 of the report is a summary of the findings of the activities in Bayanzurkh district and the impacts. Section 2 presents the feedback from the participatory process used for analysis in areas currently not yet applying the RED strategy (five urban sites and one rural aimag). And section 3 contains the recommendations and is a synthesis of the lessons learned from Bayanzurkh district and from the barrier analysis in the areas targeted for RED strategy activities to better inform the scaling up plans. In addition to case study findings from the barrier analysis, the report includes highlights of the findings in boxes also scattered through the first two sections.

*Map of khoroo 19, Bayanzurkh district, drawn by health workers to identify unreached areas*
GETTING STARTED WITH RED

The assessment area of Bayanzurkh district consists of a population of 228,379. The district is divided into 21 subadministrative areas referred to as a ‘khoroo’. The khoroo is further subdivided into neighbourhood areas (sub khoroo), which is sometimes referred to as a ‘section’. These sections have experienced rapid migration in recent years (figure 1). Bayanzurkh is considered as a ‘ger district’ because more than 90 per cent of the population lives in a ger (traditional mobile dwelling).15

Figure 1: Growing number of population of Bayanzurkh district, 2005-2009

History of RED activities at the community level

In 2008, a mapping exercise was conducted with district health planners and FGP staff. They identified the most-at-risk populations and their locations and documented the health system and community factors that restricted vulnerable groups’ access to health services. They then selected priority activities for reaching those groups and determined the financial costs of doing so.

For the mapping exercise in the preparatory stage, the participants opted to use a sample of households in high-risk areas to estimate the numbers of people unreached. But they quickly discovered when they made a site visit that it was necessary to walk house to house to detect the vulnerable groups. A district
manager reported that in one khoroo, after this switch in tactic, they started to find many children who had never been immunized. Another participant described the increased numbers of those with an unmet need for health and social services as «unexpected».

Thirteen of the district’s 24 khorooos were selected for the activities, based on the following criteria:

- new khoroo
- high population density
- remote ger town
- presence of student dormitory
- large market areas
- poor infrastructure
- presence of many charity centres.

Implementing of the first RED strategy activities began in 2009 with funding support from UNICEF. The objective of the strategy, as defined by the Bayanzurkh planners and practitioners, was to «detect target populations, determine their encountered problems and implement a health and social package of services». Specific objectives were as follows:

- implement health and social package service among the targeted group of population
- increase routine immunization coverage
- improve social mobilization to the targeted group
- establish monitoring and supportive supervision system
- expand a monitoring and use of data for future action
- improve the planning and management of financing and other resources.

A district health administrative order was issued authorizing the implementing of the initiative. Following the launch, a training programme was conducted for heads of FGP, Bayanzurkh district and khoroo governors, health programme specialists and the administrative team of the Bayanzurkh district health centre. The training, called ‘Strengthen family nurses’ capacity and motivation’, entailed a five-day lecture and community practice sessions that included 60 nurses from the selected 13 khorooos. Five programme supervisors were nominated from the district level (this was later expanded to 10 due to the work load). The RED leaders were the health officers in charge of the FGP clinics.
The specific roles of the supervisors were as follows:

- monitor accuracy of reports from the FGP
- problem solving and decision making
- meet with the targeted group and monitoring assistance given by the FGP
- work with nurses to solve difficult problems, with help from other organizations.

The supervisors also assisted in conducting quarterly and half-yearly review meetings with the FGPs, other sector officials and NGO and administrative partners.17

Each of the FGP nurses were assigned to subkhorooos. Each month (typically over three days), each nurse would walk through the subkhoroo to identify new residents. No services were provided, but the nurses would request or invite residents to visit the health facility or registration office for residency registration (khoroo governor’s office) or health registration (at the FGP) and for any needed medical service, such as immunization.

Initially, the field walks proved overwhelmingly insightful. In one khoroo, for example, after a house-to-house search in the mapped area, the nurses discovered a total of 155 persons not monitored by the FGP, 120 women who were not covered by family planning and 69 unimmunized children (both those with had never been immunized and those who had dropped out of an immunization programme). There were indications from a number of sites that unregistered populations were not considered in the denominators in health coverage statistics and thus that the numbers of unregistered populations were underestimated.

Under the RED strategy, the nurses received a monthly stipend of 12,000 tugrik (US$10), ostensibly for transportation costs – although there were no actual transportation expenses because they walked. But the stipend served essentially as an incentive to walk to each household. Walking door to door is of course time consuming, and the nurses in one khoroo commented on the difficulty of this strategy when the community continues to expand. In another khoroo, a nurse remarked that quite often the very poor tend to congregate in the most remote locations. In addition to meeting community members in their homes, nurses also needed to liaise with NGO officers, subkhoroo leaders and social welfare and registration staff at the khoroo governor’s office for dealing with the various social issues they discovered.
Management activities

The nurses transmitted their monthly data to the district level where it was analysed on a quarterly basis. Data sheets documented the names of staff members in each khoroo health centre and the numbers of clients contacted (according to target group and service classification). The district supervisors compile data on the services provided.

A RED Working Group was established at the district level that included the district health director, Social Development Department staff, an accountant and other district technical staff. The role was to provide oversight to the programme, share information between offices (such as population data) and organize and participate in the quarterly and annual reviews.

Partnership activities

In addition to the community outreach, the nurses conducted activities to strengthen community partnerships. The Bayanzurkh district progress report documents collaboration with the following partners:

- governors of Ulaanbaatar, districts and khorooos
- sub khoroo (section) leaders
- social workers
- NGO partners (World Vision, the Red Cross, the Bayarmaa Foundation and the TavanBogd company
- Social institutions, including the Naidvar hospice, the Children’s Nursery No. 40 and the Infants Nursery Home and Christian church located in khorooos 1, 21 and 22.

As an ongoing partner, World Vision based one of its liaison officers in an FGP clinic who worked with the nurses to identify and respond to some of the social needs of the population, including emergency food and shelter.

A total of 144 children from Bayanzurkh were referred for care to the Infants Nursery Home, mostly for malnutrition. The FGP nurses provided the medical attention they needed. The FGP staff detected social problems and malnutrition through their RED-related visits into the community or through liaising with other organizations that work in the community. Referrals were then organized by the FGPs and the parents (through the district) for the children to attend the Infants Nursery Home for nutritional rehabilitation or for temporary care while social issues were resolved in the family. This is an example of how the nurses, through their new interaction in the vulnerable areas of the community, tackled both health and social issues.
RED TARGET GROUPS

Target groups for the RED strategy in Bayanzurkh included an array of vulnerable groups: the poorest, the elderly, people with a disability, those who do not have civil registration (and hence do not have access to social benefits and health insurance) or who live in remote areas or in temporary residences. Others were those who have no home, children in orphanages or without caregivers, single mothers, working children and school drop-outs.

The nurses in the 13 khorooos identified an overall population of 22,726 in the targeted areas through their mapping exercise.

Using agreed criteria, the nurses then identified a subpopulation of 8,708 highly vulnerable people, of whom 3,126 were children, 708 were elderly, 538 were people with a disability and 103 children without a caregiver. Malnutrition was identified as a significant issue within the subpopulation.

In khoroo 12, the nurses visited one-third of all households in the community (in the targeted high-risk area) and identified 773 people within a total population of approximately 4,700 as ‘high risk’ and in need of special attention. The case studies (included in the report) from Bayanzurkh highlight the plight of these vulnerable groups. Most FGP team leaders indicated that ‘the poor’ may have numbered in the range of 30–40 per cent, but the classification of ‘very poor’ was in the range of 5–10 per cent of the population. This is the group that the piloted RED strategy targeted. Other subgroups included street children, alcoholics and the unemployed. In terms of their vulnerability, one FGP practitioner noted:

“The difficulty with the poor is that they are always in an emergency situation. So they cannot think [act] ahead for preventive care. They don’t come for check-ups. It’s only when they are very sick that they will come, and this means they will go directly to the hospital.”

People are working for survival at dump site of Ulaanbaatar city

Bayanzurkh district health team, 2009
At all sites it was reported that the local population is increasing rapidly due to migration into the city. According to the Social Development Office in Bayanzurkh, a typical khoroo should have a population of 6,000–8,000 people. However, some of the expanding khorooos have 15,000–20,000 residents. Bayanzurkh planners provided data on population growth trends in the past five years. The Civil Registration Office in Bayanzurkh indicated that there were 500 new registrations per day in the district. If calculated at 500 per five-day week, this would mean additional registrations of 120,000 in one year. Civil registration staff work mostly in the office; it is a ‘desk job’ explained one respondent. Due to the high rates of mobility and migration, workloads are also increasing rapidly for staff in the khoroo governor’s offices as well as for the FGPs. One district social sector manager commented that FGP staff are more effective in identifying unregistered people than staff in the khoroo civil registration offices.

Population estimates for the most vulnerable are approximately five per cent. According to FGP staff, this five per cent of the most vulnerable populations are living in day-to-day emergency situations. However, it should not be presumed that populations beyond this five per cent do not have unmet health needs.

**FINANCING THE PILOTED RED STRATEGY**

The strategy was implemented in the 13 khorooos at a cost of 17 million tugrik (US$14,166) for one year. The funding expenditure breaks down as follows: 24 per cent for training, 15 per cent for supervision and 66 per cent for service delivery (which in effect means incentive/transport payments to FGP staff to outreach to vulnerable communities).

As noted, the nurses received 12,000 tugrik (US$10) a month for so-called transportation costs. However, the payment was not disbursed until the district supervisors had checked the quality of data that each nurse provided.

The quarterly reports provided by the district team detail the activities per community and provider and the number of client contacts (by type of target group).

**IMPACTS OF THE RED STRATEGY**

Based on the improvements in reaching people, the mapping, barrier analysis and capacity-building interventions proved to be cost effective, with early indications of improved health service and some social service access and potential for more significant impacts on public health and institutional development in the coming years.
The rapid assessment identified three primary impacts from the RED activities: i) increased numbers of vulnerable people accessing health services, ii) improved motivation of FGP staff and iii) improved inter-sector partnerships.

Case study 1: Peri-urban families need routine outreach services from health, social protection and local government side, Bayanzurkh district

Khoroo 12 has a population of 14,288 people. Once a mapping of the community was completed, one-third of the population was selected for inclusion in the house-to-house check. A target group of 559 people was then determined and entailed the elderly without caregivers, persons with a disability, children younger than 5 years and single mothers, each of whom had either lived there a long time or were migrants; most of them, however, are very poor. Each of the six nurses visited a section of the khoroo on a monthly basis. Initially, the plan was for each nurse to visit a random selection of households in the mapped high-risk area. But after realizing that many people within the target group were being missed, the nurses changed tactic and visited all households identified as vulnerable.

The house-to-house search revealed 155 individuals who were not monitored (registered) by the FGP, 120 eligible women who had not accessed family planning and 71 unimmunized children (among 1,180 children younger than 5 years living in the khoroo). There were also significant social problems, including malnutrition, poor shelter, unemployment, illiteracy and lack of registration with civil authorities. About 60–70 per cent of the population are insured. Although insurance coverage costs only 500 tugrik (US$.42) FGP staff reported that many people who are poor cannot afford it. Some of the children not immunized were in migrant families and families with temporary residence status, which are groups not in the denominator for calculating immunization coverage. Immunization coverage is reported as 98 per cent, but there is now concern that the coverage is overestimated because of the people not included in the population denominator.

Of the 559 people in the targeted group, 93 were provided with social services and 466 with health services such as immunization, antenatal care and family planning services. Civil registration at the FGP has improved, and the nurses report improved public attitudes towards FGPs. A World Vision health worker is now based at the FGP, and the nurses have worked collaboratively with World Vision to respond to shelter issues for the people they met in need.

The social work is an additional burden for the nurses and other FGP staff. But they report that it is very rewarding and they are proud of their achievements in helping the most vulnerable people. As several FGP staff noted, if social needs are not met, then health services are not accessed. The nurses expressed considerable enthusiasm for the new-found engagement with the community. Although some nurses had resided in the community for many years, the house-to-house visiting strengthened their link with the residents, resulting in reported increased uptake of preventive health care services.
The nurses expressed interest in further strengthening partnership links with the local authority and other NGOs in order to expand their capacity to respond to the unmet social needs of the population, including unemployment, shelter and care for people elderly or disabled.

**Conclusion:** There is a need for partnering with the khoroo governor’s office, with civil registration and social workers. Khoroo offices should be formally recognized as part of the RED strategy and there should be awareness training for khoroo officers. Section leaders should be the main partners – they typically visit households and distribute public announcements, organize waste management and are aware of new arrivals.

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**Increasing health care access**

More people among the vulnerable population (children and families) are now accessing health and social services in the RED areas. As reported by the FGPs, the size of the vulnerable population (the most poor) is as much as five per cent more of the total FGP population. Additional health services provided include immunization, antenatal care and family planning. According to the FGP records, 100 per cent of the health service needs and 38 per cent of their social needs (food security, unemployment, schooling, aged and disability care, homelessness) of the targeted vulnerable population are now being addressed. Additional social services being provided include registration, shelter, emergency nutritional support and employment. Of the 22,726 residents in the 13 khoroo (of the 24 in the district), 8,708 people were selected as the most vulnerable. According to the Bayanzurkh Health District office records, the RED activities reached additional numbers of community members, as follows:

- 219 children immunized
- 2,486 people registered at an FGP clinic
- 508 women received antenatal care
- 1,047 received family planning support
- 515 people received emergency food supply.

In the rapid assessment interviews, central and city managers and planners reinforced the significance of these results, particularly in terms of the capacity of the FGP nurses to make contact with unregistered and migrant populations. As one district planner commented:

«No one knows these communities better than the nurses do.»
Increased motivation of health staff

Some FGP staff remarked on the increased motivation they felt due to their closer involvement with the community. The nurses in one location commented that although the problems of the vulnerable population were overwhelming and they could not solve them all, they felt a high level of satisfaction and sense of achievement in helping resolve some of the problems. Others noted that before the RED programme, they could only see one perspective but that now they could see things from different points of view. The sense of motivation reportedly comes from the satisfaction in «making a difference» to the daily conditions in which people live, which is hard to achieve when working strictly from a facility.

A district planner said that, previously, work focused mainly on facility care but that the RED programme had opened up the possibility to work outside the facility and in the community:

«Before, I worked in the facility only. Now I work in the community and so my work is more interesting and challenging.»

Although these changes in attitude are difficult to document in an interim formative evaluation such as this assessment, there was sufficient evidence from a number of sources (district and FGP level) who reported on increased motivation of health staff in the RED area. This warrants more in-depth research to understand the impact of closer involvement with the community on health workforce motivation.

But limits to motivation were noted. The 12,000 tugrik (US$10) per month for the nurses was considered too small. Others suggested that the strategy may not be sustainable because the communities continue to expand as internal migration pressures increase. Some FGP staff maintained the opinion that it will not be possible to sustain the house-to-house checks on vulnerable people. One manager commented that nurses were doing social work, which was considered as ‘other people’s work’. A further limitation expressed was that to meet the social needs of the population, incentive systems should be devised for local authorities (section leaders) and social workers in order to increase registrations at the FGP.
Partnerships and leadership

There was overwhelming consensus from the various people interviewed during the rapid assessment that unless basic social needs of the vulnerable population are met, then health service needs cannot be met. FGP staff and managers stated that the health situation of the vulnerable population is socially determined, highlighting the need for close partnerships between health and social planners and service providers.

These types of partnerships take different forms in the RED strategy. At the central level, lessons already learned from the initial implementing of the RED strategy have been absorbed into the design of GAVI’s health system-strengthening approach. Both funding sources (GAVI and UNICEF) will be managed by the same working group at the NCCD and a higher-level policy working group at the Ministry of Health will serve as adviser to both as well. In this sense, the RED strategy has been a catalyst for mobilizing and coordinating resources.

At the city level, planners and managers are monitoring the strategy and are supportive of a proposal to scale up the strategy.

In recognition of the value and need for health and social sector partnerships, partners in RED (the departments for city health, social development and civil registration and the district health authority) proposed that the RED Working Group be broadened to include civil registration officers and representatives from social welfare agencies.

At the community level, the involvement of an NGO (World Vision) employee as a liaison officer with the FGP highlights how partnerships are evolving. That is, rather than health being an FGP-only concern, the linking of health and social issues, in addition to closer involvement of FGP staff with the community, has resulted in an expressed need by various RED stakeholders for closer partnerships for community health service provision. For example, various people interviewed during the assessment cited links with the khoroo governors’ offices (where civil registration officers and social workers are based) and section leaders as partnerships that could be strengthened, particularly in relation to responding to the social needs of the population who end up having health impacts. The increase of civil registrations through the RED programme has resulted in needed health and other services being made available to people in the vulnerable population as well improved communication within the community. As one FGP nurse commented:

«The RED strategy is there to solve problems – this means running after the social needs of the population so their health needs can be met.»
Table 3 provides a summary assessment of the RED programme using the standards for monitoring progress set out in the Reaching Every District: Implementation and Guidelines (draft). What this analysis demonstrates is that although progress has been made, the process is still in the early stage of development, particularly in relation to forming partnerships for improving access to health and social services.

**Table 3: Criteria for field-level assessment of RED**

<table>
<thead>
<tr>
<th>Criteria for assessment of RED</th>
<th>Results to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many additional children have been reached?</td>
<td>The population in the targeted areas was 22,726. Of them, a target group (the most vulnerable) of 8,708 people were selected. This included 3,126 children aged 0–15 who became the focus of health service and social support.</td>
</tr>
<tr>
<td>Has there been observed morbidity reduction and awareness-raising campaigns?</td>
<td>No information was provided on morbidity reductions. However, it can be assumed that with the increase in civil registrations and contacts for immunization and maternal and child health services that the incidence of morbidity was reduced.</td>
</tr>
<tr>
<td>Are volunteers being mobilized for public duty?</td>
<td>No volunteer networks were established. The nurses with their home visits were conducting the community contact roles in collaboration with district supervisors, section leaders and World Vision.</td>
</tr>
<tr>
<td>What have been observable rates and outcomes of training?</td>
<td>A five-day training was conducted to strengthen the capacity of the FGP nurses (60 nurses in the 13 khorooos). The training included a practice component that helped the nurses identify the targeted people. Mid-year review meetings were organized along with on-the-job training (problem solving), using the district supervisors.</td>
</tr>
<tr>
<td>Have partnerships been established with organizations and NGOs in the local area?</td>
<td>Yes, one NGO partnership (World Vision) was strengthened as were partnerships with various social agents (churches, social workers, section leaders and khoroo governors’ office staff).</td>
</tr>
</tbody>
</table>
How many reports have there been of new arrivals and departures?

No information was provided on the numbers of new arrivals and departures, although district supervisors are very aware of population increases. The district supervisors reported that the number of ‘discovered’ unreached populations was unexpected, indicating that the house-to-house visits were successful in detecting new arrivals. The evidence for this is also in the increased number of client contacts for immunization and maternal and child health care services.

Are RED activities integrated into the district plan (to ensure good alignment with district planning and harmonization with other forms of support)

As yet, there is no evidence to suggest that RED activities have been integrated into the annual planning system. However, there was interest expressed in identifying the feasibility of developing a flexible district Health and Social Fund for pro-poor health and social services.

What supportive supervision programmes have been implemented?

The strategy of supportive supervision was only recently initiated. However, the district health team has taken a problem-solving and supportive approach to the FGP teams. The ‘supportive’ approach has been translated into health action at the community level where nurses have demonstrated how active they can be in resolving some of the acute social problems of the vulnerable populations. Supervisors made site visits to check data quality and assist the nurses in problem solving.

Have performance agreements been established between the district and the FGP?

The incentives for nurses are provided as a transport subsidy; performance is verified by district supervisors through the review of quarterly reports and field visits.

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**The long-term challenge in Bayanzurkh – Re-engaging communities into the health and social system**

There are further significant shifts that need to be made in order for health services to be sustainably accessed by the very poor. As noted by many of the district health authorities and FGP staff, the health access issues are in many ways linked to social issues, such as poverty, unemployment, disability and mobility.

Being outside the system in terms of social benefits is a significant form of social isolation. The quarterly reports from nurses in Bayanzurkh district highlight the level of social isolation of some of these vulnerable families (Figure 2). The isolation manifests itself in a several ways:
• being outside the health system in terms of unregistered status at the FGP
• being outside the administrative system, as measured by lack of civil registration
• being outside the economy, as measured by unemployment or low-income status
• being outside of any social system, as measured by the lack of caregivers (single mothers, orphans without caregivers, elderly people without caregivers and school drop-outs).

Some interviewees reported that the transition to the market economy had loosened social bonds, which weakened traditional community leadership and extended family ties.

Sometimes, there is an overlap of factors that reinforce the isolation. In some areas, for example, many of the single mothers are unemployed. They either do not have the money or the capacity to care for their children. In Bayanzurkh district, up to 144 cases of malnutrition among children were identified. At the Infant Nursery Home in Bayanzurkh (the referral centre for malnourished children), staff explained that parental knowledge and financial capacity were the main reasons for referral. In all cases, the children were from very poor families. More than half of them lived with a single mother who was unemployed.

One respondent commented that the main problem for the vulnerable groups is that they have no legitimacy in the current system. That is, they have no health insurance, and have no civil registration which entitles them to the health and social benefits.

Social isolation and social stability

Lack of social participation is a warning signal not only for health care access and disease outbreaks. It is also an important warning sign of social instability. Although some of the people interviewed for the rapid assessment expressed pessimism about engaging the socially excluded, the overall impression was that the situation of the poor can be realistically improved through the implementation of an ‘active search’ (identify and respond to the needs) and a social networking ‘community partnership’ strategy, particularly with respect to improving access to immunizations, maternal health, social support and civil registration. Continuing with a system that sustains lack of social participation and isolation for a marginal sector of the population carries high social and political risk for the whole of society – not just the vulnerable.
Figure 2: Examples of social isolation, based on quarterly FGP reports, Bayanzurkh district
BARRIER ANALYSIS IN THE NON-RED AREAS

BARRIER ANALYSIS – COMMUNITY FACTORS

The community barriers to health and service access documented in the five non-RED areas included in the rapid assessment entail poverty, lack of civil registration (and knowledge of the population), social isolation and living conditions. Although the sites varied in context, what they all had in common were high levels of absolute poverty and high rates of migration. The sites, some of which are included in detail in the case studies that follow, have the following types of social context:

- A summer camp, which has a more rural location and high rates of fluctuation in population – these communities are based in the northern hills on the edges of Ulaanbaatar and are characterized by the ger accommodation and large distances between homes and from service centres. Migration here is seasonal, with a large influx from the city in the summer. There are also migrants who reside in the summer camps during the winter months.

- A more central urban area with a large series of day and night markets and very high rates of daily migration. In this location, many poor people live in apartments and or temporarily in a hostel. Child labourers are typically found here, particularly working as porters for vendors. There are also temporary shopkeepers and sellers. High rates of homelessness and alcoholism are also documented in this area.

- A ger khoroo has a very high rate of internal migration because there is ample room for expansion westwards. Here, many residents are migrants and live towards the northern side. The population has doubled in the past ten years. Approximately 10 per cent of the population is identified as the poorest – unemployed, single mothers, families with many children, the disabled and those with a chronic disease.

- In the ger district, 11 per cent of the population lives in an apartment and 89 per cent live in a ger; 1,900 people of 12,000 do not live at a registered address. The at-risk population in the barrier analysis included 140 single mothers and 380 people with a disability.

- In a khoroo to the south of the city near the airport, many of the very poor resided on the riverbank in a temporary shelter made from boxes, scrap materials and iron. The vulnerable here include the homeless, people who are unemployed and unimmunized children.
Poverty

To identify people considered as poor, different methods were used. One FGP used 70,000 tugrik (US$58) or less family income per month as a marker for the poverty profile, while another group used 50,000 tugrik (US$42) or less to represent vulnerable status. In one FGP, poverty was assessed as capacity to pay for prescribed medicines. Their local analysis indicated that only 60 per cent of the local population could meet that standard. This suggests that, despite health insurance mechanisms and health-financing capitation models (with adjustments for poverty risk), there remain significant financial barriers to health care access. In some locations, FGP staff reported that the very poor had no money at all.

The poverty profiles created for the barrier analysis and the case studies that were documented describe conditions that are not particularly different from those in other Asian cities, such as Manila and Phnom Penh. Common characteristics are high rates of internal migration and seasonal or daily mobility, unemployment, illness, unsanitary living conditions and crowded living environments. People who are particularly at risk are the elderly, the disabled, children (especially the very young) and single mothers. What is most striking about the profiles of these people is their level of social isolation, as measured by their levels of exclusion from the economy, health and education systems, and social services. Poverty in Mongolia is therefore more than income based, it is also a compound effect of low income, unhealthy daily living environments and social vulnerability and isolation.

Case study 2: Informal migrants health and social protection are at risk, Uyanga soum, Uvurkhangai aimag

Uvurkhangai aimag (population 111,000) is a mix of mountains, steppe and desert. Only some of its soums were affected by the recent dzud, which resulted in the death of many livestock animals (up to 80 per cent of livestock in some soums). This led to some herders and their families relocating to the aimag centre. A survey conducted after the disaster found that 7,000 people had fallen into poverty, and the findings indicate that the vulnerable population may be as high as 50 per cent of this group.

An estimated 10,000–20,000 migrants who illegally mine for gold are living in Uyanga soum, about 100 km from the aimag centre, in addition to the registered population of around 8,000 people. Most of the miners live in a camp with their family in a ger up a narrow mountain pass along the banks of the waterway, about 10 km from the soum centre. There are other groups of itinerant miners who live up to 140 km from the soum centre. The winters are severe, and snowstorms cut off access for immunization and other health care services.
Three groups of people occupy these sites: i) formal mining license holders, ii) illegal miners and iii) small traders who follow them to make business. There are unofficial bagh and soum communities that have formed on the basis of original place of residence (communities that have relocated along with their informal leaders). There is a kind of social network, although the soum managers and leaders indicated that the population is difficult to communicate with in an organized way. The number of illegal miners, though large, is stable at the moment; their numbers increase in summers and decline in winters.

The environmental conditions are poor and significant damage to the natural surroundings have occurred as a result of the mining activities. Some of the mine shafts are 23 m deep. Morbidity is said to be rising with the rising poverty – diarrhoeal disease is the most common complaint. The health system has difficulty with active searching – the Ministry of Health finances services for 8,000 people, but there are 20,000–30,000 people in the catchment area. A mobile specialist health team financed through the United Nations Population Fund (UNFPA) provided quarterly visits until last year, and the aimag centre has maintained the service, although modified it to an annual visit. The soum hospital records reflect treatment of many injury cases, and there are almost 200 live births per year. The problem is that the miners and their families require significant health service support, but the soum is not financed to support this service. Meanwhile the ‘native’ vulnerable population (particularly those who suffered in the dzud) also requires significant health service support.

The FGP staff and local authorities recommended additional funding for community outreach on a regular basis, more of a focus on public health and building communication networks with the local people. A change in the capitation-based funding was also recommended to address the obvious health resource inequities, which have persisted for 10 or more years, prompting managers and leaders to conclude that the problem is very difficult to solve. The soum governor is pessimistic about promoting civil registration because so many people are coming and going all the time. There is equally limited motivation and capacity for temporary registration because the miners do not have the necessary documents, such as transfer and birth certificates (transfer certificates refer to local authority approval for change of address, which enables registration at the new community). The miners are also seasonal itinerants. According to one manager, «They have other priorities – they don’t even know what they are doing tomorrow.»

Conclusion: Civil registration, health insurance and capitation-based funding models, although providing a solid basis for strengthening the health system, have not resolved the problem of health care access for itinerant populations in this remote area.
Financial barriers

Challenges were reported in terms of financial barriers to health care access. For primary care, prevention services are free for children, pregnant women and the elderly. But for treatment, there is a check-up fee and drugs must be purchased. People who are not registered have to pay all hospital charges and the full cost of medicine. Thus, people who are poor delay preventive care. This delay in health care-seeking behaviour means that the poor then are more represented among emergency or severe illness cases. Recalled one FGP practitioner:

«There was one family who had twins one year and 11 months later had another set of twins. The father is a severe alcoholic. He has no ID card, apart from an old socialist passport. Due to the absence of registration, the family now has a 4 million tugrik debt to the hospital. The problem is, how can health problems be solved when social problems are not?»

Another FGP practitioner explained that for the vulnerable population:

«There is no motivation to go to prevention services if you have no money for treatment. So some referrals do not go or may not be admitted because they have no money.»

As noted earlier, one FGP reported that up to 60 per cent of its client population does not have the capacity to pay for essential medicines, and a minority has no money at all. Although the capitation-based funding, health insurance and civil registration mechanisms have established the basis for social protection, the system clearly lacks sufficient depth and breadth of entitlements to capture the most vulnerable groups of the population. In some locations, these groups are now outside the system.

Lack of civil registration

A number of barriers prevent people from undertaking the civil registration process, including high mobility, concern that they would not be permitted to stay where they have relocated, lack of transfer certificates from the original place of residence (which makes it difficult for migrants to register for health and social services) or lack of birth certificate. Although birth certificates can be obtained at the civil registration office, there are fees and additional documents required.

One khoroo officer described the situation as «information chaos» because people had no fixed residential address or street number. In another area, there is lack of a clear boundary between khorooos because the administrative affiliations are unclear. This happens to be where the vulnerable people have concentrated.
In one khoroo, officials estimate that they have 1,900 unregistered people living there and no active seeking them by health workers to make health service more accessible.

One planner noted:
«In this FGP, there were 685 new clients identified in a population of 14,670. But perhaps there are a 1,000 more unregistered. These include those living in dormitories and hostels [young couples and students].»

The point of this statement is that there are many residents in this khoroo and additional mobile and migrant populations that the FGPs are not detecting and thus they are not included in the population statistics. During the barrier analysis in one location, some of the assessors reported that there was evidence to suggest that pregnant women were advised to go elsewhere for care because they were not registered.

In the rural areas of one western aimag, the furthest soum is 300 km from the aimag centre. These areas consist of mobile populations, such as gold miners. The presence of military units in this area and recent natural disasters (the previous summer drought followed by the dzud have increased people’s mobility out of the area. The combination of mobility and remoteness factors is clearly a major challenge to tracking the population (and registering or keeping them registered).

In one khoroo, the FGP staff developed a social network of volunteers and information exchange among section leaders to improve the reporting of new arrivals, pregnant women and newborns. As part of the barrier analysis in another community, an FGP staff member guided assessors to new arrivals who were found living on the edge of the community, and who had unimmunized children and no civil registration. Additionally, the children were not attending school in this location.
Case study 3: ‘Health service is not able to expand at the speed of increased migration to peri-urban area, Songinokhairkhan district

Khoroo 3 in Songinokhairkhan district is located on the western edge of Ulaanbaatar. Its population has doubled in the past 10 years and is still expanding outwards with new migrants, most of whom are dwelling in either a ger or temporary housing. Of the 2,700 households (14,000 population), 1,200 would be characterized as poor, with about 200 as the poorest. Most of the poorest households consist of unemployed people or someone with a chronic disease or are headed by a single mother or someone who is disabled, or are families with many children. The population is constantly expanding, highly mobile and there are no address systems. Thus, tracking pregnant women or the immunization status of children is regarded as very difficult (especially because there is no immunization unit based there). In addition, the limited water supply and sanitation conditions, poor hygiene practices, lack of family planning practices and lack of health knowledge largely contribute to people’s poor health. The community has recently experienced outbreaks of H1N1, hepatitis A and foot-and-mouth disease.

For the rapid assessment, two ger households were visited, each located 5 km from the FGP clinic. Both families had recently moved from another district in Ulaanbaatar. In one family, the father was disabled. In the other, there were 10 people; of the six children, the two elder daughters each had a child. Both families scavenged around the landfill for objects they could sell to a trader. The children were not immunized and did not attend school. World Vision was providing some support to both families. The FGP is doing as much as possible to meet the various needs of families, such as the two visited. Social networks have been developed with section leaders who provide information on new arrivals, pregnant women and newborns. There is also a group of elderly women (retired teachers) who provide volunteer assistance in exchange for priority health care services at the FGP. There is also the World Vision link, and collaboration with the khoroo office is reported to be good. However, the population has doubled in the past 10 years but the FGP staff has not increased as the pressures of clinical practice increased. More human resources and incentives are required for community leaders and nurses in order to reach out to the vulnerable population.

Conclusion: Social networking can help to improve health care access for immunization and maternal and child health coverage. However, there are limits to its effectiveness in resource-poor settings. With a static level of health resources and rapidly increasing numbers of urban poor, policy flexibility and foresight will be required to prevent the potential for escalating social distress and widening health inequities. The mobilizing of human resources and the establishment of an immunization unit could make a big difference where vulnerable populations are located.
BARRIER ANALYSIS – HEALTH SYSTEM FACTORS

The establishment of the FGP system along with the development of health insurance mechanisms and a capitation-based model of funding have provided a solid foundation for the development of the health system in Mongolia. However, it is quite clear that this solid foundation is currently insufficient to meet the needs of the most vulnerable groups in society who have fallen ‘outside the system’.

Based on this rapid assessment, there are three main reasons for the health system’s insufficiency:

First, the level of capitation-based funding is inadequate to meet even the basic needs of the population in the catchment area. Large portions of the vulnerable population cannot afford to buy essential medicines, and practitioners lack insufficient operational funding and motivation to reach out to help the poorest families in the community. There is no evidence from this assessment that pro-poor financing (in the form of risk adjustment for levels of capitation) was being applied in such a manner as to meet the needs of the very poor. This inequity in financing is reinforced by a civil registration system that denies social participation and entitlements for marginal groups.

Second, the model of funding (capitation and health insurance) is not well adapted to the needs of the poor. Even if capitation levels are raised from the current 6,500 tugrik per capita to 9,000 tugrik, as one FGP staff member suggested, it is not clear that this additional funding would immediately translate into a pro-poor service delivery or resource allocation strategies.

Third, the service-delivery model of the FGP is, in many ways, built around the concept of primary medical care (first level of health care) and less on the concept of primary health care – services and strategies across sectors for improving people’s health, including community development, water and sanitation, education and employment changes. Although there are examples in non-RED areas in which the FGPs were actively reaching out to communities to service the needs of the very poor, there are many locations in which little active search and engagement was conducted with the unregistered and socially marginalized populations.

The concept of ‘active search’ does not simply mean participation in door-to-door household visits by nurses, feldshers (medical assistants) or FGP doctors. There are some examples in the RED and non-RED areas in which FGPs have adopted effective social networking strategies to identify and respond to the needs of the vulnerable population. Most of these community-based approaches involve a linking of volunteers, NGOs, section leader and soum or khoroo governors’ offices.
Although mandated by a ministerial order to service the health needs of the registered and non-registered elderly, children and pregnant women, it remains the case that some FGPs are simply not funded or organized to reach them. Even with the best intentions, it is all too easy for the poor and powerless to fall outside the scope of mainstream service provision. The awareness in Bayanzurkh after the house-to-house search of a surprisingly large number of vulnerable clients seems to confirm this, as does the finding in some non-RED areas that unregistered and migrant populations are not coming into contact with the FGPs. These findings have important implications for the financing and organization of health care service delivery for the very poor.

**Case study 4: ‘Open market areas need routine outreach services too, Bayanzurkh district**

Khoroo14 has a population of 9,760 people, is divided into six sections and is primarily a large market area. There are five open markets, including a night market. In addition to the resident and temporary resident population, 10,000 people visit from other parts of Ulaanbaatar every day for the markets. Around 90 per cent of the population lives in a ger, and 10 per cent reside in an apartment. The difference in registration numbers at the khoroo office (9,760 people) and the FGP (11,071 people) indicate a degree of mobility among residents. Khoroo officers estimate that approximately 47 per cent of the population is poor (a monthly disposable income of less than 74,000 tugrik) while the FGP workers cite 60 per cent, based on those who cannot afford to buy medicines when needed. At this site, the FGP clinic defined the vulnerable population as those with a monthly income of less than 50,000 tugrik.

Many migrants and temporary residents live near the open markets where they also sell items as their livelihood. Waste management is very bad in this area, with a proliferation of open-waste dump sites. There are three deep wells supplying water for the entire population, and water transportation services are available. The migrants set up their ger anywhere they want and connect to the electricity, which they do not pay for. When that situation is discovered, the inspectors cut their access and they move to other access points. A large number of people are homeless and/or there is a large number of people with an alcoholic problem living in the streets; some have died in the winter cold. Other vulnerable population groups include the unemployed, people who rent a hostel room, the disabled and there were reports of street children who live in the sewer tunnels below the street. There are also child beggars and children employed by market vendors. There are residents who come to collect the daily rubbish and sell it. These workers are considered as outsiders because they are not registered with the khoroo office; some manage to register with the FGP, which then entitles them to health services. Some receive health services even if they are not registered. The ratio of doctors to patients through the FGP clinic is very high due to the temporary visitors.
The standard is 1 doctor per 1,800 residents; but in khoroo 14, it is now 1 to 4,000 people, with a high staff turnover. There are unimmunized children because some families do not even know where the FGP is located.

District and FGP planners recognize the need to establish a permanent EPI unit at the FGP so that community members do not have to travel far to the district and to increase the supply of essential drugs at the facility. Other identified needs include addressing the social and environment determinants of health (in particular, conducting environmental risk assessments, providing appropriate response and improving the water and sanitation situation) and building up networks at the grassroots level through training and the deployment of volunteers. A cross-sector task force or working group was recommended that would encourage greater cooperation between the FGP and the governor’s office, the district governor’s office and the Social Development Department.

Conclusion: An important insight from this case study was the overwhelming impact of the social determinants of health on health status and capacity to access health services. There are limits to FGP capacity as well as its role and function. Although the FGP can resolve some social problems, it has the potential to develop and strengthen social networks to improve people’s access to health care and raise public and government awareness of the needs of the vulnerable.

Community barriers to health service access

Findings from the barrier analysis conducted in five non-RED areas indicate high levels of social distress and isolation among the vulnerable groups. There is some evidence that significant minorities of the population are not accessing health and social services. An important conclusion from the rapid assessment and case studies was the overwhelming impact of the social determinants of health on health status and capacity to access health services. The perception of FGP staff in non-RED areas is that the problem is escalating. One central planner referred to the situation as being «out of control». Money is not the only answer. Mapping and barrier analysis and problem solving approaches are required, as well as building stronger social networks to provide more inclusive local support for the very poor.
CONCLUSIONS AND RECOMMENDATIONS

FINDINGS IN RELATION TO THE INTERNATIONAL CONTEXT

These developments in the RED strategy in Mongolia (the Bayanzurkh pilot and the GAVI HSS strategy) are in accord with the most recent developments in global health policies and strategies. The most recent World Health Assembly resolutions have stated the commitment of health ministries to create health policies that regard the social determinants of health\(^2\) and reorient medical care towards more primary health care approaches.\(^2\) The social determinants of health perspective asserts that the fundamental causes of ill health are the basic conditions of daily living, necessitating a reorientation of health policy towards multi-sector action and public health policy advocacy.

A UNICEF study recently completed in Cambodia reached similar conclusions as this RED assessment in Mongolia. In the Cambodian study, the main respondents were members of the communities. What they asserted was that health and health care access were related yet distinct issues, with the main determinants of poor health relating to daily living conditions of families and communities, including access to adequate levels of income, nutrition, security, education, safe water and sanitation – and not only health care services.\(^2\) What is notable in this Mongolian RED assessment is that health providers and health policy makers have reached similar conclusions – that is, that health and social issues are inextricably linked and that for effective and sustainable responses, partnership mechanisms in the health and other social sectors are required to make a difference in the very poor’s ability to access to health and other social services.
In terms of primary health care, one of the perennial questions, particularly with respect to vulnerable populations, is whether health services should promote demand for fixed facilities or whether health workers should reach out to communities. The difficulty with a sole emphasis on a fixed-facility approach is twofold: First, health issues become contextualized in terms of clinical health responses only. There is less opportunity for community networking for improved health and a tendency to ‘personalize’ what are actually social health issues. The repeated observation by health managers and providers in this assessment that it is hard to assist the health needs of the population without dealing with the social problems first reflects the daily reality of the social determinants of health and its impact on health and health care access.

Other pillars of public health care, including intersector action for health and the promotion of public health policy, were identified in this assessment as critical factors for sustaining the RED success. These issues are also highly current in the international health literature and policy debates. This is particularly the case in relation to partnerships for improving health between the health sector and local authorities, which is a major issue identified in both the Mongolian and Cambodian assessments.
A review of health inequity studies in the literature over a 20-year time period has demonstrated that only 17 per cent of the studies and interventions articulated described roles for municipal government in the reduction of local health inequities. As well, the review indicates that studies and interventions demonstrate a “pervasiveness of ‘behavioural’ and ‘biomedical’ perspectives”.

The RED approach provides Mongolia with the opportunity to further develop partnership mechanisms between health providers, local authorities and civil society. Trial and evaluation of these mechanisms could hold important lessons in future years not only for Mongolia but also for other countries in the region that are experiencing similar challenges of social transition and inequities in health care access and health outcomes.

At the policy level, some significant challenges are presented by internal migration and health inequities, which is also a regional challenge. Along with rapid rates of internal urban migration, income inequities within countries are highly significant. The three countries with the highest levels of inequities (Nepal, Philippines and Thailand) have experienced episodes of civil unrest in recent years. The twin and reinforcing impacts of widening health inequities and urban migration will accelerate the need for effective health and social management responses, such as RED.

Mongolia, no doubt due to the history of its socialist period, has lower rates of income inequity than many of its neighbours. But the perspective of respondents in this rapid assessment was that the inequities and rates of migration are gathering pace and have been exacerbated by the recent dzud and longer-term effects of climate change.

One of the important features of the RED strategy, especially as it has been designed and implemented in Mongolia on a trial basis, is that it is a pro-poor social management plan to pull vulnerable populations from the margins of society and into the mainstream. This mainstreaming of the poor into the system is not just symbolic – civil registration brings social benefits, as does linking to social welfare agencies for shelter, management of malnutrition and improved access to immunization and family planning services.
Reconnecting communities this way is not simply demonstrating the implementation of interventions for strengthening the social safety net. The linking of health and social issues also provides an ‘opportunity rope’ for populations to achieve their optimal potential for development through their full participation in the wider community and the sharing of the benefits of wider access to health and social services.

“Much current policy and practice assumes that the main barrier to effective empowerment is the lack of skills and competencies at the community level, but research suggests that barriers arising from professional and organizational culture and practice are more important. These include negative stereotypes of communities, inappropriate timing and style of meetings, failure to accommodate cultural diversity, accessibility issues, inadequate resources and misuse of professional power to control agendas.”25

What the experience in Bayanzurkh district has demonstrated is the capacity of health managers and providers to take the lead in initiating organizational change and the reorientation of professional behaviour, leading to very impressive early gains in improvement to health care access by the very poor and even to an improvement in some of the social conditions of this group.

HEALTH FINANCING
Consistent findings of this assessment is the widespread perception among FGP staff that they are not adequately financed or in some cases mandated to actively search and include the vulnerable populations in the health care system (particularly unregistered populations). In relation to health-financing models, consideration needs to be given to the following:

- raising capitation levels and ensuring appropriate risk adjustments for the poor
- subsidizing health insurance premiums for the very poor
- introducing programme-based budgeting that will allow more opportunity for financing of public health-specific activities at the district level and below
- introducing results-based financing (performance-based incentives) for FGP staff.

These are all high-level health policy and planning options that respondents reported are currently under consideration by the Ministry of Health but that may take some time to translate into practice. Some FGP staff noted that some of these issues have been lingering under consideration for many years, leaving them with a feeling of pessimism regarding the capacity of the central level to
mandate change in the short to medium terms. Central policy and planners are more optimistic, but emphasized that «these things take time», especially with regard to developing the appropriate laws, regulations and procedures to mandate change.

This perception of the rigidity of the system is reinforced by observations by FGP staff and district managers that the growth in health resources (human resources and financial resources) is not keeping pace with the acceleration in the numbers of urban poor. In one FGP visited, the population had doubled in the past 10 years but the number of health personnel remained the same. This suggests health policy is lagging behind social transition. Policy flexibility and foresight will be required to dissipate the potential for escalating social distress and health inequities among the urban and rural very poor.

SERVICE DELIVERY MODELS AND COMMUNITY PARTNERSHIPS

It is important to remember that RED is not a financing strategy. It is also important to educate all levels of government officials on how much impact can be made with little financial investment. For example, one manager seemed surprised and sceptical of what the RED had achieved:

«I cannot believe that for $10 a month, such improvements can be made by the actions of the staff. Do you have evidence of this? You will need a sample survey to prove it.»

This lack of credibility of non-financial strategies for health improvement is probably a reflection of the decline in emphasis on non-economic models of explanation as to why things work and do not work. It is true that the lack of financing can be a constraint, particularly for outreach activities and public health education. But the point is that, as implemented in Bayanzurkh district, the RED approach is principally an organizational and community participation strategy to establish health facility and social networks for health service provision using a pro-poor perspective. In this way, it is more representative of a transition from a primary medical approach to a primary health care approach (services and strategies across sectors for improving people’s health, including community development, water and sanitation, education and employment changes). The RED strategy mostly focuses on changing the behaviour of managers and service providers in the way they work as well as on the provision of leadership, management and financial support to enable this reorientation of organization to take place.

But as respondents in the assessment indicated, there are limits to the FGP capacity as well as its role and function in relation to the social determinants of health and the expansion of population health needs associated with internal
migration and population mobility. This leads to the conclusion that although the FGP can resolve only health service issues and some social problems, it still has the potential to develop and strengthen social networks for improving people’s health status. As activities in the RED area have demonstrated, the strategy has the potential to improve people’s access to health care and raise awareness of the needs of the vulnerable.

In terms of socio-cultural sustainability, the ability demonstrated in both RED and some non-RED areas to establish communication networks demonstrates the potential to connect vulnerable families with the health care and social support systems. Actors in this networking include the FGP staff and district health authorities, section leaders, khoroo governors’ offices staff, NGO staff, volunteers and the families. The box below provides some ideas from this rapid assessment on how these partnership mechanisms could work.

The FGP is of course a ‘family’ group practice and not a ‘facility’ group practice, so additional community participation mechanisms will ensure that families remain the focus of the health care system and not only the facility. This involves a transition from a primary medical care to a primary health care model of operations for the FGP. This will require local mechanisms for participation in order to formalize the networks and develop procedures for resolving health problems, which the nurses in Bayanzurkh district have demonstrated must come from a range of organizational and social actors and not only from the health sector.

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**Partnership mechanisms for health service at the community level**

**What are realistic models and options for operations?**

A RED Working Group was established at the district level in Bayanzurkh to coordinate and provide oversight on the implementation of the RED strategy. Members include the district health director and health team, Social Development Department staff and Civil Registration Department staff. This multi-sector participation in the RED Working Group is the recognition by leaders of the impact of the social determinants of health on health services access and health outcomes.

Such mechanisms are in the early stage of implementation, and there is potential for replication of this model at the FGP or community level.

As the experience in Bayanzurkh demonstrates, there are many actors for health service provision. These include the FGP staff, NGO officers, khoroo governors’ office staff, section leaders, volunteers and the families. A replication of the RED working group at the community level would be quite possible, with a participation mechanism for:
• providing a forum for resolution of important public health concerns of the community
• promoting civil registration
• coordinating health and social services for new arrivals and the very poor
• discussing methods and systems for motivating section leaders and volunteers to communicate health and social problems to the relevant agency
• coordinating NGO activities.

Ideally, such a community participation model should be chaired by the khoroo or soumgovernor. Capacity-building programmes, administrative orders and the development of more refined terms of reference would be required to establish, trial and evaluate such mechanisms.

RAPID ASSESSMENT FINDINGS AND FUTURE DIRECTIONS

The first major conclusion from the rapid assessment is that the current financing and service delivery models of Mongolia’s Ministry of Health as currently implemented, although forming a strong foundation for health service access for the majority of the population, are still not working effectively for the very poor.

The second finding is that sectors of the population are falling ‘outside the system’, mainly as a result of the recent social transition that has accelerated economic inequities and high levels of internal migration.

The third major finding is that implementing the RED strategy can make a difference among the very poor’s ability to access health care and some social services. Evidence from Bayanzurkh district and some areas targeted for the RED strategy indicates that it is feasible to attract these populations back into the system to some degree through strategies of active search and community social networking.

There are three mechanisms for such active searching and community social networking:
1. More active involvement in the community by FGP staff.
2. Development of mechanisms for partnership between the health and social sectors at the district and community levels that address the overwhelming effects of the social determinants of health on health status and service access.
3. Establish, in the medium term, a health and social development fund (or some other form of innovation in health financing) at the district level to increase the
operational capacity and flexibility of managers and practitioners to respond at the community level to the linked health and social needs of the very poor.

In the medium term, there is a case for further trialling and scaling up of the RED strategy, with financial support from UNICEF and other partners for 2011. Once partnership mechanisms at the district and community levels are more clearly defined, efforts should then be made to mainstream the strategy into the health system, particularly through the identifying of funding models that are sufficiently flexible and targeted to respond in a prompt manner to the emergency health and social needs of the very poor.

Whether looking at short-, medium- or long-term responses, a common finding based on the reality of persisting health inequities is the need to reorient FGP practices from a primary medical approach to a primary health care approach.

This will require action at the policy, management and operational levels in order to provide the appropriate mechanisms and resources to ensure the best prospects for health and social participation by the very poor in the mainstream systems. Policy flexibility is a high priority, notwithstanding the need for adequate legislation and administrative mechanisms and procedures to put the appropriate policies and funding models in place. But given the rapid pace of Mongolia’s social transition, there is a shrinking window of opportunity for the health and social policy response.

RECOMMENDATIONS

Many of the respondents in the assessment (especially implementers and district planners) think that the RED strategy lacks a sustainability component, particularly in relation to financing. The following options (not mutually exclusive) were raised during consultations that should be considered by policy makers:

1. **Strengthen community and district partnerships.** There is a case for improved social networking at the community level that focuses on building cooperative strategies between FGPs, local government, section leaders and NGOs. The mechanism needs to be defined. The reinforcement of the RED Working Group at the district level (with participation from social welfare and civil registration department staff) is a step in this direction. Also proposed is a district governor’s order for the RED strategy to be put in place, which would enable a more formal coordinating mechanism between the health and social welfare sectors at the community level.
2. **Review funding models for vulnerable populations to improve social protection.** The following options should be considered:

   - Increase the per capita allocations based on new population numbers (not preferred by implementers who say that the funds will remain at the central level or be absorbed into the FGP clinic and not be allocated to the vulnerable).

   - Identify a special fund for vulnerable groups. This could be a combination of health funding and welfare funding pooled at the district level and below. Given the reality of the social determinants of health for vulnerable populations, joint social welfare and health funding should be pooled in order to strengthen partnership models at the community level (policy makers expressed some caution because various administrative and legal procedures will need to be put in place first). There is also potential for using the Human Development Fund as a pro-poor funding source for RED activities.

As a next step, respondents recommended that the Ministry of Health (and development partners) assist in scaling up the RED programme in the following ways:

3. **Scale up activities where RED planning or barrier analysis has already been undertaken.** This would include priority khoros in the districts of Bayanzurkh, Songinokhairkhan and Sukhbaatar in Ulaanbaatar and priority soums in the aimags (including Uvurkhangai aimag, which was part of this assessment).

4. **Consider the following management support strategies for coordinating the scaling up process:**

   - use the existing RED trainers from Bayanzurkh district to expand the strategy
   - finalize the RED guidelines, based on amendments in 2009 by the NCCD and recommendations from RED facilitators in 2010
   - broaden the existing RED Working Group and establish others at the district level (with participation from the civil registration and social development authorities) and pilot test more formalized partnership mechanisms at the community level
   - establish additional immunization units in popular migration areas of Ulaanbaatar to promote more outreach (active searching) to identify unimmunized and at-risk children (including strengthening of central-level monitoring for the same purpose)
• review the human resource requirements in the migration areas of Ulaanbaatar to address the widening health resource inequities.

5. **Strengthen the research capacity.** In addition to reviewing the funding models for use with vulnerable populations and developing partnership mechanisms, there is a need to capture more conclusively the demand-side factors that affect vulnerable groups’ access to health and social services (build the evidence base). Such community-based research could form the basis for advocacy with policy makers and political leaders. However, the community-based research should be balanced with higher-level policy maker surveys (including development partners) to detect, strategize and advocate the supply-side approaches for government and partners in meeting the escalating health and social needs of vulnerable populations.
ANNEXES

ANNEX 1: RED RAPID ASSESSMENT DEBRIEFING PAPER

Background and methods
The objective of the rapid assessment of the Reaching Every District (RED) strategy was to assess the impact on health service access and consider recommendations for refinement and scaling up. The strategy has the main component areas of health mapping and micro planning, community outreach, delivery of immunizations, maternal and child health services, a related social services package and strengthening of partnerships at the community level. The main implementers are family group practice (FGP) staff supported by district, city and central managers. Principal methods applied for this assessment included informant interviews, onsite visits to Bayanzurkh district (RED areas) and barrier analysis and strategy development undertaken in five FGPs in Ulaanbaatar and one rural location (non-RED areas).

Main findings
1. Increased numbers of vulnerable populations (children and families) are accessing health and social services in the RED areas (as much as five per cent of total FGP populations). Additional health services provided included immunization, antenatal care and family planning. According to FGP information, 100 per cent of the health service needs were being met for the vulnerable populations that were identified in the targeted group. Additional social services being provided included civil and FGP registration, shelter assistance, emergency nutritional support and employment. According to the FGP data, 38 per cent of the social needs had been addressed. Information on additional numbers of community members reached in the 13 khoroo (of 24) in Bayanzurkh are as follows:

- 219 additional immunized children
- 2,486 additional registered populations at FGPs clinics
- 508 additional ANC care contacts
- 1,047 additional family planning contacts
- 515 additional emergency food supply provision.

2. Targeted groups consisted of the poorest, disabled, unregistered, remote and temporary populations, children in orphanages, single mothers, child labourers
and school drop-outs. Around five per cent of the population was targeted as the most vulnerable. This does not mean that populations beyond the 5 per cent do not have unmet health needs. According to FGP staff, the 5 per cent who are the most vulnerable population live in day-to-day emergency situations. The civil registration office in Bayanzurkh reported it has received 500 new registrations per day, indicating continuing trends in population growth.

3. The principal method for detecting the needs of the vulnerable in the RED strategy was through house-to-house contact by the FGP nurses who are assigned particular areas of the khoroo for monitoring and visiting (three days per month). This was a routine follow-up programme from the initial mapping and barrier analysis. In some locations, there were reports of increased motivation of health staff linked to this closer involvement with the community. Others suggested that the strategy may not be sustainable as the communities expand further under pressures of internal migration.

4. The strategy was implemented in Bayanzurkh district at a total cost of 17 million tugrik for one year. Based on the additional people reached, the interventions were clearly cost effective (cost breakdown 24 per cent training, 15 per cent supervision and 66 per cent service delivery level).

5. According to respondents in the assessment, many of the nurses are undertaking social work – but some questioned the sustainability of this approach while others expressed high levels of satisfaction in meeting the social needs of the population and being more involved with the community.

6. There was overwhelming consensus from stakeholders that unless basic social needs of the vulnerable population are met, then health service needs cannot be met (social determinants of health). Without prompting, health staff and managers said that the health situation of the vulnerable population is socially determined, highlighting the need for close partnerships between health and social planners and service providers. There were numerous cases highlighting this finding.

7. Findings from the barrier analyses conducted in the five non-RED areas indicate high levels of social distress and isolation among the vulnerable group. There is some evidence that significant minorities of the population are not accessing the health and social services. An important conclusion from the case studies is the overwhelming impact of the social determinants of health on health status and capacity to access health services. The perception of FGP staff in non-RED areas is that the problem is escalating.
8. There are limits to FGP capacity and its role and function in relation to the social determinants of health and the expansion of the population’s health needs associated with internal migration and mobility. This leads to the conclusion that although the FGP can solve only health service issues and some social problems, the FGP has the potential to develop and strengthen social networks for health service provision. As activities in the RED areas have demonstrated, the strategy has the potential to improve health access and raise public and stakeholder awareness about the needs of the vulnerable.

9. In view of the sustainability risks of the strategy, partnership mechanisms need to be strengthened at the district level. In the assessment interviews, planners proposed involvement of social welfare and civil registration managers in the district Red Working Group. At the community level, good practice partnership models for health service (partnership mechanisms) and social development are required, building on the early experience of the RED strategy (linking efforts of FGPs, khoroo governor’s office, section leaders and NGOs).

10. There is a perception among FGP staff and district managers that the growth in health resources (human resources and financial resources) is not keeping pace with the acceleration in the numbers of urban poor. In one FGP visited, the population had doubled in the past 10 years but health personnel remained the same. This suggests health policy is lagging behind social transition. Policy flexibility and foresight will be required to prevent the potential for escalating social distress and health inequalities among the urban and rural very poor.
RECOMMENDATIONS

Sustainability strategies

Concerns were expressed by many stakeholders (especially implementers and district planners) that the RED strategy lacks sustainability, particularly in relation to financing. Options (not mutually exclusive) were raised during the consultations that policy makers should consider:

1. Strengthening community and district partnerships. There is a case for improved social networking at the community level that focuses on building cooperative strategies between FGPs, local government, section leaders and NGOs. The mechanism needs to be defined. The reinforcement of the RED Working Group at the district level (with participation from the social welfare and civil registration offices) is a step in this direction. It is also proposed that a district governor’s order for the RED strategy could put in place a more formal coordinating mechanism between the health and social welfare sectors at the community level.

2. Review funding models for vulnerable populations to improve social protection. Options:
   - Increase the per capita allocations, based on new population numbers (not preferred by implementers who say that the funds will remain at the central level or be absorbed into the FGP clinic and not be allocated to the vulnerable).
   - Identify a special fund for vulnerable groups. This could be a combination of health funding and welfare funding pooled at the district level and below. Given the reality of the social determinants of health for vulnerable populations, joint social welfare and health funding should be proposed to strengthen partnership models at the community level.

SCALING-UP STRATEGIES

Scaling up may need to proceed in a two-step manner. In the first step (short term), a project focus may need to be maintained with funding from external sources (such as GAVI and UNICEF) in order to develop partnership mechanisms and strengthen the evidence base (2010–2011 consolidation phase).

In the longer term, measures will be required to align the strategy with overall health system strengthening and financial management processes of the Ministry Health and the Ministry of Labour and Social Welfare. In this period (scale-up phase), a feasibility assessment could be undertaken to devise a means by which
such mechanisms as the Human Development Fund and results-based financing initiatives can be applied to sustain the programme. This will also allow time for piloted areas to develop good practice models for the RED strategy, particularly in terms of developing partnership mechanisms between the health and other social sectors at the district and khoroo/soum levels.

The following are suggested recommendations that the Ministry of Health and UNICEF and other development partners should consider to assist the scaling up of RED activities (or a related pro-poor strategy):

3. In terms of locations for scaling up, it is recommended that activities take place where RED planning or barrier analysis has already been conducted. This would include priority khorooos in the districts of Bayanzurkh, Songinokhairkhan and Khan-Uul in Ulaanbaatar and priority soums in the aimags where RED planning has been undertaken.

4. To coordinate the scaling up process, the following management support strategies are recommended:
   - use of existing RED trainers from Bayanzurkh to expand the strategy
   - finalize the RED guidelines, based on amendments in 2009 by the National Centre for Communicable Disease Control and recommendations from RED facilitators in 2010
   - establish a broader RED Working Group at the district Level (with participation of civil registration and social development authorities) and pilot test more formalized partnerships mechanisms at the community level
   - establish additional immunization units in high migration areas of Ulaanbaatar to promote more active searching of unimmunized and at-risk children (and increase central-level monitoring to promote this active searching)
   - review human resource requirements in high migration areas of Ulaanbaatar to address widening health resource inequalities.

5. To implement these operational strategies, policy action and resource support will be required. Areas for policy action to support these operational strategies include the following:
   - A review of funding models for vulnerable populations (see the sustainability recommendations). Results-based financing should be introduced with joint funding from the Department of Social Welfare and the Department of Health. This Special Fund for Vulnerable Populations should be managed by the district RED Working Group and dispersed to
FGPs on a performance-related basis. Potential sustainable sources of funding include the Human Development Fund. Other options include the implementing of programme-based funding models through the Ministry of Health’s financial management and budgeting systems.

- The developing of partnership mechanisms at the district and community levels between the health and other social sectors (see sustainability recommendations).
- The strengthening of research capacity to capture more conclusively (build the evidence base) the main demand-side factors affecting vulnerable groups’ access to health and social services. Such community-based research could form the basis for advocacy to policy makers and political leaders. However, such community based research should be balanced by higher-level policy maker surveys in order to detect, strategize and advocate for the main supply-side approaches of government and partners to respond to the challenge of meeting the escalating health and social needs of vulnerable populations.
ANNEX 2: INTERVIEW GUIDELINE

For interviews with informants from health services and local authorities

Date: Location:

1. What are the main barriers to access for hard-to-reach populations in this area?
   - System barriers (human resources, finance, transport and communications, management)
   - Community barriers (knowledge, attitudes, practices, socioeconomic factors)
   - Programmatic barriers (drug and vaccine supply, cold chain, IEC materials, etc.)

2. What activities are currently implemented for reaching hard-to-reach populations? (Refer to the supportive supervision checklist for detail of activities.)

3. What have been the main effects of programme implementation until now? (for RED areas)

4. What have been the main lessons learned to date, and what are the continuing gaps in service access?

5. Based on these observations, what needs to be done (recommendations) to improve access?
Endnotes

1. World Health Organization, Reaching Every District Guidelines
6. This refers to a per capita-based funding model. The system in Mongolia applies a formula that allocates 65% of available funding on the basis of risk-adjusted capitation, 20% on the basis of asset costs, 10% on the basis of variations in distance-related costs, and 5% on the basis of satisfactory attainment of quality of care targets. See Hindle, D. and Khulan, B. «New payment model for rural health services in Mongolia» in Rural and Remote Health 6 (online), 2006: 434. at: www.rrh.org.au
9. ibid.
12. MOH, Mongolia Health System Strengthening Strategy, GAVI, Ulaanbaatar, 2009 at: www.gavialliance.org/resources/Mongolia_HSS_proposal_Jun09.PDF
13. Information sourced from central level at the Ministry of Health.
17. ibid.


