WHO Country Cooperation Strategy for Mongolia

2010-2015
TABLE OF CONTENTS

EXECUTIVE SUMMARY ................................................................. 10
1. INTRODUCTION ........................................................................... 12
2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES
   AND NATIONAL RESPONSES ..................................................... 13
   2.1 Macroeconomic, political and social context ......................... 13
       2.1.1 Demographic profile ................................................. 13
       2.1.2 Socioeconomic situation ...................................... 14
       2.1.3 Political and governance structure ......................... 15
       2.1.4 Level of development and development process .......... 15
   2.2 Other major determinants of health .................................... 16
       2.2.1 Income distribution and poverty ............................ 16
       2.2.2 Socio-cultural determinants ................................. 16
       2.2.3 Environmental determinants ............................. 16
       2.2.4 Urbanization and health ................................. 16
   2.3 Health status of the population ......................................... 17
       2.3.1 Burden of communicable diseases .......................... 17
       2.3.2 Burden of noncommunicable diseases ................ 18
       2.3.3 Maternal and child health ..................................... 19
       2.3.4 Environmental health ......................................... 21
   2.4 National responses to overcoming health challenges ............ 22
    2.5 Health systems and services ........................................... 22
       2.5.1 Health service delivery ........................................ 22
       2.5.2 Health workforce .............................................. 23
       2.5.3 Health care financing ......................................... 23
       2.5.4 Drugs, pharmaceuticals, health laboratories and technologies .... 24
       2.5.5 Health information system ................................ 25
   2.6 Summary ............................................................................. 25
3. DEVELOPMENT COOPERATION AND PARTNERSHIPS:
TECHNICAL COOPERATION, AID EFFECTIVENESS AND COORDINATION...... 27

3.1 Overview of aid environment in the country................................. 27
3.2 A stakeholder analysis ......................................................... 27
3.3 Coordination and aid effectiveness in the country......................... 28
3.4 United Nations reform status and the CCA/UNDAF process............. 29
3.5 Key issues and challenges in development cooperation ............... 29

4. REVIEW OF WHO COOPERATION OVER THE LAST CCS PERIOD .......... 30
4.1 Key aspects of WHO’s contribution to the national health strategy and plans.......................... 30
4.2 Implementation of the strategic agenda of the past CCS................ 30
4.3 Logistics and infrastructure .................................................. 32
4.4 Summary of observations ..................................................... 32

5. STRATEGIC AGENDA FOR WHO COOPERATION ......................... 33
5.1 Introduction ............................................................................ 33
5.2 The Strategic Agenda ........................................................... 34

6. IMPLEMENTING THE STRATEGIC AGENDA:
IMPLICATIONS FOR WHO SECRETARIAT, FOLLOW-UP
AND USE OF CCS AT EACH LEVEL .............................................. 39
6.1 Core capacity required to take forward and implement the strategic agenda .................................. 39
6.2 Implications for the WHO Secretariat ....................................... 41
  6.2.1 WHO at country level ....................................................... 41
  6.2.2 Support from the Regional Office and Headquarters ............... 42
6.3 Implementing CCS strategic priorities with partners .................... 42
  6.3.1 CCS and UNDAF ............................................................ 42
  6.3.2 Other partners .............................................................. 42
6.4 Monitoring and evaluation ....................................................... 42

REFERENCES .............................................................................. 45

ANNEX 1 ORGANIZATIONAL STRUCTURE OF MINISTRY OF HEALTH, MONGOLIA .... 46
LIST OF TABLES, FIGURES AND BOXES

Table 1. Key economic and social indicators
Table 2. Leading causes of death and DALYs, all ages, 2004
Table 3. Number of health facilities, hospital beds and physicians by level of care
Table 4. Sources of health sector financing by percentage, 2004–2008
Table 5. Survey findings: baseline, challenges and priority actions for Mongolia
Table 6. WHO’s main focuses and core functions of the CCS for Mongolia (2010–2015)
Table 7. Current and future allocations WHO of staff in the country office
Table 8. CCS priorities and possible partnerships/collaboration with partners

Figure 1. Population pyramid 2008
Figure 2. Five leading causes of death 1998–2008
Figure 3. Trends of maternal mortality, under-five mortality and infant mortality (1998–2008)
Figure 4. Resource allocation of the WHO biennium workplans for 2006–2007 and 2008–2009

Box 1. Key health achievements/opportunities and challenges
FOREWORD

This Country Cooperation Strategy (CCS) defines the broad framework for WHO’s work with the Government of Mongolia over the period 2010–2015. It articulates a coherent vision and priorities for WHO to support the Government in promoting health and strengthening the health system to ensure universal access to essential health services by all sectors of the population, especially those living in the rural and remote areas.

WHO and the Ministry of Health of Mongolia jointly developed this CCS. The process of CCS development was based on a systematic assessment of Mongolia’s development challenges and health needs, the Government of Mongolia’s policies and expectations, and existing projects and programmes of other development partners. The process included consultation with all levels of WHO, the Ministry of Health, other relevant government organizations, United Nations agencies, multilateral and bilateral partners, and nongovernmental organizations (NGOs).

The aim of the CCS is to ensure greater responsiveness to country needs and to reflect WHO’s own mandate, core functions, global strategic objectives, values and principles, as well as regional strategies. Consequently, WHO will strive to maximize its role through increased utilization of expertise at the three levels of the Organization: country office, Regional Office and Headquarters.

It is expected that the CCS will serve as a tool to guide cooperation between WHO and the Government of Mongolia on a medium-term basis. The strategies outlined in the CCS comprise the essential elements of the national health development programme, which will contribute to the achievement of global initiatives, including the Millennium Development Goals (MDGs). It is anticipated that the implementation of this CCS will contribute significantly to improvements in health of the people of Mongolia.

Dr Shin Young-soo  
Regional Director of the  
WHO Western Pacific Region

Dr Sambuu Lambaa  
Member of the Parliament  
Minister of Health  
Mongolia
ACKNOWLEDGEMENTS

We greatly acknowledge the significant contribution of the Government of Mongolia, particularly the Ministry of Health, other government organizations, United Nations agencies, multilateral and bilateral agencies and nongovernmental organizations in the development of this Country Cooperation Strategy. We would also like to thank WHO staff at the country office, Regional Office and Headquarters for giving valuable inputs and advice.
## ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency International</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>APSED</td>
<td>Asian Pacific Strategy for Emerging Diseases</td>
</tr>
<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
</tr>
<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability adjusted life year</td>
</tr>
<tr>
<td>DOTS</td>
<td>Direct observed treatment, short-course</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
</tr>
<tr>
<td>FGP</td>
<td>Family Group Practices</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross national income</td>
</tr>
<tr>
<td>GTZ</td>
<td>German Technical Cooperation Agency</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HDR</td>
<td>Human Development Report</td>
</tr>
<tr>
<td>Hib</td>
<td>Haemophilus influenza type B</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HSSMP</td>
<td>Health Sector Strategic Master Plan</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>MCA</td>
<td>Millennium Challenge Account</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>Multidrug-resistant tuberculosis</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal mortality ratio</td>
</tr>
<tr>
<td>MNT</td>
<td>Mongolian currency (Tugriks)</td>
</tr>
<tr>
<td>MORSS</td>
<td>Minimum Operating Residence Security Standards</td>
</tr>
<tr>
<td>MOSS</td>
<td>Minimum Operating Security Standard</td>
</tr>
<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NLM</td>
<td>Norwegian Lutheran Mission</td>
</tr>
<tr>
<td>RDTC</td>
<td>Regional diagnostic and treatment center</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>STEPS</td>
<td>Stepwise approach to surveillance</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Mongolia has made steady progress in improving the health of its population in recent decades. The country is on track to meet the Millennium Development Goal (MDG) targets for maternal and child health and is experiencing a declining trend in the prevalence of communicable diseases, especially vaccine-preventable diseases.

Noncommunicable diseases such as heart disease, diabetes, stroke and cancer of the breast and cervix as well as injuries have become the leading causes of morbidity and mortality. Common risk factors associated with unhealthy lifestyle behaviours, such as smoking, alcohol use, unhealthy diet and lack of physical activity, are becoming highly prevalent and are the major causes of premature death in the productive age group.

Environmental factors such as air pollution, poor access to water and sanitation and chemical safety are of concern to the public health, especially in urban centres. Rapid migration from rural areas to urban and sub-urban areas also poses a challenge to health service delivery.

Despite government efforts to improve public health through comprehensive national health policies, strategies and plans, several key challenges still need be addressed. Some of these challenges are disparities in health between urban and rural populations, maldistribution of the health workforce, lack of coordination of stakeholders’ input into the health sector, and inadequate preparedness and response to health emergencies and disasters.

The development of this Country Cooperation Strategy (CCS) is very timely as this key strategic document will appropriately define the challenges and opportunities that exist in the health and other related sectors in Mongolia and formulate the strategic agenda for WHO support towards resolving the health problems and facilitating the national health development processes.

The CCS was developed through a consultative process with the Government, especially the Ministry of Health, and all other development partners in the health sector, including, bilateral and multilateral agencies, United Nations agencies and nongovernmental organizations. Consultative meetings, one-on-one discussions, workshops and retreats were carried out at every stage of the CCS development process.

A strategic agenda has been developed for the next six years (2010–2015) in line with the priorities identified in the Health Sector Master Plan of the Government of Mongolia and keeping in view the following:

- key health and development challenges confronting the country as analysed by WHO in full consultation with the Government, national stakeholders and partners at country level;

- contributions to health development by other development partners and challenges and gaps in health sector cooperation, recognizing the potential adverse effects of the 2008/2009 global financial crisis;
lessons from the review of WHO’s cooperation over the last CCS cycle and beyond;

WHO’s comparative advantage; and

WHO’s General Programme of Work, the strategic objectives in the Medium-term Strategic Plan and other regional and global orientations and priorities.

Five strategic priorities for WHO cooperation have been identified for the next six years:

- health systems strengthening through primary health care approach;
- scaling up prevention and control of noncommunicable diseases, injuries, violence and their determinants;
- sustaining and accelerating the achievement of health-related MDG targets;
- strengthening health security including control of communicable and vaccine-preventable diseases; and
- strengthening environmental health management.

For each of the strategic priorities, a set of “main focuses” and “strategic approaches” have been formulated. The main focuses, which clarify the role the WHO in addressing the priorities, reflect WHO’s comparative advantage, are areas where the potential for impact exists, and emphasize both the convening and policy adviser role of WHO.

The priorities cover a wide range of technical expertise that is available at WHO Headquarters, the Regional Office and the country office. WHO will work closely with the Government of Mongolia to provide technical assistance and other resources together with its partners to plan, implement and evaluate the strategic agenda.
1. INTRODUCTION

The WHO Country Cooperation Strategy (CCS) for Mongolia outlines the strategic framework for WHO’s collaboration with the Government of Mongolia and other partners from 2010 to 2015. The CCS is based on priorities identified in the National Health Sector Strategic Master Plan 2006–2015 and will bring country health priorities into WHO’s work by linking them with WHO’s Medium-term Strategic Plan (2008–2013) and the Eleventh General Programme of Work (2006–2015), which reflects the long-term vision for global health. By linking the strategic agenda of the CCS with the strategic objectives and Organization-wide Expected Results identified in Medium-term Strategic Plan, the CCS becomes the key instrument in the planning, budgeting and evaluation of the WHO-supported country programmes. The CCS will also be used as an advocacy and resource mobilization tool to address priorities identified for supporting the national health development plans and strategies.

The CCS will also be used to harmonize the work of United Nations agencies and other partners in the country for better aid effectiveness. For its part, Mongolia will be able to contribute to the global health agenda and the overarching values of the United Nations, which include human rights, equity and gender equality.

The first CCS developed in 2002 served as the basis for WHO-supported country programmes for over three biennia. Lessons learnt while formulating, implementing and evaluating programmes during the first CCS, were used to inform the current CCS. Mongolia has been facing major political, social and economic challenges due to the recent global financial crisis, food insecurity, rising fuel costs and natural disasters. With all these factors affecting the health sector, the Government has been confronted to find new ways of planning, financing and delivering effective health services to its people, especially those who live in remote and rural areas.

The development of the second CCS is very timely as this key strategic document will appropriately define the challenges and opportunities that exist in the health and other related sectors in Mongolia and formulate the strategic agenda for WHO support towards resolving the health problems and facilitating the national health development processes.

The CCS was developed through a consultative process with the Government, especially the Ministry of Health, and all other development partners in the health sector, including bilateral and multilateral agencies, United Nations agencies and nongovernmental organizations. Consultative meetings, one-on-one discussions, workshops and a retreat were carried out at every stage of the CCS development process. The ownership of the CCS remains with the Ministry of Health and the WHO country office.
2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSES

2.1 MACROECONOMIC, POLITICAL AND SOCIAL CONTEXT

2.1.1 Demographic profile

Mongolia is located in the heart of Central Asia, sandwiched between China and the Russian Federation. The total population in 2008 was estimated at 2.68 million [1], living sparsely over a territory of 1,566,500 square kilometres, making it the least densely populated country in the world with an overall population density of 1.7 per square kilometre. The sparse distribution of the population makes it challenging to deliver health care services to rural and remote areas, especially to herders who lead a nomadic lifestyle.

The population structure reveals that 28.1% are under the age of 15 years, 67.8% are between 15 and 64 years of age, and 4.1% are above 65 years, Figure 1 [1]. Mongolia’s demographic transition is characterized by declining fertility and mortality and an increasing aging population. The population growth rate decreased from 2.7% in 1990 to 1.7% in 2008. Life expectancy at birth increased from 62.8 in 1992 to 67.2 in 2008 (64.9 years to 71.0 years for women and 60.7 years to 63.7 years for men). The elderly population, however, is growing and is estimated to make up 6.3% of the total population by 2025. This may lead to high prevalence of chronic diseases and increasing demand on health and social systems.

Figure 1. Population pyramid 2008
Over the last decade, an increasing trend in rural to urban migration has been observed as people seek better living standards, employment opportunities, children’s education and health care in cities. As a result, in 2008, about 60% of the total population were living in five major urban cities, with 50% living in the capital city (Ulaanbaatar) alone. The rural population, the majority of which leads a traditional nomadic lifestyle, declined from 42.8% in 2000 to 38.2% in 2008. Urban migration has imposed great socioeconomic and health challenges on the Government, mainly due to the floating nature of the migrant population, which remains largely unregistered.

2.1.2 Socioeconomic situation

Mongolia has experienced positive economic growth since 2004, following a transition from negative GDP growth in the early 1990s. Mining and agricultural remain the major sources of economic growth. As a consequence of the global financial crisis of 2009, Mongolia’s economic growth has slowed down, with devaluation of Mongolian currency by almost 40%. Inflation and rising prices for basic food items, essential commodities and health care, including drugs and supplies, has had a negative impact on the health of the population.

Mongolia’s per capita GDP reached US$ 998 in 2005, placing it among lower- and middle-income countries [2]. Table 1 shows socioeconomic indicators from 2005 to 2008.

Table 1. Key economic and social indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Fiscal year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
</tr>
<tr>
<td>Income and growth [2]</td>
<td></td>
</tr>
<tr>
<td>GDP growth (% in constant prices)</td>
<td>7.3</td>
</tr>
<tr>
<td>GDP per capita in US$ [2]</td>
<td>801</td>
</tr>
<tr>
<td>GNI per capita in US$</td>
<td>829</td>
</tr>
<tr>
<td>Demographic indicators</td>
<td></td>
</tr>
<tr>
<td>Total population (million)</td>
<td>2.24</td>
</tr>
<tr>
<td>Annual growth rate (% change)</td>
<td>1.6</td>
</tr>
<tr>
<td>Health outcome indicators [3]</td>
<td></td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>2.8</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100 000 live births)</td>
<td>93.0</td>
</tr>
<tr>
<td>Infant mortality rate (below 1 year/1000 live births)</td>
<td>44.4</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>63.8</td>
</tr>
<tr>
<td>- Female</td>
<td>65.4</td>
</tr>
<tr>
<td>- Male</td>
<td>62.1</td>
</tr>
<tr>
<td>Primary school gross enrolment rate (%)</td>
<td>91.4</td>
</tr>
<tr>
<td>Secondary school gross enrolment rate (%)</td>
<td>55.4</td>
</tr>
</tbody>
</table>
### Child malnutrition (% below age 5)
- Underweight  6.3
- Stunting  21.0
- Wasting  2.2

### Population with access to safe water (%) [4]
- Underweight  52.0
- Stunting  52.0
- Wasting  54.5

### Population with access to sanitation (%) [4]
- Underweight  4.6
- Stunting  8.1
- Wasting  7.9

### Public education expenditure (% of GDP)
- Underweight  4.6
- Stunting  8.1
- Wasting  7.9

### Human Development Index [2]
- Underweight  0.727
- Stunting  0.727

### Poverty indicators
- Poverty headcount
  - Urban  36.1
  - Rural  43.4
- Poverty gap  11.0
- Poverty severity  4.7
- Gini coefficient  0.33

Source: UN Common Country Assessment (CCA 2008)
Note: GDP per capita and GNI per capita were estimated based on the World Bank atlas method.

#### 2.1.3 Political and governance structure

Mongolia is still in the midst of political transition to democracy. Administratively, Mongolia is divided into 21 aimags (provinces), which are further subdivided into soums (rural districts) and baghs (villages or communities). Ulaanbaatar, the capital city, is divided into nine districts, which are further subdivided into khorooos (sub-districts). The Minister of Health is responsible for all public health functions and oversees the management of all tertiary and secondary hospitals. The aimag and soum governors are responsible for the administration of primary hospitals and public health functions at aimag and soum level.

#### 2.1.4 Level of development and development process

The Human Development Index (HDI) looks beyond GDP to a broader definition of well-being. The HDI provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and gross enrolment in education) and having a decent standard of living (measured by purchasing power parity in US dollars). Between 2000 and 2007, Mongolia’s HDI rose by 1.02% annually from 0.676 to 0.727, which gives the country a rank of 114th out of 182 countries with data [2].
2.2 OTHER MAJOR DETERMINANTS OF HEALTH

2.2.1 Income distribution and poverty

Despite the positive trends in economic growth, thousands of Mongolians lead highly insecure lives. There have been growing disparities between rural and urban areas, and between residents of gers (traditional Mongolian tents) and other type of housing (e.g. apartments) within urban areas. Effective public provisioning in rural areas is hampered by long distances, scattered populations and nomadic lifestyles.

2.2.2 Socio-cultural determinants

Childhood nutrition remains as a challenge to be addressed. The Multiple Indicator Cluster Survey (MICS 2006) revealed that the levels of underweight, stunting and wasting have decreased significantly. However, other surveys have shown that the decline in stunting was only 5% and that it remains the most prevalent form of malnutrition in Mongolia, affecting one in five children under the age of five. Anaemia among pregnant mothers and children is also a common problem together with vitamin A and D deficiencies [5].

2.2.3 Environmental determinants

Mongolia is prone to natural disasters such as earthquakes, flooding and dzud (extremely cold weather). Mongolia has severe climatic conditions, with long, cold winters and short, hot summers. During the last 70 years, the average annual temperature has increased by 2.14°C and is projected to increase up to 5°C by the end of the 21st century. Surface water inventory conducted in 2007 revealed that 852 rivers and streams out of a total of 5128 have dried up. In addition, intensive warming will result in accelerated desertification. Currently, 78.2% of Mongolia has been affected by medium or high rates of desertification.

2.2.4 Urbanization and health

Increased socioeconomic development in Mongolia has led to rapid urbanization, transforming the lives of people gathering in the capital city and big provincial centres. With urbanization comes major changes in population migration, types of work, transportation, and urban lifestyle. Migration from rural areas to big cities has resulted in peri-urban expanded congestion in slum areas (or so-called ‘ger districts’), unemployment, unmet need of safe water supply, poor sanitation and limited access to health services. Increased pollution from congested road traffic is commonly observed almost every day, together with a rise in traffic injuries. Consumption of alcohol and tobacco is increasing. In addition, people are becoming physically inactive, are increasingly adopting unhealthy diets and are consuming more salt with the availability of processed foods.
2.3 HEALTH STATUS OF THE POPULATION

2.3.1 Burden of communicable diseases

Overall, communicable diseases have decreased over the years, though they still account for a high proportion of overall disability-adjusted life years (DALYs) and are of significant socioeconomic importance due to their potential for causing outbreaks and health emergencies.

Vaccine-preventable diseases

Mongolia eradicated polio in 2000 and its polio-free status has been sustained since then. The immunization programme has also successfully controlled diphtheria, pertussis and neonatal tetanus. Localized outbreaks of measles still occur. The country introduced hepatitis B vaccine for infants in 1992, resulting in reduction of chronic hepatitis B infection among children. However, viral hepatitis continues to be a major public health issue as vaccination does not affect the existing carriers. Expanding the scale and scope of hepatitis B vaccination must be urgently addressed. Hib vaccine was introduced in 2005 and has resulted in a substantial decline in Hib meningitis. In 2009, trivalent measles-mumps-rubella vaccine was introduced into the routine Expanded Programme on Immunization (EPI) schedule. Though the national coverage is more than 96%, there are still areas and population groups with low coverage such as remote and rural areas and the mobile and unregistered population in urban areas. Some of the most cost-effective vaccines against pneumonia and diarrhoeal diseases, the main killers of Mongolian children, are still not included in EPI. Ensuring adequate regulation and legislation to guarantee vaccine quality remains as a challenge.

Tuberculosis and HIV/AIDS and STI

Mongolia has the seventh highest burden of tuberculosis (TB) in the Western Pacific Region, with an estimated TB prevalence of 234 per 100 000 and TB mortality rate of 29 per 100 000 [6]. Though both prevalence and mortality are declining, it will still be a challenge to reach the MDG target (indicator 23). Moreover, 74% of notified TB cases are among poor people living below the poverty line. The quality of DOTS, access to diagnosis and treatment, multidrug-resistant TB and persistent stigma continue to be areas of concern.

Though the prevalence of HIV/AIDS is less than 0.02%, the number of registered cases has been increasing in the recent years. The main mode of transmission among the reported cases has been unprotected sex between men and unprotected commercial sex [7]. Increasing rates of other STI such as syphilis, gonorrhoea and chlamydia may potentially fuel the spread of HIV/AIDS. A survey in 2008 indicated that 25.5% of pregnant women had at least one STI. Prevalence of syphilis among female sex workers is 17.0% and for men having sex with men is 5.0% in the latest second generation sentinel surveillance (2009). Human papillomavirus was found in 35% of working women in Ulaanbaatar [8].

Emerging and re-emerging infectious diseases

Mongolia’s large herder population has a greater chance of contracting zoonotic diseases as the livestock population was 43 million in 2009. Several anthrax and plague cases have been
recorded every year. In addition, Mongolia is one of the highest prevalence countries of Brucellosis in the world [9]. Highly pathogenic avian influenza (H5N1) was first recognized in late 2005 and subsequently identified in 2008 and 2009 among wild birds. Cases of pandemic influenza (H1N1) 2009 were first identified in Mongolia in early October 2009 and quickly spread to the rest of the country. As of April 2010, a total of 1384 confirmed cases and 30 deaths have been reported [10].

2.3.2 Burden of noncommunicable diseases

Mongolia is experiencing an epidemiological and demographic transition, with declines in morbidity and mortality from communicable diseases and an increase in burden due to chronic and noncommunicable diseases, as reflected in the five leading causes of mortality. Based on the report of the Mongolia’s Department of Health, diseases of the circulatory system, neoplasm and injury, poisoning and other consequences of external causes together accounted for 73.3% of all deaths (Figure 2).

Figure 2. Five leading causes of death, 1998–2008 [3]

According to WHO estimates, cerebrovascular disease, liver cancer, ischaemic heart disease, and road traffic accidents are the main causes of death and accounted for nearly one third of total deaths in 2004 [11] (Table 2). The major contributors to DALYs in Mongolia are perinatal conditions, cerebrovascular disease and road traffic accidents.
Injuries and poisonings are among the major causes of death and disability in younger age groups. The rate of injury and poisoning in the 16–19 year age group is 2.3 times the rate in the total population.

Table 2. Leading causes of death and DALYs, all ages, 2004

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease or Injury</th>
<th>% Total Deaths</th>
<th>DALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cerebrovascular disease</td>
<td>14.0</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Liver cancer</td>
<td>8.6</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>Ischaemic heart disease</td>
<td>6.4</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>Road traffic accidents</td>
<td>5.4</td>
<td>29</td>
</tr>
<tr>
<td>5</td>
<td>Perinatal conditions</td>
<td>4.3</td>
<td>35</td>
</tr>
<tr>
<td>6</td>
<td>Lower respiratory infections</td>
<td>3.8</td>
<td>23</td>
</tr>
<tr>
<td>7</td>
<td>Stomach cancer</td>
<td>3.8</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Hypertensive heart disease</td>
<td>3.8</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Diarrhoeal diseases</td>
<td>3.2</td>
<td>21</td>
</tr>
<tr>
<td>10</td>
<td>TB</td>
<td>3.2</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Diseases and Injury Country Estimates, Department of Measurement and Health Information, WHO, 2009

According to preliminary data from the 2009 Mongolian STEPS survey on the prevalence of noncommunicable disease (NCD) risk factors, the overall prevalence of current smokers was 27.5 %, 62.7% of the surveyed population had high blood pressure and 58.5% had consumed alcohol in the past 12 months. The proportion of people who consumed fewer than five servings of vegetables and fruits was 93.2%. The proportion of people who were overweight and obese was 53.6%, and the proportion with raised levels of cholesterol was 40.5%. Around 70% of Mongolians drink salted tea and the average daily intake of salt (15.1 grams) is more than two times the salt intake recommended by WHO (6 grams) [12].

Liver cancer stands out as one of the most common causes of mortality and morbidity that require special attention. Hepatitis B and C viruses are the most important causes of chronic liver disease and hepatocellular carcinoma in the country [13]. The high intake of alcohol accelerates the course of chronic liver disease from these two viruses, leading to the development of chronic hepatitis and liver cancer at a much younger age than seen in other countries.

2.3.3 Maternal and child health

The Government of Mongolia has placed a high priority on achieving Millennium Development Goal 5. Some of the major achievements in maternal and child health are associated with high coverage of antenatal care (87.7%) and delivery by skilled birth attendance (99.8%). However, providing maternal services to mobile and migrant populations is a challenge.
Strong political commitment and support from several international and national partners led to a steady decline in the maternal mortality ratio (MMR) over the last two decades, as shown in Figure 3. The MMR was 49 per 100 000 live births in 2008 [3].

Figure 3. Trends of maternal mortality, under-five mortality and infant mortality (1998–2008)

There is a wide variation in MMR between urban and rural areas. In some remote aimags, especially in the western part of the country, the MMR is as high as 213 to 365 per 100 000 live births. This is four to six times the MMR in the capital city of Ulaanbaatar. One unfavourable trend has been the increasing birth rate among adolescents in the last five years. The percentage of total births occurring among adolescents in 2008 varied from 26.3% in the rural areas of the south, to 18.3% in provincial centres, and to 5.3% in Ulaanbaatar [14].

The MDG targets for the under-five mortality rate (29.2 per 1000 live births) and infant mortality rate (22.0 per 1000 live births) were attained in 2006 (Figure 2). However, a reverse trend has been observed for both MMR and the under-five mortality rate in the last two years, largely due to the current financial crisis and pandemic influenza.

Common diseases and conditions that affect children, including diarrhoea, respiratory infections, malnutrition and measles, have been greatly reduced due to cost-effective interventions such as routine immunization against targeted diseases, introduction of the Integrated Management of Childhood Illness (IMCI) strategy nationwide, and improvements to infant and child nutrition, including breastfeeding and micronutrient supplementation, e.g. vitamin A and D. Maintaining and further reducing child mortality will depend on improvements to neonatal health, as almost 65.3% of all infant deaths take place in the first 28 days of life, with 70% of these occurring in first week of life [3]. The main causes of infant deaths are asphyxia, sepsis and congenital defects.
2.3.4 ENVIRONMENTAL HEALTH

Access to safe water and sanitation

It is estimated that, in 2006, 54.5% of the population had access to a safe water source and 43.1% had access to improved sanitation facilities. There is a large urban-rural disparity in access to water and sanitation in Mongolia. As per MDG 7 and Target 16, coverage is expected to increase up to 60% for improved water sources and to 40% for improved sanitation services, respectively, by 2015 [4]. The 2005 WHO and Ministry of Health survey showed that only 25% of soum schools and hospitals had access to improved water and sanitation [15]. Inconsistencies exist between national and global reporting of Mongolia’s data on provision of safe water and sanitation. The WHO/UNICEF Joint Monitoring Programme definitions have not been fully applied into the national statistical monitoring mechanisms.

Unsafe water and hygiene practices are the main causes of infectious diseases such as viral hepatitis A, typhoid fever, dysentery and diarrhoea. Provision of safe water and sanitation among the community and especially in schools and health facilities remains a major challenge to be addressed.

Health care waste management

Currently, the health care waste handling practices at health facilities are inadequate and pose a high risk for health care workers, the community and the environment. In Mongolia, 90.9% of health facilities practise low-temperature combustion of health care waste, which is environmentally unsafe [16]. Studies have shown high rates of sharps injuries and prevalence of hepatitis B and C among health care workers [17]. The challenge is to build appropriate infrastructure for the collection, transportation, treatment and disposal of health care waste and to strengthen capacity in health care waste management.

Food safety and air quality

Significant incidents of foodborne illness and food contamination have occurred in Mongolia over the past few years. These include large-scale outbreaks of foodborne illness and ongoing concerns and issues regarding microbiological and chemical contamination of food.

Ulaanbaatar’s population increased by 41% between 1989 and 2002 and the city is now home to half of Mongolia’s total population [1]. The city’s major air pollution sources include three coal-fuelled combined heat and power plants, approximately 400 heat-only boilers, over 13 000 home-heating stoves, and wind-blown dust. In addition to copious pollution emissions, Ulaanbaatar’s topography makes the city particularly susceptible to high air pollution concentrations.

Pollutants such as dust, carbon monoxide and sulfur dioxide can cause child respiratory diseases, especially acute and chronic bronchitis, pneumonia and cardiovascular disorders. The number of
children suffering from bronchitis is 5–15 times higher in Ulaanbaatar than in rural areas. Studies also revealed the negative impact of air pollution on the physical growth and development of children [18, 19] and non-specific immunity of children [20]. Recent studies on environmental lead exposure showed air and soil contamination, increased blood lead levels in children, and signs of decline in memory and attention capacity in children [21].

2.4 NATIONAL RESPONSES TO OVERCOMING HEALTH CHALLENGES

The State Public Health Policy, approved by the Parliament in 2001, described Mongolia’s policy direction for the next 15 years. The Health Sector Strategic Master Plan (HSSMP), approved in 2005, is a long-term policy framework for 2006–2015. The overall outcomes to be achieved by 2015 include: increased life expectancy; reductions in the infant, child and maternal mortality rates; improved nutritional status, particularly micronutrient status among children and women; improved access to safe drinking water and basic sanitation; prevention of HIV/AIDS; sustainable population growth; reduced household health expenditure, especially among the poor; a more effective, efficient and decentralized health system; and an increase in the number of client-centred and user-friendly health facilities and institutions [22].

The Government is highly committed to achieving the health-related MDGs. In 2005, Mongolia endorsed the International Health Regulations, or IHR (2005), and the Asia Pacific Strategy for Emerging Diseases (APSED), which has been used to build core capacity for surveillance and response including pandemic influenza. A beyond-APSED strategy (2010–2015) is being developed to continue to consolidate the activities earlier and expand the scope to cover other areas such as food safety and clinical management.

2.5 HEALTH SYSTEMS AND SERVICES

2.5.1 Health service delivery

Health services delivery is organized under three levels based on the administrative structure of the government at national, aimag and soum levels (Table 3). Mongolia’s health system is based traditionally on the Russian model of placing greater emphasis on hospital and clinical care rather than on preventive and promotive care. As of 2008, there were 68 hospital beds per 10 000 population in Mongolia. A number of general tertiary hospitals and specialized institutions such as the National Center for Communicable Diseases, National Center for Mental Health, and National Center for Cancer are operational at the central level in Ulaanbaatar. Primary health care services are provided mostly by soum health care workers at soum hospitals, bagh feldshers at bagh clinics and practitioners at family group practices in urban family clinics in the capital and aimag cities. Six districts in the capital city also provide primary and secondary health services.
Private sector involvement in the provision of health care services is growing. Private hospitals, outpatient clinics, traditional medicine hospitals and clinics, and laboratories are being established. Challenges remain in regulating the quality and costs of their services.

Table 3. Number of health facilities, hospital beds and physicians by level of care

<table>
<thead>
<tr>
<th>Type of health facilities</th>
<th>Number</th>
<th>Hospital beds</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care organizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family group practices (FGPs)</td>
<td>228</td>
<td>--</td>
<td>794</td>
</tr>
<tr>
<td>Soum, inter-soum and rural hospitals</td>
<td>327</td>
<td>3949</td>
<td>655</td>
</tr>
<tr>
<td>Secondary health care organizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aimag general hospitals</td>
<td>17</td>
<td>3670</td>
<td>1017</td>
</tr>
<tr>
<td>District general hospitals</td>
<td>9</td>
<td>NA</td>
<td>720</td>
</tr>
<tr>
<td>Maternity homes in Ulaanbaatar</td>
<td>3</td>
<td>NA</td>
<td>93</td>
</tr>
<tr>
<td>Tertiary health care organizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional diagnostic and treatment centers</td>
<td>4</td>
<td>789</td>
<td>207</td>
</tr>
<tr>
<td>(RDTCs) (in Dornod, Uvurkhangai, Orkhon and Khovd aimags)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical hospitals and national specialized centres</td>
<td>15</td>
<td>3983</td>
<td>1232</td>
</tr>
</tbody>
</table>

Source: Health Indicators 2008. Ministry of Health, National Center for Health Development, Mongolia. NA, not available

2.5.2 Health workforce

In 2008, there were 18.8 physicians per 10 000 population in rural areas, while there were 43.4 physicians per 10 000 population in the capital city of Ulaanbaatar. A shortage of physicians and other health workers such as nurses, midwives and feldshers at the primary health care level undermines the universal access to quality health services, especially to those in greatest need. Moreover, training of human resources is not linked to policies and planning in the health sector. The training of doctors is focused mostly on curative care rather than prevention and health promotion. There is insufficient skill mix and inequitable workforce distribution.

2.5.3 Health care financing

Health expenditure as a share of GDP has dropped from 4.9% in 2001 to 3.2% in 2008; however, according to data from the National Statistical Office of Mongolia, per capita health expenditure has increased from 33.2 thousand MNT (US$ 23.00) to 80.0 thousand MNT (US$ 55.40) between 2005 and 2008 in real terms.

A predominant share of the health expenditure is assigned to secondary and tertiary care, leaving only 32.15% to primary health care. In 2002, only 4.7% of the total health expenditure was
spent on prevention and public health services, and 77% of the total expenditure on public health was mobilized through international loans and grant aid.

A review of the health sector budget for the period 2000–2008 revealed the main contributors to be the Government (79.0%) and the Health Insurance Fund (18.0 %), followed by revenues from fees for services and supplementary activities (3.0%). The percentage of health financing from the Government budget increased from 2006 to 2008, while the percentage from the Health Insurance Fund and from revenues from fees for services and other supplementary activities decreased (Table 4).

Health insurance coverage (introduced in 1994) reached 78.3% of the population in 2007, an increase from 74.4% in the previous year. However, about 20% of the population, especially migrants and herder populations, are still not covered by social health insurance. As of 2008, around 81.7% of health insurance fund expenditure was on inpatient care, 14.3% on outpatient care, and the remaining 4.0 % on discounted drugs, sanatoriums and other costs.

Table 4. Sources of health sector financing by percentage, 2004–2008

<table>
<thead>
<tr>
<th>Source of financing</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>State budget (%)</td>
<td>71</td>
<td>69</td>
<td>73</td>
<td>77</td>
<td>79</td>
</tr>
<tr>
<td>Health insurance fund (%)</td>
<td>24</td>
<td>26</td>
<td>23</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Other (%)</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>


2.5.4 Drugs, pharmaceuticals, health laboratories and technologies

The pharmaceutical sector is currently facing several challenges, including uncontrolled sale of drugs, poor quality of drugs, increasing flow of counterfeit drugs from neighbouring countries, insufficient regulatory measures, weak enforcement and quality control, and drug shortages in rural areas. The 2003 household survey revealed that spending on pharmaceuticals represented over 60% of households’ out-of-pocket spending, with this share being larger in areas with smaller total spending for health [23].

Traditional medicine is widely used as an alternative form of therapy for many health conditions and has strong support from the government. Integration of traditional medicine into the national essential drug policy is an option which the Ministry of Health is considering. Safety, quality and rational use of traditional medicines are issues that need consideration.

The commercialization of health services is evident at many health facilities where high technology equipment has been purchased through external funding or provided by donors. Without additional funding for maintenance or operational costs, there is no way to repair equipment when it breaks down. The private sector has become increasingly involved in procurement
and distribution of drugs, medical supplies and equipment in the health sector. Lack of proper regulation on public–private partnership in health has compromised the quality and safety of such initiatives.

Public health laboratories designed to support health service delivery, especially in rural areas, need strengthening. Large numbers of public and private laboratories in urban centres lack networking, referencing and quality control. The Government is making efforts to bridge the gap between public and private initiatives in the health sector through changes in legislation in financing, coordination and improving the quality of health services.

2.5.5 Health information system

A centralized health statistics information system in charge of collection, transfer, processing and feedback of data and information on population health status, health services quality, accessibility, health institutions, resources and capacity is in place throughout the country. Death registration, cause specific mortality collection, disease registries, STEPS surveys have been also conducted. The electronic record system started in 1987, with the Ministry of Health, Health Department-implementation agency of the Government of Mongolia, City and Aimag Health Departments, aimag/district general hospitals, specialized centers and hospitals being computerized from 1997 to 2000. Routine health reporting software is used throughout the country, which had been tailored for the Mongolia’s specific needs. A national strategic plan or e-health in the health sector has been developed with full participation of all stakeholders and approved. National health information system is still facing a challenge of fragmented data collection system, provision of high quality data including sub-population groups, and improved utilization of collected data.

2.6 SUMMARY

In conclusion, much progress has been observed in the areas of health development in Mongolia. However, with underlying socioeconomic and geographic patterns as well as the significant level of major determinants of health in the country, many constraints and challenges have been identified. Box 1 summarizes the key achievements/opportunities and challenges in the health sector.
Box 1. Key health achievements/opportunities and challenges

### Achievements/opportunities

- MDG targets (4 and 5) for maternal and child mortality reduction on track
- High immunization coverage
- Declining trend in communicable diseases
- Noncommunicable diseases and human resources development set as priorities of the Ministry of Health
- Increased resource mobilization for priority areas
- Health sector master plan in place

### Challenges

- Disparities in health and weakness in primary health care
- Suboptimal quality and maldistribution of human resources
- Inadequate investment for health sector
- High burden of noncommunicable diseases and injuries
- Sustaining achievement of MDGs 4, 5 and 6
- Inadequate health sector preparedness and response for health security
- Persistently high prevalence of some communicable diseases, e.g. STI, viral hepatitis, TB, pneumonia
- Environmental degradation, poor coverage of potable water, sanitation
- Weakness in aid coordination mechanisms
3. DEVELOPMENT COOPERATION AND PARTNERSHIPS: TECHNICAL COOPERATION, AID EFFECTIVENESS AND COORDINATION

3.1 OVERVIEW OF AID ENVIRONMENT IN THE COUNTRY

Mongolia was among the most aid-dependent countries in the world with US$ 2.5 billion of foreign aid received during the period 1991–2002. However, due to strong economic performance in last five years and nearly doubling of GDP, driven primarily by mining gains, Mongolia has reduced its dependency on aid.

3.2 A STAKEHOLDER ANALYSIS

United Nations agencies including WHO have been active in Mongolia for many years and maintain a generally high level of involvement in health sector programmes. WHO, as the main United Nations agency involved in the health sector, has been supporting the Government of Mongolia since 1962. The United Nations Development Programme (UNDP) has been contributing to the achievement of the national MDGs through capacity-building, knowledge-sharing, forging partnerships, and policy dialogue. The United Nations Children’s Fund (UNICEF) has been focusing mainly on health, nutrition, child survival and growth, maternal health and newborn care, water and sanitation, behaviour change communication, and HIV/AIDS. The country programme of the United Nations Population Fund (UNFPA) has a reproductive health (RH) component. The UNAIDS Regional Support Team for Asia and the Pacific has been supporting the areas of capacity development, implementation and monitoring of the national HIV/AIDS strategy, including strengthening human rights-based and gender-responsive policies and approaches to reduce stigma and discrimination.

The Asian Development Bank has supported improvements in infrastructure and service delivery in Mongolia. The World Bank, which focuses mainly on the poverty reduction programme, has not provided direct support to the health sector until very recently. The World Bank is currently supporting an avian influenza and human pandemic influenza preparedness and response project and a water supply project that targets the urban poor. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has approved grants for HIV/AIDS, TB and health sector strengthening focusing on public health laboratories.

Japan’s country assistance program for Mongolia has been supporting the National Immunization programme and the procurement of medical equipment. Support from the German Technical Cooperation Agency (GTZ) to reduce infectious diseases, to lower morbidity and mortality
from STI/HIV, and to improve maternal and child health. The Millennium Challenge Account for Mongolia, a United States Government grant, has been supporting the noncommunicable diseases (NCD) programmes.

World Vision, an international NGO, has been implementing various health-related projects since 1995 in Mongolia with a view to improve maternal and child health, nutrition, TB, HIV/STI prevention, health education, drinking-water supply and food security in selected project sites. Other NGOs, including faith-based organizations such as Norwegian Lutheran Mission (NLM), International Red Cross Society, Mongolian Red Cross Society, Médecins du Monde, Action Contra la Faim and Adventist Development and Relief Agency International (ADRA) also support specific health projects and programmes.

### 3.3 COORDINATION AND AID EFFECTIVENESS IN THE COUNTRY

Mongolia has endorsed the Paris Declaration on Aid Effectiveness. In 2006, the Organisation for Economic Co-operation and Development, through its Working Party on Aid Effectiveness conducted a baseline survey on monitoring the Paris Declaration among 34 self-selected countries. The survey also set targets for Mongolia to reach by 2010 according to the 12 indicators [23]. Table 5 presents the main findings on Mongolia.

#### Table 5. Survey findings: baseline, challenges and priority actions for Mongolia

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>BASELINE</th>
<th>CHALLENGES</th>
<th>PRIORITY ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>Low</td>
<td>Relationship between planning and budgeting remains weak.</td>
<td>Complete the national development strategy.</td>
</tr>
<tr>
<td>Alignment</td>
<td>Moderate</td>
<td>Little aid is recorded in the national budget.</td>
<td>Improve recording of aid in the budget.</td>
</tr>
<tr>
<td>Harmonization</td>
<td>Low</td>
<td>Minimal proportions of donor missions are coordinated.</td>
<td>Encourage harmonization.</td>
</tr>
<tr>
<td>Managing for results</td>
<td>Moderate</td>
<td>Public access to information, especially on poverty data, is limited.</td>
<td>Build a country-level monitoring and evaluation system.</td>
</tr>
<tr>
<td>Mutual accountability</td>
<td>Low</td>
<td>A single platform for mutual reviews of progress is lacking.</td>
<td>Establish a mechanism for joint assessment of progress in implementing commitments on aid effectiveness.</td>
</tr>
</tbody>
</table>


As shown in Table 5, the principles of the Paris Declaration are being implemented in Mongolia, but there room for improvement in all five principles, especially ownership, harmonization and mutual accountability. The lack of harmonization among partners can partly be attributed to the absence of an effective donor coordination mechanism in Mongolia. WHO has an opportunity to take the lead in supporting the health sector in donor coordination as well as coordination of external resources for effectiveness and harmonization of international aid.
The Division of International Cooperation of the Ministry of Health has formal responsibility for the coordination of international support for health. Most projects are managed by project teams and project implementation units and are overseen by steering committees that have common members in order to facilitate collaboration and coordination between projects. Several high-level committees, such as the National AIDS Committee and the Inter-Sectoral Coordinating Committee for Health Sector Human Resources, have been established to coordinate stakeholders’ activities at the national level.

### 3.4 UNITED NATIONS REFORM STATUS AND THE CCA/UNDAF PROCESS

The United Nations system in Mongolia has been operating within the United Nations Development Assistance Framework (UNDAF), focusing specifically on the Millennium Development Goals. The current UNDAF (2007–2011) describes the joint United Nations response to the national development priorities of Mongolia.

Although envisaged as cross-cutting, the current UNDAF does not place prominence on health. Instead, it briefly mentions health in outcome 1: “Pro-poor good quality socioeconomic services available to vulnerable population in disadvantaged regions and areas”. The focus of this outcome is on improving health, including reproductive health and nutritional status, especially of women and children, and providing access to safe water and sanitation services for vulnerable and at-risk groups (24). The current UNDAF will expire in 2011. The United Nations country team is in the process of undertaking a Common Country Assessment (CCA), which will be followed by the development of a new UNDAF (2012–2016). The priorities identified in the subsequent section of this CCS should contribute to shaping the health dimension of the new UNDAF.

Agencies in the United Nations system coordinate their work through the Resident Coordinator system, through various theme groups or task forces. In Mongolia, WHO is currently chairing the HIV/AIDS thematic group and is an active member of the maternal and reproductive health task force and of the thematic working groups for water and sanitation, MDG monitoring and evaluation and gender.

The role of WHO as the specialized agency in health is well recognized within the United Nations country team. Agencies with health-related programmes, particularly UNICEF and UNFPA, work closely with WHO, seeking technical advice and actively engaging in partnerships on health-related programmes.

### 3.5 KEY ISSUES AND CHALLENGES IN DEVELOPMENT COOPERATION

While the HSSMS has the strategic objective to establish an effective sector-wide management system based on sector-wide approaches, including enhancing coordination with partners and stakeholders, this has not been fully realized thus far. Health development partners have expressed the need for an effective and efficient use of external resources. Two of the critical areas pointed out by stakeholders were better aid coordination and more effective aid alignment for the attainment of the country-specific MDGs. Improvement of aid effectiveness is one of the most challenging issues in Mongolia.
4. REVIEW OF WHO COOPERATION OVER THE LAST CCS CYCLE

4.1 KEY ASPECTS OF WHO’S CONTRIBUTION TO THE NATIONAL HEALTH STRATEGY AND PLANS

WHO’s collaboration with the Government of Mongolia, starting in 1962 (although with full-time WHO Representative since 1971), has been focused mainly on policy advice, technical support for developing and strengthening health policy and systems, developing norms and technical guidelines for service delivery and priority health interventions, promoting and strengthening health research, building national and institutional capacity through human resources development, and providing technical support for environmental health and public health and humanitarian emergencies. Throughout the years, WHO has maintained a good working relationship with the Government, especially the Ministry of Health, and has remained a valuable technical resource and privileged partner of the Government of Mongolia, especially to respond to changing health needs and priorities of the country, and thereby contributing to improve the health status of the population. WHO has been a key partner in the health sector, working collaboratively with other United Nations agencies, bilateral and multilateral development partners, and international NGOs.

WHO in Mongolia has been credited for its technical expertise in wide areas of public health, knowledge management, information sharing and networking as well as resource mobilization for the health sector.

4.2 IMPLEMENTATION OF THE STRATEGIC AGENDA OF THE PAST CCS

The Country Cooperation Strategy for 2002–2007 focused on six priorities:

- Priority 1. Policy analysis and institutional strengthening in the health sector: Working with ministries and agencies across the health sector to achieve better alignment of policies and capabilities for health; assessment of how policies are developed, implemented and evaluated and how policy decisions are communicated and compliance obtained; ensuring that health sector staff have appropriate technical knowledge and management skills.

- Priority 2. Facilitation of donor coordination: Assisting the establishment of a comprehensive information system on donor support to facilitate Ministry of Health decisions on priorities for donor contributions, monitoring and accountability, effectiveness assessment, promoting synergies and avoiding duplication.

- Priority 3. Controlling communicable and noncommunicable diseases: Providing technical support for communicable and noncommunicable diseases.
Priority 4. Environment and healthy lifestyles: Working with the Ministry of Health and other ministries in the field of “healthy settings” to influence policy development and service delivery, especially for rural water and sanitation, medical waste and monitoring of air pollution.

Priority 5. Health Information and evidence for policy: Improving health information in the context of decentralization to support resource allocation, analysis of service quality, workforce planning and policy analysis; making better use of existing data and integrating data collection and analysis in routine planning, management and monitoring.

Priority 6. Emergency preparedness and response: Providing support together with other agencies to alleviate the effects of emergency situations such as recent dzud disasters and possible earthquakes.

While many of the elements in the strategic agenda were reflected in the country programme budgets over the last two bienniums, CCS was used in guiding planning and resource allocation across the Secretariat. “Controlling communicable and noncommunicable disease control” (priority 3) received more than 50% of the budget during the last two bienniums (Figure 3), followed by “Policy analysis and institutional strengthening in the health sector” (priority 1), “Environment and healthy lifestyles” (priority 4) and “Emergency preparedness and response” (priority 6). “Facilitation of donor coordination” (priority 3), while identified as one of the six priorities, did not have explicit resources during the last two bienniums. It is assumed that one of the key roles of the WHO Representative and his team is to support the Government for effective coordination of external resources and partners for making aid effective for the health sector. However, putting such a mechanism in place and sustaining it would require resources for both WHO and the Ministry of Health, especially to make the donor coordination more effective.

Figure 3. Resource allocation of the WHO biennium workplans for 2006–2007 and 2008–2009
4.3 LOGISTICS AND INFRASTRUCTURE

The WHO country office is located in the Ministry of Health building. The physical proximity has greatly facilitated collaboration. However, the Ministry of Health building has limited space. According to the standard space requirements of the United Nations, the WHO country office has shortage of almost 180 square metres. There is an apparent shortage of space for archives, storage room, canteen, toilets and office vehicle parking. Adequate and environmentally friendly office space will also be needed. Regardless, over the last two bienniums, with budgetary support from the WHO country office and the Regional Office, compliance with the Minimum Operating Security Standards (MOSS) and Minimum Operating Residence Security Standards (MORSS) was achieved.

4.4 SUMMARY OF OBSERVATIONS

It was observed that the expansion of the WHO country office has been based on resource availability rather than the demand and expectations of the perceived needs of WHO in the country and partners. The capacity of the country office has not been reviewed in recent years to assess the competency and skill mix required to effectively respond to these expectations. Unpredictability of resources, especially voluntary contributions, coming to the country office (sometimes very late at the end of the biennium) further compromises the country office’s capacity to effectively respond to the country needs and priorities.
5. STRATEGIC AGENDA FOR WHO COOPERATION

5.1 INTRODUCTION

A strategic agenda has been developed for the next six years (2010–2015) in line with the priorities identified in the Health Sector Strategic Master Plan of the Government of Mongolia and keeping in view:

- key health and development challenges confronting the country as analysed by WHO in full consultation with the Government, national stakeholders and partners at country level;
- contributions to health development by other development partners and challenges and gaps in health sector cooperation, recognizing the potential adverse effects of the 2008/2009 severe global financial crisis;
- lessons from the review of WHO’s cooperation over the last CCS cycle and beyond;
- WHO’s comparative advantage; and
- WHO’s General Programme of Work, the strategic objectives in the Medium-term Strategic Plan and other regional and global orientations and priorities.

Five strategic priorities for WHO cooperation have been identified for the next six years:

- health systems strengthening through the primary health care approach;
- scaling up prevention and control of noncommunicable diseases, injuries, violence and their determinants;
- sustaining and accelerating the achievement of health-related MDG targets;
- strengthening health security including control of communicable and vaccine-preventable diseases; and
- strengthening environmental health management.

For each of the strategic priorities, a set of “main focuses” and “strategic approaches” have been formulated. The main focuses, which clarify the role the of WHO in addressing the priorities, reflect WHO’s comparative advantage, are areas where the potential for impact exists, and emphasize both the convening and policy adviser role of WHO (rather than confining its contribution to supporting the implementation of routine public health activities in the country).

The strategic approaches reflect the way WHO will adopt in undertaking the actions identified under the “main focus” and are based on WHO’s core functions. Given the cross-cutting nature and inter-relationship among strategic approaches, a strategic approach under one main focus may have a positive impact on other main focuses and priorities.
5.2 THE STRATEGIC AGENDA

Strategic priority 1: Health systems strengthening through primary health care approach

- Main focus 1.1: Supporting health sector reform to ensure universal access of quality services and address disparities
  - Strategic approach 1.1.1: Support the development of primary health care policy, and strengthen systems for capacity-building, quality assurance, universal access and reducing disparity.
  - Strategic approach 1.1.2: Support the development of viable human resource development policies for production, capacity-building and management of health workforce to ensure good-quality primary health services including a focus on licensing, performance standards, rational income, distribution, quality, ethics and incentive mechanism, and strengthening of high-level committee functions.
  - Strategic approach 1.1.3: Support the development of a viable health care financing policy, and provide support to enhance and sustain the National Health Account.
  - Strategic approach 1.1.4: Provide support to establish mechanisms for health systems research in the areas of policy analysis, health economics, priority interventions and capacity-building.

- Main focus 1.2: Strengthening the performance of the health care system
  - Strategic approach 1.2.1: Support the development/upgrading and implementation of policies on essential medicines, traditional medicines, public health laboratories, and technology and equipment for improving quality, safety and rational use.
  - Strategic approach 1.2.2: Support health information systems including e-health, e-medical record, integrated surveillance systems, community-level information, service availability mapping, telemedicine, and knowledge management and dissemination.
  - Strategic approach 1.2.3: Support safe blood supply and transfusion services, patient safety and quality assurance.
Main focus 1.3: Promoting coordination and partnership for health

~ Strategic approach 1.3.1: Provide support to further strengthen partnerships and mechanisms for aid coordination.

Strategic priority 2: Scaling up prevention and control of noncommunicable diseases (NCD), injuries, violence and their determinants

Main focus 2.1: Supporting NCD, injury and violence surveillance

~ Strategic approach 2.1.1: Provide support to strengthen surveillance and disease registries for noncommunicable diseases, injury and violence.

Main focus 2.2: Supporting NCD and injury prevention policies

~ Strategic approach 2.2.1: Support the development of evidence-based guidance for NCD and health promotion services in health and other sectors.

~ Strategic approach 2.2.2: Support the development of human resources in health and other sectors for NCD prevention and health promotion.

Main focus 2.3: Integrated prevention and control of risk factors through enabling environments

~ Strategic approach 2.3.1: Support the development and implementation of policies and strategies for the prevention and control of tobacco and alcohol abuse, unhealthy diets and physical inactivity.

~ Strategic approach 2.3.2: Promote healthy cities and healthy settings approaches for risk factor reduction.

Main focus 2.4: Comprehensive approaches for management and rehabilitation of people with noncommunicable diseases, injuries and violence

~ Strategic approach 2.4.1: Provide support for policies and guidelines for early diagnosis, management, and rehabilitation of major noncommunicable diseases, injuries and violence.

~ Strategic approach 2.4.2: Support institutional capacity-building for early diagnosis, management, and rehabilitation of major noncommunicable, injuries and violence.

~ Strategic approach 2.4.3: Support programmes on mental health and interventions on alcohol and substance abuse.
Strategic priority 3: Sustaining and accelerating the achievement of health-related MDG targets

- Main focus 3.1: Strengthening public health approach to reduce disparity in maternal, newborn, child and adolescent health
  - Strategic approach 3.1.1: Provide support to expand coverage and access to and improve quality of priority maternal, child health interventions, particularly in most needed areas.

- Main focus 3.2: Strengthening the continuum of care
  - Strategic approach 3.2.1: Support the integrated delivery of services on pregnancy, child birth, postpartum and neonatal care, Integrated Management of Childhood Illness (IMCI), Expanded Programme on Immunization (EPI) and nutrition.
  - Strategic approach 3.2.2: Support the integration of RH, HIV and STI services and the adoption of a one-stop approach for elimination of congenital syphilis and mother-to-child transmission of HIV and hepatitis.

- Main focus 3.3: Reducing neonatal mortality
  - Strategic approach 3.3.1: Support interventions and capacity-building to reduce neonatal mortality.

- Main focus 3.4: Supporting the prevention and control of tuberculosis, HIV/AIDS and STI
  - Strategic approach 3.4.1: Provide support to improve quality and access to directly observed treatment, short-course (DOTS), to improve management of multidrug-resistant tuberculosis (MDR-TB) and to overcome the social stigma against tuberculosis.
  - Strategic approach 3.4.2: Provide support to accelerate the health sector response to HIV/STI prevention, care, treatment and strategic information.

Strategic priority 4: Strengthening health security including control of communicable and vaccine-preventable diseases

- Main focus 4.1: Strengthening surveillance and response capacity to communicable diseases
  - Strategic approach 4.1.1: Support the strengthening of the surveillance and
outbreak response system as required by International Health Regulations (2005).

~ Strategic approach 4.1.2: Support the development of national policies in line with international best practices on communicable disease surveillance, outbreak response, prevention and care.

~ Strategic approach 4.1.3: Support the development of health care infection control policies and programmes.

~ Strategic approach 4.1.4: Promote collaboration between human and animal health sectors and strengthen capacity in controlling zoonotic diseases.

• Main focus 4.2: Strengthening capacities for regulation and monitoring of food safety

~ Strategic approach 4.2.1: Support the strengthening of food safety management and National Codex Team.

~ Strategic approach 4.2.2: Support to strengthen foodborne disease prevention and surveillance system including the integration activities under the International Food Safety Authorities Network and the Early Warning and Response System to epidemic-prone diseases.

~ Strategic approach 4.2.3: Support standard setting and monitoring for food fortification.

• Main focus 4.3: Emergency and disaster preparedness and response

~ Strategic approach 4.3.1: Support the development and implementation of the national strategy for health emergency preparedness and response.

~ Strategic approach 4.3.2: Support capacity-building for improved risk communication.

• Main focus 4.4: Sustaining and accelerating control of vaccine-preventable diseases

~ Strategic approach 4.4.1: Support the effective control, elimination and eradication of vaccine preventable diseases.

~ Strategic approach 4.4.2: Provide support to evaluate and introduce new vaccines and technologies for potential inclusion in the programme.
Strategic priority 5: Strengthening environmental health programmes

- Main focus 5.1: Mitigating the health impacts of climate change.
  - Strategic approach 5.1.1: Support the development and implementation of national climate change and health strategies, policies and plans.
  - Strategic approach 5.1.2: Support capacity-building of health and related sectors to mitigate the effects of climate change on health.

- Main focus 5.2: Strengthening programmes to improve provision of safe water and adequate sanitation
  - Strategic approach 5.2.1: Support the expansion of provision of safe water and sanitation in health care facilities.
  - Strategic approach 5.2.2: Support the development and implementation of policies on water quality and sanitation, and promote community-based activities.

- Main focus 5.3: Supporting the implementation of the national environmental health programme
  - Strategic approach 5.3.1: Provide support to strengthen environmental hazard management and health impact assessment.
  - Strategic approach 5.3.2: Provide support to strengthen management of health care waste, chemical safety and occupational health.
6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO SECRETARIAT, FOLLOW-UP AND USE OF CCS AT EACH LEVEL

6.1 CORE CAPACITY REQUIRED TO TAKE FORWARD AND IMPLEMENT THE STRATEGIC AGENDA

The core functions of WHO are:

- providing leadership on matters critical to health and engaging in partnership where joint action is needed;
- shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge;
- setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy actions;
- providing technical support, catalysing change and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

Among the six core functions above, the main functions required for taking forward and implementing the strategic agenda are: (1) setting norms and standards, and promoting and monitoring their implementation; (2) providing leadership on matters critical to health and engaging and partnership where joint action is needed; and (3) providing technical support, catalysing change and building institutional capacities. Table 6 compares the main focus of the CCS for Mongolia with the core functions of WHO.
Table 6. WHO’s main focuses and core functions of the CCS for Mongolia (2010–2015)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supporting health sector reform to ensure universal access of quality services and address disparities</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2. Strengthening the performance of the health care system</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>3. Promoting coordination and partnerships for health</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>4. Supporting NCD, injury and violence surveillance</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>5. Supporting NCD and injury prevention policies</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>6. Integrated prevention and control of risk factors through enabling environments</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>7. Comprehensive approaches for management and rehabilitation of people with noncommunicable diseases, injuries and violence</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>8. Strengthening the public health approach to reduce disparity in maternal, newborn, child and adolescent health</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>9. Strengthening the continuum of care</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>10. Reducing neonatal mortality</td>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>11. Supporting the prevention and control tuberculosis, HIV/AIDS and STI</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>12. Strengthening the surveillance and response capacity to communicable diseases</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>13. Strengthening capacities for regulation and monitoring of food safety</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>14. Emergency and disaster preparedness and response</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>15. Sustaining and accelerating control of vaccine-preventable diseases</td>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>16. Mitigating health impacts of climate change</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>17. Strengthening programmes to improve provision of safe water and adequate sanitation</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>18. Supporting the implementation of the national environmental health programme</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Remark: the ‘+’ sign represents the correlation between the main focuses and the core functions, from less relevant (+) to most relevant (+++)
6. 2 IMPLICATIONS FOR WHO SECRETARIAT

The proposed shift in programmatic focus set out above has clear implications for the mix of professional staff required in the country office, and for the support needed from the Regional Office and Headquarters.

6.2.1 WHO at country level

Over the years, technical cooperation between WHO and the Government of Mongolia has been expanding both in terms of financial resources and technical programmes. Simultaneously, there has been an increase in the number of partners (multilateral and bilateral agencies, development banks and international NGOs) working in the health sector. Their expectations of WHO providing high-quality and upstream policy advice and donor coordination are increasing.

However, the number of international staff and support staff in the WHO country office has not increased commensurate with the increasing expectations. That being said, over the last two bienniums, four national professional officers have been recruited to manage increased technical needs. Currently, the country office has three teams under the WHO Representative: (1) health systems, including health promotion and maternal and child health, led by a public health specialist; (2) communicable diseases, including emergency and outbreak response, led by an epidemiologist; and (3) administration and management, led by the WHO Representative (Table 7).

<table>
<thead>
<tr>
<th>Strategic priorities</th>
<th>Current level</th>
<th>Future level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. FTE</td>
<td>%</td>
</tr>
<tr>
<td>Health systems strengthening through primary health care approach</td>
<td>0.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Scaling up prevention and control of noncommunicable diseases, injuries, violence and their determinants</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Sustaining and accelerating the achievement of health-related MDG targets</td>
<td>1.5</td>
<td>10.7</td>
</tr>
<tr>
<td>Strengthening health security including control of communicable and vaccine-preventable diseases</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Strengthening environmental health management</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Administration and support staff</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Total country office staff</td>
<td>14</td>
<td>21</td>
</tr>
</tbody>
</table>

FTE, full-time equivalent

A thorough review of the country office’s capacity in terms of staff (both professional and support), budget, logistics and office requirements would be useful for making WHO’s support to the Government of Mongolia more effective during the implementation period of CCS. A
competency review of the staff’s capacity to deliver the strategic priorities would be helpful. Capacity in the areas of health financing, public health laboratory and environmental health assessment also needs to be assessed. Additional programme support staff such as secretaries, a translator and an IT assistant will be necessary.

6.2.2 Support from the Regional Office and Headquarters

The strategic priorities in the CCS cover a wide range of technical expertise available at WHO Headquarters and the Regional Office. These areas include health systems strengthening, noncommunicable diseases and injuries, maternal and child health, communicable diseases including HIV/AIDS and TB, health emergencies and environmental health. Close working relations between the country office and relevant technical units at Headquarters and the Regional Office will add value to the work of WHO in the country and minimize the need for external technical assistance.

6.3 IMPLEMENTING CCS STRATEGIC PRIORITIES WITH PARTNERS

6.3.1 CCS and UNDAF

The United Nations country team is revising the current CCA, which will be the basis for the next UNDAF. The CCS priorities will be fully reflected in the CCA and UNDAF, thus enabling greater collaboration among United Nations agencies on planning and implementing priority programmes of common interest such as on health-related MDGs, improving aid effectiveness, climate change and health, water sanitation and HIV/AIDS. This will also enable a common monitoring, evaluation and reporting mechanism.

6.3.2 Other partners

There are many development partners supporting health programmes in Mongolia. Collaboration between WHO and other key players has been considered an essential strategy to strengthen programme activities, promote effectiveness and efficiency of the work and avoid duplication or utilization of resources. Table 8 proposes possible collaboration between WHO and international partners in the five areas of CCS priorities.

6.4 MONITORING AND EVALUATION

The strategic agenda of the CCS will be the basis for developing the three biennial workplans (covering the period 2010–2015) for WHO’s collaborative programmes in Mongolia. These workplans will be validated against the CCS agenda.

The WHO results-based strategic planning framework will provide a transparent mechanism for regular monitoring and evaluating of the workplans and CCS agenda as well.
A CCS review will be undertaken near the midpoint or at the end of CCS cycle to assess WHO’s contribution to the national health sector plan through implementation of the CCS strategic agenda. At the end of each biennium, WHO country office staff and national counterparts in the Ministry of Health will closely review, discuss and evaluate the achievements made in implementing the strategic agenda and main focus areas of the Country Cooperation Strategy. The findings and lessons from this review will be used as an input into the next CCS strategic agenda.
Table 8. CCS priorities and possible partnerships/collaboration with partners

<table>
<thead>
<tr>
<th>WHO CCS priorities</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WHO HQ</td>
</tr>
<tr>
<td>1. Health systems strengthening through</td>
<td>+</td>
</tr>
<tr>
<td>2. Scaling up prevention and control of noncommunicable diseases, Injuries, violence and their determinants</td>
<td>+</td>
</tr>
<tr>
<td>3. Sustaining and accelerating the achievement of health-related MDG targets</td>
<td>+</td>
</tr>
<tr>
<td>4. Strengthening health security including control of communicable and vaccine-preventable diseases</td>
<td>+</td>
</tr>
<tr>
<td>5. Strengthening environmental health programmes</td>
<td>+</td>
</tr>
</tbody>
</table>

REFERENCES

ANNEX 1

ORGANIZATIONAL STRUCTURE OF MINISTRY OF HEALTH, MONGOLIA

Minister of Health

Vice Minister

State Secretary

Health Minister’s Council

Administration Council

Department of Public Administration and Management

Department of Strategic Policy Planning

Department of Public Health Care Policy Implementation and Coordination

Department of Medical Care Policy Implementation and Coordination

Department of Finance and Investment

Department of Information, Monitoring and Evaluation

Division of Pharmaceuticals and medical Devices

Division of International Cooperation

Minister’s Secretariat

Service team