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Abbreviations

ADB  Asian Development Bank
ADRA  Adventist Development & Relief Agency
AHD  Aimag Health Department
ALOS  Average length of Stay
CBOs  Community Based organisations
CHD  City Health Department
CIDA  Canadian International Development Agency
CP  Community Participation
CVD  Cardiovascular Diseases
DA  Drug Act
DANIDA  Danish International Development Agency
DiD  Department for International Development (UK)
DIME  Division of Information, Monitoring and Evaluation
DoH  Department of Health (city)
ECPS  Essential and Complementary Package of Services
EGSPRS  Economic Growth Support and Poverty Reduction Strategies
FGPs  Family Group Practices
GDP  Gross Domestic Product
GoM  Government of Mongolia
GTZ  German Technical Co-operation Agency
HIF  Health Insurance Fund
HIL  Health Insurance Law
HSDP  Health Sector Development Programme
HSMP  Health Sector Strategic Master Plan
HSUM  Health Sciences University of Mongolia
IC  Inter-sectoral Collaboration
ICD  International Classification of Diseases
IF  Implementation Framework
IMF  International Monetary Fund
JICA  Japan International Cooperation Agency
JICWELS  Japan International Corporation of Welfare Services
KOICA  Korea International Cooperation Agency
MCHRC  Maternal and Child Health Research Centre
MDGs  Millennium Development Goals
MEI  Mongolemimpex
MEF  Monitoring & Evaluation Framework
MNS  Mongolian National Standards
MNT  Mongolian Tugrigs
MoD  Ministry of Defence
MoFA  Ministry of Foreign Affairs
MoF  Ministry of Finance
MoH  Ministry of Health
MoInf  Ministry of Infrastructure
MoJustice  Ministry of Justice and Internal Affairs
MoLSW  Ministry of Labour and Social Welfare
MoScience  Ministry of Science, Education and Culture
MTEF  Medium Term Expenditure Framework
NIMR  National Institute for Medical Research
NCHD  National Centre for Health Development
NCDC  National Centre for Communicable Diseases
NCPCS  National Committee for Physical Culture and Sports
NGOs  Non-Governmental Organisations
NSO  National Statistics Office
ODA  Official Development Assistance
OECD  Organisation for Economic Cooperation and Development
PBF  Planning & Budgeting Framework
PHC  Primary Health Care
PHP  Public Health Policy
PHI  Public Health Institute
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>PIU</td>
<td>Project Implementation Unit</td>
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<tr>
<td>PSFML</td>
<td>Public Sector Financial and Management Law</td>
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<tr>
<td>RDT</td>
<td>Regional Diagnostic and Treatment Centre</td>
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<tr>
<td>SCF</td>
<td>Save the Children Fund</td>
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<tr>
<td>SIA</td>
<td>State Inspection Agency</td>
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<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<td>SP</td>
<td>Synthesis Paper</td>
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<td>SPC</td>
<td>State Property Committee</td>
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<td>SSIGO</td>
<td>State Social Insurance General Office</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TACIS</td>
<td>Technical Assistance for Commonwealth of Independent States</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UB</td>
<td>Ulaanbaatar</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>URI</td>
<td>Upper Respiratory Tract Infections</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>UTI</td>
<td>Urinary Tract Infections</td>
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<tr>
<td>VSO</td>
<td>Volunteer Services Organisation</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WPRO</td>
<td>Western Pacific Regional Office</td>
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Foreword

There has been an increasing need to improve the integration and coordination of policies, projects and programs in the health sector and to change health services to meet client needs, in relation with reforms and changes in all spheres of political, social and economical life over the last couple of years.

I am very pleased to present the Health sector Strategic Master Plan, a comprehensive document identifying direction and actions for the short, medium and long term development of the health sector during 2006-2015, initiated by the Ministry of Health, developed through the financial support of the JICWELS and approved by the Government. The Master plan comprises 7 key areas and 24 strategies.

The three companion documents, comprising the resource envelope, planning, budgeting, monitoring and evaluation tools required to implement this plan also come with this plan.

The Health sector Strategic Master Plan serves as a reference document describing the concept of policy reform in improving the health for all the people of Mongolia till 2015, and is aimed to change the paradigm of the health services.

A functional analysis of the current situation in the health sector, numerous capacity building meetings and an extensive consultative process were carried out with the participation from all levels of the health sector and partner organisations during the development of the Master Plan in order to address in a comprehensive way the issues facing the health sector, resulting in the creation of a unified understanding among the health sector community.

The Health sector Strategic Master Plan will serve as an important tool to facilitate the delivery of socially responsive, equitable, accessible and quality services to all the people of Mongolia, the rational implementation of technical developments, the inculcation of higher responsibility in health professionals and workers and the eradication of the outdated ethics and old ways of thinking.

The implementation of the Health sector Strategic Master Plan will depend on the participation and cooperation of government and non-government organisations, various UN development agencies, other international partners and civil society. Being the core document to implement health policy, it is designed to help the organisation to develop and integrate health related policies and conduct activities along with its supporting partners to minimise risks and choose the right directions for productive and effective cooperation, investment and utilisation of resources. The creative thinking, knowledge and skills of all health workers are important factors critical for the implementation and achieve the outcomes of the Master Plan, and therefore I call for a creative and innovative approach.

I would like to publicly express deep appreciation to health workers from all levels, international partners, other sectors, organisations, to all who contributed to the development of the Master Plan and particularly to Japan International Cooperation of Welfare Services’ Long-term Advisor Dr. Indermohan Narula and to the members of the HSMP Core Group.

Good wishes for all kind deeds.

T.Gandhi, PhD
Minister of Health,
Member of Parliament
Acknowledgements

The Health sector Master Plan is the strategic document critical for the development of the sector, which was developed ensuring participation from all levels and employing a wide consultative process and a capacity building approach.

First of all the Ministry is grateful to the many health professionals and staff members from all levels, members of the Key Area of Work and Companion Document Working Groups, participants of national and regional consultative meetings who, in spite of their busy schedules and heavy workload, actively participated and took ownership of the drafting of the strategic plan and its companion documents.

I would also like to express my deep appreciation to the members of the Health Sector Strategic Master Plan Coordinating Committee for the sectoral outlook, their leadership and guidance, and for their professional and technical support during the development of the plan. The Ministry of Health is also very pleased with the outstanding and hard work of the Core Group and the JICWELS Long-term Advisory Team who took the primary responsibility for managing the complex process of developing the plan through the day to day management ensuring continuity and timeliness.

The active and consistent support of Embassy of Japan, WHO, WB, ADB, UNICEF, UNFPA, GTZ and particularly JICWELS and other partners for the implementation of the Road Map is also gratefully acknowledged.

In conclusion I would like to highlight the constructive thoughts, ideas and bold sense of direction demonstrated by all participants that inspired us all to take major strides to develop the sector employing a sectoral orientation to improve the health status of people of Mongolia, especially that of the poor and socially disadvantaged.

Ts Sodnompil, PhD, State Secretary
Chair, Health Sector Coordinating Committee,
Ministry of Health, Ulaanbaatar, Mongolia
In order to achieve the objectives reflected in the Government plan of actions to reform the health sector system, to establish health services corresponding to the new economic relations, the Government of Mongolia has resolved:

1. To endorse the “Health Sector Strategic Master Plan”.

2. To authorize the Minister of Health (T. Gandhi) to organize the implementation of the “Health sector strategic master plan”; to reflect the resources needed for the implementation of the plan in the key annual economic and social development directions and the centralized state budget subsequently; to finance the “Health sector strategic master plan” through the involvement of international, domestic organizations and the private sector resources.
Executive Summary

The commitment to contribute to poverty alleviation and socio-economic development by ensuring the delivery of quality health care that is equitable, user friendly evidence based and sector-wide, to improve the health status of all the people of Mongolia through efficient targeting and management of resources, especially to the poor and to areas in greatest need is the Mission of the Ministry of Health of Mongolia.

The ministry has listed 17 policy elements outlining future directions for the next 10 years to achieve this mission. These elements have also guided the development of this Strategic Master Plan.

The policy elements state that all people in Mongolia of whatever gender, age, place of residence or ability to pay, should have equitable access to affordable, good quality, essential and specialised health services, staffed by competent health professionals. They should have information that empowers them to make informed choices about matters affecting their and their families’ health and well being.

Infant and child mortality rates are still high despite their having decreased over recent years and the maternal mortality ratio remains unacceptably high. Around a quarter of all children are malnourished particularly Vitamin D, iodine and iron micronutrient deficiency in children under 5. Micronutrient deficiencies are also common in adolescents, would be mothers and pregnant and lactating women. The burden of communicable disease, especially STIs and tuberculosis is still heavy. At the same time, non-communicable diseases, especially CVDs, cancers and injuries, especially injuries in younger children are emerging as major public health issues.

Critical success factors have been identified. They include increasing acceptance of a preventive basis for health care service delivery at the policy and senior management level in the Ministry of Health and health institutions; an officially approved Essential and Complementary Package of Services (ECPS) widely accepted as a basis for delivering essential and complementary health services; increased awareness of quality improvement; steadily increasing allocation of the state budget to the health sector; development of long-term sector wide strategic plan using a consultative and capacity building process; appropriate technical and financial support from partners and political commitment by the government and the MoH to the MDG and the EGSPRS.

Overall, the Health Sector Strategic Master Plan:

- Serves primarily as a comprehensive technical long-term planning document that can be implemented by any government whatever its ideology or political mandate
- Takes a predominantly primary health care and health promotion approach
- Highlights pro-poor interventions
- Shows that the strategies and outcomes are interlinked with the policies, priority issues and targets in each key area of work.
- Reflects the need to think creatively if we are going to be even more successful in the future.
- Takes an incremental and gradual approach to change.
- Recognises that health financing policies combined with non-financing measures are needed to address financial and resource allocation challenges.
- Is not prescriptive. It allows for flexibility at different levels of the health system.
- Recognises that improving the health status of the people of Mongolia depends not only on actions within the health sector, but also on actions taken by other sectors.

To achieve its mission and policies, Ministry of Health has adopted 24 strategies, of which some will be entry point strategies, in 7 key areas of work. While all the strategies are important there are some entry point strategies and these strategies are highlighted. These strategies are intended to be the focus for action by the Ministry and all health sector partners over the next 10 years. The strategies are:

**Key Area of Work: Health service delivery**

1. Further increase coverage, access and utilisation of health services sector-wide especially for the mothers and children, the poor and other vulnerable groups
2. Strengthen the delivery of quality primary and general care through soum health facilities and FGPBs based upon essential part of the ECPS

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1 The criteria for choosing these entry point strategies were urgency, cost-effectiveness and feasibility capacity.
3. Strengthen the delivery of quality specialized, advanced and emergency care in secondary and tertiary health facilities based upon the complementary part of the ECPS using an effective referral system

Key Area of Work: Pharmaceutical and Support Services

4. Ensure continuous and equitable sector-wide access to essential drugs and bio-preparation
5. Establish a unified drug, bio-preparation, food and cosmetics quality assurance system
6. Ensure rational drug and bio-preparation use
7. Strengthen the capacity of diagnostic services through establishing a system to supply and regularly maintain medical equipment.
8. Ensure routine infrastructure and facility maintenance, transport services and communication sector-wide

Key Area of Work: Behavioural change and Communication

9. Further develop and integrate Behavioural Change & Communication/IEC activities sector wide to change the behaviour promoting healthy lifestyles, subsequently decreasing the incidence of most common communicable and non-communicable diseases.
10. Build a health promoting client friendly service
11. Create a health promoting environment through improved community participation and inter-sectoral collaboration

Key Area of Work: Quality of Care

12. Continually improve the quality of care sector-wide
13. Further develop standards, guidelines and indicators for health care services

Key Area of Work: Human resource development

15. Reform the pre, post and in-service training system for health professions and health related workers.
16. Further develop the incentives and motivation scheme including the social security for all health workers in the sector

Key Area of Work: Health financing

17. Ensure regular and increasing flow of funds to the health sector
18. Strengthen financial management system to improve the efficient and effective use of health sector financial and related resources
19. Strengthen the health insurance system (HIF)

Key Area of Work: Institutional development and Management

20. Strengthen and integrate on-going health sector reform using a Sector Wide Approach (SWAp)
21. Implement effective sector wide decentralization
22. Enhance risk management capacity to respond to natural disasters and emerging public health problems

23. Develop a unified health management information system
24. Establish an optimal public and private mix of health care services

Overall outcomes to be achieved by 2015 include increased life expectancy; reduced infant mortality rate; reduced child mortality rate; reduced maternal mortality ratio; 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; more effective, efficient and decentralized health system and increased number of client-centred and user-friendly health facilities and institutions.

Implementing the strategic plan is the critical next step. It will involve all stakeholders – the government, all levels of the Ministry of Health, other sectors, all international partners, clients, civic groups and the private sector providers. An Implementation Framework using a SWAp, supported by sector wide management will ensure effective and efficient implementation.

Strong human and financial resource planning and management, as well as thorough monitoring and evaluation to measure results will be required. It will require tools that have been developed to be used at all levels to enable this process. These tools would include a revised planning manual to facilitate better operational planning, budgeting and implementation and would be based on the three frameworks namely financial resourcing, monitoring and evaluation and annual operational plan development. Client feedback mechanisms will have to be built and institutionalised to ensure that the pro-poor and client-centred focus is realised.
Implementation responsibility for the seven areas of work has been assigned to lead departments and implementing units of the MoH (See Annex B). This will be reinforced using a SWAp. Key to successful implementation is the increased financial investment by the Government of Mongolia and its international partners along with the critical success factors mentioned earlier.

Risks to successful implementation have also been recognised. They include poor macroeconomic growth reducing government allocation to health sector; frequent staff turnover related to general elections and changes in government, continuity and institutional memory in the sector; major institutional, regulatory and technical constraints facing the restructuring, rationalization, and privatisation of the health sector; resistance to change within the Ministry of Health, its staff especially at the more central levels and in the overall government; natural disasters and emerging public health issues; increasing prevalence of STIs and related potential for increase in HIV/AIDS; no project or programme on basic sanitation and hygiene in the past; poor provider attitudes; ad hoc human and financial resource management; reduced support from international partners as a result of changes in their policies or in response to adverse political changes; salaries of the health workforce not rising sufficiently; lack of a quality culture and not enough attention to health promotion and changing health and health seeking behaviour.

This Strategic Master Plan is volume 1 of four volumes. Volume 2 is the Medium Term Expenditure Framework. Volume 3 is the sector-wide Monitoring and Evaluation Framework. Volume 4 serves as the Planning and Budgeting Framework. These volumes will be supplemented by an Implementation Framework to be used by each cost centre and implementing facility. In addition, a short booklet will summarise the Strategic Master Plan. The booklet and all the volumes are available in both Mongolian and English.
Core Values, Principles and Policy Elements

Mission

The Mission of the Ministry of Health is the commitment to contribute to poverty alleviation and socio-economic development by ensuring the delivery of quality health care that is equitable, user friendly evidence based and sector-wide, to improve the health status of all the people of Mongolia through efficient targeting and management of resources, especially to the poor and to areas in greatest need.

Values

- Right to health and well-being
- Equity
- Pro-poor\(^2\)
- Client Centred
- Gender Sensitive

Working Principles

- Focus on rural and peri-urban areas
- Listening to what people want
- More focus on health of poor and vulnerable groups
- High quality evidence based interventions and services
- Capacity building including human resource development
- Sector-wide approach
- Good governance and accountability
- Affordability and sustainability
- A primary health care approach
- A government regulated market oriented health sector

\(^2\) This concept describes the resource allocation and management processes that will guarantee that the poor and very poor are not prevented from accessing the required quality care thus ensuring vertical equity.
Policy Statement

This policy statement is derived from the National Public Health Policy, the health and related laws, the Constitution and various other documents of the Ministry of Health.

The following are the 17 main policy elements that provide the basis for this strategic master plan. The 24 strategies in the strategic master plan flow from these elements.

Policy Elements

1. Implement sector wide management through a common mission and effective partnerships among all stakeholders based on a Sector Wide Approach (SWAp)
2. Provision of essential health services to the people of Mongolia with emphasis on the elderly, adolescents and vulnerable groups such as the poor, with the full participation of the community and other stakeholders
3. Provision of affordable complementary and specialised health services through an appropriate public private mix
4. Drug policy and its management focusing on essential drug availability and rational use
5. Decentralization of planning, monitoring, evaluation, financial and administrative functions within the health sector
6. Priority emphasis on prevention and control of prevalent communicable and selected non-communicable diseases, on injury and public health crises.
7. Priority emphasis on provision of good quality care to mother and child especially through Safe Motherhood, Integrated Management of Childhood Illnesses (IMCI) and nutrition
8. Active promotion of healthy lifestyles and health-seeking behaviour among the population through integrated and effective IEC and health promotion.
9. Active promotion of a safe and healthy environment through the establishment of healthy settings and habitat including provision of adequate potable water and sanitation and effective domestic and industrial waste management.
10. Emphasis on quality, effective and efficient provision of health services by all health providers
11. Optimisation of human resources through appropriate planning, management including deployment and capacity development within the health sector
12. Promote the partnership between the state and private sectors for effective and efficient care through promoting coordination, regulation and competition.
13. Effective use of the evidence-based health information for planning, implementation, monitoring and evaluation in the health sector using a unified health information system
14. Implement health financing systems that includes the separation of purchasing of health services from its provision, the elimination of fragmented funding and the monitoring of the performance based payment systems.
15. Normative allocation of resources across the levels of care in accordance with the health needs of the population
16. Further development of appropriate and harmonized health legislation to protect the health and rights of providers and clients.
17. Establish and implement a system that will ensure the identification, introduction and maintenance of appropriate and essential health technology.

3 Main Directions for the Development of the Health Sector and Improving Population Health until 2005, 4th Congress of Medical Professionals, MoH Mongolia, 1990
Chapter 1: Context

This chapter describes the context for the development of the Health Sector Strategic Master Plan in terms of the Millennium Development Goals, the Government of Mongolia’s Economic Growth Support and Poverty Reduction Strategy, its Enhancement of Economic Growth and Poverty Reduction Programme and the Development Framework for the country. It also briefly presents the legal and policy context for the health sector by summarizing the basic laws and core policies that govern and guide operations and activities in the sector. The chapter also, succinctly, portrays the socio-economic environment to provide a background for describing the main external challenges faced by the health sector.

Millennium Development Goals

Commitment to the Millennium Development Goals

In Box 1a are the Global 2001 Millennium Development Goals and Targets for the health sector.

Box 1a. Global Millennium Development Goals and Targets to be achieved by 2015

- Halve, by 2015, the proportion of people whose income is less than US$1 a day
- Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
- Reduce by three quarters, between 1990 and 2015, the ratio of maternal mortality
- Attain universal access to safe reliable contraceptive methods by 2015
- Have halted by 2015 and begun to reverse, the spread of HIV/AIDS
- Have halted by 2015 and begun to reverse, the incidence of malaria and other major diseases
- Halve, by 2015, the proportion of people without sustainable access to safe drinking water
- Halve, by 2015, the number of people living with hunger
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

The above goals are ambitious for Mongolia given our relatively high levels of mortality and morbidity and poor resource base. So, Mongolia has set the health targets in Box 1b to be achieved by the end of 2015, in other words within the time-frame of this strategic master plan. Achievement of these targets will contribute to reducing poverty.

Box 1b. MDG related development targets for achievement by Mongolia by 2015

- Reduce the under-five mortality rate from 42.4 (1998) to 29.2 (2015) per 1000 live births
- Reduce the ratio of maternal mortality from 158 (2000) to 50 (2015) per 100,000 live births
- Eliminate the spread of HIV/AIDS
- Reduce the prevalence of TB from 125 to 40 per 100,000 population
- Increase access to safe water supply to 80% of the population

The Government of Mongolia is a signatory to many international conventions and declarations targeting health issues as determined in the WHA and these have been considered during the planning process.

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4 Such as Global Reproductive Health Strategy; IMCI; Infant Feeding; Stop TB Initiative; HIV/AIDS, Framework Convention on Tobacco Control and others.
Economic Growth Support and Poverty Reduction Strategies (EGSPRS)

In the EGSPRS document under the section on the health sector, a number of strategies were included. The implementation of these strategies will improve population health and provide and guaranteed opportunities for the poor and vulnerable groups to be fully covered by health services.

These strategies are:

- To reduce Maternal and Child Mortality through the implementation of the National Program on Reproductive Health and the Child Health Program in accordance with the targets derived from the MDGs in the Millennium Development Agenda\(^5\)
- To improve the quality of, and accessibility to essential health services for the population of Mongolia, and the rural population in particular, through implementation of the Essential and Complementary Package of Services (ECPS)
- To strengthen Family Group Practices (FGPs)
- To ensure conditions for normal functioning of soum hospitals and regional diagnostic and treatment centres
- To ensure conditions for settled employment of personnel
- To expand the scope of coverage of the health insurance system
- To improve conditions for providing free medical aid and services to poor and members of the vulnerable groups
- To reduce the incidence of infectious diseases
- To ensure food security and nutrition

Enhancement of economic growth and poverty reduction

The Government has set itself the goal of reducing poverty through higher economic growth, which will be based on active private sector participation and an export oriented trade policy. Regional and sustainable development concepts will be incorporated in the general economic growth strategy. In addition, a stable macroeconomic situation, investment and the building of human capital factors will play a significant role in ensuring pro-poor growth and sustainable human development. Moreover, the development of more efficient mechanisms of budget and financial management as well as reforms in the public sector will be another important ingredient in securing pro-poor economic growth\(^6\).

Development Framework

The following are the social services and environment sector related priorities defined within the framework of the EGSPRS and the Mongolian development goals:

- to support regional as well as rural development, through intensive infrastructure development;
- to create an equitable environment for ensuring human development through the improvement, at all levels, of accessibility and quality of education and health services;
- to reduce unemployment and poverty and generally improve the living standards of the population;
- to ensure sustainable development and ecological balance, by mainstreaming nature conservation and environmental policies as priorities in regional socio-economic development;
- to reduce the air, water and soil pollution in large cities and settlements and through the reprocessing of waste to improve the living environment of the people;
- to improve governance to ensure human security;
- to create a fair, moral and democratic society that protects concepts of democracy, basic human rights and the freedom of each citizen;
- to mainstream gender dimensions in poverty interventions to promote gender equality.

\(^5\) 8th World Assembly of the UN, 2000
\(^6\) Mongolia EGSPRS 2003
Public Investment Programme

The Public Investment Programme of the Government of Mongolia in 1997 was 24% of the GDP and the lion’s share of the investment was directed to energy, infrastructure, industry, agriculture and the development of small to medium scale businesses. The investment in the health sector was relatively small but has been gradually increasing, especially since 2000. Much of this public investment was for the development of the rural health services at the soum level. International partners and the development banks also support public investment, particularly in the capital investment area.

Legal Environment

The main laws and policies that define the legal environment for the health sector are summarized here. There are numerous laws governing the operations of the health sector and most of these are listed in the Synthesis Paper.

The Constitution of Mongolia

Article 16 states that

The citizens of Mongolia are guaranteed to enjoy the following rights and freedoms:

- The right to healthy and safe environment and to be protected against environmental pollution and ecological imbalance
- The right to material and financial assistance in old age, disability, childbirth and childcare and in other cases as provided by law
- The right to the protection of health and medical care
- The procedures and conditions for free medical aid shall be determined by law

Health Law

The purpose of the Health Law is to define the state policy and basic principles on health to regulate the relations raised in connection with the responsibilities of organisations, business entities and individuals in safeguarding the social health and the rights of the citizens and officials of this country to health protection and medical aid and service; to regulate the legal framework of activities of health organisations and employees thereof.

All citizens have a right to receive medical care and services from doctors and health organizations (Article 47). According to the health law, the citizens of Mongolia shall obtain the following medical aid and services such as medical emergency and ambulance service, tuberculosis, cancer, mental or some diseases, which require long-term rehabilitation process, disinfection and outbreak management of infectious diseases and medical services for pregnant women, free of charge regardless of whether he or she is covered by the health insurance (Article 28)

Health Insurance Law

The Health Insurance Law determines the form of the health insurance, the health services it covers, the paying of its premiums and the relations between the health insurance and health institutions, state, citizens and legal entities connected with the assembling, distributing and utilizing the health insurance fund.

The Drugs Act

The purpose of Drug Act is to regulate relations in regard with manufacturing, importing, storing, retailing, distributing, utilizing and monitoring of drugs and bio-preparations for humans and livestock.
Policies

State Public Health Policy

This policy aims to protect and promote people’s health by establishing a healthy and safe environment to live, work and study through improving the harmony between people, nature and society. The foremost priority of the public health policy is to increase involvement and participation of Government and NGOs, family and community to encourage healthy behaviour and focus equally on health promotion, preventive and curative issues.

There are 20 national programmes currently being implemented within this policy framework (see Annex D) to supplement the routine delivery of health services in the public health sector. These national programmes cover a wide range of areas. All of these programmes have targets and these are included in the ECPS (Annex C). The working groups used these targets and other health sector related targets included in the Government Programme of Action when developing the strategies described later in this document.

Drug Policy

The purpose of this policy is to provide the population with effective, safe and good quality registered medicines and drugs, continually and with equal access. Drug procurement, manufacturing, financing, quality assurance, drug control and rational drug use issues are regulated within this policy framework.

Population Development Policy

The purpose of this policy is to create an environment for the population to live longer, healthy and creatively thus ensuring sustainable population growth.

Mongolian Traditional Medicine Development Policy

The purpose of this policy is to develop Mongolian Traditional Medicine on the basis of the principles of disease prevention, treatment and rehabilitation by enriching with modern scientific achievements.

Health sector Human Resource Development Policy (HRDP)

The HRDP is intended to “provide guidance for staffing of the health services and the training of health service personnel to the year 2013”. The policy also highlights the limitations of workforce planning in the current policy environment. It also emphasizes the importance of developing a long-term Health Sector Master Plan, identifying health service directions and needs on which to base the human resource development policy.

Socio-economic Environment

The socio-economic environment for Mongolia could be characterised by evidence of increasing poverty and disparity between the rich and the poor, emerging population segments, such as unregistered migrants and illegal gold miners and a widening rural urban divide7. The reduced economic growth rates during the transition period, despite the recent upturns, contributed to increasing unemployment with current unemployment figures still being unacceptably high. The increasing poverty and the widening rural urban divide, including the people living in remote areas, has contributed to a rapid and accelerating urbanisation in terms of access to social amenities and employment opportunities. The poverty has also contributed to increased number of homeless, street children and vulnerable groups such as single-headed families, women, adolescents and children in difficult circumstances and the single elderly.

This process has been further fuelled by the rapid movement to a market economy with increasing privatisation and the sale of public sector assets. During the 1990s there were frequent staff turnovers that added to the loss of continuity. The increasing poverty, urbanisation and the need to manage basic livelihoods has also contributed to an accelerating degradation of the local environment particularly with the unsustainable number of livestock maintained during the transition years.

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7 Human Development Report, Mongolia 2003
Box 2. Selected socio-economic indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>2,504,000</td>
</tr>
<tr>
<td>Population projection (2015)</td>
<td>2,918,624</td>
</tr>
<tr>
<td>Percentage of population in rural areas</td>
<td>46.6%</td>
</tr>
<tr>
<td>Population below poverty line (2003)</td>
<td>36.1%</td>
</tr>
<tr>
<td>Gini-Coefficient (2003)</td>
<td>0.32</td>
</tr>
<tr>
<td>Proportion of national poverty in rural areas (2003)</td>
<td>43.4%</td>
</tr>
<tr>
<td>Percentage of the unemployed (registered)</td>
<td>3.5%</td>
</tr>
<tr>
<td>Gross domestic product per capita (2003)</td>
<td>USD 477.2</td>
</tr>
<tr>
<td>Percentage of women without any education (2003)</td>
<td>5.2%</td>
</tr>
<tr>
<td>Percentage of men without any education (2003)</td>
<td>4.9%</td>
</tr>
<tr>
<td>Percentage of men with only primary school (2003)</td>
<td>11.8%</td>
</tr>
<tr>
<td>Percentage of women with only primary school (2003)</td>
<td>15.8%</td>
</tr>
<tr>
<td>Households in the country with access to electricity (2000)</td>
<td>67.3%</td>
</tr>
<tr>
<td>Households in rural areas with access to electricity (2000)</td>
<td>34.1%</td>
</tr>
<tr>
<td>Population who obtain drinking water from open sources (2000)</td>
<td>42.2%</td>
</tr>
<tr>
<td>Households with latrines/toilets (2000)</td>
<td>77.2%</td>
</tr>
</tbody>
</table>

External Challenges to the Health Sector

The transition from Soviet dominated centralised system to a market based democratic system posed many challenges particularly for the health sector.

The aftermath of the break-up of the Soviet Union affected Mongolia deeply. There were severe funding shortfalls particularly in the health sector as a result of the cessation of the subsidies to the health and other sectors. The delivery of preventive and curative health services, which was based on the centralised model, depending on large infusion of state funds, also suffered greatly. The services that had been routinely provided and had not been sufficiently responsive to the needs of the rural population became even less and less responsive to the changing population needs, the alterations in the nomadic lifestyle and the increasing urbanization.

The funding shortfalls also created massive unemployment and especially affected the health sector as many staff left the service to earn their livelihoods. This created significant shortages in the human resources especially in the rural areas and also resulted in widespread shortages in drugs, medical supplies and reagents in non RDF areas. Due to a lack of funds, maintenance activities were suspended and the health infrastructure deteriorated and much of the equipment, which was already old, became outdated.

During the peak of transition, the increasing poverty, the weakening of the social services and poor availability of amenities in the rural areas, led to a large and rapid migration to the cities, especially to Ulaanbaatar.

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8 Mongolian Statistical Yearbook 2003, NSO, 2004
9 Population projections of Mongolia NSO Census 2000
10 Mongolian Statistical Yearbook 2003, NSO, 2004
12 Household income and expenditure survey/living standards measurement survey 2002-2003, NSO, WB, UNDP, Ulaanbaatar 2004
14 Mongolian Statistical Yearbook 2003, NSO, 2004
15 Mongolian Statistical Yearbook 2003, NSO, 2004 (MNT 547,155,5 @ MNT 1146.5 per USD)
16 Household income and expenditure survey/living standards measurement survey 2002-2003, NSO, WB, UNDP, Ulaanbaatar 2004
17 Household income and expenditure survey/living standards measurement survey 2002-2003, NSO, WB, UNDP, Ulaanbaatar 2004
18 Household income and expenditure survey/living standards measurement survey 2002-2003, NSO, WB, UNDP, Ulaanbaatar 2004
20 National Census 2000; Main Results; pg 103
21 National Census 2000; Main Results; pg 103
22 Population and Housing Census 2000; Housing; pg 55
23 National Census 2000; Main Results; pg 104
widening existing spatial inequalities and deepening the rural and urban divide thus giving rise to the challenge of caring for the rapidly increasing urban poor in the peri-urban areas. The consequences of transition created a legacy of unique and specific challenges in the health sector, which will be described in more detail in the next chapter. Suffice to say that the transition created a particular set of circumstances that have brought the health sector to its current situation where the major challenges it faces, have to be met in a systematic, coherent and sector-wide manner.

Rapid globalisation has, in the recent years, been another potent factor that has accelerated the spread of emerging diseases of public health importance such as SARS and Avian Flu that have impacted significantly on the health and economy of the country.

Road Traffic and Industrial Accidents

The poor overall general infrastructure in terms of building maintenance, roads and communications has had a negative impact on the performance of the health sector affecting access by the population, especially for the poor and in the rural areas, to the health services and for the provision of supplies and maintenance of the health infrastructure. On the other hand, the increasing number of roads and vehicles and their poor maintenance has sharply increased the number of road traffic accidents and the consequent morbidity and mortality. Childhood injury is also emerging as a new trend. The poor standards, especially during the transition period, in the local industries and the lack of adequate funds for maintenance of the factories, workshops and industrial plans following the rapid and unregulated privatisation have increased the incidence of industrial accidents and occupational injuries. The situation is, in fact, worsening in the urgent drive to increase the rate of economic growth and industrialization without considering the related infrastructural and occupational safety issues.

Environmental Health

Environmental pollution is increasingly becoming an important factor affecting the health of the people particularly in Ulaanbaatar city. The rapidly increasing population, because of urbanisation, has resulted in higher incidence of diseases caused by environmental pollution and the poor living and sanitary conditions. This is particularly marked in the ger districts and is aggravated by lack of access to safe water, safe food and the availability of non-polluting stoves and heating equipment. The growth of the ger districts exceeds the ability of the city administration to provide the needed infrastructure to combat pollution and reduce the incidence of diseases related to the environment.

The issues of environmental sanitation, unsafe food and drinking water associated with the nomadic lifestyle practices in the rural areas such as sharing water sources and living space with livestock especially during the winter season, the disposal of human and animal waste and garbage need urgent attention especially at the community level and will require adherence to healthy lifestyle and environmental health practices. There is some arsenic contamination in drinking water in the south and east parts of Mongolia24. It will require the integration of the promotion of public health, environmental sanitation, safe food, drinking water and other key factors with a greater focus on the needs and circumstances of the rural poor and vulnerable groups whose poor living conditions are a direct result of inadequate environmental hygiene (poor latrines, accommodation), unhealthy lifestyle, unsafe food and drinking water and absence of a public health awareness at the community level.

Changing food habits and sedentary lifestyles

The traditional Mongolian diet was suited to the weather, seasonal variations, a nomadic lifestyle and local conditions. However, new socio-economic circumstances, namely the transition to the market economy and changing lifestyles has brought about changes in food consumption patterns. The increased availability, even in the rural areas, of many cheap, poor quality and unsafe imported and local food products has contributed to these changing food consumption patterns.

The migration into the urban areas has also contributed to a shift in lifestyles from “nomadic” to “sedentary”. There are numerous consequences of this shift. One is a persistent nomadic diet that is no longer compatible with sedentary lifestyles. Secondly, there is an inadequate and/or inappropriate nutritional intake and an increase of gastrointestinal and nutritional diseases. The increasing unemployment especially in the urban areas, leads to poverty and social exclusion, depression, increased smoking and alcohol consumption, domestic violence and rising divorce, negatively affecting the physical and mental health of the people.

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General and micronutrient malnutrition, as a result of unhealthy food habits, increasing unemployment and poverty, is threatening the health of mothers and children. Chronic nutritional disorders due to health lifestyles and food habits contribute to the fact that 1 in 4 Mongolian adults are overweight while 1 in 20 underweight.

The combined effect of a lifestyle change from nomadic to sedentary, the change in food consumption patterns with the persistence of a nomadic diet, has significantly altered the disease and health service delivery landscape requiring the overall approach to the delivery of health care to be revisited.

**Natural disasters**

There are frequent nationwide natural disasters occurring, with heavy snowfall and severe winters (dzud) and droughts being the main ones. Forest fires and floods also occur but they tend to be localized. Disease outbreaks often follow these disasters especially the fires and floods. These nationwide disasters can cause widespread loss of cattle and lead to depression among the people. Natural disasters also aggravate poverty and accelerate migration especially because of the loss of cattle. There is also widespread shortage of food and during the dzud, access to health facilities and services is blocked leading to increased morbidity and mortality.

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21 UNICEF, Situation analysis of Mothers and Children in Mongolia, 2000;
Chapter 2: Current Situation

Where are we now?

This chapter summarizes the current situation in the health sector in terms of the population structure, the epidemiological transition, morbidity and mortality, nutrition, utilisation of health services, the growing private sector and the corresponding need to rationalise the secondary and tertiary level hospital sector. It also describes the health sector reform and decentralisation activities currently underway and the structure and organization of the Mongolian Health Sector. It particularly focuses on supervision and coordination of external resources and partners. It also goes into considerable detail about what is working well in the seven key areas of work (see below) and the challenges being faced by the health sector and concludes with the future policy directions emphasising the pro-poor, client-centred focus, community participation and sectoral reform using a sector-wide approach.

### Box 3. Current health and demographic indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (2003)</td>
<td>63.63</td>
</tr>
<tr>
<td>Total fertility rate (2003)</td>
<td>2.0</td>
</tr>
<tr>
<td>Population Growth rate (2002)</td>
<td>1.3</td>
</tr>
<tr>
<td>Crude Death rate (2003)</td>
<td>6.08</td>
</tr>
<tr>
<td>Crude Birth rate (2003)</td>
<td>18.05</td>
</tr>
<tr>
<td>Infant mortality rate (2003)</td>
<td>23.49</td>
</tr>
<tr>
<td>Under-five mortality rate (2003)</td>
<td>31.33</td>
</tr>
<tr>
<td>Percentage of children under five years with stunting (2004)</td>
<td>19.6</td>
</tr>
<tr>
<td>Percentage of children who are overweight (2004)</td>
<td>6.4</td>
</tr>
<tr>
<td>Tuberculosis incidence rate/10,000 (2003)</td>
<td>15.2</td>
</tr>
<tr>
<td>HIV seroprevalence rate among 15-49 age group/100</td>
<td>0.00015</td>
</tr>
<tr>
<td>STI incidence as % of communicable disease (2003)</td>
<td>38.5%</td>
</tr>
<tr>
<td>Immunization Coverage (2003)</td>
<td>97.8</td>
</tr>
<tr>
<td>% of the population covered by HIF</td>
<td>77.6</td>
</tr>
<tr>
<td>Health Worker population ratios (2003)</td>
<td></td>
</tr>
<tr>
<td>Doctors/10000</td>
<td>26.66</td>
</tr>
<tr>
<td>Nurses/10000</td>
<td>31.06</td>
</tr>
<tr>
<td>Midlevel health workers/10000</td>
<td>56.83</td>
</tr>
<tr>
<td>Doctor and Nurse ratio</td>
<td>1:1.16</td>
</tr>
<tr>
<td>Management and clinical staff ratio</td>
<td>1:19.5</td>
</tr>
<tr>
<td>Ratio of public and private (with FGP) facilities (2002)</td>
<td>1:1.5</td>
</tr>
<tr>
<td>Ratio of public and private (without FGP) facilities (2002)</td>
<td>1:3.1</td>
</tr>
<tr>
<td>Ratio of public and private beds (2002)</td>
<td>10.5:1</td>
</tr>
<tr>
<td>Number of beds per 10,000 (2003)</td>
<td>73.02</td>
</tr>
<tr>
<td>Average length of Stay (ALOS) (2003)</td>
<td>10.01</td>
</tr>
<tr>
<td>&lt;15 years of age as % of total population (2003)</td>
<td>32.6</td>
</tr>
<tr>
<td>Contraception prevalence rate (2003)</td>
<td>51.8</td>
</tr>
<tr>
<td>Abortion rate/1000 live births (2003)</td>
<td>234.04</td>
</tr>
<tr>
<td>Women in fertile age as % of the population (2003)</td>
<td>27.3</td>
</tr>
<tr>
<td>Total Outpatient visits per year (2003)</td>
<td>13,416,668 (5.42 visits/person)</td>
</tr>
<tr>
<td>Total Inpatients per year (2003)</td>
<td>893,908</td>
</tr>
</tbody>
</table>

Note: Mortality data is different in other survey reports some of which show higher rates.

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26 Health Sector 2003, MoH, Mongolia
27 Mongolian Statistical Yearbook 2003, NSO, 2004
29 National Survey on Nutrition-3, MoH, PHI, UNICEF, 2004
30 TB Registration Data, National Centre for Communicable Diseases, 2003
31 Health Indicators 2002; DMS, Mongolia
32 Health Indicators 2002; DMS, Mongolia
33 Health Indicators 2002; DMS, Mongolia
34 Health Indicators 2003; DMS, Mongolia
35 Includes officially registered abortions (much of private sector data is not included)
The population structure

Mongolia is in demographic transition, a period characterized by declining fertility and mortality rates and aging of the population. Nevertheless, the population remains relatively young with a large dependent portion comprising of the 0-14 age-group (32.6%) and the over 65 age-group (3.51%). Of the total population numbering 2,504,000 (mid 2003), 50.4 percent are women and 49.6 percent are men, and 35.8 percent of the population are children aged 0-14 years. Overall, the Mongolian population is young compared to Europe and North America. The median age is 23 (2003), up from 19.4 years in 1994. The overall population density is 1.5 persons per square km, making Mongolia the least densely populated country in the world.

Currently it is estimated\textsuperscript{36} that about 60% of the total population is living in the urban areas. Seventy two percent of the urban population lives in five major cities with Ulaanbaatar having 57% of the total urban population. This is a little over one third of the total population of Mongolia.

Total fertility rate is 2.0 births per woman (2003), down from 6.41 in 1980, now comparable to upper middle-income countries such as Thailand and Chile. This has significant repercussions on the growth of the population in a country that still has a pro-natalist policy. The goal of the state policy on human development is to ensure sustainable population growth through the reduction of morbidity and mortality and through supporting all births meeting the criteria for appropriate delivery\textsuperscript{37} while respecting free choice and reproductive rights.

The percentage of the elderly is also increasing and by 2025 it is expected to increase from 3.51% to 6.3% of the total population

**Epidemiological transition (mixed infection (rural) and chronic (urban) disease profile)**

Mongolia is experiencing epidemiological transition over the last decade. The prevalence of lifestyle related chronic diseases is rapidly increasing and has become one of the main public issues. The top five leading causes of death have changed since 1989. Currently, cardiovascular diseases (CVDs), cancer, injuries and accidents are leading causes of mortality. During 1995-2000, circulatory system diseases, cancer and injuries have been increasing and remained priority health issues.

Morbidity however, is still, primarily due to infectious diseases. Respiratory and gastrointestinal diseases still dominate the morbidity pattern. The burden of disease from pregnancy related pathologies is almost as high as CVD. When looking at the mortality figures\textsuperscript{38}, a mixed picture emerges with the mortality figures showing a distinct epidemiological transition.

Not all infectious diseases are decreasing as rapidly as expected. This appears to be related to a deteriorating socio-economic situation, insufficient and poor quality public health services and relative inaccessibility. Infectious diseases namely, HIV and STIs, TB, viral hepatitis and zoonotic diseases, which are related to risk factors such as behaviour, lifestyle choices and living conditions, are also showing a tendency to increase.

The major burden of disease falls on younger age groups and poor, which in the case of Mongolia comprises the largest portion of the population (the age group 0-19 years comprises 47% of total population). It also shows a picture in which infectious diseases still dominates the epidemiological landscape. Another point worthy of note is that amongst the men in the age group 20-44 (comprising 20% of total population) road traffic accidents, injury (occupational and other) and poisoning (industrial and others) dominate and amongst the women in the same age group the picture is dominated by pregnancy related pathologies and a very high burden of urinary tract and gynaecological diseases. In last few years, there are an increasing number of deaths caused by suicide and violence.

**Mortality**

The crude death rate has declined from 7.9 in 1990 to 6.08 in 2003. The under-five mortality rate has also been declining steadily over the last decade. It is currently (2003) 31.3 per 1000 live births declining from 82.7 per 1000 live births in 1993. Correspondingly, the IMR has decreased from 63.4 per 1000 live births in 1990 to

\textsuperscript{36} Internal Migration and Urbanization in Mongolia, National Statistics Office, 2002
\textsuperscript{37} These are deliveries occurring in mothers between 20-39 years and with birth spacing of 2 to 3 years at least
\textsuperscript{38} HSSMP Synthesis Paper; MoH pp 34-36
23.49 per 1000 live births in 2003. It must also be stated that the number of births has also decreased from 51,323 in 1999 to 44,928 in 2003.

Maternal mortality, on the other hand, fluctuated between 150 and 118 per 100,000 live births during the period 1985 to 1990. It increased up to 243 per 100,000 live births in 1993, almost certainly because of the transition related disruption of the health services system. The number of maternal deaths was 243 in 1993, but dropped to 145 in 1997. However, since 1994, it has shown a continual downward trend. In 2002, the number of maternal deaths had decreased by 26.6% to 124.8 per 100,000 live births when compared to the previous year. In 2003, MMR was 109.5. Nevertheless, there are large regional disparities in MMR as with the other indicators. For example, MMR is higher in Ulaanbaatar when compared with the state average.

**Nutrition**

35.1% of the population is poor and very poor under the officially defined poverty line. A decrease in the net income level of the population, contributed negatively to the food security and daily intake of micronutrients among vulnerable groups, particularly children aged 0-5. There is an increasing problem with Vitamin D, A and iodine deficiencies. 1 in 3 children under 5 years old show Vitamin D deficiency. The average prevalence of anaemia in mothers of children under-five was 58.8%, and it was much higher among mothers living in soums (71%) than those living in urban areas. Nationally, iodized salt consumption rate reached 74.4% in 2004 from 60% in 1999.

Almost all newborn (97%) babies receive colostrum after the birth (within 30 min – 3 hours) nationwide. Although there is good practice on breastfeeding and its promotion till 1-2 years after the birth, exclusive breastfeeding rate (only breast milk till 6 months) has been declining year by year due to aggressive marketing of breast milk substitutes (BMS). A major cause for being underweight among the children aged 12-24 months are the inadequate complementary feeding practices.

Problems of both over and under-nutrition exist. A study in 2004 (see above table) found that 19.2% of children were stunted (low height for age), 0.6% were wasted (underweight for height), and 6.4% were underweight. The protein-energy malnutrition was more prevalent in rural areas when compared with the urban areas. 1 of 4 Mongolians is overweight.

**Utilization of services**

The predominantly curative orientation makes the services provided very dependent on the attitudes, ability and competence of the health care providers. Their generally poor communication skills and discriminatory attitudes coupled with the inadequate information about the services available at the hospitals make the health services unfriendly and confusing to the clients.

In addition to the above barriers, there are requirements for extra-official payments, patronage, increasing malpractice and poor accountability of the providers, absence of a fair and responsive appointment system along with absence of choice of caregivers contribute to making the current services unfriendly to clients, especially the poor and vulnerable groups such as mothers and their children, adolescents, elderly and the very poor. The consequence of the unfriendly services is that many of those who can afford seek more acceptable, higher quality and more friendly care overseas.

**Growing private sector**

The rapidly growing and ineffectively regulated private sector tends to provide doubtful quality of care that is aimed at maximum profit and responding to client wants and demands. This results in poly-pharmacy and excessive use of laboratory and other investigations increasing cost to the clients. There is a strong curative focus in the private facilities with little or no health education. Their rapid growth is fuelled by reimbursements from the HIF and also from additional user charges. It is further compounded by ineffective licensing and accreditation. Ultimately the high cost, the doubtful quality of care, excessive use of medicines and laboratory and other investigations create the circumstances for the people (affluent and other) to seek more reliable and friendly overseas care. Regulation of the private health sector is therefore a key task over the next decade.

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39UNICEF Study “Children and Women in Mongolia” Situation Analysis Report 2000
40 National Survey on Nutrition #3, MoH, PHI, UNICEF 2004
The FGPs originally meant to be the PHC aspect of the private sector, are now in a questionable no-man’s land between the private and public sector as they are funded through an annual capitation fee from the HIF and from the state budget. The status of the FGPs and the availability of reimbursements from the HIF to private sector hospitals need to be resolved in the short to medium term.

**Rationalisation of excess hospital capacity at the secondary and tertiary level in Ulaanbaatar**

There is an excess hospital capacity at the secondary and tertiary level particularly in Ulaanbaatar. This excess capacity is closely associated with the high level of specialisation of the health workforce and the higher status of the specialists. There is also a widespread perception in the community and among the providers that equates better services with more specialised services. This reinforces the preservation of the current hospital structure and capacity and makes it difficult to reduce the number of hospitals beds. This excess capacity consumes increased resources through high fixed costs and encourages overuse of this hospital and bed capacity.

Over the last ten years numerous reports have been written and recommendations made about reducing this excess bed capacity, as reflected in the large number of hospitals at the secondary and tertiary levels, but not much headway has been made. The reduction in the current capacity is also prevented by the fact, among the others mentioned earlier, that many of the hospital beds are used by long term patients because other options such hospices, palliative care centres, etc. are unavailable and the absence of competition in the health sector between the public sector facilities and with the private sector.

The current ALOS ranging between 8.6 to 11.4 days and the HIF reimbursement system creates an incentive to at least maintain, if not, increase the number of beds so as to maximise HIF reimbursements. The calculation of the HIF outlays based on the MoH projection of beds for the forthcoming year further reduces the willingness to rationalise excess capacity especially at the tertiary and secondary level.

**Sectoral reform and decentralisation**

The reform and decentralization processes and the transfer of many activities, duties and responsibilities to the local governments has not produced a meaningful increase in the level of primary stakeholder participation or an improvement in the performance of the health services at these decentralized levels.

Sectoral reform in the MoH was a response to the decentralisation that was initiated by the government in the mid 1990s in response to the reduction in subsidies and in an effort to transfer the responsibilities previously held at the central level to the local governments. In response, the MoH reorganised itself as financial responsibilities for the operation of the local level health facilities were transferred to the local government who had not been trained and equipped with the guidelines and procedures to implement decentralisation. Nevertheless, during the last decade, piecemeal attempts were made to strengthen the management of the MoH and the aimag and soum health services to manage and deliver services. Some changes were made at the central and aimag level and a number of new institutions such as DMS, FGPs and RDTCs were established.

The parliamentary approval of the PSFML introduced additional dimensions into the decentralisation process and highlighted the need for sector wide reform and the development of a comprehensive sector wide strategic plan for the medium to long term as a means of making this reform process coherent and systematic.

Presently the capacity of the health managers at the central and local levels is inadequate and there are no clear guidelines and procedures for systematically implementing decentralisation and the related application of the PSFML, neither within the MoH at the central and aimag level, nor within the local government.

While the basic elements of the legal framework for decentralisation and sectoral reform are in place, the implementation of these legal provisions leaves much to be desired in terms of the policies, guidelines and procedures and the reconciliation of the conflicts between the various laws. There is also a prevalent tendency for structural and organisational changes to be guided by the assumption that function should follow structure instead of the other way around. There have been many structural changes over the last decade in response to changes in government and to large scale partner inputs (HSDP 1 and 2) that now need to be coordinated and integrated through the development of the sector wide plan, institutional development and establishment of the sector-wide approach to management.

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41 Yondon Dungu, Lagshmaa Baldoo, Preparing the second Health sector Project, Mongolia, Participation – Final report. September, 2002
Supervision

Supervision is currently periodic and centralised using a more expensive specialised approach. Routine supervision is often project instigated and in case of the MoH it is usually problem oriented and tends to be undertaken when there is a problem that has arisen that cannot be solved at the local level, or needs a more central level intervention. Guidelines, procedures or checklists for routine or regular supervisory activities within and between levels are not clear and un-enforced. Beneficiaries and other stakeholders are usually not involved. Hence technical and management supervision is problem linked, generally corrective and punitive in nature and not associated with on the job training.

Routine supervision appears not to be linked with systematic in-service training though some training may be involved. Some types of inspections are periodically carried out by the state inspection agency but clinical and management auditing is rare except when there are problems. Some limited internal auditing in the financial areas is also carried out. However, there is regular financial reporting and reporting related to the transmission of health indicators. Recently there has been an increase in the reporting of some types of management and other indicators. The development of the Annual Report of the MoH is also seen as part of the annual supervisory process as it is preparation for the review and planning meetings early in the planning cycle.

Generally, information generated during the supervisory process is used more at the central level. Its use in decision making and remedial actions at the point at which it is generated is limited and much of the information and conclusions derived from the supervisory monitoring and evaluation exercises tend be used for ranking of the various facilities and health departments. There is a strong perception that supervision linked to M & E is a specialised activity and is not to be routinely carried out as an ongoing self-assessment of performance against the planned objectives at the operational level. This perception tends to make supervision as an unwelcome exercise at the best of times.

Coordination of external resources and partners

Relative to the population, there are significant external resources being channelled into the health sector. The current mechanisms to coordinate the allocation and utilisation of these resources is through the department responsible for international cooperation, occasional round table meetings with the partners involved in the health sector, and UN led donor group meeting where the health sector is one of the sectors, and the numerous steering committees. The Department of International Cooperation has the task of coordinating the inputs and activities related to the international partners. At the highest level of the MoH, the coordination is also done at the Minister’s level with the support of the Minister’s Council and beyond the MoH by the Aid Coordination Council under the direction of MoF and eventually by the Cabinet. There is also a law on foreign investments and loans that provides the legal framework but its implementation is poor at present. It could be said that coordination of the external resources and partners in the MoH, though much better than in the other sectors, is still fragmented.

There is no sector wide coordinating agency within the MoH that allows for an interactive forum involving the MoH at various levels, the stakeholders, international partners, NGOs and beneficiaries. Partner inputs are managed by project teams and Project Implementation Units (PIUs) and overseen by steering committees who have some common members to promote coordination and collaboration between them and therefore by implication between the projects. However, this does not happen as the agendas for the steering committees are set by the project management teams and not by the MoH. At present, a Health Sector Coordinating Committee has been established with the responsibility of overseeing the HSMP development process. It could potentially serve as the sector wide coordination committee to coordinate external resources and promote ministry directed collaboration between partners with the Department of International Cooperation serving as the secretariat.

In the absence of a sector wide strategic plan and implementation framework beyond the annual plans of the MoH and the lack of a proactive planning approach, directed and managed by the MoH, there is a strong tendency of the partners, who plan over the medium to long term, to, by default, impose their interest and agendas on the MoH leading to various projects and activities that may overlap and even duplicate, thus resulting in ineffective use of these valuable resources. Often the partners themselves do not effectively coordinate their inputs because of issues of attribution and for various protocol and political reasons. In such circumstances, partners end up coercively instigating projects and activities, which a resource-starved MoH is then unable to refuse these significant resource inputs even though they may not conform to the MoH priorities and health needs and may not be sustained beyond the fiscal lifetime of the project. The lack of coordination within the MoH often leads to a situation where different departments and divisions present different
perspectives that further encourage the partners to support similar and multiple projects with parallel management and monitoring systems, compounding duplication and consequent misuse of scarce resources.

The current financial management systems of the MoH and the government in general do not inspire confidence in terms of effective tracking of the use of partner funding. This prompts the partners to set up parallel project management mechanisms to ensure proper utilisation of the funding and technical assistance provided. Many of the project activities, particularly those funded by international partners, are generally not sustainable and do not continue beyond the fiscal life of the project. This is further compounded by poor feedback between the projects, the partners, the MoH and beneficiaries and is therefore an area of great concern to the partners and the MoH.

Structure and Organization of the Mongolian Health Sector

The Ministry of Health (MoH) is the government’s central administrative body responsible for sector-wide health law and policy formulation, planning, regulation and supervision and ensuring the implementation of health-related activities and standards. Funding for the various health sector activities comes from the state budget (MoF), the HIF, ODA, development loans and out of pocket payments.

The Ministry of Health consists of five divisions and two departments

- Division of Finance and Economic Management Planning
- Division of Public Administration and Management
- Division of Medical Services
- Division of the Health Policy and Coordination
- Division of Information, Monitoring and Evaluation (DIME)
- Department of International Cooperation
- Department of Pharmacy and Medical Equipment

The National Centre for Health Development (NCHD) is appointed by the MoH to support policies and assist technical activities of the Government body responsible for health in strengthening health management and information, providing accreditation of health organizations and licensing of the health professionals, managing continuous postgraduate training and promoting population health. The NCHD has the following five departments.

- Health Management Department
- Health Professionals Licensing and Training Department
- Accreditation Department
- Health Statistics and Information Department
- Health Promotion Department

The Public Health Institute is the organisational structure for the research functions under the supervision of the Ministry of Health to provide public health research activities at the national level and implement joint research projects and programs with domestic and international institutions. They receive funding from the MoECS and the MoH.

The structure of health services in Ulaanbaatar reflects the three levels, even though names of the health facilities are different. At the primary level, the services are provided by FGP’s, soum and village hospitals. At the secondary level, services are provided by district hospitals and their ambulatories (Health Centre). At the tertiary level, services are provided by specialized tertiary level hospitals, which serve the city and the whole country. The management of health services is the responsibility of City Health Department, which is under the City Mayor’s (Governor) Office. This management structure is similar to the aimags. However, the management of tertiary level hospitals in Ulaanbaatar is directly under the MoH.

At the aimag level, the Aimag Health Department is in charge of implementing policies on public health and medical care and services, improving the infrastructure, organization and operation of the health institutions, and efficient allocation and management of financial and material resources. There is a coordinator for each national programme. The health administration at the aimag level has undergone numerous changes since

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42 Approved by Government resolution #236, 2004
43 Approved by Health Minister’s order #11, 2005
44 Usually one officer coordinates a number of national programmes especially in the smaller aimag health departments
1990 and this has led to wide variations in the staffing patterns and structure of the health administration itself. The structure of the departments has yet to be standardized. The Health Department generally has three functions, Public Health, Medical Services and Management. It provides the aimag hospital, soum hospital, Family Group Practices and bagh feldsher posts with technical and management supervision. The Health Department is also involved in the licensing of private facilities but there is no integrated policy or coordination of this activity.

Three aimags have **Regional Diagnostic and Treatment Centres** that are responsible for providing tertiary level care for all the aimags in their region. These centres provide tertiary level care and serve as the second referral level. Since these also serve as aimag hospitals, they also serve as the first referral level providing secondary level care.

**Family Group Practices** have been established in Ulaanbaatar and in all aimag capitals. They provide primary level care, which is general professional care with a focus on preventive care. They also serve a critical gate-keeping function. FGPs are set up in soum centres, aimag capitals and UB. As part of the gate keeping function, FGPs serve as the first point of contact with the health services. They refer clients to the next higher-level facilities for specialised care.

The **soum hospital** is the central health facility that provides the soum population with primary health care. This is general professional care (in accordance with the ECPS) and includes a mix of promotive, preventive, clinical and follow-up care. A soum hospital with a reasonably large population and in a suitable location can be used for primary referral services for the neighbouring soums. Such a hospital is termed as an *inter-soum hospital*.

The **private health sector** means health organisations that provide health care for profit and are wholly self-financed. These organisations get their income from user charges and fee for service and when accredited, reimbursements from the health insurance fund. They are licensed and regulated by the government and are required to meet minimum practice, facility and equipment standards. Some NGOs and religious organisations also provide private health care though they may not be for profit. At present, the private sector dominates the areas of dentistry, internal medicine, obstetrics and gynaecological care, traditional medicine and high-tech laboratory services to support the diagnostic capacity of the public sector. Approximately 10% of the hospitals beds are operated by the private sector.

**Traditional medicine** includes treatment with herbs and medicinal plants, acupuncture, and massage therapy and moxibustion (the use of suction pumps) and other diet related therapies. There is also considerable parallel and concurrent use of modern medicines along with the traditional therapies. Each aimag hospital has a department of traditional medicine and 21 aimag hospitals have in-patient beds. Most district and national level hospitals in Ulaanbaatar also provide outpatient services in traditional medicine. There are numerous private traditional medicine hospitals and sanatoria.

The current organisational charts for the various levels are shown in Annex A

**What is working well?**

The achievements and accomplishments in the health sector are described here. These are listed under the seven key areas of work that were identified during the situation analysis stage and were endorsed during a national consultative meeting as the main functions (see Box 6 and Figure 1) of the health sector that needed to be carried out to deliver health services.
Box 4. Critical success factors in the health sector

- Increasing acceptance of a preventive basis for health care service delivery at the policy and senior management level in the Ministry of Health and health institutions
- An ECPS widely accepted as a basis for delivering essential and complementary health services
- Significant rural focus reflected in the legal and policy framework and in the implementation of the various health programmes and initiatives
- Increased awareness of quality improvement
- A supportive, harmonized and evolving legal environment
- Increased access to essential drugs through the establishment of RDFs in remote areas
- Effective implementation of some national programmes
- Active participation of the MoH in the overall government wide public sector reform process
- Steadily increasing allocation of the state budget to the health sector
- Establishment of the NHA as a major policy and planning tool
- Growing number of IEC activities especially in high population concentration areas
- Development of long-term sector wide strategic plan using a consultative and capacity building process
- Increasing competition to the public health sector from a growing private sector
- Appropriate technical and financial support from partners
- Political commitment by the government and the MoH to the MDG and the EGSPRS

Health Service Delivery and Pharmaceutical & Support Services

In order to better serve the rural populations and also in keeping with the regional development approach stated in the EGSPRS, well equipped and autonomous RDTCs were established in selected aimag capitals and have started providing acceptable quality tertiary level specialised and advanced health care, continuing education and professional training.

The Soum Hospital Development Programme has been underway for some time and has succeeded in improving the services provided at these rural facilities in selected aimags along with the renovation and upgrading of the health infrastructure including construction of new hospitals, upgrading the ambulance services and hospital equipment. The programme has also been providing in-service training and continuing education in clinical and management areas for the soum level staff to improve their diagnostic, treatment and management skills and competence. Part of the strengthening of the rural services is also improving the living and working conditions of the soum level staff as incentives for them to continue serving at the soum level.

Parallel to and reinforcing the Soum Hospital Development Programme is the expansion of the RDF scheme to improve access to acceptable quality essential drugs especially in more remote areas resulting in an increase in the availability of essential drugs from 20-25% at the start of the programme to 70-80% currently. The adoption of the drug policy and an essential drugs list for all levels has also lead to considerable improvement in the continuity, affordability, financing and supply of essential and other drugs including their manufacture. It has also set the stage for the systematic promotion and implementation of rational drug use guidelines and the consolidation of quality assurance.

The Family Group Practice System (FGPs) has, since its establishment, been providing primary level general professional care with a significant focus on prevention. As part of the gate-keeping function, FGPs also serve as the first point of contact with the health services. FGPs are set up at all urban centres with their number currently reaching 232.

Over the last few years, numerous national programmes have been set up. These programmes support the various levels of the health service to deliver the services to be provided by these programmes in an integrated way. The implementation of these programme activities contribute to the strengthening the service delivery capacity at the various levels of the health service. One of the direct consequences of the effectiveness of these national programmes is the sustained immunization coverage rates and the consequent reduction of Vaccine Preventable Diseases such as Hepatitis B. The achievement of a polio free status is another fine example of the success and effectiveness of some of the national programmes. The implementation of the RH programme and the almost universal application of the IMCI guidelines have also resulted in significant reductions in the MMR and IMR respectively. The recent Global Fund supported TB control programme is also working well.

The approved ECPS stimulated wide-ranging discussion and dialogue within the health sector and with stakeholders about how the products and services are to be delivered, the evidence base for the selection of
these services, the quality of the services to be provided and increase in access and affordability of these services especially for the poor and vulnerable. It is currently guiding the development of the HSMP, the business and operational plans and is also being used as the basis for costing services for budgeting. It also provides a boundary for public and private services.

The ECPS is a framework for the full range of services that could be provided in the health sector. The essential part of the ECPS is to cover those public good services whose provision must be ensured by the government to fulfil its mandate as given in the constitution, the health and related laws and in accordance with the epidemiological profile. The complementary part of the ECPS summarizes the services that may be provided to supplement the essential services to reflect the specialized and advanced specialized care and does not impose any limits or restrictions on the type and frequency of these services. However, it does imply that the cost of providing these advanced and specialised services, whatever these may be, may not be borne by the public sector funds. Thus the ECPS serves as a boundary between those services that must be provided by the public sector and those that may be funded from other sources including out of pocket. The ECPS does not suggest that there are any non-ECPS services. However, the government may designate individual and private goods types of services and treatments that may or may not be eligible for public sector funds.

**Behavioural Change and Communication**

Behavioural change and provider attitudes are essential components to improve the delivery of health services. It is an “organized communication process that prompts individuals to change their personal attitude, behaviours and practices …” All national programmes, therefore, have significant IEC components. Recently the MoH has approved an IEC strategy in accordance with the State Public Health Policy. This is beginning to provide the basis for integrating and streamlining IEC components of the various national programmes and other IEC activities to reduce overlap and duplication and sharpen the focus of the IEC components of the national programmes. The recent upsurge in IEC activities and increasing emphasis on the improvement of provider attitudes and movement towards a more client friendly services are some of the early positive outcomes of the recent initiatives. The updating of the health worker ethical norms to further improve the effectiveness of the Ethical Committee and the inclusion of National Sport and Fitness activities under the MoH are other examples of this positive influence. The IEC activities focusing on promoting healthy lifestyles have also stimulated the implementation of a Health Promoting Settings Programme. It is noteworthy to mention the increasingly significant role of NGOs in IEC activities especially in terms of targeting and relevance.

**Quality of Care**

There has been a dramatic increase in the awareness and emphasis on quality assurance and management in the health sector as an essential ingredient for client-friendly and pro-poor services. Consequently various standards and guidelines have been developed and are in the process of being implemented. These guidelines cover health facility standards, clinical and treatment protocols and guidelines and norms for governing provider behaviour. Adherence to standards is also reinforced by the institution of a licensing and accreditation system for all health and pharmaceutical facilities.

To improve the management of quality in the health services, a quality management structure has been put in place. Since 1998, quality managers were appointed at all secondary and tertiary level hospitals and in 2000 this was upgraded through the establishment of a quality unit in these facilities. Quality units are technically supported and supervised by a recently appointed officer in charge of Quality of Medical Care of the MoH. This structure can be a good foundation for the further development of the quality management system.

**Human Resource Development**

The approval of the Human Resource Development Policy for the health sector is a major step in systematising human resource management. In addition to the key policy elements, it defines the workforce and staff population ratio targets for the next decade.

The professional licensing system links re-certification with continuing education to further improve the competence of the health providers and is being further refined to meet the needs of the health providers. Supporting this is development of the legal and administrative framework establishing incentives to facilitate the deployment and retention of human resources in the rural areas, an area of great concern for the government, the people and the international partners.
Recent developments in the post-graduate training standards and the job descriptions developed will advance the standardisation of the performance contracts and continue to provide a basis for the ongoing, fair and timely staff assessments. This has been further reinforced by the changes that have occurred over the last decade in the medical and mid-level pre-service training, which has gradually started moving away from a specialist to a more general practitioner focus.

**Health Financing**

In the area of health financing, since the year 2000, there has been a steady increase in the state budget for the health sector both in terms of % of the GDP and of government expenditure. Recently the budget has been further supplemented by the increasing size of the outlays from the HIF to support the costs of the public health sector.

The establishment of the National Health Accounts supported by World Bank, building on the financial management system developed in anticipation of the implementation of the PSFML by the Tacis Financial Management Project, is a key step towards making improvements in the financial management of the public health sector, though considerable work still remains to be done to make the system effective and reliable.

**Institutional Development & Sector-wide Management**

Following independence and during the transition the government undertook wide-ranging reforms of the legal framework particularly related to the transition to democracy and a market economy. Other laws such as administrative and territorial unit management law and PSFML, related with decentralization and budgeting, were drafted and approved. The legal framework related to the health sector was also affected and the health law, the health insurance law, the drugs act and other related laws were amended and/or supplemented. Numerous efforts have been undertaken to integrate and streamline the legal environment for management and technical decentralization from a sector wide perspective in accordance with overall public sector reform.

The direct effect of the development of the legal framework and the transition to a market economy has been the emergence of the private sector in health and pharmaceuticals and rapid growth in the number of private hospitals and clinics creating a climate of increased competition to the public health sector, a development that has significantly raised an awareness of quality assurance needs in the health sector. This awareness has been reinforced by a number of experimental and pilot activities to promote privatization.

The ratification by the Government of Mongolia of the MDGs and the adoption of the EGSPRS included Mongolia specific targets derived from the MDGs. These targets are now reflected in main targets and goals of the MoH sector-wide long-term strategic master plan. This has also focused increasing attention on harnessing the benefits from external funding and the relatively large ODA being channelled into the health sector. In last few years, coordination of international partners and stakeholders has been given increasing attention through various participation mechanisms such as creating a separate department of International Cooperation in the MoH, formation of a government level Health Sector Aid Harmonization Sub-committee and establishment of a sector level Health Sector Coordinating Committee overseeing the HSMP development process.

Responding to the changing needs and the demands of health care delivery, a Directorate of Medical Services was operational during 2002 to 2004 to ensure implementation of the policies and programmes and to coordinate the delivery of health services. The establishment of the Directorate was a major first step in the reform of the management and administrative structure of the Ministry of Health to further improve the performance of the health services in terms of quality and effectiveness. Simultaneously, as part of the overall government reform, the Government adopted the PSFML in 2003 to increase effectiveness and efficiency of public sector. Consequently, in 2004, the MoH began the process of developing a medium term business plan.

The response to the frequent winter and summer disasters such as dzud (heavy prolonged snowfall) and forest fires respectively, combined with the spread of new diseases such as SARS and Avian Influenza has contributed to an improvement in the preparedness capacity of the health sector and other government agencies for managing these disasters and controlling the outbreaks of these re-emerging and new diseases. However, much more needs to be done for this capacity to be sustainably institutionalised.

To further increase institutional capacity, the MoH, in 2003, initiated the development of a long-term sector-wide strategic master plan to guide sector development, facilitate coordination of domestic and external resources, integrate the various health programmes and service delivery activities in the sector and improve efficiency and effectiveness of the operation of the public health sector. The development of the strategic plan,
from the outset, employed a wide consultative process engaging various stakeholders within and outside the sector and used a capacity building process.

**What are the key issues within the health sector?**

The health sector, within the context of an emerging market economy, is facing many challenges, particularly in the areas of equity, financing and responsiveness, in the short, medium and long-term. These issues were identified in the Synthesis Paper and were further processed and prioritised during activities of the Working Groups. The following table summarises the priority issues.

<table>
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<tr>
<th>Key Area of Work</th>
<th>Priority Issues</th>
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<tr>
<td>Health Services Delivery</td>
<td>• MMR and IMR have been showing steady decline but are still high.</td>
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<td></td>
<td>• Low utilization of the health services by the poor and the vulnerable groups</td>
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<td></td>
<td>• existing referral system is not functioning well</td>
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<td></td>
<td>• Gate-keeping function of the FGPs and the soum hospitals in very inadequate</td>
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<td></td>
<td>• Curative based hospital centred approach contributes to the over-capacity of hospital beds at the secondary and tertiary levels especially in Ulaanbaatar</td>
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<td>• Community participation in the planning, implementation, monitoring and evaluation of the health services is very limited</td>
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<td></td>
<td>• Hospital services are not appropriate for the corresponding level of care</td>
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<td></td>
<td>• Costly and wasteful services predominate</td>
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<td></td>
<td>• Ambulatory services and day, home and palliative care are inadequate</td>
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<td></td>
<td>• Technological developments are not introduced into the health services in a timely manner,</td>
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<td>• No continual decline in the incidence of communicable diseases coupled with a corresponding increase in non-communicable diseases</td>
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<td>Pharmaceutical &amp; Support Services</td>
<td>• Availability of essential drugs is still problematic especially in rural areas</td>
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<td>• Logistic management with particular reference to drugs, medical supplies, commodities and equipment is fragmented and there is no integrated Logistics Management Information System (LMIS) covering procurement, inventory, warehousing and distribution.</td>
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<td></td>
<td>• Low and counterfeit quality drugs are commonly available and used because of poor quality assurance and control.</td>
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<td></td>
<td>• There is widespread poly-pharmacy and irrational drug use by prescribers.</td>
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<td></td>
<td>• Widespread self medication including an indiscriminate and excessive antibiotic usage and a high injection rate per person are very common in the community</td>
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<td></td>
<td>• Outdated equipment and technology and their being in a state of poor repair</td>
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<td></td>
<td>• Hospital buildings and transportation in terms of the premises and vehicles being unsuitable and also in a state poor state of repair.</td>
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<td></td>
<td>• No suitable diagnostic standards and guidelines for laboratories at the various levels of care.</td>
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<td>• Diagnostic capacity is generally poor throughout the system.</td>
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<td>Behavioural Change &amp; Communication</td>
<td>• Sedentary lifestyles especially of the urban and peri-urban dwellers</td>
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<td></td>
<td>• Unhealthy lifestyles associated with increasing smoking, alcohol consumption, high calorie fatty diets and reduced consumption of micronutrients</td>
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<td>• Increase in unsafe sexual behaviour especially among the young people</td>
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<td>• Other risk-taking behaviours especially on the road resulting in higher incidence of fatal road traffic accidents</td>
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<td>• Poor sanitation, improper latrine use, poor waste management and personnel hygiene at household level and the lack of availability of safe water</td>
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<td>• Biological and chemical contaminants, such as Arsenic, in the environment because of industrial and other pollution and inadequate disposal of garbage and waste.</td>
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<td>• IEC activities are fragmented, often duplicated, inappropriately targeted and not effectively monitored and evaluated to determine their impact.</td>
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<td>• Service providers frequently exhibit negative and judgmental attitudes and lack appropriate communication and counselling skills</td>
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<td>• Services currently provided in the health sector are not client-friendly in terms of the providers’ attitudes, health-setting environments and access to information about health promotion, clinical services and skilled personnel.</td>
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<td>• Lack of initiative and willingness to exercise among the general population reinforced by a very underdeveloped community fitness infrastructure</td>
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<td>Key Area of Work</td>
<td>Priority Issues</td>
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| Quality of Care                        | • Current quality management system is not well developed and there is no culture of quality because of lack of knowledge and methods.  
• Absence of a sector-wide national programme for continuous quality improvement  
• No award or incentive mechanisms for good and improved quality  
• Standards are inadequate for different levels of health care and services  
• Few evidence based quality standards and related application guidelines, training programs and materials  
• Professional associations are currently not involved in quality of care management  
• Unsatisfactory use of quality indicators in the evaluation of the services  
• Shortage of health workers in the rural areas and over-staffing in Ulaanbaatar city  
• Lack of interpersonal communication skills and poor ethics among health workers  
• Inappropriate pre-service, limited continuing education and in-service training combined with a strong over-emphasis on specialisation.  
• Insufficient and inappropriate continuing education for mid-level health workers.  
• Poor clinical and management competence of staff in health facilities  
• Rapid staff turnover in the rural areas  
• Low salaries (lowest salaries in the social sector) of the health workers combined with insufficient incentives, inadequate social protection and a poor working environment  
• No career pathways or incentives, especially for the mid level health workers  
• Excessive workload on the soum doctors leads to the neglect of the provision of public health services  
• Weak professional associations resulting in a poorly organised and managed health workforce.  
• The production of human resources not linked to policies and planning in the health sector  
• Fragmented health financing and inefficient financial management  
• Lack of capacity to understand and implement the PSFML and the related international accounting practices at all levels.  
• Budgeting practices vary widely between different health facilities and levels because the implementation of the PSFML is not uniform.  
• Financial deficits incurred by hospitals are written off by the government encouraging fiscal and managerial irresponsibility.  
• Health insurance financing is not linked with the performance or reduction in costs  
• HIF co-payments and related user charges are a significant barrier for the poor and vulnerable to accessing health care especially at the secondary and tertiary care levels.  
• The ownership of the HIF and the control over its operations is split between the MoSWL and MoH and this makes management and use of HIF funds cumbersome.  
• weak management capacity at all levels,  
• inappropriate organizational structure,  
• dominant project based management not integrated with the various health policies,  
• weak integration and coordination of programs and projects implemented by international partners,  
• absence of sector wide approach  
• poor preparedness and response to and fragmented management of natural disasters and emerging public health problems  
• inefficient budgetary planning and resource allocation, (PSFML)  
• weak system of accountability and lack of transparency  
• lack of continuous and sustainable development of local and top level managers through in-service training and continuous education  
• transfer of many activities, duties and responsibilities to local governments without adequate capacity building,  
• no integrated policy on privatisation  
• no appropriate regulations and guidelines to monitor the private sector  
• poor quality of information,  
• weak capacity to use information for decision making  
• the lack of an integrated health research system  
• weak routine monitoring and participatory evaluation of performance |
In addition to the above specific issues and the cross-cutting issues identified during the situation analysis, a number of required shifts were acknowledged to address these issues. These are summarized here as they, along with the others mentioned earlier, help to clarify the basis for the direction and scope of the Strategic Plan.

The dominant provider and curative orientation of the health services needs to give way to a more client-centred and community outreach (PHC) orientation through a priority emphasis on prevention and control of communicable and non-communicable diseases and injuries focusing on the vulnerable and the poor. This would also include a major system-wide emphasis on the provision of good quality care and nutrition for mothers and children. This shift would be achieved also through the provision of essential health care services funded publicly and affordable complementary services as defined in the ECPS.

Another shift that will be necessary, as the Mongolian health sector moves into the 21st century, is moving away from only dealing with the consequences of unhealthy lifestyles, behaviours and a polluted environment to changing behaviour and adopting healthy lifestyles. It also includes creating an enabling environment for pursuing these healthy lifestyles and appropriate health seeking behaviour. This could be achieved by the active promotion of healthy lifestyles and acceptable health-seeking behaviour through integrated and targeted IEC activities and client-oriented health education at every point of contact with the health services.

Greater ownership by the community of the operations of the health services from the current domination by providers is another essential shift that has to occur. This could be achieved through increased and systematic participation of all stakeholders, domestic and international, and through partnership with the private sector. Widespread participation of the community through a variety of mechanisms in supervision, planning, funding, implementation, monitoring and evaluation would be essential.

In the management of the health sector a number of shifts are also envisaged. These are, moving to a service structure that is user-friendly, has a pro-poor and rural focus and enshrines the principles of equity and fairness; moving away from a soviet style impersonal centralised system to a more balanced decentralized management of health care delivery; gravitating away from a solely vertical programming approach to an appropriate mix of vertical and sector wide programmes within the framework of sector-wide management and, finally, from a primarily state funded health care delivery system to a sector-wide optimal public and private partnership based on the ECPS but without sacrificing equity.

To achieve these management shifts in the health sector, a sector-wide approach to management would need to be institutionalised through the decentralisation of planning, monitoring, administrative and financial functions. Optimisation of human resources through appropriate planning, management and deployment of human resources and their capacity development would also become obligatory. Effective public-private partnership for efficient essential and complementary care will have to be encouraged and institutionalised. Quality, effective and efficient health care services would need to be highly emphasized and ensured.

Health and management information and evidence would be effectively used, in a timely manner, for planning, implementation, monitoring and evaluation. Effective financial management systems that would include a separation of the purchaser and provider functions and unification of the fragmented payment systems using performance based payment mechanisms, would have to be instituted to promote and ensure sustainable and equitable access while guaranteeing affordability, especially for the poor and vulnerable. All of the above would have to be done within an evolving legal and policy framework that would protect the rights and health of the clients and providers.

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45 Synthesis Paper, Second Revised Reprint, MoH 2004, pg 177
46 Removing the purchasing of health care services function from the government to a legal and autonomous but well regulated financing body or agency, or alternatively removing the health care services provider function from the government or its agencies but not its regulation and coordination
47 Bodies that provide funds for purchasing health care services from health care providers.
48 Institutions, facilities and individuals (public and private) that provide health care services to clients.
Chapter 3: Strategic Plan direction and scope

This is the main chapter as it covers the direction and scope of the Health sector Strategic Master Plan, the strategies for the Key Areas of Work and describes what was done differently in the process of developing the Master Plan. It then lists the key benefits resulting from the implementation of the Strategic Master Plan and presents the goal of the Master Plan and the main outcomes. It then depicts the relationship of the strategies of the Plan to impacts.

This is followed by the main issues for each Key Area of Work which were derived from the Synthesis Paper as prioritized by the working groups during the development of the strategies. The strategies are then presented along with the detailed strategic actions as included in Annex B in the form of a matrix that would make it very straightforward for developing a medium-term implementation framework. The strategies for each Key Area of Work are followed by the main outcomes and each section concludes with the implications that these strategies will have on the organisation and structure of the health services, the conditions that will need to be taken into consideration and the priority tasks that will need to be carried out to ensure that the strategies and their strategic actions will be implemented.

The chapter concludes by listing the main risks that would be encountered during the development and implementation of this strategic plan. The need to monitor, minimise and manage these risks during implementation is also highlighted along with the assumptions against which they were set.

What is new or different in the health sector strategic plan?

For the first time, a long-term Health sector Strategic Master Plan has been developed that is responsive to the health needs and situation of the people in Mongolia. The planning was for the whole sector and not for the state budget funded public health sector alone. Outcomes were identified for the health sector incorporating the outputs of the projects and programmes. It also anticipated the operationalization of the plan through the development of companion framework documents that addressed the crosscutting domains. The Plan is flexible because its implementation framework is separate and therefore can be adapted to respond to the changing circumstances.

An extensive consultative process was employed. This process involved staff of the MoH and its agencies and private health sector representatives from all levels of the health sector. Staff and representatives from other ministries and government agencies, domestic and international NGOs and representatives from academia and stakeholders in the civil society also participated in the consultations. Consultations were also carried out through individual meetings with experts, at regional and national consultative meetings and in discussions during the various working groups and with visiting and participating international consultants and advisors. Consultation was also accomplished through the circulation of drafts and documents for written feedback and through meetings of the HSCC. Consultative meetings were also held between the Core Group and the Technical Assistance teams of various projects and programmes and with the academic and research institutions.

The consultative process was organised and facilitated by a Core Group and supported and overseen by a high-level Health Sector Coordinating Committee appointed by the Minister. The core methodology employed was the use of team work at all levels involving as many stakeholders as possible given the short time available for the consultation process.

For the first time, values and working principles applicable to the MoH were agreed to and highlighted right at the beginning of the planning process. These were used to guide the various stages of the consultative and drafting process and informed the discussions and deliberations of the key area of work and companion document working groups. These values and working principles were also instrumental in helping to elaborate the core policy elements and for the integration of the shifts and policy elements to define the overall policy direction for the HSMP. They were also used during the drafting and review stages of the development of the Master Plan.

Wide-ranging prior consultation was undertaken with the international partners before the initiation of the process to develop the HSMP. The international partners participated in discussions organized by the MoH for the development of the Road Map and its implementation. The partners were active members of the Health Sector Coordinating Committee appointed by the Minister. Local and international staff of these agencies was also appointed to the various working groups and worked closely with the MoH and other government staff and

representatives in the development of the HSMP and the companion documents. In addition there were numerous formal and informal meetings between the members of the Core Group and the local staff and consultants of the international partners.

*For the first time the planning process for developing the Health sector Strategic Master Plan served as a capacity building exercise* and promoted ownership. The Plan and its companion documents are, therefore, the outcome of this capacity building and ownership process. This was achieved through learning by doing, through ensuring that the composition of the membership of the working groups was derived from all levels of the health sector (public and private), government agencies and the local international agency staff, through structuring the active participation of the attendees at the regional and national consultative meetings and through obtaining feedback from the peripheral health institutions. An overall sector-wide management perspective was maintained and constantly reinforced during all interactions relating to the development of the Health Sector Strategic Master Plan at all levels and with all partners and stakeholders.

**Overall, the Health Sector Strategic Master Plan:**
- Serves primarily as a comprehensive technical long-term planning document that can be implemented by any government whatever its ideology or political mandate
- Reflects the need to think creatively if we are going to be even more successful in the future.
- Highlights pro-poor interventions
- Takes a predominantly primary health care and health promotion approach
- Shows that the strategies and outcomes are interlinked with the policies, priority issues and targets in each key area of work.
- Takes an incremental and gradual approach to change.
- Recognises that health financing policies combined with non-financing measures are needed to address financial and resource allocation challenges.
- Is not prescriptive. It allows for flexibility at different levels of the health system.
- Recognises that improving the health status of the people of Mongolia depends not only on actions within the health sector, but also on actions taken by other sectors.

**Targets, goals and strategies**

**How was the direction and scope for the strategic plan derived?**

*The Plan clearly derives its basis from the EGSPRS and the MDGs and from other government policy and planning documents. It is closely linked with the national policy frameworks and builds on and encompasses the strategies, goals and objectives of the national programmes, projects and initiatives funded by international partners.*

*The development of the HSMP was guided by a functional analysis of the current situation in the health sector. This was done through a systematic and careful review of a wide range of existing documents and reports commissioned by the MoH and the international partners over the last five years. The Synthesis Paper, which was the summary of this functional analysis, along with the Essential and Complementary Package of Services, provided the evidence base for the drafting of the HSMP.*

The determination of the *direction and scope of the Plan* was achieved through a wide ranging consultative process.
Box 5. Main Issues in the next 10 years

- Still high infant and child mortality including post-neonatal mortality
- High maternal mortality ratio
- Still high mortality and morbidity from diarrhoeal diseases, acute respiratory infections, vaccine-preventable diseases
- Malnutrition among women (micronutrient) and children (general and micronutrient)
- High incidence of infectious diseases such as STIs and TB
- Increasing non-communicable diseases
- Poor Quality of Care
- Increasing injury and accidents especially amongst children and young adults
- Poor access to safe drinking water and basic sanitation in peri-urban and rural areas
- Increasing environmental pollution in the cities
- Poor access to health care by the poor and vulnerable
- Poor quality management and regulation in the public and private sectors
- Harmful practices among consumers and providers including self-medication through injudicious and excessive use of antibiotics and injections, unhealthy lifestyles and widespread inappropriate health seeking behaviour
- Weak sector-wide management (particularly financial and human resource management and supervision)
- Predominant in-patient services and inappropriate service delivery structure at the secondary and tertiary levels resulting in duplication
- Poor quality management and regulation of the public and private sectors and an unclear privatization policy
- FGP and soum services weak and not responsive to local expectations and health needs.

Goal of the Strategic Master Plan

To improve the health status of all the people of Mongolia, especially mothers and children, through implementing sector wide approach and providing responsive and equitable pro-poor, client-centred and quality services.

Outcomes for the goal are:

- Increased life expectancy
- Reduced infant mortality rate
- Reduced child mortality rate
- Reduced maternal mortality ratio
- Improved nutritional status among children and women
- Increased access to quality health services especially for the poor and vulnerable.
- Increased coverage of rural baghs and soums and peri-urban areas with basic sanitation and safe water
- Sustainable population growth
- Reduced household health expenditure among the poor especially for catastrophic illnesses
- More effective, efficient and decentralised health system
- Increased number of client-centred and user-friendly health facilities and institutions
- Optimum public private mix

Strategies within Key Areas of Work

The strategies resulted from a consultative process involving Ministry of Health policy makers and implementers together with international partners and other stakeholders. These strategies are listed according to the seven key areas of work that were identified as the main functions (see Figure 1) of the health sector. The areas are shown in Box 6.
Box 6. Key areas of work

- Health service delivery
- Pharmaceutical and support services
- Behavioural change & Communication
- Quality of Care
- Human resource development
- Health financing
- Institutional development & sector-wide management

The 7 Key Areas of Work are listed in a conceptually logical order. Unless things change in how and where health services are delivered, there will be limited success in reducing the high levels of mortality and morbidity in the country, especially among mothers and children. Issues surrounding communication, lifestyle and quality are linked to the demand for, and use of, health services. Whatever is done over the next ten years has major implications for human resources and for the financing of the health sector. Unless there are changes in the health sector as a whole, and in the MoH as an institution, then the chances of successful achievement of the intended outcomes are limited. During implementation, health service delivery is top priority but all the other areas need to be considered as vital to each other and to health services. Therefore due weight should be given to each of the other areas depending on needs and problems at each level of the health system.

Relationship of the Sector Strategic Master Plan Elements to the Impact

Figure 1: From Plans to Results: Development of the Health Sector
The Medium-term Expenditure, Planning and Budgeting and Monitoring and Evaluation frameworks serve as the tools to implement strategies in the 7 key areas of work to deliver the health and related services in accordance with the ECPS. The above diagram depicts how the implementation of the HSMP will eventually lead to the results and impacts that will be measured by improvements in the health status indicators, achieving the MDG and EGSPRS goals eventually resulting in development and poverty reduction.

**Strategies** - There are 24 strategies and they have been grouped according to the key areas of work. The strategies are our priorities for the system as a whole and they reflect the values and principles of the ministry. While all the strategies are important there are some entry point strategies and these strategies are highlighted in Box 7 below. The criteria for choosing some entry point strategies were urgency, cost-effectiveness, and feasibility. The strategies are a guide for resource allocation and for work at each level of the health system. All the 24 strategies, strategic actions, outcomes, time frame and responsibilities are described in detail in Annex B.

**Box 7. The Strategies of the Health Sector Strategic Master Plan**

1. Further increase coverage, access and utilisation of health services sector-wide especially for the mothers and children, the poor and other vulnerable groups
2. Strengthen the delivery of quality primary and general care through soum health facilities and FGP\(\text{s}\) based upon essential part of the ECPS
3. Strengthen the delivery of quality specialized, advanced and emergency care in secondary and tertiary health facilities based upon the complementary part of the ECPS using an effective referral system
4. **Ensure continuous and equitable sector-wide access to essential drugs and bio-preparation**
5. Establish a unified drug, bio-preparation, food and cosmetics quality assurance system
6. Ensure rational drug and bio-preparation use
7. Strengthen the capacity of diagnostic services through establishing a system to supply and regularly maintain medical equipment.
8. Ensure routine infrastructure and facility maintenance, transport services and communication sector-wide
9. Further develop and integrate Behavioural Change & Communication/IEC activities sector wide to change the behaviour promoting healthy lifestyles, subsequently decreasing the incidence of most common communicable and non-communicable diseases.
10. **Build a health promoting client friendly service**
11. Create a health promoting environment through improved community participation and inter-sectoral collaboration
12. **Continually improve the quality of care sector-wide**
13. Further develop standards, guidelines and indicators for health care services
14. **Further strengthen human resource management sector-wide based on the Human Resource Development Policy (HRDP) for the health sector.**
15. Reform the pre, post and in-service training system for health professions and health related workers.
16. Further develop the incentives and motivation scheme including the social security for all health workers in the sector
17. Ensure regular and increasing flow of funds to the health sector
18. **Strengthen financial management system to improve the efficient and effective use of health sector financial and related resources**
19. Strengthen the health insurance system (HIF)
20. **Strengthen and integrate on-going health sector reform using a Sector Wide Approach (SWAp)**
21. Implement effective sector wide decentralization
22. Enhance risk management capacity to respond to natural disasters and emerging public health problems
23. **Develop a unified health management information system**
24. Establish an optimal public and private mix of health care services
Health Services Delivery

Issues

The key issue facing the health services delivery is the poor coverage and accessibility of services especially for the poor and the vulnerable. There are numerous reasons for this and chief among these are long distances to be travelled to health facilities especially in the rural areas, infrequent outreach activities, the poor quality of the rural health services many of which are not adequately responsive to the changing health needs of the population and inadequate numbers of qualified health workers in the rural areas. This inequity in access is further aggravated by curative based hospital-centred approach with a strong provider orientation especially in the urban areas and the high cost of curative services and inappropriate provider attitudes.

Another factor is that services are not geared to the current epidemiological profile and there is a greater emphasis on the high-end expensive treatments. There is an imbalance in the configuration of the secondary and tertiary services resulting in much duplication. Day, home and palliative care are not considered as part of the continuum of health care provided. The weak diagnostic capacity further contributes to poor quality and inappropriate care.

The other main area of concern is the current referral system. It is influenced by the fact that the primary health services are not working as well as expected and the emergency services system is very inadequate. There is also inefficient performance of secondary and tertiary level hospitals because there was no clear sector-wide package of essential and complementary services upon which to base the health services at these levels of the health sector, thus contributing to duplication and ensuing wastage. It is also adversely influenced by the poor gate-keeping functions of a relatively new FGP system and by the co-payments and user charges that act as barriers for the poor, in their efforts to access quality and relevant services in a timely manner. This, in turn, also contributes to excessive use of the private sector, which is not well regulated and is profit orientated.

MMR and IMR have been showing a continual decline but are still high requiring more concerted and sustained action especially in terms of improved access to and the quality of the maternal and child health related services.

Community participation is negligible and the involvement of the households especially at the bagh level is still very poor because of the strong provider orientation of the bagh and soum health services, still strongly reflected in the present role of the FGPs. This is further reinforced by the expectation that health is the responsibility of the health services and not the household or individual and yet contrasts with the high level of self-medication in the local population.

Strategies

1. Further increase coverage, access and utilisation of health services sector-wide especially for the mothers and children, the poor and other vulnerable groups
2. Strengthen the delivery of quality primary and general care through soum health facilities and FGPs based upon essential part of the ECPS
3. Strengthen the delivery of quality specialized, advanced and emergency care in secondary and tertiary health facilities based upon the complementary part of the ECPS

Main Outcomes

- Increased coverage and accessibility for the population, especially for the mothers and children, the poor and other vulnerable groups, to health services sector-wide
- Improved delivery of quality primary, specialized, advanced and emergency care based upon ECPS
- An effective referral system established and operational
- Geographical, financial and quality of care related barriers that prevent the poor and vulnerable groups from accessing and using health services reduced.
- ECPS used as the basis for providing essential health care services at the soum health facilities and the FGPs
- Increased utilization of the soum and FGP health services particularly by mothers and children.
- Integrated operation of relevant national programmes supporting service delivery at the soum and FGP health facilities
- Private sector health facilities deliver the complementary package of services in accordance with the licensing and accreditation requirements
- Appropriate utilization of secondary and tertiary health services
Implications

Implementation of the above strategies will be done employing a PHC approach that would include community participation as an essential component. The widespread application of the ECPS as a basis for planning and budgeting at all health institutions and for determining range of services\(^{50}\) to be provided at various levels will require building the management and technical capacity of the health institutions and the MoH itself. It will also, where needed, require restructuring of these promotive, preventive, curative and rehabilitative services through an optimisation of hospitals to enable them to respond to the health needs of the population, especially the vulnerable groups such as the children, mothers and elderly, and in facilitating the creation of an enabling environment where the individual and the community can be encouraged to take responsibility for adopting healthy lifestyles and behaviours and building healthy environments.

The design and operation of the referral system should reduce barriers for the poor and vulnerable and yet not provide perverse incentives to health institutions and individuals to abuse and bypass the system.

For an effective application of the ECPS at all the levels, the referral system should work optimally. To ensure this can happen, the system should have clear enforceable guidelines and procedures with incentives for the client to follow the system and for the provider for referring the client to a higher referral level. Another essential element for an effective referral system is the level of competence of the staff at the primary level and the perception of the client and the community about the status of the health services provided at the primary level facilities and the FGP. The guidelines and procedures will need to closely integrated with the copayments and user charges such that the referring provider or facility do not lose out in financial terms especially with regards to reimbursements from the HIF.

Community perceptions, health seeking behaviour and the tendency to self-medication are also important aspects to be considered in the design of the referral system. Travelling to the city to seek specialised care and the perception that tertiary level services are better than the peripheral levels will also need to be addressed through community education campaigns. Other factors that encourage bypassing such as claiming routine visits to facilities as emergencies and the use of patronage will also have to considered during the designing and operationalisation of the referral system.

The improvement in the performance and acceptability of the FGP will depend largely on the quality of their services, their competence, the clarification of their position and status in the medical and professional hierarchy and in the financing for their services. The location of the FGP vis-a-vis the private and public health sectors will be a crucial determining factor in defining their role, effectiveness and acceptability of their essential care provision and gate-keeping functions.

Pharmaceutical\(^{51}\) and Support Services

Issues:

Soum hospitals still have a persistent lack of essential drugs due to a variety of procurement and financial problems. This persistent lack is despite the efforts that have been made to improve access to essential drugs. At the aimag level, essential drug supply is 70-80% of requirements while at the soum level (not including the soums that are included in the Revolving Drug Fund Scheme where the supply is in the range of 70-80%), the percentage is much more lower (20-25%).

Logistic management with particular reference to drugs, medical supplies, commodities and equipment is fragmented and there is no integrated Logistics Management Information System (LMIS) covering procurement, inventory, warehousing and distribution. While different logistic functions at different levels of the health care services and at various facilities are routinely being carried out, these are not coordinated or linked to each other, thus leading to potential duplication and consequent wastage.

The quality of the drugs from some of the vendors is also very poor. In several cases, the drugs are counterfeit or sub-standard. Figures from the Quality Assurance Agency show that 10% to 12% of these drugs are not of acceptable standards. Nevertheless, awareness about drug quality has increased during last few years.

\(^{50}\) This includes a full range of promotive, preventive, curative and rehabilitative services at the relevant levels

\(^{51}\) This includes medical supplies
Self-medication, poly-pharmacy, excessive use of antibiotics is still prevalent even though the rational drug use is being more actively promoted.

Lack of a regular supply and maintenance system of medical equipment and laboratory technology within the sector weakens the diagnostic capacity which is further aggravated by problems related with budget constraints, maintenance procedures and availability of spare parts. This is further compounded by poor management and inappropriate utilization. Medical equipment and technology for emergency care and ambulance services are still outdated and old despite donor support in last few years. This is seen as one of the contributing factors for an increased flow patients going overseas seeking better health care.

**Strategies**

4. Ensure continuous and equitable sector-wide access to essential drugs and bio-preparations52
5. Establish a unified drug, bio-preparation, food and cosmetics quality assurance system
6. Ensure rational drug and bio-preparation use
7. Strengthen the capacity of diagnostic services through establishing a system to supply and regularly maintain medical equipment.
8. Ensure routine infrastructure and facility maintenance, transport services and communication sector-wide

**Main Outcomes**

- Continuous availability of affordable essential drugs in all health facilities especially in rural and remote areas through an efficient and cost-effective drug supply and distribution system operational integrating Revolving Drug Fund (RDF)
- Safe, affordable, quality drugs, bio-preparations and traditional medicines available at all levels of health service as a result of an operational single drug bio-preparation, food and cosmetics quality assurance agency.
- Good prescribing practices routinely used by all prescribers.
- Public awareness of RDU will be increased.
- Medical & laboratory equipment technology supplied in a timely manner and regularly maintained through systematic contracting out of these maintenance services
- Equipments, computers and vehicles at all levels maintained to meet required standards.
- Laboratory and diagnostic capacity improved sector-wide
- At least 70% of the aimag and soum hospitals will be provided with buildings that meet required standards including improved two way communications available at all health facilities and institutions

**Implications**

The key to reducing the frequent shortages of essential drugs in the rural areas could be the expansion of the RDF scheme with improved monitoring and the strengthening of the capacity of the national drug procurement and supply system through improved management and access to required finances. A detailed and rational assessment of the drugs and medical supply needs for the country will be essential to determine the resources required for ensuring adequate supplies throughout the country. The issue of continuous supply and management of quality drugs and commodities cannot be addressed without a proper Logistic Management Information System.

This availability of essential and other drugs will need to be supported by an effective and unified drug quality assurance system that will also address the presence of counterfeit and sub-standard drugs in the local drug market.

Commensurate with the improvements in the supply and access of essential drugs will be the task of integrating rational drug use and good prescribing practices from both the community and provider perspectives. Systematic community education campaigns to educate people about the danger and disadvantages of self-medication and excessive use of antibiotics and injections, including self-injecting, combined with an ongoing in-service training for the prescribers to improve prescribing practices, will be needed.

Improvement of diagnostic capabilities and the proper use of the medical technology will depend on more than just the availability of the latest and sophisticated equipment and a regular supply of reagents. The capacity to routinely service, maintain and repair the equipment and ambulances and the establishment and maintenance

52 Bio-preparations includes here vaccine, reagents, blood and blood product
of proper facilities and communication channels is also essential. The other critical factors to be taken into account are the availability of competent laboratory and technical staff and trained health professionals to appropriately use this equipment and technology in conformity with the approved standards, diagnostic protocols and quality assurance. Laboratory equipment procurement will also require improvement and local rationalization and proper priority setting.

**Behavioural change and Communication (BCC)**

**Issues**

Lifestyle related factors account for approximately 50-55% of illnesses. Environmental factors are the second leading cause of illness and account for 15-20%. Hereditary factors account for another 15-20%, with about 10% of illnesses occurring due to health service related factors. These figures underscore the critical importance of promoting healthy lifestyles.

Lifestyle related factors, particularly urban and sedentary lifestyles, affect both communicable and non-communicable disease incidence and these are related to risk taking health behaviours such as smoking, alcohol use, bad food habits, risky sexual behaviour, especially in young people, physical inactivity and work and lifestyle related stress. Fitness facilities and infrastructure are not developed. These risky health and sexual behaviours are compounded by widespread self-medication, excessive use of drugs and antibiotics and a very high rate of self-injections. The poor environmental living conditions due to lack of safe water and poor sanitation, increased city air pollution, coupled with low community participation and inadequate inter-sectoral collaboration in environmental health activities, especially in the rural and peri-urban areas add to the above-mentioned risk factors making behavioural change an area of major focus of the health services.

Currently IEC activities are ad hoc, fragmented and linked to different projects and national programmes and formal health education activities in primary and secondary schools are of questionable quality. Even the various IEC programmes and campaigns are not integrated and effectively targeted. IEC activities carried out are not effectively monitored and evaluated to determine their impact.

IEC still does not rate high in the service provider’s repertoire of skills because of the predominant curative orientation of the service providers and the health services and the poor and inappropriate provider attitudes and their lack of interpersonal and related communication skills. Services currently provided in the health sector are not client-friendly in terms of the providers’ attitudes, health-setting environments and access to information about health promotion, clinical services and skilled personnel. At the individual level health education does not occur routinely between the client and the service providers.

Injuries and accidents are also emerging as another major area of concern because of the increasing number of road traffic accidents, occupation related injuries, unsafe home environment and increasing domestic violence. Majority of these injuries, many of which afflict children, are preventable through community and individual education and appropriate regulation of road traffic and through the provision of safe working, home and educational environments.

**Strategies**

9. Further develop and integrate Behavioural Change & Communication/IEC activities sector wide to change the behaviour promoting healthy lifestyles, subsequently decreasing the incidence of most common communicable and non-communicable diseases.

10. Build a health promoting client friendly service

11. Create a health promoting environment through improved community participation and inter-sectoral collaboration

**Main Outcomes**

- BCC/IEC activities are integrated and coordinated using network approach and through the operationalisation of a National Health Promotion Centre (NHPC)
- Better utilization of the health services by vulnerable groups through an increasing number of client friendly health institutions
- Improved interpersonal communication skills of the service providers

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• Increased number of health promoting workplaces
• Increased community participation and inter-sectoral collaboration in promoting healthy environment programmes and activities
• Improved community fitness infrastructure

Implications

Shifting the focus of the health services and the providers from a curative to a health promotion orientation will require increased awareness and commitment of the policy and decision makers and the implementers to systematically integrate IEC activities and focus on BCC. It will also require sustained and intense effort to retrain service providers in the areas of interpersonal and other communication skills and include mechanisms for increasing the accountability of the providers for their actions and negligence. Training should also cover attitudes and behaviour and not just knowledge and skills related to clinical or management competence.

Developing client friendly services implies that the structure and organisation of the hospitals services should be responsive to the client’s needs and expectation, the hospital information system should be improved and be more user friendly and the sharing of information with the client and about clients should reflect the requirements of privacy, confidentiality and respect and safeguard client rights.

Within the health services, additional emphasis will need to be placed on building individual and institutional capacity to carry out integrated IEC activities and to ensure that inter-sectoral collaboration mechanisms are operationalized through political and financial support. Integration of the IEC components of the national programmes and projects will also require effort and coordination at the central and peripheral levels. An area of particular concern is the coordination of IEC activities in the prevention of HIV/AIDS/STIs in young people and the promotion of exclusive and continued breastfeeding. Care must also be taken to ensure that the programmed IEC activities take into consideration the latest approaches and methods in IEC and also reflect the Global Strategy on Diet, Physical Activity and Health (WHA 57.17 dated 22/05/04).

In the area of environmental health and in promoting healthy environments to enable adoption of healthy lifestyles, reduce risky health behaviour and improving provision of safe water and sanitation, the mobilization of the local communities, local governments, other ministries and mass media will be essential. Tax incentives for business entities that promote greater personal and corporate responsibility for healthy lifestyles, behaviours and products could also be considered.

Quality of Care

Issues

There is no culture of quality and good quality of care is not rewarded. The current quality management system is not well developed and needs to be carefully reviewed and improved. The current standards are inadequate for different levels of health care and services. While the awareness of quality of care of the services among the providers and the clients has increased, the actual quality of the care being delivered has deteriorated. There is no sector-wide national programme for the quality improvement.

Quality improvement activities are episodic and ad hoc and there is a clear lack of activity for continuous quality improvement. The present mechanisms and standards are unable to provide effective and appropriate quality assurance. Professional associations are currently not involved in quality of care management at any level. The existing mechanism to link the health insurance financing with the accreditation system of health institutions is not practical.

The increasing number of clients seeking overseas care may also be a consequence of the poor quality of care, domestically.

Strategies

12. Continually improve the quality of care sector-wide
13. Further develop standards, guidelines and indicators for health care services

54 To include renewal and implementation of quality control and sanitation standards for safe water and the setting up laboratories for safe water testing in aimags and rural areas
Main Outcomes

- Sector wide quality management system established and operational
- Self assessment of doctors and health professionals continuously coordinated and evaluated
- Increased participation of professional associations and interested stakeholders in quality of care improvement
- Appropriate quality of care standards, national clinical outcome indicators and guidelines approved in conformity with international standards and applied.

Implications

There is relationship between the quality of care and the attitude and competence of the service providers. The setting up of a national quality assurance programme, (policies, standards, guidelines and procedures) without a change in attitudes and the commensurate clinical competence of the service providers and the accountability and transparency of the management and audit system, will not achieve the envisaged improvements in the quality of care. The improvement in the quality of care would also be strengthened along with the optimisation of hospitals thus allowing more resources to be focussed on a more manageable number of well run hospitals, at the secondary and tertiary service levels particularly in UB city.

There is a clear need for introducing/implementing new approaches for Quality of Care and emphasizing the role and participation of the relevant auditing body. This will need to be complemented by decisive actions to facilitate a change in the attitude of health inspectors gradually replacing the old penalizing mentality and fostering facilitative supervision among and by all health managers.

Establishing a quality culture is a long-term affair. It will require a clear legal framework, intense and sustained political and financial commitment and in particular the involvement of the professional associations, effective client representation and involvement of the civic society. The establishment of a fair and transparent internal quality control system that includes incentives and rewards and standardized duties of health care providers will help the development and institutionalisation of a quality culture in the health institutions and the MoH.

Human Resource Development

Issues

The current human resource management system in the health sector is improvised, irrational and weak. The management capacity of the health facilities and organisations still reflects the management style of the past Soviet era and appears not to be based on modern methods or the recent computer based technological advances. Workforce planning is at best ad hoc both at the macro and micro levels with a short time frame and does not include regular annual analyses and assessments. It is not linked to factors such as population growth, the current and projected epidemiological profile of the population and the tendencies within the health sector namely privatisation, rationalisation and modernization.

The regulation of the overproduction of medical personnel by the public and private universities requires increased participation of the MoH in the various coordinating and governing bodies of these institutions, along with the Ministry of Education, to gradually bring the ratio of specialists to general practitioners more in line with international standards and reduce the overproduction of medical personnel. Professional licensing and registration processes also need to be strengthened and enforced.

Significant mal-distribution of the health workforce, with shortages of staff in remote soums and baghs characterizes the current health workforce profile. Despite the overproduction of doctors, there remains a serious shortage of doctors in rural and remote areas. The current salary and working conditions for staff working in those areas are not sufficient to motivate staff and graduates to move from urban regions to these locations. Career pathways and an incentives and motivation package are still in their early stages of development and what is there is not effective.

The training of the clinical specialists is not guided by any human resource policy, or related to a medium to long-term planning of the sector. It appears to be driven by the area of specialisation or discipline and by specialist practitioners. The training curriculum has not yet been revised and in-service training is often not relevant and poorly attended.
Strategies

15. Reform the pre, post and in-service training system for the health professionals and health related workers.
16. Further develop the incentives and motivation scheme including the social security for all health workers in the sector

Main Outcomes

- An authoritative national body responsible for sector wide human resource planning and management system operational
- A human resource database and information system established with links to other important personnel databases and managed by trained personnel
- Trained health and health related workers, with appropriate attitude, relevant skills and adequate knowledge to able to meet community health needs and job requirements
- Ongoing, regular and relevant continuing education and in-service training provided for all cadres of health workers with special emphasis on middle level health workers
- An incentives and motivation scheme developed and applied to all health workers in the sector with special emphasis on retaining doctors and health specialists in rural areas reducing rural urban disparities.

Implications

The implementation of the strategies in this key area of work will require that human resource management have sufficient authority through the establishment of an authoritative body with powers for policy and decision-making and enforcement at all levels, including regulating the private sector. A legal instrument will also need to be approved to regulate training of health personnel, including intakes, in public and private sector. This will need to be reinforced with the development and approval of standardised job descriptions for all cadres of health workers available and used in the training and deployment of the workforce.

To carry out the decisions taken by the human resource development authority, trained and skilled human resource managers and planners will have to be in place and retained in the health services.

The area of training will also require considerable attention. Training programmes, both continuing education and in-service, will need to be rationalised to avoid duplication especially those conducted by the national programmes and projects and by public and private training institutions. A long-term health personnel training plan will need to be developed and followed by all public and private training institutes.

New health projects funded by donors and external agencies should include in their plans and budgets modalities to provide financial and technical support to fund replacements of skilled staff being recruited from existing programmes.

The present low salaries and weak incentives system in the health service will also require particular attention. The revised system would need to be in line with the government service regulations and be based on performance. It should include a variety of relevant cash and in-kind incentives.

Health Financing

Issues

Despite the rather substantial current per capita health expenditure of US$ 23, additional resources will be needed to complete the move to a more market-based model and to implement the Health sector Strategic Master Plan. Therefore a key issue is to steadily increase resources available to the health sector through improved and efficient financial and resource management and from the state, HIF, taxes on alcohol and tobacco, external and other domestic sources and also include effective coordination of the external resources. The numerous informal payments levied in the health services need to be examined and formalised as necessary. The rising “out of pocket” payments, especially for drugs, are another issue that needs to be examined and taken into consideration.

However, increasing funding to the health sector does not necessarily solve all problems. There is an urgent need to improve financial management and eliminate related inefficiencies, supported by the optimisation of
hospitals. This would generate significant savings which could be redirected to primary care and public health interventions and services.

Budgeting practices are very variable between different health facilities and levels because the implementation of the PSFML is not uniform. There is a lack of capacity to implement the PSFML and is further complicated by it not being easy to define products for the health sector that relate to its performance. Consequently costing these products is also not easy. The existing accounting systems, despite recent inputs, still permit considerable possibility for misuse of state budget and HIF funds.

The current mechanisms of the resource allocation are weak and there is a lack of normative (unit cost based) allocation of resources across levels of care. The priority issue to address promptly is the lack of separation of the purchaser and provider functions along with the poor coordination of the resources from a variety of funding sources, exacerbated by the adverse incentives associated with the existing payment mechanisms.

HIF reimbursement is not efficient as it covers mainly inpatient services and not preventive and promotive (except when pertaining to the FGPs) and favours the more expensive and larger hospitals against the rural and smaller ones. It is also not related to performance and serves as a disincentive to reduce costs while sharply increasing bed capacity and use. Reimbursement is automatic irrespective of the quality of services provided by health facilities. Very poor people find the HIF co-payments as a significant barrier to accessing health care especially at the secondary and tertiary care levels.

The ownership of the HIF and the control over its operations is split and this makes management, use and monitoring of HIF funds cumbersome. Managerially the international accounting practices and standards are not fully applied and there are no clear guidelines for the use of the HIF surpluses. This contributes to the poor management of the HIF and weaknesses in the reimbursement and payment methods.

**Strategies**

17. Ensure regular and increasing flow of funds to the health sector
18. Strengthen financial management system to improve the efficient and effective use of health sector financial and related resources
19. Strengthen the health insurance system (HIF)

**Main Outcomes**

- Increase health expenditure as proportion of the GDP to sustainable levels.
- Appropriate performance based payment system that promotes quality and addresses adverse incentives established at all levels of care.
- Sector-wide health financing policy implemented.
- Purchaser and provider functions separated with pooling of variety of funding sources.
- Sector wide accounting and financial management information system based on National Health Accounts (international standards) and the PSFML established and operational.
- Increased proportion of the budget allocated to primary health care services.
- Resource allocation criteria established and used in decision making at the macro and micro levels.
- Improved health insurance coverage of the population especially the poor and vulnerable.
- Improved performance of the health insurance system.

**Implications**

The primary challenge facing the health sector in implementing these strategies is at the level of political decision-making required for their implementation. This is especially so concerning the ownership of the HIF, its management and financial autonomy. The internal corporate management of the HIF in terms of its accountability and transparency are also crucial.

The other key implication is that of implementing the PSFML, both in conceptual and procedural terms. A very high level of political and organizational commitment to decentralization and sectoral reform will be required so critical decisions can be taken prior to the capacity building that will need to be undertaken to implement the strategy to strengthen the financial management including systematic costing of the services. This will be vital if the MoH and the government, supported by the international partners, plan to move towards implementing the Sector Wide Approach (SWAp), the separation of the purchaser and provider functions and
setting up of a unified payer system with performance based payment mechanisms including more managerial hospital autonomy and higher fees for those bypassing the referral system. This would need to be done in close consultation with Ministry of Finance, Ministry of Social Welfare and Labour and its SSIGO and other related Ministries.

The sources of funding (HIF, state budget, international partners funding and out of pocket payments) for planning resource allocation at the macro budgeting level may need to be separated, the effects of this can be avoided through ensuring that payment to the hospitals and health facilities be done through a unified payment system.

Another area is the institutionalization of the national health accounts for which an accountable, transparent and standardized accounting system for all health facilities and institutions will need to be put in place immune from the periodic political changes and old soviet style financial practices and associated attitudes and secrecy surrounding financial management.

Institutional Development & Sector-wide Management

Issues

The present organizational and management structure does not enable effective and efficient performance of the health sector. It increases administrative costs, permits duplication and creates unexpected and unwanted bureaucracy. Frequent politically motivated re-organization and structural changes have taken place during the last decade, which have particularly affected the central level and did not always consider effectiveness, efficiency and better performance. A number of activities to improve the management of the public sector are being undertaken under the label of health sector reform, but these are fragmented and not linked. A major challenge is to shift management thinking from input to outputs and from planning on an ad hoc basis to planning strategically and sector-wide and to use resources effectively and efficiently to achieve the defined goals and objectives based on medium- to long-term planning and budgeting. A result based management orientation needs to be sustainably institutionalised.

Poor management capacity is a widespread problem at all levels and there is no continuous and ongoing professional development of managers. Management of different programmes and projects is dominated by insulated project-based management and is fragmented. It is further aggravated by poor integration and inadequate coordination of policies and programmes carried out by international and national partner institutions. This further contributes to the existing inefficient resource allocation and utilization and significantly impairs accountability and transparency.

Limited preparedness and anticipatory planning for dealing with disasters at the local government and community levels is compounded with the prevailing attitude of the local people and local government to disasters, which is to wait for help from central level. There is low public awareness among the population to prevent man-made disasters such as fires and need for being prepared for natural disasters. There is also a lack of immediate access to additional financial and material resources for dealing with disasters especially at the local level. There are poor management structures at the local government level to respond in a timely and adequate manner to disasters. This is often aggravated by a delayed and often inappropriate central response that is, time and again, hampered by bureaucracy, poor inter-sectoral collaboration between various domestic and international agencies, lack of accessible resources and severe logistic constraints because of the local geography and the extreme climate. A scattered population also hinders a collective community response. Other related issues are the ability to respond to preventing disease outbreaks; water and food distribution and the provision of emergency health services such as vaccinations and medicines.

With health sector privatisation on the increase, along with the rapidly growing private sector, there is no integrated legal framework and associated policies, guidelines and procedures on the development and regulation of the private sector, on health sector privatisation and on optimisation of hospitals even though there is a list of health facilities selected for social sector privatisation adopted by the Parliament of Mongolia. The increasing growth of the private sector in the urban areas, which also coincides with the growing poverty, inadequate accessibility and the poor quality of health service especially for the poor and vulnerable people, demands the urgent attention of the government to develop and strengthen the regulation of the private health sector.

55 For details please refer to the TA reports from the ADB TA TA-4123-Mongolia; Health Sector Reform, Options for Health Care Financing in Mongolia, December 2004
Another critical issue is the fragmented management information system that is characterised by poor quality of information generated and collected. Its sole emphasis is on a specialist approach to monitoring and evaluation, a weak capacity to use information for decision-making and the absence of an integrated health research system exacerbated by an ad hoc and inefficient funding of research.

**Strategies**

20. Strengthen and integrate on-going health sector reform using a Sector Wide Approach (SWAp)
21. Implement effective sector wide decentralization
22. Enhance risk management capacity to respond to natural disasters and emerging public health problems
23. Develop a unified health management information system
24. Establish an optimal public and private mix of health care services

**Main Outcomes**

- Effective and efficient organisational structure in place
- Improved management capacity of public health sector institutions at all levels
- Improved risk management capacity through developing and implementing comprehensive disaster preparedness plans
- Decentralized, accountable and transparent, sector-wide management system operational
- Increased support and finance by the local government to the health sector
- Enhanced coordination with partners and stakeholders
- Unified and user-friendly HMIS operational
- Effectively regulated private health sector

**Implications**

Traditionally institutional development and sectoral reform has been incremental and often cosmetic. It has been politically motivated and related to the changes in the government. However, to implement these strategies, a deep and sustained political commitment will be required on part of the management and the professional staff of the MoH. The urgent necessity to define an alternative structure based on functions will require far-reaching change in thinking and orientation at the individual and collective levels, focusing on the client and poor, and will need to be supplemented with extensive and ongoing continuing education and in-service training. This would create the necessary management environment and organisational structure for institutionalizing the coordination and oversight of the implementation of the HSMP at all levels.

A clear policy document defining the elements of sectoral reform, in accordance with the sector wide approach, along with guidelines and procedures for implementing decentralisation will have to be a prerequisite if the reform process is to be sustained and continuous to achieve the desired changes and obtain the benefits.

Implementation of these strategies will also require capacity building at all levels for implementing the Sector Wide Approach. SWAp includes, among other things, the strengthening of multi- and bilateral cooperation and coordination, improvements in resource management, reduction in bureaucratic procedures and in the duplication and wastage of resources. Organizational and management reform should serve as a starting point of the longer-term process to improve the sectoral performance.

Mainstreaming for disaster preparedness and management would require the appointment of a full time person in the MoH responsible for disaster preparedness plans and the inter-sectoral collaboration and coordination required. This would include improved access to relevant and timely information to assess severity of disaster and needs, drafting a comprehensive disaster management plan involving inter-sectoral partners that would include guidelines and procedures and identification additional logistic capacity. In-service training for MoH and local government staff in disaster preparedness and management would need to be instituted and regularized. Increase awareness of the local population in the prevention of and preparation for disasters would also need to be undertaken in collaboration with other inter-sectoral partners, NGOs and community based organisations and the local population groups.

**The link between planning and performance is information.** For improved performance, the quality, relevance and timeliness of information are a vital necessity. The current orientation in the health sector that accepts collection and management of information as a specialist function rather than a routine management function needs to be changed. Ownership of and freedom to use the information generated, based on a minimum set of
indicators that are appropriate for each level, is an essential element of a good information system that will then set the stage for monitoring and consequently improving performance and quality of services. This shift in orientation is a prerequisite for the establishment of a unified HMIS that will guide and influence management and resource allocation decision making through providing reliable, accurate and timely information. Essential for the development of a Health Management and Information System is the availability of a reliable, modern and sustainable information technology and infrastructure and a review and updating of the rather archaic National Statistics Law that limits the collection and use of sector information only by the respective sector ministries.

The effective regulation of the private health sector, will require an active involvement of the government and other stakeholders, such as the professional associations, in determining the range of services that should be provided by the private sector establishing a boundary between services that are a public good and those that are not, and in establishing standards and mechanisms by which these standards will be enforced universally. On the other hand, the government will also have to determine what mechanisms will be pursued in the health sector privatisation such as promotion of competition between the public sector facilities and with the private sector to promote cost-savings and improve efficiency, accelerate the rationalisation of beds such that additional state funds will be released for allocation to primary essential care activities. The formulation and implementation of an overall policy for the development and regulation of the private health sector, the further development of the legal framework, the financial regulations and guidelines and effective forms of contracting in and out with adequate and enforceable performance monitoring will be needed for the implementation of the strategic actions to safeguard the sustainable development of the private health sector while ensuring accessible and equitable health care provision to all.

Risks and assumptions

Some important risks and assumptions were identified in the various reviews and documents, and were summarised in the Synthesis Paper. In the real world things sometimes happen that can seriously hinder the successful achievement of the best written plans. Through asking ‘what if…?’ time and time again, the ministry concluded that the risks in Box 8 below are the most important ones. These risks were considered during the development of this strategic plan and to the extent possible these risks would need to be monitored, minimised and managed them during implementation. While developing the strategies, the ministry also listed the assumptions against which they were set. (Also in Box 8) These assumptions will be an important part of the implementation monitoring and evaluation process to see the rate of progress towards achievement of the outcomes.

Box 8. Risks and assumptions

<table>
<thead>
<tr>
<th>Risks:</th>
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<tbody>
<tr>
<td>Poor macroeconomic growth reducing government allocation to health sector</td>
</tr>
<tr>
<td>Frequent changes in government affecting staff turnover in the sector</td>
</tr>
<tr>
<td>Major institutional constraints facing the restructuring, rationalization, and privatisation of the health sector</td>
</tr>
<tr>
<td>High unemployment, increasing poverty, poor social amenities and unsustainable use of natural resources is increasing environmental degradation thus contributing to an increased burden of disease</td>
</tr>
<tr>
<td>Increasing prevalence of STIs and related potential for increase in HIV/AIDS prevalence</td>
</tr>
<tr>
<td>Rapid spread of new and re-emerging infectious diseases as a consequence of globalization</td>
</tr>
<tr>
<td>Frequently occurring natural disasters affecting access to health services especially in the rural areas</td>
</tr>
<tr>
<td>Rapid urbanisation increasing the burden of work of health facilities in the major cities and towns</td>
</tr>
<tr>
<td>Interruption of support from international agencies as a result of changes in their policies or because of political instability</td>
</tr>
<tr>
<td>Salaries of the health workforce do not rise sufficiently</td>
</tr>
<tr>
<td>Not enough attention to health promotion and changing health and health seeking behaviour</td>
</tr>
<tr>
<td>The operation of the vertical programmes resulting in aimag level implementers having limited opportunity to change management approaches or doing things differently</td>
</tr>
</tbody>
</table>
Management of risks that directly originate in the operation of the MoH and in the health sector are managed piecemeal within the MoH by various departments and divisions and some specially assigned officers. At the peripheral levels this is done by the Aimag Health Departments in a similar manner. However much of this risk management is done on an ad hoc basis. To streamline and integrate these disparate risk management activities in the MoH, the planning unit should be tasked to coordinate risk management activities.

The Strategic Plan is, therefore, primarily a comprehensive technical long-term planning document that can be implemented by any government whatever its ideology or political mandate. It takes a predominantly primary health care and health promotion approach. There is no sudden, surprise big change to be introduced immediately and it is not prescriptive. It allows for flexibility at different levels of the health system. It recognises that improving the health status of the people of Mongolia depends not only on actions within the health sector, but also on actions taken by other sectors.

The implementation of the Strategic Plan will reveal the need to review and revise the existing legal framework for the health sector. This would impact not only on the laws directly relating to the health sector but also those laws that affect the financial and administrative management of the entities in the health sector and those that would safeguard the rights of the clients and the providers. The development of the Implementation Framework and the subsequent implementation of the Strategic Plan will make clear what changes and amendments would be needed and when.

To ensure that the Strategic Plan is implemented, a number of implementation issues are discussed in the next chapter which summarises the three cross-cutting domains that were highlighted in the diagram above as the foundation for the implementation of the Strategic Master Plan.

Assumptions:
- Economic growth increasing government allocation to health sector
- Regional development concept enables an increased accessibility of services for the rural population
- Continuity of availability of international resources
- Implementation of the NHA and performance based budgeting and management increasing transparency and accountability of the sector
- Increasing focus of the government and the partners on supporting essential and primary health care and changing lifestyles and behaviours.
- Implementation of an effective legal and policy framework for the health sector including the private sector
- Public Sector fiscal and management reform for good governance
Chapter 4: Implementation issues

This chapter outlines the processes to operationalise the various strategies, i.e. developing annual operational plans, deciding on resource allocation and budgets and the monitoring and evaluation of performance. It examines issues that could affect the implementation of the HSMP and change management in the public health sector in terms of the ways of working, resource allocation and legislation. It then portrays the interactions between the Medium-term Expenditure, Monitoring and Evaluation and the Planning and Budgeting Frameworks and summarizes the principles, approach and methods in the three companion documents. It concludes by briefly describing the development of the Implementation Framework and discusses the new work that will arise during the implementation of the Strategic Plan and the main implications of this new work in each key area of work when developing the annual operational plans. Since the strategic plan serves as a common framework for all stakeholders in the sector, building partnerships is of critical importance and the last section addresses the issue of achieving these partnerships.

Some Issues affecting implementation of the HSMP

The implementation of the strategic master plan is a challenge for all stakeholders, the government and all levels of the ministry, private sector providers, the consumers and external partners. There are a number of key issues that will need to be addressed in the process of implementing the HSMP. These relate to the ways of working in the ministry, between ministries and with external partners and stakeholders, issues related to resources allocation and budgeting and the linkages between planning, budgeting and monitoring performance. Finally there are the issues related to legislation and other administrative and financial procedures. To ensure transparency, accountability good governance and coordination during the implementation of the Strategic Master Plan, a SWAp would be the most optimal approach.

Implications for ways of working, for resources, and for legislation

There are a number of implications of this strategic master plan. The key ones are the need for:

- Emphasis on health outcomes for the population
- Linking planning with budgeting and need
- Separation of the purchaser and provider functions in the health sector and unifying payer mechanisms
- Emphasis on creating competence for sector-wide management, the management of change and organizational development
- Operationalizing the values and working principles of the Ministry of Health at all levels and by all stakeholders
- Continued emphasis on systems development and capacity building
- Increased delegation and capacity to manage effectively and efficiently at delegated levels
- Increased decentralization and deconcentration
- Systematic and regular monitoring and evaluation using appropriate health, management and financial indicators
- Integration of national programmes at the operational (aimag/district and soum/FGP) level
- Partners working within the framework of the strategies and their desired outcomes
- Phasing in some of the strategies and strategic actions as resources become available
- Ensuring consistency between legislation and the health and related policies of the Ministry of Health and their effective implementation

The role of MTEF, MEF and PBF in the implementation of HSMP

The diagram below shows how the strategic master plan sets the stage for the development and implementation of operational plans using a renewed planning cycle described in the planning and budgeting framework, plans that will be adjusted to the available funding described in the medium-term expenditure framework that combines resources from a variety of funding sources. Performance is measured against the strategic master plan; its implementation framework and the annual operational plans through an ongoing monitoring and evaluation process.
Figure 2: Linkage of HSMP with MEF, MTEF and PBF

The Strategic Planning and Implementation Process
Implications for change management and organisational development during implementation

To implement these strategies, a deep and sustained political commitment will be required by all direct beneficiaries of the current organisational structure and its management system to define an alternative structure based on functions focusing on the client and poor. It will need to be supplemented with extensive and ongoing continuing education and in-service training. Implementation will also require capacity building at all levels. This includes the strengthening of multi- and bilateral cooperation and coordination, improvements in resource management, reduction in bureaucratic procedures and in the duplication and wastage of resources. Organizational and management reform should serve as a starting point of the longer-term process to improve the sectoral performance and implement a sector wide approach.

Responsibilities for the strategies within the key areas of work have been assigned to lead departments, implementing units and cost centres. (See Annex B) The consultation process initiated during the design phase needs to be continued to ensure issues are raised and ideas flow, bottom up, to feed into strategic decisions. This entails the development and strengthening of the coordination processes, mechanisms and structures and that would enable staff at the periphery to regularly and systematically participate in decisions that affect sector-wide priorities.

Central level support to aimag level planning and implementation is essential and mechanisms such as the Senior Managers meetings, routine management meetings at each level, ongoing training and partner coordination will help identify responsibilities from both levels to ensure joint accountability in achieving planned outcomes. Ownership of strategy implementation has to be with line managers at all levels, as it is they who will make most things happen, hence the emphasis on building management capacity including leadership skills. Since the PSFML grants adequate operational responsibility and authority for expenditures as part of effective decentralisation and administrative reform, the general and financial management capacity of the line managers at all levels will need to be systematically developed and supported particularly for resource allocation and financial decisions. There is a critical need for institutional measures that strengthen teamwork at all levels.

The implementation of the Master Plan during the period 2006-2015 also calls for an urgent need to integrate planning and budgeting at all levels, to monitor expenditures against activities and to validate reported expenditures and outputs in accordance with the stipulations of the PSFML. This will require closer working relationships between the various departments at the central and aimag levels particularly between the planning, finance and health information monitoring departments and with those directly involved with service delivery. Along with the above mentioned entry point activities, the development of the human resources in management and clinical areas, improved coordination with partners to harmonize and integrate their various inputs, improvement of management practices and the associated restructuring of the departments and organization at the different levels to progressively bring about sector-wide performance based management, will need to be institutionalised.

Financing the Strategic Master Plan

Medium Term Expenditure Framework

Achievement of targets and outcomes of the HSMP is dependent on having an adequate resource envelope over the medium term and a close link with planning, monitoring and evaluation. Thus the MTEF is a multi-year (4) public expenditure plan comprising all available sectoral domestic and external resources, existing and projected, used to set out future budget requirements for existing services and to assess the resource implications of future policy changes and any new programmes. As an information tool, it serves to programme all resources and expenditures together for the effective allocation of resources within the sector’s priorities. It is an essential tool to successfully implement the strategies and achieve the outcomes in the strategic master plan in an effective and efficient manner at all levels of the health sector. It is closely linked to the Monitoring and Evaluation and the Planning & Budgeting Frameworks.

Linkage of the medium term financing with planning and budgeting process (PSFML)

The MTEF links primarily with the steps 4 and 5 of the planning and budgeting cycle during the preparation and adjustment of the annual budgets for the business and annual operational plans, as described below. It provides

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56 (See Medium Term Expenditure Framework, Volume 2)
57 “Medium Term Expenditure Frameworks” DFID Health Systems Resource Centre Briefing Paper, Mark Pearson, 2002
the structure of the resource base for the overall planning and budgeting cycle of the government (PSFML) and provides the context and sets the stage for the development of the operational budgets for these plans.

**Benefits of the medium term resource envelope:**

The benefits of the MTEF as a companion document to the HSMP can be summarised as follows:

- Serves as a financial tool for the implementation of the HSMP
- Increases the efficiency of health sector expenditure by shifting resources that would result from improved efficiencies in financial management and optimisation of hospitals, towards the neglected public health and primary health care areas and associated health programmes
- Facilitates the separation of the purchaser and provider functions in the health sector
- Takes into consideration the funds required for the implementation of the medium term policy changes (e.g. EGSPRS) and newly introduced programmes such as SWAp
- Raises resource awareness and promotes more output or outcome oriented approaches
- Creates a more cooperative and transparent environment between Government and external partners concerning efficient resource allocation
- Identifies the undeveloped financial resources and defines their capacity through improving accountability and transparency within the various government ministries and agencies
- Enhances inter-sectoral cooperation

The MTEF comprises not only the government health expenditure funds but also the resources available to the health sector from foreign and domestic grants and loans (referred to as public sector health expenditure).

The MTEF development process, consisting of both the “top-down” cost estimation, namely, establishing the realistic expenditure limits for health sector within the framework for the medium-term policy for macro-economic and consolidated budget, and the “bottom-up” methodology that calculates the resources required to implement the strategic priorities of the sector as described in the HSMP, provides an integrated expenditure framework. It helps create a more cooperative and transparent environment between Government and international partners concerning efficient resource allocation.

**Steps underlying the development of the MTEF**

1. Forward projections of government spending
2. Compiling and updating information on donor funding for the medium term
3. Estimation of costs based on strategic activities
4. Integrating available resources into the planning process
5. Identifying the financing shortfalls and the ways for resolving them
6. Monitoring and updating the MTEF

**Implementing the strategic plan using the MTEF**

The strategic master plan comprises many components that will be funded by the government and its different agencies and international partners through technical and financial assistance. Several mechanisms will be used including the state budget, HIF, co-payments and user charges (out of pocket) and international partner funds. International partner funding for this strategic master plan will be targeted to specific strategies and actions featured in the strategic master plan and its implementation framework in close consultation with the MoH and its aid harmonization mechanisms.

The medium term expenditure framework will be the key public expenditure plan for the sector indicating planned expenditures for major actions/activities against implementing units and cost centres (see volume 2). The framework -- also part of the larger government financial reform strategy embodied in the PSFML -- will present resource needs estimated through cost projections of planned activities and financial allocations based on the current resource envelope.

Projecting the resource envelope for the later stage of the implementation of the strategic master plan will be less accurate as government and donor financing flows are contingent on many external factors and subject to changes in priorities. Nevertheless, the spending limits for this period will be indicative and updated annually as expenditures are monitored and information on resource availability becomes more precise throughout the

\[\text{Currently being done through an ADB funded Technical Assistance Project}\]
strategic and business planning cycles. The medium term expenditure framework will indicate shortfalls and duplications against major strategies and actions that would enable the government and its partners to plan jointly and allocate resources more efficiently. The institutional process of monitoring expenditures and making informed decisions indicate the need to strengthen the capacity of the central ministry as well as provincial and district staff in financial management.

The Resource Envelope

A resource envelope is the estimate of resources available, which can be applied at both sector and aggregate spending levels. The resource envelope for the health sector in Mongolia consists of government spending on health (State budget, HIF, and co-payments and fees paid to state health service providers) and donor financing.

Resources available till 2004

The following table (which is also included in the MTEF, Vol. 2) summarises the amounts and percentages of the various types of funding that have been available to the health sector since 1999 to the present.

Table 1  Public sector health spending by source for 1999-2004 (Millions US$)

<table>
<thead>
<tr>
<th>Sources</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Government health spending</td>
<td>34.67</td>
<td>43.04</td>
<td>49.45</td>
<td>51.93</td>
<td>54.14</td>
<td>66.55</td>
</tr>
<tr>
<td>1.1 State budget</td>
<td>24.39</td>
<td>31.76</td>
<td>32.70</td>
<td>33.23</td>
<td>37.34</td>
<td>47.14</td>
</tr>
<tr>
<td>%</td>
<td>70.3</td>
<td>73.8</td>
<td>66.1</td>
<td>64.0</td>
<td>69.0</td>
<td>70.8</td>
</tr>
<tr>
<td>1.2 HIF59</td>
<td>8.04</td>
<td>8.78</td>
<td>13.64</td>
<td>16.37</td>
<td>13.49</td>
<td>16.94</td>
</tr>
<tr>
<td>%</td>
<td>23.2</td>
<td>20.4</td>
<td>27.6</td>
<td>31.5</td>
<td>24.9</td>
<td>25.5</td>
</tr>
<tr>
<td>1.3 Out of pocket payment60</td>
<td>2.24</td>
<td>2.51</td>
<td>3.12</td>
<td>2.34</td>
<td>3.32</td>
<td>2.47</td>
</tr>
<tr>
<td>%</td>
<td>6.5</td>
<td>5.8</td>
<td>6.3</td>
<td>4.5</td>
<td>6.1</td>
<td>3.7</td>
</tr>
<tr>
<td>% of total government expenditure</td>
<td>10.13</td>
<td>10.91</td>
<td>11.08</td>
<td>8.86</td>
<td>10.08</td>
<td>11.73</td>
</tr>
<tr>
<td>% of GDP</td>
<td>3.99</td>
<td>4.60</td>
<td>4.87</td>
<td>4.65</td>
<td>4.56</td>
<td>5.19</td>
</tr>
<tr>
<td>Per Capita Government Health Expenditure (in USD)</td>
<td>14.6</td>
<td>18.0</td>
<td>20.4</td>
<td>21.1</td>
<td>21.7</td>
<td>26.3</td>
</tr>
<tr>
<td>2 Donor financing</td>
<td>11.20</td>
<td>8.37</td>
<td>25.57</td>
<td>8.54</td>
<td>7.61</td>
<td>8.67</td>
</tr>
<tr>
<td>2.1 Grants</td>
<td>9.87</td>
<td>4.70</td>
<td>20.15</td>
<td>7.22</td>
<td>6.30</td>
<td>6.30</td>
</tr>
<tr>
<td>2.2 Soft loans</td>
<td>1.33</td>
<td>3.67</td>
<td>5.42</td>
<td>1.32</td>
<td>1.31</td>
<td>2.37</td>
</tr>
<tr>
<td>% of GDP</td>
<td>1.29</td>
<td>0.89</td>
<td>2.52</td>
<td>0.76</td>
<td>0.64</td>
<td>0.68</td>
</tr>
<tr>
<td>% public sector health spending</td>
<td>24.42</td>
<td>16.28</td>
<td>34.08</td>
<td>14.12</td>
<td>12.32</td>
<td>11.53</td>
</tr>
<tr>
<td>Total Public Sector Health Spending</td>
<td>45.87</td>
<td>51.41</td>
<td>75.02</td>
<td>60.47</td>
<td>61.75</td>
<td>75.22</td>
</tr>
</tbody>
</table>

- planned figures, (others are actual figures)

Source: Ministry of Health (government spending)
Ministry of Finance & Economy, (donor financing)

Resources projected from 2005-2008

Using the steps for developing the MTEF, the following table summarises projected funding for the various types of sources for the period of the MTEF (2005-2008) based on the Government Fiscal Expenditure Framework that was developed based on macroeconomic criteria in 2003 and approved in 2004 by the Government of Mongolia.

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59 The amount excluding HIF’s operational cost
60 Only out of pocket payments made to state health service providers
Projection for public sector health spending

Table 2  Projection for sources of government health expenditure 2003-2008 (in million USD)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1  State Budget</td>
<td>37.34</td>
<td>47.14</td>
<td>47.87</td>
<td>49.82</td>
<td>52.37</td>
<td>53.67</td>
</tr>
<tr>
<td>%</td>
<td>69.0</td>
<td>70.8</td>
<td>69.0</td>
<td>61.1</td>
<td>60.1</td>
<td>59.5</td>
</tr>
<tr>
<td>2  HIF</td>
<td>13.49</td>
<td>16.94</td>
<td>19.03</td>
<td>27.66</td>
<td>30.46</td>
<td>32.01</td>
</tr>
<tr>
<td>%</td>
<td>24.9</td>
<td>25.5</td>
<td>27.0</td>
<td>33.9</td>
<td>34.9</td>
<td>35.5</td>
</tr>
<tr>
<td>3  Out of pocket payment</td>
<td>3.32</td>
<td>2.47</td>
<td>2.57</td>
<td>4.08</td>
<td>4.36</td>
<td>4.51</td>
</tr>
<tr>
<td>%</td>
<td>6.1</td>
<td>3.7</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>4  Government health spending</td>
<td>54.14</td>
<td>66.55</td>
<td>69.47</td>
<td>81.55</td>
<td>87.19</td>
<td>90.19</td>
</tr>
</tbody>
</table>

Note: * actual, ** projected

Table 3  Projection for international partner/donor financing (in million USD, 2004-2008)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development official aids, grants (mil. USD)</td>
<td>6.30</td>
<td>7.74</td>
<td>8.53</td>
<td>9.62</td>
<td>10.90</td>
</tr>
<tr>
<td>Soft loans (mil. USD)</td>
<td>2.37</td>
<td>5.62</td>
<td>4.32</td>
<td>1.30</td>
<td>0.39</td>
</tr>
<tr>
<td>Total international partner/donor funding (mil. USD)</td>
<td>8.67</td>
<td>13.36</td>
<td>12.85</td>
<td>10.92</td>
<td>11.29</td>
</tr>
<tr>
<td>% of total health expenditure</td>
<td>8.8</td>
<td>12.0</td>
<td>11.0</td>
<td>9.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Total Government health expenditure and international partner/donor funding (in mil. USD)</td>
<td>75.22</td>
<td>89.94</td>
<td>94.40</td>
<td>98.11</td>
<td>101.48</td>
</tr>
<tr>
<td>% of total international partner/donor funding</td>
<td>11.5</td>
<td>14.9</td>
<td>13.6</td>
<td>11.1</td>
<td>11.1</td>
</tr>
<tr>
<td>International Partner/Donor funding as % of GDP</td>
<td>0.7</td>
<td>1.0</td>
<td>0.8</td>
<td>0.7</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Key principles underlying resource allocation in the MTEF

- That the government will maintain and further increase, as required\(^{61}\), the health spending in terms of % of GDP and government spending over the MTEF period 2005-2008.
- Increasing the proportion of HIF contributions in financing the health sector.
- Henceforth, the HIF surplus would not exceed 25% of its annual revenue at the end of any fiscal year and the current accumulated HIF surplus amounting to 16 billion tugriks\(^{62}\) at the end of 2003 (currently equivalent to 72% of annual revenue) will be reduced by 60%, 50%, 30%, 25% in 2005, 2006, 2007 and 2008 respectively.
- That the out of pocket spending is expected to remain at the current level of 5% of the government health spending during the MTEF period in line with the recent amendments to Health Legislation.
- The Health Ministry’s order no.297 of 2003, states that government health spending for essential package of services should reach US$12 per capita. However, current spending in 2004 is at USD 6.8 per capita with USD 1 of this amount coming from the HIF. To reach this level of spending by 2005, an additional sum of about USD 13.54 million (16 billion tugriks) will be required. This additional funding can however be obtained through a restructuring of the existing resource envelope but only in the medium term and not

\(^{61}\) Following joint consultations between Ministry of Finance and Health and Social Welfare and Labour
\(^{62}\) Based on figures available as of 2003
in the short term. This could be achieved by gradually increasing the per capita expenditure on health to about US$11 over the MTEF period.

- That per capita health expenditure for public health components of the essential package of services such as: vaccination, social health programmes, promotion of healthy lifestyles will be increased to US$ 4.0 which would be 10 times higher than what was spent in 2004.

- That by the year 2008 the per capita health expenditure at soum hospitals will reach US$ 7.4 and for FGPs US$ 5.4 from the current per capita expenditure of USD 11.4 for the soums and USD 1.8 for FGPs. This would translate to a readjustment of funds for the soum level from the current financing in 2004 of USD 11.53 million to USD 7.56 million by 2008. However, this does not suggest that the total amount for the rural level services will be reduced. It will be redistributed based on agreed resource allocation criteria.

To accomplish this readjustment would require either, structural changes to be made at soum hospitals, such as reducing the number of beds and staff or, by modifying the HIF and related payment methods for soum hospitals by replacing the current method of financing centred on number of in-patients treated with a per capita payment method that is based on the catchment population thus reducing the perverse incentives for the soum hospitals to maintain more than the required number of beds.

- To reverse by 2008, the current (2004) ratio of financing the complementary health care services component of the ECPS from the current level of 62.7% from the state budget and 31.8% from HIF, to 15.5% from the state budget and 74.4% from the HIF or other alternative financing scheme assuming that pooling of funding may not occur. If global budgeting is instituted then this may not apply.

- To increase the out of pocket payments as percentage of total health spending for secondary and tertiary level complementary health services from the current (2004) level of 5.6% to 10% by 2008. This would be accomplished through the introduction of fee for services for specialized care at the secondary and tertiary levels. Thus, out of pocket payments could also be employed to control behaviour of patients and reduce possible overuse of services.

- The health sector’s management expenditure for 2005-2008 would also increase from the current 3.4% to 4% for period 2005-2006 and 5% 2007-2008.

- For the period 2005-2008, the percentage of government spending as investment in medicines, machinery, medical and other equipment will also be increased.

Current payment mechanisms for disbursing government health spending

While it may be necessary to separate the sources of funding (HIF, state budget, international partners funding and out of pocket payments) for planning resource allocation at the macro budgeting level, payment to the hospitals and health facilities should be through a unified payment system. An overhauled HIF could be utilized as a vehicle to manage a performance and outcome based payment system while keeping the system integral, un-fragmented and consistent through reasonable pooling of funds while maintaining a sector-wide resource allocation policy. The hospitals and facilities would submit a single consolidated global budget using the various standards and norms provided by the MoF and the HIF and report back in the same way. Specific bed use data may still be submitted to the SSIGO for purposes of planning and reporting on utilization of the health facilities.

Monitoring the Strategic Master Plan

Monitoring and Evaluation Framework

Achievement of the targets and outcomes of the HSMP is dependant on a close link between planning, financing, and monitoring and evaluation. Thus the MEF is a framework for monitoring and evaluating the

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63 If global budgeting is instituted then this may not apply.
64 It would include the cost associated with the setting up of a SWAp arrangement over the next three years
65 (See Monitoring and Evaluation Framework, Volume 3)
implementation of the strategic master plan. It is a tool to help move from the strategies and outcomes in the strategic master plan to successful, effective and efficient implementation at all levels of the health system. It is closely linked to the Planning & Budgeting Framework and in future years will influence the Medium Term Expenditure Framework.

**Linkage of monitoring and evaluation with planning and budgeting process (PSFML)**

The MEF cycle links primarily with the steps 6 and 1 of the planning and budgeting cycle as described earlier, with setting of targets as a critical prerequisite for developing the business and annual operational plans. It also coincides with the overall planning and budgeting cycle of the government (PSFML) and sets the stage for the development of operational plans and budgets.

**Benefits of routine monitoring and evaluation:**

1. Employs an integrated health management information system (HMIS) in order to obtain the full benefit of the operation of the various standalone/individual systems already in place
2. Uses acceptable quality of data and information to monitor and evaluate the health sector including traditional medicine
3. Assures accurate data and information (validity, reliability, timeliness)
4. Uses a standard matrix consisting of strategies, activities, outputs, indicators and means of verification for monitoring and evaluation at all level health organizations, international partners and private sector
5. Employs an appropriate set of indicators for evaluating performance of health institutions.
6. Allows national programs to be integrated by matching their own monitoring and evaluation with the sector-wide monitoring and evaluation framework
7. Builds capacity as a pre-condition for implementation of HMIS
8. Changes staff attitudes towards monitoring and evaluation as a crucial requirement
9. Makes M & E a routine activity to be done by all managers/staff while implementing the annual operational plans
10. Incorporates and integrates periodic evaluations from the central and local levels to supplement and validate the routine and ongoing monitoring activities

**Steps of the Monitoring and Evaluation cycle**

1. To identify new/continuing targets and outputs based on the annual health sector review
2. To use targets and outputs to develop indicators to monitor and evaluate annual operational plans
3. To implement monitoring and evaluation activities
4. To carry out data analysis and interpretation
5. To share results horizontally and vertically

**At the operational plan level:**

To standardize the monitoring of the annual operational plan and budgets, a ME matrix is provided that includes the basic strategies with columns for activities, planned outputs (targets), indicators and means of verification, is provided for implementers^66^.

**At the strategic and business plan level:**

To standardize monitoring of projects and programmes and integrate them into the overall M & E, use of a Logical Framework matrix for development and revision of national programmes and projects as a standardized format is recommended. This matrix includes the goals with columns for strategies, outcomes, indicators and means of verification and is recommended for use by health organizations, international partners and the private sector.

Monitoring and evaluation should be routinely done by all health facilities, institutions and agencies at the unit level by:

- Each staff of health institutions
- Manager of the unit
- External auditing institution

^66^ Peripheral and central level departments, health facilities, international partners and the private sector
The following questions that should be asked to perform routine monitoring and evaluation on a day-to-day basis:

- Is this the best way to work?
- Might it be more efficient to do it another way?
- Are we well on the way to meeting our objectives, and if not, why not?

Each unit monitors and evaluates its performance on a regular basis on a certain day of month employing the following steps.

1. Each staff member should develop his or her weekly and monthly work plans.
2. The manager of the Unit should develop the unit’s monthly and quarterly plan, which would form the basis for the staff weekly, and monthly work plans. The unit monthly and quarterly work plans would be derived from the annual operation plan and would include all the indicators.
3. Objectives and activities for each key area of work would be assigned to individual staff that would be responsible to either carry out the activity or oversee its implementation and prepare monthly progress report using the relevant indicators listed in the annual operational plan and the M&E guidelines.
4. A regular monthly unit-wide progress review meeting would be held with a clear, well-developed agenda distributed in advance. The meetings would be chaired by rotation.
5. The progress reports with recommendations for action would be presented and discussed and decisions taken and assigned to responsible staff for reporting during the next meeting.
6. Minutes of the meeting would be kept, prepared and distributed before the next meeting with assigned tasks to be completed highlighted.

**Output evaluation**

This is the evaluation at the objective and activity level and uses a variety of indicators that are derived from the Master Plan’s strategic and implementation framework and are included in the business and annual operation plans. These are used to monitor performance in the short to medium term (1-3 years). Output evaluation is critical for effective and efficient planning, decision-making and resource allocation. It is a critical requirement of the PSFML.

**Outcome evaluation**

This is the evaluation at the goal and strategy level and uses a variety of high-level indicators (as listed under the MDGs and in the EGSPRS) that are derived from the Strategic Master Plan matrix. These are used to monitor performance in the medium to long-term (5-10 years). Outcome evaluation is essential to determine the overall direction of the development of the health sector and the scope and nature of the health services to guide planning, decision-making and resource allocation, particularly the regular review and updating of the Medium Term Expenditure Framework.

**Feedback and reporting**

The preparation and sending of various monthly, quarterly and semi-annual reports vertically to the supervisory levels, and horizontally to the supporting peripheral institutions and facilities, will ensure feedback to all involved in the implementation of the strategic and annual operational plans. The Annual Health Sector Review will be jointly developed with the international partners and be sent to all levels of the MoH, the international partners and other stakeholders in the government and civic society.

**Health and Management Information System (HMIS)**

An integrated HMIS system\(^{67}\) would serve as an effective tool for creating conditions that would enable effective use of information in decision-making about planning, financial management, resource allocation and implementation of policies and laws. It would have at least the following sub-systems:

- **Public Health**
  - Programmatic Information Systems
  - Surveillance Information System
  - Environmental Health Information System
- **Medical Services**
  - Hospital Information Systems

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\(^{67}\) Based on the ADB funded MoH HMIS Working Group working document titled “Classification of HMIS Components”; December 2004
Laboratory Information Systems
- Diagnostic and Imaging Information Systems
- Pharmacy Information Systems
- Traditional and Rehabilitation medicine information system

Supportive Functions
- Human Resource Information System
- Medical Equipment Information System
- Pharmaceutical Information System
- Health Facility Information System
- Health Research Information System

Financial Information System

Private Health Sector Information System
- Other Government Health Facilities Information Systems

Planning the Implementation of the Strategic Master Plan

Planning and Budgeting Framework68

The basic principles of the revised planning cycle can be applied to all institutions at all levels of the health sector. The planning and budgeting cycle covers the steps for developing the annual operational plan and budget at all levels. According to the planning cycle, partners and stakeholders at each level shall also develop their respective activities and cost them so that these are reflected into the operational and budgetary planning process of the health institutions.

Linkage of planning and budgeting (PSFML)

The revised planning cycle will primarily be focused on linking planning and budgeting with planning preceding budgeting. It will coincide with the overall planning and budgeting cycle of the government (PSFML) and will lead to an operational plan and budget based on needs and for the whole sector.

Benefits of completing operational plan before developing budgetary plan:

- Operational planning would reflect the needs of the sector and not just be developed for those activities that will be funded from public sector funds
- Permits a better allocation of resources
- Help to reduce duplication and overlap and the consequent wastage and misuse of resources
- Makes planning and budgeting realistic in terms of addressing the health needs
- With the increasing involvement of the partners, stakeholders and community in the planning and budgeting for the sector, the opportunity for accessing additional resources from a variety of sources becomes more feasible and practical and optimises resource allocation
- Facilitates accountability and transparency in planning and budgeting

Steps of renewed planning cycle:

1. To prepare an annual sector review
2. To set outputs, targets and objectives
3. To develop an operational plan according to the outputs, targets and objectives
4. To estimate operational costs and plan a budget
5. To make required adjustments to operational plans and their budgets for approval
6. Routine monitoring throughout the next year and year-end evaluation

What are the benefits of having Joint and Comprehensive Planning?

The planning system promotes joint planning and comprehensive plans at all levels. ‘Joint’ refers to a planning process in which all partners participate. By ‘Comprehensive’ the ministry means that it includes the plans of each central department, aimag/district, soum, facility, national programmes and stakeholders.

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68 See Planning and Budgeting Framework, Volume 4
Joint planning as a process

In support of developing comprehensive plans, the planning framework promotes sector wide participation of all relevant stakeholders involved in implementing the health sector strategic plan in a joint planning process. Key activities influencing this process are the annual review, the 1st step of the planning cycle and steps 2 and 3 of the planning cycle, namely the development of targets, objectives and operational plans.

Comprehensive plan as a product

A comprehensive plan is more than just a compilation of national programme plans or the incorporation of the priorities and activities supported by non-governmental, international agencies and other partners. The annual operational plan needs to be comprehensive in that it includes all actions/activities planned within the scope and priorities of the health sector strategic plan. Comprehensive also means one plan for each central level department or agency, aimag/district, soum and facility.

In terms of activities this means that, in order to reflect the priorities of the health sector strategic plan, annual operational plans at all levels include national programme activities as well as activities implemented with support from non-governmental and international organizations.

In terms of budgets, operational plans do not only focus on activities implemented through the government health budget, but also include all activities funded through national programmes as well as those funded by non-governmental organizations and other partners.

National programmes, at aimag/city health departments and soum/FGP levels, participate in the overall planning process. Activities to be implemented by national programme staff are developed jointly with other staff, taking into consideration other priorities and linkages with other planned activities. Detailed annual plans for the various national programmes can be taken from the comprehensive plans and, if required, developed in more detail in order to meet the specific needs of respective national programmes.

In a similar way, non-governmental organizations and other partners participate in the overall planning process and develop annual operational plans jointly with other stakeholders and in support of implementing the health sector strategic master plan 2006 – 2015.

Development of the Implementation Framework

An Implementation Framework will serve as the intermediate step between the HSMP and its companion documents and the annual operational plans. It will unpack the strategic actions in the HSMP and permit the development of objectives and activities from which indicators will be derived. It will provide a forum and opportunities for participation of the other stakeholders and international partners to participate in the planning processes. It will provide the basis for the development of planning manuals and guidelines for each level of health facilities for the development of the annual operation plans and budgets thus translating the HSMP into operational plans at the local facility and agency levels incorporating the MEF, MTEF and PBF. It will form the foundation and basis for employing a SWAp for implementing the HSMP.

In summary, the annual operational plans should include objectives for all government and externally financed work, within the framework of the strategic master plan. These plans should also meet requirements for preparation of the annual budget of the Ministry of Health and be in line with the government's budget cycle and the overall agreed allocation to the health sector. The annual operational plans will be performance-based and clearly define measurable outcomes and outputs that can be monitored to improve transparency and accountability of public sector health expenditures. At the end of each year, as part of the sector wide management approach, the ministry and its partners will review progress. Overarching assumptions and risks will again be considered during the development of operational plans including the analysis of local situations concerning the willingness and support from partners, i.e. local authorities, other ministries and external partners.
**Bottom-up approach and integration**

A bottom-up approach is a key guiding principle for the planning-budgeting process. Planning will start from soum/FGP level and merge into the aimag/district plans, which will relate national priorities to work at the peripheral level. Efforts will also be made to integrate the annual operational plans of national programmes into local plans.

For effective implementation of the Master Plan that will also contribute to on-going capacity building, the role of planning and monitoring should primarily be to enhance performance rather than place exclusive emphasis on control of resources. To achieve this, planning has to be integrated and decentralised (See the Glossary Annex E: Decentralisation). Integrated through a central level agency responsible for coordinating and ensuring effective planning according to regulations, guidelines and procedures and decentralised through durable and efficient management structures at the aimag/district level. **Thus the need for setting up a central level division/department responsible for coordinating and integrating planning and budgeting in the Ministry of Health becomes a paramount task to ensure implementation of the strategic plan. It will take the lead role in guiding the development and ensuring the quality of plans and the relevance of the budgets at both the central and aimag levels.**

Proposed plans and budgets will be assessed by this central level planning division/department, which will then make decisions, in consultation with the aimag/district planning units, to allocate financial resources against activities. At the same time, it will require active and ongoing participation of other stakeholders and partners to include their priorities during the development of the annual operational plans and also to ensure the reflection of national level priorities and objectives.

**New work and its implications for planning**

The process of developing a synthesis paper and the subsequent drafting of the Master Plan along with the consultative processes employed, highlighted a number of areas of new work to be undertaken in the health sector.

**Health Service Delivery and ECPS**

A priority area of new work is the reform of health service delivery, especially at hospitals, to be based on the nationally approved ECPS and linking this service delivery reform with the development and rehabilitation of the rural and peri-urban health services being undertaken with the support of ADB. There are adequate numbers of health facilities in Mongolia. However, the appropriateness of these facilities to deliver the package of services described in the ECPS needs to be urgently addressed at the level of the FGP and soum health facilities and also in terms of the optimization of the secondary and tertiary hospital services.

**Pharmaceuticals and Support Services**

Two new tasks emerge as priorities in this Key Area of Work. One is the integration of the logistics management to streamline and systematize the ordering, procurement, storage, distribution and monitoring the performance of the drug and medical supplies system at all levels. The other task is the integration and unification of the regulatory and quality assurance functions of the Ministry of Health for drugs, bio-preparations, food supplements and bioactive substances.

**Behavioural Change and Communication**

IEC activities should be coordinated to become fully integrated and part and parcel of the health care delivery system. Thus the new work in the area of behavioural change and communication would include education and communication focusing on behaviour/lifestyle change, promoting a healthy environment, adherence to standards and procedures and emphasising improvement of inter-personal communications skills of the providers. It would also place a high priority on encouraging consumers to adopt appropriate health seeking behaviour, avoiding risky behaviours and self-medication, using quality health services and in integrating the measurement of provider and consumer behaviour change with the routine monitoring and evaluation systems.
Environmental Health

Advocacy for policy and decision makers at all levels on allocating resources for activities and programmes for creating a healthy environment is the new work in the area of Environmental Health (EH). Such advocacy will place EH higher up on the political and executive agenda of the various government ministries and agencies and raise its profile in the community and amongst civic groups and NGOs. Consequently resources would be routinely allocated to environmental health activities, funding increasing inter-sectoral and community participation in activities and programmes to create a healthy environment.

Quality of Care

Quality improvement is another area in which new work would be required. A sector-wide programme would need to be developed and implemented for establishing integrated decentralised quality management and monitoring mechanisms at all levels for on-going quality improvement. Emphasis would need to be placed on enabling the emergence of a quality culture through increased participation of professional associations and interested stakeholders in quality of care improvement. A “Quality Seal” incentive system and the systematic revision, modification, upgrading and, where required, developing quality standards application guidelines and related training materials and programs will be needed.

Human Resource Development

Within the area of human resource development, the focus of the new work would be the overhaul of the current HR planning and management system. This would include establishment of a high level body to regulate the training, recruitment, deployment and career development of health personnel sector-wide. The core of this management would be a central HR database and information system linked with other personnel databases in the sector and managed by specifically trained personnel. Approved standardised job descriptions for all cadres of health workers would be used and closely linked with an effective personnel performance evaluation system operating at all levels.

The other new work in this area would be to develop and implement a sector-wide system to provide access to ongoing and relevant continuing education to meet the re-licensing requirements. This would employ mainly distance learning methods for CE and IST; especially for staff in the remote areas using the RDTC based Regional Training Centres.

Institutional Development and Sector wide Management

The most challenging of all the new work is in the area of institutional development and sector-wide management. This is because it requires a high level of political and executive commitment to initiating and sustaining the change process. It is related to strengthening management and leadership in the Ministry of Health and working towards excellent collaboration and coordination with partners to ensure effective use of available domestic and external resources.

The key vehicle for strengthening and integrating the numerous on-going health sector reform activities being undertaken by the MoH and various partners in different areas of the sector would be a Sector Wide Approach (SWAp) to help put in place an effective and efficient sector-wide management system and structure based on a responsive and effective organizational culture. It would employ an output-based management system using regular and systematic internal and external monitoring including a well-regulated private health sector.

Widespread participation of stakeholders and partners would be accomplished through establishing appropriate mechanisms to increase the involvement of community, local government NGOs and international partners in planning, implementing and in monitoring and evaluating health service delivery. Decision-making at all levels would be strengthened through a functioning unified and user-friendly H&MIS that would be integrated with a national research framework.

See section on Environmental Issues earlier on the document
Based on the ECPS
Health Financing

New work in the area of health financing would be the separation of the purchaser and provider functions and the unification of the payment systems and the corresponding amendments in the health and insurance laws. This would be linked with normative allocation of resources across levels of care and performance based payment mechanisms and the institutionalisation of the National Health Accounts. It directly affects the MTEF and the Planning and Budgeting Framework. It helps health policy-making by providing internationally comparable information regarding the overall level of spending on health care. It allows for a multifaceted analysis of how financial resources in health care systems are raised (by different financing programmes/agents), how these resources are allocated among functions and service providers, as well as – in a more developed stage - it will show how resources are utilized by regional and social groups in the population. It would provide information about changes in the structure of health spending, the factors that drive growth in health spending and how such growth differs across countries. It would also provide a tool to monitor the effects of particular health reform measures over time. It would enable analysts to monitor changes in health care systems from an economic point of view; to describe the position and main tendencies of health care within the national economy.

As with the NHA at the national level, the budgeting of the health facilities/agencies will need to be unified through global budgeting so that the use of the budget is reported in a unified manner to the supervisory authorities. This would significantly contribute to improvements in financial management through better transparency and accountability and therefore more efficient utilization of the financial and other resources that would result from an optimisation of hospitals and further build on the work done by the Tacis supported Financial Management Programme. Amendments to the Health and Citizens Health Insurance Law will also be needed.

Another new work that has far reaching implications on planning and budgeting would be the costing of the health services based on the service delivery pattern and structure derived from the ECPS. This costing is to be done on a unit basis and also for the total package of services. The approved costs will form the basis for output based budgeting as required by the PSFML.

Other management issues

Client consultation

Client participation is a continuum that ranges from “compliance” to “participation” with “involvement” sitting somewhere in the middle.

Participation of the clients is missing at almost all levels of the health services, but especially at the higher referral levels. The service-mix presently provided at the health facilities does not include client participation in its frame of reference. This is partly due to the orientation of the providers, partly because of the way social sector policies are implemented and the exclusive provider focus of pre-service education. It is largely determined by the attitude of the community in the transition countries where the role of the community, traditionally, has been a passive one in almost all aspects of social, administrative and cultural life.

Increased participation of the clients and their representatives in those services that focus on reducing risk factors and promoting increased individual and community responsibility in the delivery of these services is essential for making the health services more responsive to client and local health needs. It is critical to build in new mechanisms to obtain feedback from clients, particularly to ensure the pro-poor approach of the strategic plan. The role of the existing participation mechanisms such as Health Volunteers, hospitals boards, complaint mechanisms, ethical committees and interest groups should be expanded to collect information on preferences and opinions on service delivery strategies, quality and affordability.

It will also be important to assess client and community perspectives systematically, countrywide, to feed into national level strategies and plans. Qualitative and/or quantitative customer surveys, with appropriate sampling to ensure representation of the poor and socially disadvantaged, will be carried out periodically to inform whether intended outcomes are being achieved. The results will then be channelled through the monitoring and evaluation system to be incorporated into future planning and decision-making.
Building partnerships within government and local non-governmental sectors

Inter-sectoral linkages within government are also valuable and these need to be further strengthened as a priority mainly through the sector-wide management process. The prime areas for building institutional linkages with other ministries include the following:

- For planning and budgeting - with the Cabinet Secretariat and the Ministry of Finance For mother and child health - with the Ministries of Science, Education and Culture; Labour and Social Welfare and Directorate of Radio and Television; Food and Agriculture;
- For environmental health and the control of important infectious diseases such as TB, STIs HIV/AIDS and natural foci diseases (plague, etc.) - with the Ministries of Science, Education and Culture; Directorate of Radio and Television; Justice and Internal Affairs; Defence; Nature and Environment; Trade and Industry; Urban Development and Construction; Transportation and Tourism; Food and Agriculture, Agency for Disaster Management and the National Public Health Committee
- For advocacy and other work about health issues such as, alcohol, tobacco-related and other health and related legislation, pharmaceuticals, food additives and preservatives, taxation and revenue implications - with the Ministries of Justice and Internal Affairs; Finance; Trade and Industry, Mongolemimpex, local governments, the Directorate of Radio and Television and the print mass media
- Likewise, closer interaction between the Ministry of Health with professional associations, local NGOs and private for-profit sector organisations are also encouraged to bring in opportunities that are mutually supportive and lead to overall improvement of the health of the population.

Collaboration with International Partners

The key areas for building partnerships through the strategic plan are:

- Planning for priority actions and channelling technical and financial support
- Coordination to monitor and track progress with implementation of projects and programmes
- Decisions on resource allocation for efficiency and to reduce duplications, gaps and shortfalls in financing

The role of the Ministry of Health within the context of sector-wide management requires that it proactively take the lead for the above tasks. Some tools that would enable the ministry to accomplish these three activities are:

- This health sector strategic master plan 2006-2015, because it states a mission, strategies and outcomes for all partners as a guide to their inputs to the sector (volume 1)
- The medium term expenditure framework, because it indicates support from different partners to specific components and activities in the strategic plan that helps in coordinating sector financing for more efficient results (volume 2)
- The monitoring and evaluation framework, because it outlines agreed outcomes and provides the basis for joint reviews and performance monitoring (volume 3)
- The planning and budgeting framework for developing annual operational plans, because it facilitates planning and budgeting that is linked to priorities (volume 4)

The principles of the partnership framework include:

- Consultation and sharing information on plans, financing, and management and technical support
- Coordination to agree on co-financing and responsibilities to ensure plan outcomes
- Respecting the ministry’s choices and approaches as indicated in the strategic plan
- Agreement on joint reviews and monitoring to: a) avoid unnecessary workload and extra burden of logistics on the government; and b) assess the contribution and comparative advantage of different partners
The current mechanisms to coordinate the allocation and utilisation of these resources is through the Department of International Cooperation, occasional round table meetings with the international partners involved in the health sector, and UN led donor group meeting where health is one of the sectors that is discussed and numerous project steering committees. At the highest level of the MoH, the coordination is also done at the Minister’s level with the support of the Minister’s Council and beyond the MoH by the Aid Coordination Council under the direction of MoF and eventually by the Cabinet.

At present, a Health Sector Coordinating Committee (HSCC) has been established with the responsibility for overseeing the HSMP development process. Upon completion of the Master Plan Development process, the HSCC could be institutionalised as the high-level Sector-wide Coordination Committee to coordinate external resources and promote ministry directed collaboration between partners and participate in the Aid Harmonization mechanisms of the Government of Mongolia. The department responsible for international cooperation could serve as its secretariat. This committee would serve as the central forum for reporting, discussion and coordination among partners. It would encourage debate on policy and strategic approaches and the membership would include all major international partners including multilateral and bilateral donors, development banks, technical assistance agencies, international organisations and non-governmental organisations. As and when needed, special meetings could be held to review and discuss progress and map out further work. It would also encourage discussions on issues related to this strategic plan, its implementation and the application of a SWAp. Efforts would also be made to strengthen the Committee’s effectiveness as a forum for policy debate.

At the aimag level, corresponding Coordination Committee meetings could provide opportunities to coordinate and monitor health work being planned and implemented by government, local authorities, NGOs and others.

Other venues for sharing information include the regular meetings of all NGOs and a monthly meeting among international partners as mentioned above. The latter presently serves as a venue for open discussion among international partners. However, as partner coordination improves it would be important to merge the international partners meeting into health sector coordinating committee.
Annexes
Annex A: Organisational charts

Current Organizational Structure of Health Sector (2005)
Organizational Structure of Ministry of Health (Current)

Minister of Health

Vice Minister

State Secretary

Division of Public Administration and Management
Division of Finance and Economic Management Planning
Division of Health Policy and Coordination
Division of Medical Services
Division of Information, Monitoring and Evaluation
Department of Pharmacy and Medical Equipment

Department of International Cooperation
A Possible Alternative Organizational Structure of Ministry of Health

Minister

Vice Minister

State Secretary

Division of Finance, Economy & Investment
- Budget Department
- Health Insurance Department
- Investment Department
- Economic Policy Department

Division of Health Services
- Public Health Department
- Department of Medical Services

Division of Pharmacy, Medical Equipment & Technology
- Pharmacy Department
- Department of Medical Equipment & Technology

Division of Public Administration & Management
- Department of Human Resource Development
- External Relations Department

Division of Strategic Planning, Monitoring & Evaluation
- Department of Policy & Planning
- Monitoring & Evaluation Department
- International Cooperation Department

Division of Health Services & Nursing Care

Implementin Agenc
Organizational Structure of Aimag Health Department

- Ministry of Health
- Aimag Governor
- Head of the Health Department
- Council for the Head
  - Family Group Practices
  - Aimag Hospital Ambulatory (outpatient)
  - Soum Hospitals
  - Dept of Infectious Diseases with natural foci
  - Private clinics and Private providers
  - Bagh feldsher posts
## Annex B: HSMP Strategies, Outcomes, Strategic Actions, Timeframe and Responsibilities

<table>
<thead>
<tr>
<th>Strategies by key areas of work</th>
<th>Outcomes</th>
<th>Strategic Actions</th>
<th>Priority by resource allocation</th>
<th>Timeframe 2006-2015</th>
<th>Responsible Institution Leading/ Co-Implementing</th>
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<tbody>
<tr>
<td><strong>1. HEALTH SERVICES DELIVERY</strong></td>
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</table>
| 1. Further increase coverage, access and utilisation of health services sector-wide especially for the mothers and children, the poor and other vulnerable groups | - Geographical, financial and quality of care related barriers that prevent the poor and vulnerable groups from accessing and using health services reduced.  
- Health facilities and FGP’s appropriately located to bring them closer to particularly the poor and the vulnerable in the catchment population.  
- Client friendly services provided at an increasing number of health facilities at all levels.  
- Outreach services and ambulatory care routinely provided.  
- Participation of the community based organisation and NGOs in local health service activities increased | 1. Provide an effective ambulance service particularly for the remote and rural areas as part of an effective emergency care and referral system.  
2. Conduct a situation analysis of the coverage and access of the catchment population by health service facilities and personnel and implement the recommendations through a programme to improve access and coverage especially for the poor and vulnerable.  
3. Develop and implement a standardized client friendly patient flow system for hospitals that could be scaled up sector wide.  
4. Continuously and sustainably fund and implement outreach activities and ambulatory care based on the Essential Care package and national programmes as part of the routine health care provision especially at the bagh and soum levels and in the gers districts.  
5. Ensure regular and sustained community participation through increased number of effectively operating health volunteers, of community initiated activities, early detection by the community volunteers and increased financial and non-financial resource contributions for the operations of the health services | ++  
++  
++  
+++  
+++ | 2006 / 2007  
2008 / 2009  
2010 / 2011  
2012 / 2013  
2014 / 2015 | MoH  
AHDs and CHD and Soum hospitals and FGP’s  
CBOs  
International partners |
| 2. Strengthen the delivery of quality primary and general care through soum health facilities and FGP’s based upon essential part of the ECPS | - ECPS used as the basis for providing essential health care services at the soum health facilities and the FGP’s  
- Gate keeping function of the primary level health services operational and enhanced  
- Increased utilization of the soum and FGP health services particularly by mothers and children.  
- Integrated operation of relevant national programmes supporting service delivery at the soum and FGP health facilities | 1. Restructure and sustainably deliver essential health services at the soum and FGP health facilities in accordance with the essential part of the services of the ECPS  
2. Continue and upgrade the Soum Hospital Development Programme under the Rural Health Services Initiative to ensure provision of essential health care services at the soum health facilities and the FGP’s  
3. Develop and implement a policy to clearly define the role, funding, organisational and legal position of the FGP system in the health sector to deliver the essential package of services.  
4. Systematically mobilize the community and the community health volunteers to ensure the mothers and children and elderly in particular fully utilize the soum and FGP health services.  
5. Routinely include relevant national programme activities into services of the soum and FGP health facilities | +++  
++  
+++  
+++  
+ | 2006 / 2007  
2008 / 2009  
2010 / 2011  
2012 / 2013  
2014 / 2015 | MoH  
AHDs and CHD and Soum hospitals and FGP’s  
International Partners |
| 3. Strengthen the delivery of quality specialized, advanced and emergency care in secondary and tertiary health facilities based upon ECPS used as the basis for providing specialised, advanced and emergency health care services at the secondary, tertiary and private sector health facilities with the minimum required infrastructure and equipment.  
- Minimum staff complement at | 1. Restructure and sustainably deliver health services at the secondary and tertiary health facilities in accordance with the essential part of the ECPS with particular emphasis on the top five leading causes of morbidity and mortality  
2. Develop and implement National Hospital Development Programme to ensure minimum required staff complement infrastructure, health technology and equipment for secondary and tertiary health facilities and strengthen diagnostic capacity through the establishment and | +++  
++ | 2006 / 2007  
2008 / 2009  
2010 / 2011  
2012 / 2013  
2014 / 2015 | MoH  
AHDs and CHD Tertiary Hospitals  
CBOs |
<table>
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<tr>
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</tr>
</thead>
</table>
| the complementary part of the ECPS | secondary and tertiary health facilities to deliver the complementary package of services  
  • Private sector health facilities deliver the complementary package of services in accordance with the licensing and accreditation requirements.  
  • Bypassing of the primary level health facilities significantly reduced through an operating referral system  
  • Appropriate utilization of secondary and tertiary health and services particularly by mothers and children  
  • Integrated operation of relevant national programmes supporting service delivery at the secondary, tertiary and private sector health facilities | strengthening of Diagnostic and Treatment Centers.  
  3. Establish and implement a sector wide referral system (including guidelines, procedures and forms, a list of services available at the various levels, the criteria for referral based on standard treatment and diagnostic guidelines, hospital admission criteria, minimum staff competencies required at each level) and the benefits of using the referral system and penalties for not using the referral system.  
  4. Develop and implement appropriate community participation mechanisms in the oversight and management of the hospitals at the secondary and tertiary levels to ensure delivery of quality complementary health care in accordance with the ECPS  
  5. Routinely include activities related to relevant national programmes into the services of the secondary, tertiary and, as much as possible, the private sector health facilities.  
  6. Further develop day, home and palliative care services and refocus traditional medicine | +++ | 2006 / 2007 | Private Sector Traditional Medicine Facilities  
Int’l Partners |
| 2. PHARMACEUTICALS AND SUPPORT SERVICES | 4. Ensure continuous and equitable sector-wide access to essential drugs and bio-preparation | Efficient and cost-effective drug supply and distribution system operational including Revolving Drug Funds (RDF)  
  • Essential drugs continuously available in all health facilities especially in rural and remote areas  
  • Price list for essential drugs enforced | 1. Review and improve the National Drug Supply System to include and integrate all Revolving Drug Funds.  
  2. Periodically review, revise and ensure the sector-wide implementation of the Drug Act and Policy.  
  3. Ensure the procurement of the pharmaceuticals and medical supplies and devices in accordance with the procurement law.  
  4. Ensure uninterrupted supply of the diagnostic reagents and drugs for the state funded disease control programmes such as highly contagious infectious disease, diabetes and TB control, etc.  
  5. Implement standard drug estimation procedures to guide drug procurement  
  6. Establish and enforce a price list for all essential drugs sector wide.  
  7. Operate a regular monitoring system to ensure uninterrupted access to affordable essential drugs in urban and rural areas | +++ | 2006 / 2007 | MoH  
Mongoleimpe  
AHDs CHD  
SIA |
| 5. Establish a drug, bio-preparation food and cosmetics quality assurance system | A single drug, bio-preparation, food and cosmetics quality assurance agency established and operational  
  • Safe, affordable, quality drugs, biopreparations and traditional medicines available at all levels of health service | 1. Establish a central agency responsible for managing all aspects of quality assurance of drugs (traditional medicines and products), cosmetics and food products.  
  2. Establish a quality reference laboratory for drugs (traditional medicines and products), bio-preparation and medical supplies  
  3. Develop, periodically revise and systematically disseminate the National Pharmacopoeia (Formulary)  
  4. Develop and implement a National Strategy on counterfeit drugs that | +++ | 2006 / 2007 | MoH  
Mongoleimpe  
AHDs CHD  
SIA |
<table>
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<tr>
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</table>
| **6. Ensure rational drug and biopreparation use** | ● Good Prescribing Practices (GPP) routinely used by all authorized prescribers.  
● Public awareness of RDU will be increased | 1. Establish a registration and information system on Adverse Drug Reaction to monitor RDU sector wide  
2. Strengthen the capacity of drug information center to conduct regular IEC activity on RDU among the general population with emphasis on safe injection guidelines  
3. Assess the performance and support the operations of all drug therapeutic committees and provide relevant technical inputs  
4. Train all authorized prescribers in GPP and RDU in accordance with treatment guidelines and periodically update prescription and non-prescription drug list  
5. Conduct and coordinate ongoing research on antibacterial drugs and drug resistance and develop strategy to deal with emerging drug resistance on a sector-wide basis | +++ | 2006 / 2007 | Pharmaceutical companies |
| | | | | 2008 / 2009 | Int’l Partners |
| | | | | 2010 / 2011 | MoH, Mongoleminpe |
| | | | | 2012 / 2013 | x AHDs CHD |
| | | | | 2014 / 2015 | SIA |
| | | | | | Pharmaceutical companies |
| | | | | | Int’l Partners |
| **7. Strengthen the capacity of diagnostic services through establishing a system to supply and regularly maintain medical & laboratory equipment** | ● Medical & laboratory equipment technology supplied in a timely manner and regularly maintained through systematic contracting out of these maintenance services  
● Medical & laboratory equipment technology service provision and maintenance centre established and operational  
● Laboratory and diagnostic capacity improved sector-wide | 1. Improve the implementation of “National Programme on Health Technology” the “Hospital Technology Plan” and the “Hospital Equipment Utilization Guidelines” and ensure their routine monitoring and periodic evaluation  
2. Establish a Medical Equipment Technology Center responsible for developing an essential technology package, ongoing service provision, routine maintenance, quality assurance and in-service training through increasingly contracting out these services where possible and appropriate.  
3. Further develop and regularly revise the technical standards and guidelines to be used for the accreditation and monitoring of quality assurance of laboratories at all levels based on the laboratory section of the MNS standards for health facilities | ++ | 2006 / 2007 | MoH |
| | | | | 2008 / 2009 | MoF |
| | | | | 2010 / 2011 | Medical and technical universities |
| | | | | 2012 / 2013 | International Partners |
| | | | | 2014 / 2015 | Private sector |
| **8. Ensure routine infrastructure and facility maintenance, transport and communication services sector-wide.** | ● At least 70% percent of the aimag and soum hospitals and FGPs will be provided with buildings that meet required standards  
● Equipments, computers and vehicles at all levels maintained to meet required standards.  
● Improved communications available at all health facilities and institutions | 1. Implement “Soum hospital development programme” through the provision of resources and additional technical capacity to ensure minimum required infrastructure, equipment and transportation for all soum and FGP health facilities  
2. Further improve and sustain the quality of the maintenance services for the health facility buildings and vehicles at the secondary and tertiary levels to meet the required MNS standards  
3. Provide all soum and bagh health facilities with 2 way communication systems and where possible telephones  
4. Improve the management of solid medical waste and disposal of | +++ | 2006 / 2007 | MoH, MoF |
<p>| | | | | 2008 / 2009 | Central agencies responsible for Infrastructure development |
| | | | | 2010 / 2011 | Private sector |
| | | | | 2012 / 2013 | |
| | | | | 2014 / 2015 | |</p>
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<tbody>
<tr>
<td>● Disposal of solid medical waste and expired drugs significantly improved</td>
<td>5. Implement a plan of action to routinely maintain and upgrade computers and related equipment sector wide.</td>
<td>++</td>
<td>2006 / 2007</td>
<td>International Partners CBOs</td>
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3. BEHAVIOUR CHANGE AND COMMUNICATION

9. Further develop and integrate Behavioural Change & Communication/IEC activities sector wide to change the behaviour promoting healthy lifestyles, subsequently decreasing the incidence of most common communicable and non-communicable diseases

- BCC activities (client and providers) are integrated and coordinated using network approach
- National health promotion coordination mechanism established and operational
- Improved government and community participation for IEC/BCC activities

1. Review the current IEC strategy and other related regulations and how they are managed and align the health promotion and IEC activities currently underway with National Public Health Policy

| 2. Upgrade health promotion coordination mechanism through the establishment of National health promotion apparatus that would also include IEC/BCC, school curriculum and training methodologies for all formal and informal educational institutions, community participation, health promoting and safety environment | ++ | 2008 / 2009 | MoH / AHDs and CHD |

| 3. Set up and manage the network to coordinate and exchange information between GO, NGO, partners, academic institutions, private sectors, mass media, community and individuals using IEC database | +++ | 2010 / 2011 | MoSEC, MoLSW, Radio & TV, NGOs, International partners |

| 4. Increase government and non-government organization involvement for changing unhealthy and risky behaviour with particular emphasis on the use of mass media | +++ | 2012 / 2013 | |

10. Build a health promoting client friendly service

- Better utilization of the health services by vulnerable groups
- Improved interpersonal communication skills and ethics of health workers
- Reduced complaints related with provider’s attitude and communication

1. Set up a sector wide client centred system that would include at least information desks, registration, reception and appointment system, friendly and caring staff to improve service focused more to the vulnerable and the poor

| 2. Systematically provide relevant and easy to understand health service information (service costs, types of services, responsible persons and departments) to the population especially to the vulnerable groups | +++ | 2014 / 2015 | MoH / AHDs and CHD |

| 3. Establish a transparent complaint monitoring system in all health institutions | ++ | | MoSEC, MoLSW, Radio& TV, NGOs, International partners |

| 4. Establish a compulsory mechanism to regularly review and take action on provider attitudes and interpersonal communication skills in a workplace setting | ++ | | |

| 5. Include communication skills as part of the routine performance evaluation of health care providers | + | | |

<p>| 6. Revise and update undergraduate and postgraduate training program and curriculum to include health promotion, BCC, counselling, communication skills. | +++ | | |</p>
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<th>Priority by resource allocation</th>
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<tbody>
<tr>
<td>11. Create a health promoting environment through improved community participation and inter-sectoral collaboration</td>
<td>● Increased number of health promoting workplaces &lt;br&gt; ● Resources routinely allocated to environmental health activities &lt;br&gt; ● Mass media mobilised &lt;br&gt; ● Increased community participation and inter-sectoral collaboration in promoting healthy environment programmes and activities &lt;br&gt; ● Improved community fitness infrastructure</td>
<td>1. Promote community created initiatives for healthy environment &lt;br&gt; 2. Expand and promote healthy city, healthy district, healthy soum, bag and healthy workplace, fitness and school programs &lt;br&gt; 3. Advocacy for policy and decision makers at all levels on allocating resources for activities and programmes for creating a healthy environment &lt;br&gt; 4. Mobilise mass media for creating awareness and importance of a health environment &lt;br&gt; 5. Promote inter-sectoral and community participation in activities and programmes to create a healthy environment</td>
<td>+++</td>
<td>2015</td>
<td>MoH</td>
</tr>
<tr>
<td>4. QUALITY OF CARE</td>
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<tr>
<td>12. Continually improve the quality of care sector-wide</td>
<td>● Sector wide quality management system established and operational &lt;br&gt; ● Acceptable quality of health care continually provided sector-wide &lt;br&gt; ● Self assessment of doctors and health professionals continuously coordinated and evaluated &lt;br&gt; ● Increased participation of professional associations and interested stakeholders in quality of care improvement</td>
<td>1. Upgrade the legal framework to provide the basis for continual improvement of quality of care &lt;br&gt; 2. Develop and implement a sector-wide programme for establishing integrated decentralised quality management and monitoring mechanisms at all levels for on-going quality improvement &lt;br&gt; 3. Establish an incentive scheme including using a mark of quality system for promoting development of quality of care &lt;br&gt; 4. Establish enabling mechanisms for involvement of medical professional associations and stakeholders in the improvement of quality of care</td>
<td>++</td>
<td>2015</td>
<td>MoH/ MoSEC AHDs CHDs</td>
</tr>
<tr>
<td>13. Further develop standards, guidelines and indicators for health care services</td>
<td>● Appropriate quality of care standards, guidelines and indicators approved in conformity with international standards and applied. &lt;br&gt; ● Standards and indicators application guidelines available and used &lt;br&gt; ● Diagnostic and treatment capacity improved</td>
<td>1. Review current diagnostic, treatment and facility standards and indicators and modify to conform international standards &lt;br&gt; 2. Develop and apply additional required standards and indicators for further improvement of quality assurance &lt;br&gt; 3. Revise, modify, upgrade and where required develop quality standards application guidelines and related training materials and programs.</td>
<td>+++</td>
<td>2015</td>
<td>MoH/ AHDs and CHDs</td>
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<tr>
<td>5. HUMAN RESOURCE DEVELOPMENT</td>
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<td>14. Strengthen sector wide human resource management based on the health Human Resource Development (HRD) policy.</td>
<td>● An authoritative national body responsible for sector wide human resource planning and management system operational &lt;br&gt; ● Reduced disparity in the distribution of human resources between the rural and urban areas &lt;br&gt; ● Health worker and population</td>
<td>1. Review and revise the legal framework and the HRD policy to include the establishment of HR planning and management system that includes a high level body to regulate the training, recruitment, deployment and career development of health personnel sector-wide. &lt;br&gt; 2. Develop and implement workforce plan that will reduce disparity in the distribution of human resources in accordance with the workforce standards and in line with international health worker and population ratios and norms. &lt;br&gt; 3. Periodically review, adapt and modify the job descriptions to conform</td>
<td>+++</td>
<td>2015</td>
<td>MoH/ Medical Universities</td>
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<tr>
<th>Strategies by key areas of work</th>
<th>Outcomes</th>
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<td></td>
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<td>to the requirements of a performance contract and tasks identified in the ECPS with increased emphasis on public health</td>
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<td>AHD / MoLSW Professional associations International Partners</td>
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<td></td>
<td></td>
<td>4. Strengthen national capacity in workforce planning and management through training of additional personnel and retaining them in the area of work.</td>
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<td></td>
<td></td>
<td>5. Complete and improve the HR database and conduct HR research.</td>
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<tr>
<td></td>
<td></td>
<td>6. Establish close collaboration between training institutions, employment agencies including those in the private sector, and national health services.</td>
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<tr>
<td>15. Reform the pre, post and in-service training system for health professions and health related workers.</td>
<td></td>
<td>1. Develop a legal basis for controlling the pre-service and in-service training of health personnel in training institutions.</td>
<td>+</td>
<td></td>
<td>MoH Medical universities &amp; colleges, MoSEC Local governors Health facilities at all levels</td>
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<td></td>
<td></td>
<td>2. Regularly review and update the job descriptions for all cadres of health workers and revise training curricula and train accordingly.</td>
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<td></td>
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<td>3. Establish a database to monitor the implementation of training plans, particularly CE and IST</td>
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<td>4. Develop and implement a sector wide system to provide access to ongoing and relevant continuing education to meet the revised and upgraded requirements for re-licensing</td>
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<td>5. Implement an integrated postgraduate core curriculum as described in the training standards in clinical and related disciplines to be followed by all educational institutions providing postgraduate clinical education.</td>
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<td></td>
<td></td>
<td>6. Develop an integrated postgraduate core curriculum in health management and non-clinical disciplines to be implemented by all educational institutions.</td>
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<td></td>
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<td>7. Develop and implement an integrated postgraduate core curriculum in-service training and distance learning programme especially for rural health workers.</td>
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<td>8. Develop a plan of action for using distance learning as a principal method for CE and IST especially for staff in the remote areas, using the Regional Training centres based in the RDTC and their supporting sub-centres</td>
<td>++</td>
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<tr>
<td>16. Further develop the incentives and motivation scheme including the social security for all</td>
<td></td>
<td>1. Develop new career pathways for key health professionals particularly those working in rural areas</td>
<td>++</td>
<td></td>
<td>MoH / Medical universities &amp; colleges</td>
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<td></td>
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<td>2. Implement a modified incentive system including financial and non-financial incentives</td>
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<td></td>
<td></td>
<td>3. Revise, approve and implement a salary and incentives package for all</td>
<td>+++</td>
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</table>
### Strategies by key areas of work

<table>
<thead>
<tr>
<th>Health workers in the sector</th>
<th>All health workers in the sector with special emphasis on retaining doctors and health specialists in rural areas reducing rural urban disparities</th>
</tr>
</thead>
</table>
|                             | - Regular performance evaluation carried out.  
|                             | - Alternative career pathways for professional cadres, including those in rural poor areas developed and approved.  
|                             | - Social security system (including apartments for soum doctors and professionals) developed and working for all health workers  
|                             | - Occupational safety system established and operational |

| Strategic Actions | Cadre of health workers assigned to the rural and remote areas, including mandatory postings for certain period of time  
|------------------|-------------------------------------------------------------------------------------------------------------------|
|                  | 4. Set up and operationalise a performance evaluation system including indicators, assessment methods, frequency and sanctions  
|                  | 5. Improve the social security (working conditions and living facilities) for health workers and ensure their occupational safety  
|                  | 6. Monitor staff movements and take appropriate measures to maintain adequate staffing levels. |

<table>
<thead>
<tr>
<th>Priority by resource allocation</th>
<th>Timeframe 2006-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoSEC Local governors Health facilities at all levels</td>
<td>+++</td>
</tr>
<tr>
<td>AHD MoLSW Professional associations International Partners</td>
<td></td>
</tr>
</tbody>
</table>

### 6. HEALTH FINANCING

| 17. Ensure regular and increasing flow of funds to the health sector | Increase health expenditure as proportion of the GDP to sustainable levels.  
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
|                                                                   | Community financing for the public health sector mobilized and effectively used.  
|                                                                   | User fees schedule and amounts for the mother and child, the poor and vulnerable groups revised and implemented |

| Strategic Actions | Conduct systematic activities to increase financial resources from Government using the governmental planning and budgeting processes  
|------------------|-------------------------------------------------------------------------------------------------------------------|
|                  | 2. Revise and implement finance guidelines and procedures to standardize the interaction between the aimag/city local governments and MoF treasury offices to ensure adequate volume and timeliness of the flow of funds from state budget to the health services  
|                  | 3. Modify and implement the guidelines and procedures to ensure adequate volume and timeliness of the flow of funds from HIF offices at all levels to the health services  
|                  | 4. Implement mechanisms to ensure appropriate and ongoing foreign assistance (ODA) in the public health sector in line with the Strategic Master Plan and government priorities.  
|                  | 5. Conduct systematic activities to increase financial resources from the HIF using the MoH and HIF planning and budgeting processes.  
|                  | 6. Develop and implement a plan of action to mobilize private sector financing of the health sector through restructuring of specialised care  
|                  | 7. Establish a system to mobilize and use community financing (through pilot schemes) to increase financial resources available to the public health sector, especially in the rural areas |

<table>
<thead>
<tr>
<th>Priority by resource allocation</th>
<th>Timeframe 2006-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH AHDs and CHD SSIGO, MoLSW Private sector International Partners NGOs and CBOs Community</td>
<td></td>
</tr>
</tbody>
</table>

### 18. Strengthen financial management system to improve the efficient and effective use of health sector financial and related

| Strategic Actions | Appropriate performance based payment system that promotes quality and addresses adverse incentives established at all levels of care.  
|------------------|-------------------------------------------------------------------------------------------------------------------|
|                  | Sector-wide health financing policy implemented.  
|                  | Purchaser and provider functions |

| Strategic Actions | Implement, in consultation with related ministries, sector wide financial management (NHA and PSFML) through the separation of the purchaser and provider functions and unifying the payer systems as a basis for resource allocation, financial & budget planning and management, accounting and financial reporting systems  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Clarify and institutionalise the responsibilities within the Ministry of Health related to financial management, resource allocation, utilization of user charges, other locally generated revenues, decision-making and</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority by resource allocation</th>
<th>Timeframe 2006-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH MoLSW MoF, SSIGO AHDs CHD</td>
<td></td>
</tr>
</tbody>
</table>
### Strategies by Key Areas of Work

<table>
<thead>
<tr>
<th>Resources</th>
<th>Separated with pooling of variety of funding sources.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Sector wide accounting and financial management information system based on National Health Accounts (international standards) and the PSFML established and operational</td>
</tr>
<tr>
<td></td>
<td>• Resource allocation criteria established and used in decision making at the macro and micro levels</td>
</tr>
<tr>
<td></td>
<td>• Increased budget allocated to primary health care services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Actions</th>
<th>Priority by Resource Allocation</th>
<th>Timeframe 2006-2015</th>
<th>Responsible Institution Leading/Co-Implementing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring of expenditures</td>
<td>++</td>
<td>2006 / 2007</td>
<td>Local governors, International partners</td>
</tr>
<tr>
<td>3. Modify and implement the provider payment mechanisms to ensure equitable, appropriate and timely payments and efficient and transparent management and reporting of funds by the recipient health institutions (providers)</td>
<td>+++</td>
<td>2008 / 2009, 2010 / 2011</td>
<td></td>
</tr>
<tr>
<td>4. Conduct a costing exercise for implementing the ECPS and substantially annualy increase the budget allocated to primary health care services</td>
<td>++</td>
<td>2012 / 2013, 2014 / 2015</td>
<td></td>
</tr>
<tr>
<td>5. Establish and implement resource allocation criteria, guidelines and procedures in decision making at the macro and micro levels</td>
<td>++</td>
<td>2015 /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19. Reform and Further Develop the Health Insurance System</th>
<th>Improved health insurance coverage of the population especially the poor and vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved performance of the health insurance system</td>
<td>User-friendly reimbursement system for drugs operational</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Actions</th>
<th>Priority by Resource Allocation</th>
<th>Timeframe 2006-2015</th>
<th>Responsible Institution Leading/Co-Implementing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and revise the current principles and legal framework of the HIF</td>
<td>+++</td>
<td>2006 / 2007</td>
<td>MoH, MoLSW, MoF, SSIGO, International partners</td>
</tr>
<tr>
<td>2. Approve and implement a policy that defines the purpose and operations of the HIF including linkages to the state budget, the PSFML, the National Health Accounts and other accounting and management information systems</td>
<td>+++</td>
<td>2008 / 2009</td>
<td></td>
</tr>
<tr>
<td>3. Develop and implement a plan of action to conduct a wide ranging reform of the health insurance fund that would include, its position in the health financing continuum and its corporate management and operations</td>
<td>+++</td>
<td>2010 / 2011</td>
<td></td>
</tr>
<tr>
<td>4. Implement periodic campaigns and programmes to achieve and sustain full coverage of the population particularly the vulnerable groups and the rural and urban poor</td>
<td>++</td>
<td>2012 / 2013</td>
<td></td>
</tr>
<tr>
<td>5. Revise and implement the co-payment amounts for the mother and child, the poor and vulnerable groups</td>
<td>++</td>
<td>2014 / 2015</td>
<td></td>
</tr>
<tr>
<td>6. Simplify, update and make the reimbursement system for drugs from the HIF more user-friendly</td>
<td>+</td>
<td>2015 /</td>
<td></td>
</tr>
</tbody>
</table>
### 7. INSTITUTIONAL DEVELOPMENT AND SECTOR-WIDE MANAGEMENT


- Effective and efficient sector wide management system and structure in place based on a responsive and effective organizational culture.
- Improved management capacity of public health sector institutions at all levels
- Enhanced coordination with partners and stakeholders
- Efficient decision-making and rational use of resources
- Improved inter-sectoral collaboration

1. Establish an appropriate and sustainable organizational structure for the public health sector
2. Establish an effective sector wide management system based on SWAp including enhanced coordination with partners and stakeholders.
3. Implement an output based management system including regular and systematic internal and external monitoring
4. Improve the effectiveness of inter-sectoral collaboration through the refinement of the existing mechanisms.
5. Establish a responsive and effective organizational culture through supporting organizational development

#### 21. Implement effective sector wide decentralization

- Better local management of the health services and institutions
- Decentralized, accountable and transparent, sector-wide management system operational
- Improved provision of local health services
- Increased support and finance by the local government to the health sector

1. Formulate and implement decentralization guidelines and procedures to ensure transparency, accountability, autonomy and appropriate delegation of authority.
2. Systematically enhance the management capacity of local government and health managers to implement decentralization guidelines and procedures.
3. Establish appropriate mechanisms to increase the involvement of community, local government and NGOs in planning, implementing, monitoring and evaluating health service delivery

#### 22. Enhance risk management capacity to respond to natural disasters and emerging public health problems

- Improved risk management capacity through developing and implementing comprehensive disaster preparedness plans

1. Develop comprehensive plans for emerging public health problems that address prevention, screening, treatment, palliative care rehabilitation and monitoring their implementation
2. Develop and implement health preparedness plan for natural and man made disasters and for public health crises management
3. Further extend and enforce occupational health measures for the formal and informal sectors

---

**MoH**: Health institutions at all levels, Local government, Cabinet Secretariat, International partners

**MoH/ MoF**: Health institutions at all levels, Local government, Cabinet Secretariat, International partners

**Other ministries such Environment and Disaster**: Health institutions at all levels, Local government, community based organisations, NGOs
### 23. Develop a unified health management information system

- Unified and user-friendly HMIS operational
- Timely and evidence-based management decision making at all levels

1. Establish the functions and structure of the HMIS
2. Improve evidence-based decision making through ensuring the accuracy, timeliness, validity and quality of data and information
3. Strengthen and further develop information technology infrastructure for operationalizing the HMIS
4. Further develop the human resources for implementing and managing the HMIS
5. Establish a national research framework to integrate research and nationwide surveys with the HMIS

<table>
<thead>
<tr>
<th>Management agencies</th>
<th>Local government, CBO, NGOs, private enterprises</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH (DIME) Health institutions at all levels</td>
<td></td>
</tr>
<tr>
<td>International partners</td>
<td></td>
</tr>
</tbody>
</table>

### 24. Establish an optimal public and private mix of health care services

- Effectively regulated private health sector
- Effective mechanisms to rationalise the excess capacity in the public health sector operational
- Excess hospital and health service capacity in terms of beds and numbers of hospitals and specialized centres in Ulaanbaatar rationalised.

1. Rationalize the health services (secondary and tertiary levels) in UB city in terms of the number of hospitals, spas and sanatorium, rehabilitation centres and hospital beds.
2. Formulate and implement overall policy and guidelines on private sector development
3. Further develop legal and financial regulation mechanisms for private sector.
4. Formulate and implement overall policy and guidelines on privatisation of public health facilities (contracting in and contracting out).
5. Establish mechanisms for and conduct regular monitoring of the health sector to ensure an optimal public private mix.

<table>
<thead>
<tr>
<th>Management agencies</th>
<th>Local government, State Property Committee, International organizations, NGOs, Local government Professional Associations</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH Public and private health institutions at all levels</td>
<td></td>
</tr>
</tbody>
</table>
Annex C: Essential and Complementary Package of Services
(Approved by Health Minister's order #92, 2004)

### 1. MATERNAL HEALTH

<table>
<thead>
<tr>
<th>Component</th>
<th>Desired Outcome by the end of 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal care</td>
<td>Same as soum hospital and RDTC, and projects</td>
</tr>
<tr>
<td>- Reproductive age women attend antenatal care at least twice per year</td>
<td>- To increase to 72% the number of pregnant women attending antenatal care from first trimester</td>
</tr>
<tr>
<td>- Increase to 75% the percentage of the pregnant woman in last month of the pregnancy attending maternity rest homes in rural areas</td>
<td>- Reduce the pregnancy related anaemia by 25% from 2010 rate</td>
</tr>
<tr>
<td>- Increase to 95% the percentage of the pregnant woman in last month of the pregnancy attending maternity rest homes in rural areas</td>
<td>- Increase to 80% the rate of attendance of pregnant women attending antenatal care with 6 and more visits to 80% and more</td>
</tr>
</tbody>
</table>

#### Essential Packages of Services

<table>
<thead>
<tr>
<th>Component</th>
<th>Levels of the Health Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household</td>
<td>Community</td>
</tr>
<tr>
<td>Primary level</td>
<td>Ambulatory (Outpatient)</td>
</tr>
<tr>
<td>Secondary level</td>
<td>District</td>
</tr>
<tr>
<td>Tertiary level</td>
<td>Special Centres and Hospitals</td>
</tr>
</tbody>
</table>

#### Complementary Package of Services

<table>
<thead>
<tr>
<th>Component</th>
<th>Levels of the Health Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary level</td>
<td>Ambulatory (Outpatient)</td>
</tr>
<tr>
<td>Secondary level</td>
<td>District</td>
</tr>
<tr>
<td>Tertiary level</td>
<td>Special Centres and Hospitals</td>
</tr>
</tbody>
</table>

#### Health Sector Strategic Master Plan, Volume 1

- **1.1. MATERNAL HEALTH**
  - Extract pregnancy signs and symptoms and seek care
  - To attend antenatal care
  - Know about danger signs of pregnancy and STIs and seek care
  - Know the date of delivery and date to attend maternity rest home
  - Know what to prepare for delivery (nutrition, healthy environment etc)
  - Know blood type
  - Birth preparedness
  - Early detection of pregnancy and register
  - Detect, treat and refer cases related to pregnancy complications and STIs
  - Distribute iron, folic acid and other preparation and distribute on RH
  - Organize campaign on maternal and child health
  - Know about danger signs of pregnancy and STIs and seek care
  - Bring pregnant women to the maternity rest home
  - Help for preparation for delivery (nutrition, healthy environment etc)
  - Early detection of pregnancy and register
  - Detect, treat and refer cases related to pregnancy complications and STIs
  - Distribute iron, folic acid and other preparation and distribute on RH
  - Organize campaign on maternal and child health
  - Know about danger signs of pregnancy and STIs and seek care
  - Bring pregnant women to the maternity rest home
  - Help for preparation for delivery (nutrition, healthy environment etc)
  - Early detection of pregnancy and register
  - Detect, treat and refer cases related to pregnancy complications and STIs
  - Distribute iron, folic acid and other preparation and distribute on RH
  - Organize campaign on maternal and child health
  - Know about danger signs of pregnancy and STIs and seek care
  - Bring pregnant women to the maternity rest home
  - Help for preparation for delivery (nutrition, healthy environment etc)
<table>
<thead>
<tr>
<th>Compoents</th>
<th>Desired Outcome by the end of 2015</th>
<th>Essential Packages of Services</th>
<th>Complementary Package of Services</th>
<th>Private Sector</th>
<th>National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Community level</td>
<td>Levels of the Health Service Delivery</td>
<td>Tertiary level</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bagh feldsher</td>
<td>Ambulatory</td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Group Practices</td>
<td>(Outpatient)</td>
<td>(Outpatient)</td>
<td></td>
</tr>
<tr>
<td>1.2.</td>
<td>Delivery Care</td>
<td></td>
<td>Aimag</td>
<td>RDTC</td>
<td></td>
</tr>
<tr>
<td>2010:</td>
<td>To increase the rate of deliveries managed by doctors to 70% From 2002 baseline</td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td>2015:</td>
<td>To decrease perinatal death rate to 20 per 1000 live births At least 75% of all Caesarean sections to be done according to national standards To decrease the rate of neonatal death to 15 per 1000 live births To reduce the rate of birth trauma by 50% From 2002 baseline</td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Refer urgency to maternity home a pregnant woman to the next level of care</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Ensure all antenatal care history is communicated to maternity home</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Receive an information related to mother and infant from previous referral level</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Know about infant care</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Know about infant diseases and seek care if required</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Know about infant vaccination</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Manage maternal and infant care delivery process</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Ensure availability of essential drugs</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Teat about, support and encourage breastfeeding</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Provide essential drugs to maternity home</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Provide BC</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Provide training and advice to doctors and health staff from previous referral level</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Ensure availability of essential drugs</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Provide essential drugs to maternity home</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
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</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Provide BC</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
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</tr>
<tr>
<td></td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Provide training and advice to doctors and health staff from previous referral level</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
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<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Teach about, support and encourage breastfeeding</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Know early signs of delivery and bring pregnant woman to maternity home</td>
<td>Provide essential drugs to maternity home</td>
<td>Same as FGP</td>
<td>Same as RDTC</td>
<td></td>
</tr>
</tbody>
</table>
### Health Sector Strategic Master Plan, Volume 1

#### Essential Packages of Services

<table>
<thead>
<tr>
<th>Community level</th>
<th>Bagh feeder</th>
<th>Family Group Practices</th>
<th>Soo and inter-uwom hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td><strong>Bagh</strong></td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

- **Ensure comfortable and clean space for mothers and child**
- **Provide nutritious food and adequate calories**
- **Ensure availability of essential drugs**
- **Provide RH services**
- **Carry out training and refer cases**

- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**

#### Complementary Package of Services

<table>
<thead>
<tr>
<th>Primary level</th>
<th>Secondary level</th>
<th>District</th>
<th>RDTG</th>
<th>Special Centres and Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory</strong></td>
<td><strong>Hospital</strong></td>
<td><strong>Ambulatory</strong></td>
<td><strong>Hospital</strong></td>
<td><strong>RDTC</strong></td>
</tr>
<tr>
<td><strong>Primary</strong></td>
<td><strong>Tertiary</strong></td>
<td><strong>Clinics</strong></td>
<td><strong>Hospitals</strong></td>
<td><strong>National Program</strong></td>
</tr>
</tbody>
</table>

- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**

#### Private Sector

- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**

#### National Program

- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**
- **Same as high**

### Component Descriptions

#### 1.3. Postnatal care

**2015:** Reduce the maternal mortality rate from deaths in facilities by 50% from the 2015 baseline.

**2010:** Reduce the maternal mortality rate from deaths in facilities by 50% from the 2015 baseline.

- **Reduce by 50%**
- **Reduce by 50%**
- **Reduce by 50%**
- **Reduce by 50%**

#### 1.4. Birth spacing (Family Planning)

**2015:** Strengthen the family planning system.

**2010:** Strengthen the family planning system.

- **Reduce by 50%**
- **Reduce by 50%**
- **Reduce by 50%**
- **Reduce by 50%**

#### 1.5. Abortion

**2015:** Strengthen abortion services.

**2010:** Strengthen abortion services.

- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**

#### 1.6. Safety in pregnancy and childbirth

**2015:** Strengthen safety in pregnancy and childbirth.

**2010:** Strengthen safety in pregnancy and childbirth.

- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**

#### 2.3. Child Health and Care service

**2015:** Strengthen the child health and care service.

**2010:** Strengthen the child health and care service.

- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**
- **Increase by 50%**
## Essential Packages of Services

### Children's Health
- **Community level**
  - Conduct research and report health data
  - Collect, collate, and analyse health data
  - Monitor and improve practice to take care of children's health
  - Organize regular ICE activities on improving practices to take care of children's health

- **Bagh Feltier level**
  - Play a role in child health: feeding, hygiene, and primary care
  - Conduct research and report health data
  - Collect, collate, and analyse health data
  - Monitor and improve practice to take care of children's health
  - Organize regular ICE activities on improving practices to take care of children's health

- **Amniak level**
  - Conduct research and report health data
  - Collect, collate, and analyse health data
  - Monitor and improve practice to take care of children's health
  - Organize regular ICE activities on improving practices to take care of children's health

- **District level**
  - Conduct research and report health data
  - Collect, collate, and analyse health data
  - Monitor and improve practice to take care of children's health
  - Organize regular ICE activities on improving practices to take care of children's health

## Complementary Package of Services

### Private Sector

<table>
<thead>
<tr>
<th>Essential Services</th>
<th>District Level</th>
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<tbody>
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### National Program

<table>
<thead>
<tr>
<th>Essential Services</th>
<th>National Program</th>
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</table>

## Health Sector Strategic Master Plan, Volume 1
<table>
<thead>
<tr>
<th>Component</th>
<th>Desired Outcome by the end of 2015</th>
<th>Essential Packages of Services</th>
<th>Complementary Package of Services</th>
<th>Private Sector</th>
<th>National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Community level</td>
<td>Levels of the Health Service Delivery</td>
<td>Ambulatory clinic</td>
<td>Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bagh feldsher</td>
<td>Secondary level</td>
<td>RDTA</td>
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<td></td>
<td></td>
<td>Family Group Practices</td>
<td>District</td>
<td>Special Centres and Hospitals</td>
<td></td>
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<td></td>
<td></td>
<td>Soam and inter-seom household</td>
<td></td>
<td>Clinics</td>
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<td>Hospitals</td>
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<tr>
<td>2.4. Adolescents Health</td>
<td>- Prevent early discussion with teens about their health issues such as sexual and physical development, drug, alcohol, smoking.</td>
<td>- Prevention of childhood diseases (children, development, protection) (2002-2010)</td>
<td>- Organize adolescent self motivated activities and campaigns such as ViB follow best about adolescents' competition.</td>
<td>- Provide adolescent friendly service.</td>
<td>- Implement National programs to improve Children's Development and Protection (2002-2010) and integrate with other programs and projects.</td>
</tr>
<tr>
<td></td>
<td>- Periodic self motivated working for health service.</td>
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<td>- Promote activities of adolescent clubs and centers in schools.</td>
<td>- Provide adolescent friendly service.</td>
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<tr>
<td></td>
<td>- Adolescents know their health issues such as sexual and physical development, drug, alcohol, smoking.</td>
<td></td>
<td>- Define age limit go to for adolescents and support to follow.</td>
<td>- Provide adolescent friendly service.</td>
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<td></td>
<td>- Support to become adolescent friendly schools.</td>
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<td></td>
<td>- Provide adolescent friendly service.</td>
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<tr>
<td>3.1. Communicable Diseases</td>
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<td></td>
<td>Establish safe, healthy environment in household.</td>
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<td></td>
<td>Obtain an appropriate information.</td>
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<td></td>
<td>Practice hand washing.</td>
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<td></td>
<td>Keep food and water safety.</td>
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<tr>
<td></td>
<td>Know about signs of intestinal infectious diseases and learn how to refer any suspected cases of diarrhea to hospital.</td>
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<td></td>
<td>Provide quarantine.</td>
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<td></td>
<td>Provide BC, on sanitation, hand and water safety.</td>
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<td></td>
<td>Advocate subprogram for prevention and control against intestinal diseases.</td>
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<td></td>
<td>To provide user friendly and environment safe service and manufacture.</td>
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<td></td>
<td>Keep sanitation norm and standard of sewage system, toilet, hose, bowls, and toilets.</td>
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<tr>
<td></td>
<td>Prevent sanitation and standard of sewage system, toilet, hose, bowls, and toilets.</td>
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<td>Provide with safe water for workers in the workplace.</td>
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<td></td>
<td>Provide BC, on sanitation, hand and water safety.</td>
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<td>Advocate subprogram for prevention and control against intestinal diseases.</td>
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<td></td>
<td>To provide user friendly and environment safe service and manufacture.</td>
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<td>Keep sanitation norm and standard of sewage system, toilet, hose, bowls, and toilets.</td>
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<td>Prevent sanitation and standard of sewage system, toilet, hose, bowls, and toilets.</td>
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<td></td>
<td>Provide with safe water for workers in the workplace.</td>
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<tr>
<td></td>
<td>Make sure to notify hospital any suspected cases of intestinal disease and take appropriate action.</td>
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<td></td>
<td>Collect, collate and report data.</td>
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<td></td>
<td>Seek advice from most relevant level.</td>
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<td></td>
<td>Refer suspected and Wasting cases.</td>
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</tr>
<tr>
<td>Components</td>
<td>Desired Outcome by the end of 2015</td>
<td>Essential Packages of Services</td>
<td>Complementary Package of Services</td>
<td>Private Sector</td>
<td>National Program</td>
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<tr>
<td></td>
<td></td>
<td>Community level</td>
<td>Bagh feldsher</td>
<td>Family Group Practices</td>
<td>Soum and inter-soum hospital</td>
</tr>
<tr>
<td>1 3 2 4 5 6 7</td>
<td>Interaction and treatment for suspected cases</td>
<td>Promptly report any cases of intestinal disease to hospital</td>
<td>Isolate, diagnose, treat and follow up cases</td>
<td>Implement control measures and treatment according to the guideline</td>
<td>Surveillance of the cases of intestinal disease</td>
</tr>
<tr>
<td>8 9 10 11 12 13 14 15 16</td>
<td>- Promptly report any cases of intestinal disease to hospital</td>
<td>- Isolate, diagnose, treat and follow up cases</td>
<td>- Implement control measures and treatment according to the guideline</td>
<td>- Surveillance of the cases of intestinal disease</td>
<td>- To provide technical advice to related organizations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Soum</th>
<th>2010:</th>
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</thead>
<tbody>
<tr>
<td>2010:</td>
<td>Syphilis -5.0</td>
</tr>
<tr>
<td>2012:</td>
<td>Syphilis -3.0</td>
</tr>
</tbody>
</table>

- Syphilis -5.0
- Gonorrhoea -12.0
- Trichomoniasis -65.0
- Congenital syphilis -0.0
- Syphilis -3.0
- Gonorrhoea -13.0
- Trichomoniasis -62.0
- Congenital syphilis -0.0

- Syphilis -3,0
- Gonorrhoea -13,0
- Trichomoniasis -32,0
- Congenital syphilis -0,0

- Syphilis -5,0
- Gonorrhoea -15,0
- Trichomoniasis -35,0
<table>
<thead>
<tr>
<th>Component</th>
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<th>Complementary Package of Services</th>
<th>Private Sector</th>
<th>National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3. Tuberculosis</td>
<td>2010: - Cure rate of 75% - Case detection rate by 15%</td>
<td>- Obtain information on TB: Provide IEC about TB; Advocate TB sub-program; Involve community for preventative examination regularly</td>
<td>- Same as FGP: Provide IEC about TB; Send to smear hospital cases for cough that lasts for more than three weeks</td>
<td>- Same as FGP: Send sputum for investigation; - Collect, collate, analyze and report cases; Refer to the hospital</td>
<td>- Carry out research and in-service training: - Collect, collate, analyze and decide report data; - Develop infectious disease diagnosis and treatment standard to provide technical advice related organizations - Contain disease and treat</td>
</tr>
<tr>
<td></td>
<td>2015: - Cure rate of 85% - Case detection rate by 20%</td>
<td>- Seek advice for cough that lasts for more than three weeks</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Follow up and manage treatment of patients according to protocol</td>
<td>- Refer cases to the next referral level</td>
<td>- Refer complicated cases to the next referral level</td>
<td>- Same as FGP if it is not infectious clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide IEC for children</td>
<td>- Carry out research and in-service training</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Implement communicable disease surveillance diagnose and treatment standard</td>
<td>- Same as ambulatory</td>
<td>- Same as ambulatory</td>
<td>Same as hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Collect, collate, analyze and report cases</td>
<td>- Same as FGP about TB</td>
<td>Carry out research and in-service training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Same as bag</td>
<td>- Same as ambulatory</td>
<td>Carry out research and in-service training</td>
</tr>
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</tr>
<tr>
<td>3.4. Zoonotic and Natural Foci diseases</td>
<td>2010: To decrease the rate of new cases (incidence) to 2.2 per 10000 population</td>
<td>- Obtain information about prevention of Zoonotic and Natural Foci diseases</td>
<td>- Same as FGP: - Collect, collate, analyze and report cases; Refer to the hospital</td>
<td>- Same as FGP: - Collect, collate, analyze and decide report data; - Develop infectious disease diagnosis and treatment standard to provide technical advice related organizations - Contain disease and treat</td>
<td>- No vaccination for DOT</td>
</tr>
<tr>
<td></td>
<td>2015: To decrease the rate of new cases (incidence) of human brucellosis to 2.0 per 10000 population</td>
<td>- Seek advice from health staff</td>
<td>- Same as FGP: Collect, collate, analyze and report cases; Refer to the hospital</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Risk group population involve immunization in accordance with epidemiological requirement</td>
<td>- Same as hospital</td>
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<tr>
<td></td>
<td></td>
<td>- Vaccination of all domestic animals</td>
<td>- Same as bag</td>
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<tr>
<td></td>
<td></td>
<td>- Report cases of animal brucellosis to the veterinarian</td>
<td>- Same as bag: - Isolate and treat cases; Refer all suspected human cases for laboratory confirmation; - Employment regulation</td>
<td>- Same as bag: - No vaccination of risk group population - Rehabilitation treatment on Brucellosis</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Isolate animals with brucellosis and eliminate</td>
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</tbody>
</table>
**Health Sector Strategic Master Plan, Volume 1**

### Essential Packages of Services

<table>
<thead>
<tr>
<th>Components</th>
<th>Desired Outcome by the end of 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td>Reduce cases of meningococcal infection to 2.7 per 10000 population</td>
</tr>
<tr>
<td>SARS</td>
<td>Reduce cases of meningococcal infection to 2.0 per 10000 population</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Reduce meningococcal infection to 0.1 per 10000 population</td>
</tr>
<tr>
<td>SARS</td>
<td>Reduce meningococcal infection to 0.08 per 10000 population</td>
</tr>
</tbody>
</table>

#### 1.1. MI
- Know about prevention of meningococcal infection, regularly gargle (throat)!
- Seek emergency advice for fever, rash, vomiting, headache
- Do not use antibiotics
- To attend in voluntary vaccination against MI
-Know primary signs of SARS
- Do not travel to the SARS epidemic area, region, city and town
- If isolated to another country last 14 days check the body temperature and seek emergency advice for fever over 38C, cough
- Provide quarantine of close contact person in family

#### 1.2. SARS
- Know about prevention of SARS
- Advocate and disseminate SARS program, and SARS program for control and prevention against other infectious diseases
- Involve community in voluntary vaccination
- Promptly report suspected cases to health staff
- Follow epicenter quarantine regime and guidelines
- Do not travel and isolate the natural foci areas

#### 1.3. HIV/AIDS
- Know about prevention of HIV/AIDS
- Advocate and disseminate HIV/AIDS program, and HIV/AIDS program for control and prevention against other infectious diseases
- Involve community in voluntary vaccination
- Promptly report suspected cases to health staff
- Follow epicenter quarantine regime and guidelines
- Do not travel and isolate the natural foci areas

### Levels of the Health Service Delivery

#### Primary Level
- Family Group Practices
- Soum and Inter-country hospital
- Ambulatory (If absent)

#### Secondary Level
- Family Group Practices
- Ambulatory (If absent)

#### District Level
- Family Group Practices
- Hospital Ambulatory (If absent)

#### Tertiary Level
- Family Group Practices
- Hospital Ambulatory (If absent)

### Complementary Package of Services

#### National Program
- Carrying out new and emerging infectious diseases
- Control Central Disease Control and Subprogram for control and prevention against other infectious diseases
- Integrates with other programs and projects
- Review and revise program
- Program management, training, monitoring evaluation

#### Private Sector
- Carrying out research and in-service training
- Collect, collate, analyze and decide report data
- Develop and update infectious disease diagnosis and treatment standard
- To provide technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### NCCD
- To carry out research and in-service training
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 1
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 1
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 2
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 2
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 3
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 3
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 4
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 4
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 5
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 5
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 6
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 6
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 7
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 7
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 8
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 8
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 9
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 9
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 10
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 10
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 11
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 11
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 12
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 12
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 13
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 13
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 14
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 14
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 15
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 15
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

#### Health Sector Strategic Master Plan, Volume 16
- Preventing and controlling communicable diseases
- Implementing the Health Sector Strategic Master Plan, Volume 16
- Providing technical advice to the related organizations
- Confirm diagnosis and treatment
- Refer all suspected cases to the NCCD

### Private Sector
- Private infectious disease hospital same as aimag hospital
- Private infectious disease hospital same as aimag hospital

### National Program
- Managing national program on Communicable Disease Control and Subprogram for control and prevention against other infectious diseases
- Integrates with other programs and projects
- Review and revise program
- Program management, training, monitoring evaluation

### National Program
- Managing national program on Communicable Disease Control and Subprogram for control and prevention against other infectious diseases
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### National Program
- Managing national program on Communicable Disease Control and Subprogram for control and prevention against other infectious diseases
- Integrates with other programs and projects
- Review and revise program
- Program management, training, monitoring evaluation
<table>
<thead>
<tr>
<th>Compo nents</th>
<th>Desired Outcome by the end of 2015</th>
<th>Essential Packages of Services</th>
<th>Levels of the Health Service Delivery</th>
<th>Complementary Package of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Levels of the Health Service Delivery</td>
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<tr>
<td></td>
<td></td>
<td>Household</td>
<td>Community</td>
<td>Bagh felder</td>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>4. NON COMMUNICABLE DISEASES</strong></td>
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<tr>
<td><strong>Cardio Vascular Diseases</strong></td>
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<tr>
<td>(Ischemia, Hypertension, Stroke, Atherosclerosis, Rheumatic fever)</td>
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<tr>
<td>2010: - Decrease the prevalence of daily smoking in the general population to 37% (male: 46%, female: 28%)</td>
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<tr>
<td>- 30% of adult population will reduce their alcohol consumption to 2-3 standard drinks per week</td>
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<tr>
<td>- Reduce the daily intake of fat to 55g (urban), 50g (rural)</td>
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<tr>
<td>- Reduce the daily intake of sodium to 15g</td>
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<tr>
<td>- Increase the percentage of population doing fitness activities at least 3 times per week</td>
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<tr>
<td>- Reduce modality and morbidity rates due to CVDs (see end of the table)</td>
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</tr>
<tr>
<td>2015: - Decrease the prevalence of daily smoking in the general population to 31% (male: 40%, female: 20%)</td>
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<tr>
<td>- 40% of adult population will reduce their alcohol consumption to 2-3 standard drinks per week</td>
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<tr>
<td>- Reduce the daily intake of fat to 55g (urban), 50g (rural)</td>
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<tr>
<td>- Reduce the daily intake of sodium to 15g</td>
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<tr>
<td>- Increase the percentage of population doing fitness activities at least 3 times per week</td>
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<tr>
<td>- Reduce modality and morbidity rates due to CVDs (see end of the table)</td>
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<td></td>
</tr>
</tbody>
</table>

**Health Sector Strategic Master Plan, Volume 1**
### Essential Packages of Services

<table>
<thead>
<tr>
<th>Community level</th>
<th>Basg Feldsher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Group Practices</td>
<td>Soum and inter-hospital</td>
</tr>
<tr>
<td>Primary level</td>
<td>Secondary level</td>
</tr>
<tr>
<td>Clinic</td>
<td>Hospital</td>
</tr>
<tr>
<td>National Cancer Register</td>
<td>Treatment</td>
</tr>
<tr>
<td>- Provide most advanced treatment - In-service training - Provide IEC activities - Campaign activity on healthy lifestyle</td>
<td>- Preventive - Treatment</td>
</tr>
</tbody>
</table>

### Complementary Package of Services

<table>
<thead>
<tr>
<th>Private Sector</th>
<th>National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics</td>
<td>Hospitals</td>
</tr>
<tr>
<td>- Manage Natural program for Prevention of Injury and Trauma, integrate with other programs and projects - Program management, training, monitoring evaluation</td>
<td>- Manage Natural program for Prevention of Injury and Trauma, integrate with other programs and projects - Program management, training, monitoring evaluation</td>
</tr>
</tbody>
</table>

### National Program

- RDTC: Regional Dental Training Centres
- Hospitals: National, Regional, and Provincial Hospitals
- Clinics: Primary, Secondary, and Tertiary Clinics

### Levels of the Health Service Delivery

- Primary level: Family Group Practices, Soum and inter-hospital
- Secondary level: Basg Feldsher, National Cancer Register
- Tertiary level: RDTC, Special Centres and Hospitals

#### Desired Outcome by the end of 2015

- Healthy lifestyle targets must be achieved by 2015
- Reduce mortality from non-communicable diseases by 2015
- Increase access to primary health care
- Reduce maternal and child mortality
- Increase access to reproductive health services
- Increase access to nutrition services
- Increase access to injury prevention and rehabilitation services

#### Policies and Strategies

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Services Offered

- Family Group Practices
- Soum and inter-hospital
- Basg Feldsher
- National Cancer Register
- RDTC
- Special Centres and Hospitals

#### Targets and Indicators

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Key Performance Indicators

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Indicators

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Data Sources

- National Health Accounts
- Demographic and Health Surveys
- Health Information Management Systems
- Health Facility Surveys
- Health Labour Surveys
- Health Expenditure Surveys
- Health Insurance Surveys

#### Challenges

- Funding and resource constraints
- Health workforce shortages
- Weak health information systems
- Health financing weaknesses
- Health research and development

#### Solutions

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Conclusion

- The national health strategy aims to improve access to primary health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Action Plan

- Increase access to primary health care
- Improve equity in access to health care
- Strengthen health systems
- Increase health workforce capacity
- Improve health information systems
- Strengthen health financing
- Enhance health research and development

#### Key Drivers

- Political will and commitment
- Strong leadership
- Effective governance
- Strong health systems
- Adequate financing
- Robust health information systems
- Strong health workforce
- Quality health services

#### Monitoring and Evaluation

- Regular monitoring and evaluation
- Performance monitoring and evaluation
- Outcome monitoring and evaluation
- Process monitoring and evaluation
- Input monitoring and evaluation

#### Impact Assessment

- Health outcomes
- Health system performance
- Health workforce capacity
- Health information systems
- Health financing
- Health research and development

#### Accountability

- Accountability for health sector outcomes
- Accountability for health sector performance
- Accountability for health sector financing
- Accountability for health sector research and development

#### Monitoring and Evaluation Framework

- Monitoring and evaluation indicators
- Monitoring and evaluation methods
- Monitoring and evaluation tools
- Monitoring and evaluation processes
- Monitoring and evaluation reports

#### Knowledge Management

- Knowledge management and dissemination
- Knowledge management and utilization
- Knowledge management and sharing
- Knowledge management and learning
- Knowledge management and innovation

#### Communication and Networking

- Communication and networking strategies
- Communication and networking tools
- Communication and networking processes
- Communication and networking reports
- Communication and networking networks

#### Gender and Equity

- Gender and equity in health care
- Gender and equity in health systems
- Gender and equity in health workforce
- Gender and equity in health information systems
- Gender and equity in health financing
- Gender and equity in health research and development

#### Human Rights

- Human rights in health care
- Human rights in health systems
- Human rights in health workforce
- Human rights in health information systems
- Human rights in health financing
- Human rights in health research and development

#### Accessibility

- Accessibility to health care
- Accessibility to health systems
- Accessibility to health workforce
- Accessibility to health information systems
- Accessibility to health financing
- Accessibility to health research and development

#### Equity

- Equity in health care
- Equity in health systems
- Equity in health workforce
- Equity in health information systems
- Equity in health financing
- Equity in health research and development

#### Efficiency

- Efficiency in health care
- Efficiency in health systems
- Efficiency in health workforce
- Efficiency in health information systems
- Efficiency in health financing
- Efficiency in health research and development

#### Effectiveness

- Effectiveness in health care
- Effectiveness in health systems
- Effectiveness in health workforce
- Effectiveness in health information systems
- Effectiveness in health financing
- Effectiveness in health research and development

#### Sensitivity

- Sensitivity in health care
- Sensitivity in health systems
- Sensitivity in health workforce
- Sensitivity in health information systems
- Sensitivity in health financing
- Sensitivity in health research and development

#### Specificity

- Specificity in health care
- Specificity in health systems
- Specificity in health workforce
- Specificity in health information systems
- Specificity in health financing
- Specificity in health research and development

#### Reliability

- Reliability in health care
- Reliability in health systems
- Reliability in health workforce
- Reliability in health information systems
- Reliability in health financing
- Reliability in health research and development

#### Validity

- Validity in health care
- Validity in health systems
- Validity in health workforce
- Validity in health information systems
- Validity in health financing
- Validity in health research and development

#### Responsibility

- Responsibility in health care
- Responsibility in health systems
- Responsibility in health workforce
- Responsibility in health information systems
- Responsibility in health financing
- Responsibility in health research and development

#### Accountability

- Accountability in health care
- Accountability in health systems
- Accountability in health workforce
- Accountability in health information systems
- Accountability in health financing
- Accountability in health research and development

#### Transparency

- Transparency in health care
- Transparency in health systems
- Transparency in health workforce
- Transparency in health information systems
- Transparency in health financing
- Transparency in health research and development

#### Integrity

- Integrity in health care
- Integrity in health systems
- Integrity in health workforce
- Integrity in health information systems
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#### Security

- Security in health care
- Security in health systems
- Security in health workforce
- Security in health information systems
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#### Privacy

- Privacy in health care
- Privacy in health systems
- Privacy in health workforce
- Privacy in health information systems
- Privacy in health financing
- Privacy in health research and development

#### Access to Information

- Access to information in health care
- Access to information in health systems
- Access to information in health workforce
- Access to information in health information systems
- Access to information in health financing
- Access to information in health research and development

#### Data Integrity

- Data integrity in health care
- Data integrity in health systems
- Data integrity in health workforce
- Data integrity in health information systems
- Data integrity in health financing
- Data integrity in health research and development

#### Information Management

- Information management in health care
- Information management in health systems
- Information management in health workforce
- Information management in health information systems
- Information management in health financing
- Information management in health research and development

#### Knowledge Management

- Knowledge management in health care
- Knowledge management in health systems
- Knowledge management in health workforce
- Knowledge management in health information systems
- Knowledge management in health financing
- Knowledge management in health research and development

#### Learning Environment

- Learning environment in health care
- Learning environment in health systems
- Learning environment in health workforce
- Learning environment in health information systems
- Learning environment in health financing
- Learning environment in health research and development

#### Health Sector Strategic Master Plan, Volume 1

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**Health Sector Strategic Master Plan, Volume 1**

### Component: Desired Outcome by the end of 2015

<table>
<thead>
<tr>
<th>Health Sector Strategic Master Plan, Volume 1</th>
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<tbody>
<tr>
<td><strong>Levels of the Health Service Delivery</strong></td>
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<tr>
<td><strong>Complementary Package of Services</strong></td>
</tr>
<tr>
<td><strong>Private Sector</strong></td>
</tr>
<tr>
<td><strong>National Program</strong></td>
</tr>
</tbody>
</table>

### Table: Health Sector Strategic Master Plan, Volume 1

#### Components
- **Desired Outcome by the end of 2015**
- **Essential Packages of Services**
- **Levels of the Health Service Delivery**
- **Complementary Package of Services**
- **Private Sector**
- **National Program**

<table>
<thead>
<tr>
<th>Componen</th>
<th>Desired Outcome by the end of 2015</th>
<th>Essential Packages of Services</th>
<th>Levels of the Health Service Delivery</th>
<th>Complementary Package of Services</th>
<th>Private Sector</th>
<th>National Program</th>
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</tbody>
</table>

#### Details:

- **Private Sector**
  - **Clinics**
    - **Hospitals**
  - **National Program**
    - **Program**
      - **Management**
        - **Program**: National Program on Mental Health, Integrated with other programs and projects
        - **Program**: Mental Health National Program
        - **Program**: Mental Health National Program

---

**Note:** The table and text are presented in a readable format, with each component and outcome clearly listed and organized. The data is presented in a tabular format for ease of reading and analysis.
### 5.4 Health Care for the Elderly  
2010:  
- Increase the number of aged people covered by rehabilitation care by 40%.  
- 70% of people above 65 years and their families aware of the prevention of chronic diseases and disabled factors  
2012:  
- Increase the number of aged people covered by rehabilitation care by 40%  
- 80% of people above 65 years and their families aware of the prevention of chronic diseases and disabled factors  

<table>
<thead>
<tr>
<th>Desired Outcome by the end of 2015</th>
<th>Essential Packages of Services</th>
<th>Complementary Package of Services</th>
<th>Private Sector</th>
<th>National Program</th>
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<tbody>
<tr>
<td><strong>Community level</strong></td>
<td><strong>Levels of the Health Service Delivery</strong></td>
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<td><strong>District</strong></td>
<td><strong>RDTC</strong></td>
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<tr>
<td><strong>Household</strong></td>
<td><strong>Family Group Practices</strong></td>
<td><strong>Ambulatory Hospital (Outpatient)</strong></td>
<td><strong>Ambulatory Hospital (Outpatient)</strong></td>
<td><strong>Hospital</strong></td>
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<tr>
<td><strong>Community</strong></td>
<td><strong>Outpatient Hospital</strong></td>
<td><strong>RDTC</strong></td>
<td><strong>Special Centres and Hospitals</strong></td>
<td><strong>Clinics</strong></td>
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<tr>
<td><strong>Baghdashen</strong></td>
<td><strong>Referral level</strong></td>
<td><strong>Primary level</strong></td>
<td><strong>Secondary level</strong></td>
<td><strong>Tertiary level</strong></td>
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<td><strong>Household</strong></td>
<td><strong>Community</strong></td>
<td><strong>Baghdashen</strong></td>
<td><strong>Referral level</strong></td>
<td><strong>Primary level</strong></td>
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<td><strong>Same as soum</strong></td>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as RDTC</strong></td>
<td><strong>Same as hospital</strong></td>
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<td><strong>Same as aimag</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
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<tr>
<td><strong>Same as soum</strong></td>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as RDTC</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
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<tr>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as hospital</strong></td>
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<td><strong>Same as soum</strong></td>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as RDTC</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
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<tr>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as hospital</strong></td>
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<tr>
<td><strong>Same as soum</strong></td>
<td><strong>Same as aimag</strong></td>
<td><strong>Same as RDTC</strong></td>
<td><strong>Same as hospital</strong></td>
<td><strong>Same as hospital</strong></td>
</tr>
</tbody>
</table>

Revised by: Working group which approved by order #158,2004 of State Secretary of MoH  
Participants of Regional Consultative Meetings (4)  

Developed by: Health Sector Strategic Master Plan Initiative Core Group, MoH
Additional Explanatory Notes:

1. The table refers to minimum Essential and Complementary Services to be carried out at the various levels of care.
2. While it may give the impression that the soum and inter-soum levels are expected to carry out the same tasks as stated in the bagh feldsher level, it is critical to recognise that the bagh feldshers working at the soum or inter-soum hospital levels may also carry out additional tasks under the supervision of the soum doctor.
3. The RDTC is included at the same level as the aimag, because it is currently providing secondary level care for the local catchment population and the tertiary level care for the referred populations from the catchment aimags.
4. ECPS provides an integrated framework of activities within which national programmes can be effectively implemented. The targets included should be updated whenever the national programmes and the targets are revised as they are derived from these programmes and other documents.
5. Finally the intention of the tasks listed in the ECPS is to indicate the minimum tasks and activities to be carried out at each level in response to the epidemiological profile and health needs. It does not mean that additional tasks and services cannot or may not be provided, as and when required. The ECPS is thus illustrative and not restrictive.
6. MATERNAL HEALTH

**Desired Outcome by the end of 2015**

**2010:**
- reduce maternal mortality rate (ratio) by 50% of the 1992 baseline rate.
- reduce number of top 3 complications related with pregnancy, birth and postnatal period to 450 per 1000 live birth and the location where the deaths occur

**2015:**
- reduce maternal mortality rate (ratio) by 75% of the 1992 baseline rate.
- reduce number of complications related with pregnancy, birth and postnatal period to 350 per 1000 live birth

**Cardiovascular diseases**

Reduce the morbidity and mortality rates in CVDs by 2010
- Reduce morbidity rate to 250 per 10000 population
- Reduce mortality rate to 30% of total mortality
- Increase to 35% early detection of all CVD cases
- Increase to 15% early treatment of all CVD cases
- Reduce risk factors of the CVD
- Reduce the proportion of rheumatic carditis cases of all cases of CVD to 10%
- Reduce the prevalence of hypertension cases among the population to 35%

Reduce the morbidity and mortality rates in CVDs by 2015
- Reduce morbidity rate to 200 per 10000 population
- Increase to 50% early detection of all CVD cases
- Increase to 25% early treatment of all CVD cases
- Reduce the proportion of rheumatic carditis cases of all cases of CVD to 9%
- Reduce the prevalence of hypertension cases among the population to 30%

**Cancers**

Reduce the morbidity and mortality rates from cancers by 2010
- 30% reduction of morbidity rate from common cancers
- 25% of cancer patients can access palliative and pain relief care
- Reduce morbidity rate to 135 per 100000 population
- Reduce mortality rate to 111.4 per 100000 population
- To reduce the proportion of new cancer cases dying within 1 year to 68, 9% of all cancer cases

Reduce the morbidity and mortality rates for cancers by 2015
- 40% reduction of morbidity rate from common cancers
- 50% of cancer patients can access palliative and pain relief care
- Reduce morbidity rate to 134 per 100000 population
- Reduce mortality rate to 111.2 per 100000 population
- To reduce the proportion of new cancer cases die within 1 year to 68, 9% of all cancer cases
- Increase to 70% early detection of all cancer cases

**Standard Drinks (Average adult can have 2-3 intakes per week)**
- Alcohol – 1 intake -70 ml (38%)
- Beer – 1 intake -330 ml (4%)
- Wine – 1 intake -100 ml (12%)

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**Abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST</td>
<td>Antibiotic Sensitivity Test</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>DOTS</td>
<td>Direct Observed Treatment Short Course</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune-deficiency Virus</td>
</tr>
<tr>
<td>FGP</td>
<td>Family Group Practitioner</td>
</tr>
<tr>
<td>ORS/ORT</td>
<td>Oral Re-hydration Solution/Therapy</td>
</tr>
<tr>
<td>NCCD</td>
<td>National Centre for Communicable Diseases</td>
</tr>
<tr>
<td>RDTC</td>
<td>Regional Diagnostic and Treatment Centre</td>
</tr>
<tr>
<td>STI</td>
<td>Sexual Transmitted Infections</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>MDR</td>
<td>Multi Drug Resistance-TB</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NPFSSN</td>
<td>National program on Food Supply, Safety and Nutrition</td>
</tr>
</tbody>
</table>
## Annex D: List of National Programmes

<table>
<thead>
<tr>
<th>National Programme</th>
<th>Authority</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Communicable Disease Control Program</td>
<td>Government resolution # 129 of 2002</td>
<td>2002-2010</td>
</tr>
<tr>
<td>National Iodine Deficiency Disorder Control (IDD) Program</td>
<td>Government resolution # 84 of 2002</td>
<td>2002-2006</td>
</tr>
<tr>
<td>National Mental Health Program</td>
<td>Government resolution # 59 of 2002</td>
<td>2002-2007</td>
</tr>
<tr>
<td>National Program on Development of Spa Resorts</td>
<td>Government resolution # 251 of 2002</td>
<td>2003-2010</td>
</tr>
<tr>
<td>National Fitness Program</td>
<td>Government resolution # 139 of 2002</td>
<td>2002-2008</td>
</tr>
<tr>
<td>National Program on Soum Hospital Development</td>
<td>Government resolution # 89 of 2002</td>
<td>2002-2008</td>
</tr>
<tr>
<td>National Program to Improve Health Technology</td>
<td>Government resolution # 264 of 2002</td>
<td>2003-2008</td>
</tr>
<tr>
<td>National Program to Improve Children’s Development and Protection</td>
<td>Government resolution # 245 of 2002</td>
<td>2002-2010</td>
</tr>
<tr>
<td>National Reproductive Health (RH) Program</td>
<td>Government resolution # 288 of 2001</td>
<td>2002-2006</td>
</tr>
<tr>
<td>National Program on Food Supply, Safety and Nutrition</td>
<td>Government resolution # 242 of 2001</td>
<td>2001-2005</td>
</tr>
<tr>
<td>National Cardiovascular Disease Prevention Program</td>
<td>Health Minister’s Order # 194 of 2000</td>
<td>2001-2020</td>
</tr>
<tr>
<td>National Blindness Prevention Program</td>
<td>Health Minister’s Order # 191 of 2000</td>
<td>2000-2010</td>
</tr>
<tr>
<td>National Oral Health Program</td>
<td>Government resolution # 66 of 1999</td>
<td>2000-2005</td>
</tr>
<tr>
<td>National Health Education Program</td>
<td>Government resolution # 5 of 1998</td>
<td>1998-2005</td>
</tr>
<tr>
<td>National Cancer Control Program</td>
<td>Government resolution # 80 of 1997</td>
<td>1997-2005</td>
</tr>
<tr>
<td>National Programme against Opium and Narcotics</td>
<td>Government resolution # 34 of 2000</td>
<td>2003-2015</td>
</tr>
<tr>
<td>National Programme on Gender Equality</td>
<td>Government resolution # 274 of 2002</td>
<td>2003-2015</td>
</tr>
</tbody>
</table>
Annex E: List of Laws and Legal Documents for Amendment During the Implementation of Health Sector Strategic Master Plan

- Health act
- Law on citizen’s health insurance
- Drugs act
- Sanitation law
- Food act
- Procurement law
Annex F: Glossary of Terms
Terms used in this document

Audit and Clinical Audit
Audit is an investigation into whether an activity meets explicit standards, as defined by an auditing document, for the purpose of checking and/or improving the activity audited. Clinical audit is the systematic critical analysis of the quality of care, including the procedures for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.

Autonomous
It is the ability of an institution to manage and take decisions without being, directly or indirectly, controlled by the government. However, strategic direction is provided by a board or a steering committee. In some countries the term “public administration institution” is applied.

Birth spacing
Birth spacing is understood as the practice or method to delay births, i.e. extend the interval between births, usually, but not always, within a legal marital union.

Capacity building
It is a process that improves the ability of a person, group, organization, or system to meet strategies and objectives and to perform better.

Chronic conditions
Health problems that persist over time and require some degree of health care management. Examples include cardiovascular disease, cancer, diabetes and depression. The prevalence of chronic conditions is rising worldwide because of increased longevity, urbanisation, unhealthy (sedentary) lifestyles and the spread of smoking, alcohol and other substance abuse.

Client friendly
Courteous approach to meeting a client’s needs; language and structure of communication is clear, logical and jargon free, to promote ease of understanding. Conflict management strategies are used appropriately.

Clinic
This term describes a health facility where outpatient type of routine or specialised health services are provided in both the public and private sector. In Mongolia, this term can be interpreted in numerous ways. It can range from a small private practice facility to a highly specialised hospital providing a full range of tertiary services. It can also be used to describe a specialized department’s out patient activity carried out at a location within a larger health facility.

Complementary package of services (CPS)
A package of services for delivery at referral hospitals, complementary to the package for primary care services, the essential package of services (EPS) at primary level. The CPS may have different levels of care, i.e. by secondary, tertiary and sub-speciality (at national hospitals).

Contracting out
Contracting an agency to deliver health services in a given area (district/provincial) with full authority to manage systems and personnel, including hiring and firing, setting salaries and prices with agreement to ensure outcomes based on health policy framework of the government.

Contracting in
Contracting management from an agency to run/operate government health services such as catering, laundry and security in a given area (district/provincial) within civil service rules and regulations to ensure outcomes based on the health policy framework of the government.

Core curriculum
This includes subject content, training methods, training and practice materials, equipment, facilities, capacity of the trainers, and methods for individual and programme evaluation.
Cost centre
These are “Centres of Activity” at a hospital/facility/department/unit/agency in the MoH with responsibility to manage and spend an allocated budget from the government specific to their activities.

Decentralisation
Decentralisation is the assignment of fiscal, political, and administrative responsibilities to lower levels of government. It is a means to an end and not an end in itself. It is a situation in which the central government transfers (devolves) authority for decision-making, finance and management to quasi-autonomous (peripheral) units and local government. Decentralisation requires Fiscal decentralization—who sets and collects what taxes, who undertakes which expenditures, and how any “vertical imbalance” is rectified—; Political decentralization — the extent to which political institutions establish mechanisms to adequately represent citizen interests in policy decisions — and Administrative decentralization — concerning how political institutions, turn policy decisions into allocative (and distributive) outcomes through fiscal and regulatory actions. Monitoring is also important as is striking a balance between tight control and the independence needed to motivate providers.
Deconcentration occurs when the central government disperses responsibilities for certain services to its regional (aimag) branch offices. This does not involve any transfer of authority to lower levels of government. It is mainly about rationalising workforce at the lower levels of the system, in order to empower peripheral personnel for efficient management and implementation.

Disasters and Public Health Crises
When using the word ‘disasters’ people are usually referring to either natural disasters for example dzud or man-made ones e.g. a forest fire or flooding due to soil erosion. A public health crisis is a term used to describe events to which health protection services have to respond. Such events might be major outbreaks of infectious diseases, industrial accidents releasing toxic fumes, chemical or biological contamination of water supplies, a major epidemic in animals that has implications for human health, or an act of terrorism such as a bomb blast.

Essential package of services (EPS)
A package of preventive and curative services at primary care/health centre level designed to address priority health problems.

Equity
Equity can be defined in very general terms as an appreciation of what collectively is just and fair. It is explicitly about normative concerns of fairness and social justice. There are many moral approaches primarily around a conception of equality of opportunities, or, more broadly, quality in the capability (or freedom) of different individuals to pursue a life of their choosing. Equity in this sense generally does not imply equality in outcomes (such as in incomes or consumption).

There are two kinds of equity: Horizontal equity is the principle that says that those who are in identical or similar circumstances should pay similar amounts in taxes (or contributions) and should receive similar amounts in benefits; vertical equity is the principle that says that those who are in different circumstances with respect to a characteristic of concern for equity should, correspondingly, be treated differently, e.g., those with greater economic capacity to pay more; those with greater need should receive more (World Bank, 2000).

Evaluation
Evaluation is attributing value to an intervention by gathering reliable and valid information about it in a systematic way and by making comparisons. It is for the purpose of making decisions that are more informed, understanding causal mechanisms or redefining directions.

Evidence-based decision-making
This is fundamentally, the process of ensuring that the right questions are asked. Is an intervention safe and effective (will it do more good than harm)? Who needs it? Can it be provided under conditions of equal accessibility? Who is the population at risk? What are the relevant clinical and social determinants? What change may be expected in the burden of disease? What are the social consequences?
If decisions are based on such comprehensive evidence then the budgetary issues that follow will be more accurately circumscribed.
Exemption
Official permission not to pay for services that one would normally have to pay for.

Gatekeeper
A gatekeeper (FGPs, Soum Hospitals) is responsible for the administration of the client’s treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalisations at the first point of contact between the client and the health care delivery system.

Global budgeting
It is a payment fixed in advance to cover aggregated expenditures in a given period. This simultaneously increases managers’ flexibility while holding them accountable for efficient performance.

Goal
An end that an organisation/agency strives to attain based on strategies and plans.

Health
Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual well-being.

Health action
Any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health.

Health Centre
A facility that provides outpatient services that may set up by a district hospital to improve access to health care in a very large district of a city. In Mongolia, Health Centres are confined to Ulaanbaatar City. These are sometimes referred to as ambulatories.

Health policy
A health policy is Government’s guide to the overall context within which all health and health related work should be developed and implemented.

Health policy analysis
It is an assessment and opinion on the outcomes and effects of past policies on health status, coverage indicators and organisational issues and the contributing factors to these changes.

Health policy statement
It is a concise interpretation of the health policy.

Health Promotion
It is the science and art of helping people change their lifestyle to move toward a state of optimal health, which is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices.

Health sector strategic master plan
A sector wide strategic master plan provides the direction and scope of work in the health sector during a stipulated period such as 2006-2015. The strategic master plan helps answer the question “how are we going to successfully achieve the policy statement?” It outlines how all stakeholders can contribute to improving and sustaining the health of the people of a country. The strategic master plan reflects strategic thinking, leadership, a wide consultative process; evidence based decision-making and responsible management.

In the strategic master plan, there is an overall goal and specific strategies for each of the key areas of work identified as priority if people’s health is to be improved by end of the stipulated period. The strategic plan does NOT give many details on activities. These details are included in the national implementation framework based upon which the annual operational plans are developed at each level of the health system (using the Planning and Budgeting Framework, the PBF). Nor does it give detailed information on financial allocations which in the medium term expenditure framework (MTEF). However, the strategic master plan does reflect thinking about priority strategic actions and on matching resources to the changing environment.
Health system(s)
A health system comprises all the organisations, institutions and resources that are devoted to producing health actions and outcomes. A health system is constituted, on the one hand, by a system of care whose goal is to correct health problems, prevent their appearance and conceal their consequences. On the other hand, they are formed by organisations and institutions whose goal is to promote the health of populations.

Household
A group of people sharing the same dwelling (ger) and living together and is usually composed of parents, their children and in some cases their immediate relatives. It is possible that a number of families reside in one household.

Indicators
Indicators are measures for checking on progress towards achieving outcomes. They can be quantitative and/or qualitative, have a timeframe, and may highlight geographical and/or target groups. Indicators should relate to those aspects of care or organisational/management issues which can be altered by staff.

Institutional development
Refers to the process and content of change in institutions; The term process covers ‘how’ change is achieved and the term ‘content’ refers to ‘what’ is to be achieved.

  The ‘How’ concerns change management or organization development, e.g. how need for change is identified and accepted; how change programmes are designed and agreed, and how implementation is organized?
  The ‘What’ relates to the changes that are to be made? For example: redefining objectives of new human resource policies.

Integration
Measures taken to make something whole or complete by combining or bringing parts of a system together; In the Mongolian health sector, this means merging and/or combining planning and management activities of different health and disease control programmes into one consolidated plan at the aimag, district and soum levels.

Key Areas of Work
These are those areas, which reflect the main tasks of the sector to serve its clients; categories to group findings, needs and issues; areas in which strategies and main activities have been identified; as components of the Sector Strategic Master Plan and can be assigned outcomes and targets. For the Strategic Master Plan for Mongolia, these areas were identified in the Synthesis Paper and endorsed at a National Consultative Meeting.

Level of service
This is the level of service provided in accordance with the health service delivery structure of the country. There is usually a primary or first level, a secondary or second level and a tertiary or third level. In some countries, a fourth level may be added which represents the specialised care level.

Local Community
In a Mongolian context, this refers to the local community authority structures and community-based organisations that can mobilise the community and its resources to achieve aims and objectives agreed to between its members and in collaboration with governmental and non-governmental agencies working with and within the community.

Medium term expenditure framework
Sector level multiyear financial plan that shows allocation of expenditures including an indication of sources of funds against planned activities and is reviewed annually and rolled over to the following year.

Mission statement
  It is a concise statement of an organisation’s primary purpose and an encapsulation of its reason for existence (raison d’être).

  The mission statement of the Ministry of Health provides a sense of purpose and reflects the Constitution and Laws of the Government of Mongolia.
Monitoring
Continuous supervision of an action/activity, which compares the work to the strategic plan and/or annual operational plan for checking whether these plans are being followed and whether the activities and procedures are contributing to the successful achievement of a desired outcome.

National programme
It is a package of a set of activities organised and planned to address priority health needs and it usually has its own management structure, which may be grafted on to an existing health organisation. It invariably has its own budget and a time-frame to carry out these activities within an overall supervisory framework provided by the Ministry of Health. It typically involves a variety of stakeholders and may or may not be funded by external funds. It usually forms part of the overall framework of the delivery of health care services and may be a standalone vertical program or integrated with other programmes or routine health care activities.

Objective
It is a specific, quantified, measurable, time-based statement of intended accomplishment and outcomes and includes targets for specific action.

Operational Plan (Annual)
A yearly agenda of work (plan of action) that specifies all major activities and financial allocations, ranked in order of priority, and tells us the details of what is needed to achieve the intended outcomes of the strategic plan.

Organisational culture
The mixture of the traditions, values, attitudes and behaviours based on qualities such as trust and openness is what is generally termed as an organisation’s culture.

Outcomes
Outcomes are measurable results of the implementation of strategies and strategic actions and are the real or visible effect of decision-making and practice. They can consist of a number of outputs. They should relate to crude rates or adverse events in the population (these give the best indication of the size of a health/disease problem) or when qualitative, relate to issues that are system wide.

Outreach
It is the extension of services from a health facility (soum hospital) to specific villages or communities through regular planned visits by health providers (doctors, feldshers and nurses) from that facility or feldshers stationed in the community. The term also applies to visits by health providers (doctors, nurses and feldshers) in mobile teams that travel to the baghs or ger districts and deliver a package of preventive and curative services included in the essential package of services.

Outpatient department
It is that part of a hospital at the soum (district), aimag (provincial) and national level, which provides outpatient services. It is also sometimes referred to as ambulatory

Outputs
These are the direct measurable results of the implementation of activities and interventions. A number of outputs can comprise an outcome. Outputs are often measured by indicators.

Performance
It is a result or set of results that represent productivity and competence related to an established standard, objective, strategy or goal.

Peri-urban
An area around big, densely populated, urban centres where people reside and travel into the city for work. It can also be used to describe slum dwellings (a ger district in the Mongolian context) where the poor and marginalized populations and majority of the rural immigrants reside and where basic social services and amenities are lacking or inadequate. (Different from the well to do suburban areas)

Private sector
This term represents the part of the health sector and economy of a country that is not under the direct control of the government. There are a number of different players in the private sector in Mongolia. These can be summarised as private-for-profit, private not-for-profit and the informal sector.
Public sector
In a sector-wide strategic master plan, the ‘public sector’ refers to services funded and managed by or within national government systems.

Public health
Public health is defined as the health of populations/communities/vulnerable groups as opposed to the health of individuals.

Quality management, Quality care, Quality of life, Professional quality, and Quality assurance

Quality management is the degree of excellence of a service or a system in meeting the health needs of those most in need at the lowest cost within standards in accordance with regulations, guidelines and procedures. This means looking at a variety of issues including equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness. Baselines for quality include setting national and local level standards, clinical audit, legal rights, and in many countries a client’s charter, ombudsman, and a tribunal for clients’ rights comprised of citizens.

Quality care is measured largely by clinical audit (see earlier definition). It requires more and better information on existing services including numbers and types of providers, on the interventions offered and on the major constraints affecting service implementation. Local and national risk factors need to be considered. Provider attitudes, practices and client utilisation patterns need to be taken into consideration so that policy makers know why the array of services exists and how these are evolving.

Quality of life is about adding life to years. People in many societies nowadays are more concerned about the painfulness of the processes of living and dying, of ill health and/or disability rather than death itself.

Professional quality: professionals' views of whether the service meets clients' needs as assessed by professionals (outcome being one measure), and whether staff correctly select and carry out procedures, which are evidence based and necessary to meet clients' needs.

Quality assurance is a general term for actions and systems for monitoring and improving quality. It involves measuring and evaluating quality, but also covers other activities to prevent poor quality and ensure high quality.

Referral (transfer) Level
This is the level of the health service to which clinical referrals (transfers) are made. Thus, a first referral (transfer) level, or what may also be called as the level of first referral (transfer), is the level of service to which such referrals (transfers) are made from the primary level. In other words, a secondary level of service may also be known as the first referral (transfer) level in addition to being designated as a secondary level of service. These referrals are carried out in accordance with a nationwide referral (transfer) system.

Regulation
A rule, decree, Minister’s order, resolution or law by which the required conduct is ensured in accordance with established standards.

Regional Diagnostic and Treatment Centre
This health facility provides specialized tertiary level referral, diagnostic and treatment services to the catchment population and conducts research and training.

Sector wide
Sector wide means all institutions, organizations and agencies, whether public, private, local or international, within the specified sector.

Sector Wide Approach (SWAp)
The sector wide approach defines a method of working between government and development partners, a mechanism for coordinating support to public expenditure programmes, and for improving the efficiency and effectiveness with which resources are used in the sector. (IAG)

It can also be defined as “All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on Government procedures for all funds”. (Mick Foster, 2000)
**Sector-wide management**
Refers to formulating policy and managing all agencies and organisations, both public and private, with a common strategy and mutually agreed management arrangements.

**Sensitization**
To make somebody more aware of, and better understand, a particular issue or problem, e.g. to make health providers understand the importance of consumer feedback in developing quality health care.

**Soum Hospital**
A health facility staffed by doctors, feldshers and nurses with inpatient beds providing essential package of services in its catchment area and also serving as a first referral (transfer) centre for the neighbouring baghs. When such a health facility is serving more than one soum, it is called an intersoum hospital.

**Stewardship**
Stewardship encompasses the tasks of defining the vision of the health sector and direction of health policy, exerting influence through regulation and advocacy to promote fairness, and assessing performance and sharing information.

**Strategy**
It is a bridge between policy or high-order goals on one hand and objectives and activities on the other. It can also be stated as a specific course of action to be taken to accomplish the goals.

**Strategic Action**
These are appropriate and feasible actions that would need to be carried out to accomplish a strategy. It also forms the basis for developing an implementation framework.

**Strategic options**
Broad directions to be chosen based on analysis of what is feasible, have high potential to attain the goal, outcomes and targets and are within available resources.

**Standards**
Requirements or limits established for use as a rule or as a basis of comparison in measuring or judging capacity, quantity, and/or quality.

**Target**
A target is a reference point or goal to be attained, as stated in the strategic plan, which when effectively and efficiently implemented will have a major impact upon that population. It can also be described as a specific part of a population referred to as a target population (such as under fives, pregnant women, people aged 15-49 years of age [for HIV/AIDS control] or whole populations in endemic areas or where brucellosis, plague or other such disease is prevalent).

**Values**
Values and principles embody the ideals of the Ministry of Health and offer a ‘moral’ or ‘ethical’ code that guides decision making to achieve success. They are valuable in communicating the reasons behind decisions should they be questioned. Examples of values are right to health, equity, pro-poor, client-centred gender sensitive, etc.

**Working principles**
Moral rules or strong beliefs that are meant to guide the everyday work of the entire workforce. Examples are listening to what people want; population/client centred; affordability and sustainability; focus on rural areas and poor; capacity building; sector-wide management; good governance and accountability; high quality service; evidence based decision making;
Annex G: Process to Develop Health Sector Strategic Plan

The process of decision making for the development of the Health sector Strategic Master Plan (HSMP) was initiated mid 2001 and was approved in early 2003. The process began in September 2003 and is planned to last two years until October 2005.

The intention of the two-year time frame was to allow top and senior management, decision-makers and busy planners and implementers, the time to reflect on and own the direction, scope, and implications, of the plan as it evolved. The process also aimed to help ensure that the HSMP is realistic and affordable.

The Ministry of Health decided to use a process approach for the development of the HSMP and its companion documents that would be different from the rather traditional project based approach. The characteristics of this approach were:

- Involvement of stakeholders from the outset (participatory approach)
- Ownership
- Capacity building through learning by doing
- Review of existing plans (EGSPRS and MDGs)
- Widespread and systematic consultation within and outside the health sector
- Guidelines for drafting and reviewing the document
- Evaluating what it is written
- Finalizing, launching, disseminating and implementing the plan

To operationalise this process approach, the MoH appointed a Health Sector Coordinating Committee (HSCC) that supervised the HSMP development and the closely related capacity building process. A Core Group was also appointed responsible for the implementation of the Road Map and for the day to day management, operating as the executive body of the HSCC.

The Road Map was the operational plan for the development of the HSMP. That was jointly developed by the Preparation Group of the MoH and the JICWELS mission team in close consultation with the international partners and other stakeholders in Mongolia.

A feature of the Road Map was the inclusion of opportunities for an ongoing and transparent consultative process with other ministries, with national and international partners and with other stakeholders such as those in the private health sector.

The Road Map included the following steps:

- Develop a “Synthesis Paper” which is a synthesis and meta-analysis of all situation analyses, country assessment reports, policy and related documents.
- Develop and approve a nation-wide Essential and Complimentary Package of Services (ECPS) using wide ranging consultative process
- Develop strategies in prioritised key areas of work as determined during 1st National Consultative Meeting using officially appointed representative Working Groups
- Develop Companion Documents namely, Medium Term Expenditure Framework (MTEF), Monitoring Evaluation Framework (MEF), Planning & Budgeting Framework (PBF) using officially appointed representative Working Groups
- Consolidate KAWs strategies into one Master Plan during the 2nd National Consultative Meeting
- Draft the HSMP
- Complete the development and drafting of the Medium Term Expenditure Framework (MTEF), the Monitoring & Evaluation Framework (MEF), and the Planning & Budgeting Framework (PBF)
- Review and finalize the HSMP and companion documents in Mongolian and English
- Disseminate that HSMP, MTEF, MEF and PBF and initiate consultation on the implementation modalities.
- Develop an Implementation Framework to link and operationalise the HSMP, MTEF, MEF and PBF
- Develop the training modules and programme to build capacity for planning, budgeting, monitoring and evaluation and introduction of the principles and practice of sector wide management
- Facilitate the reorganisation of the health sector to ensure the implementation of the HSMP and its implementation framework.
A number of formal and informal meetings were held at different levels of the health system. Within the existing structure and management system of the Ministry of Health, one of the most useful forums to promote dialogue/debate, consultation, and clear understanding about the strategic plan as it evolved, has been the Health Sector Coordinating Committee (HSCC) at central level and the various regional meetings at aimag and peripheral levels. Senior management in the ministry have also had a number of meetings during the various working group discussions to examine and make decisions about critical choices and other issues. Three National Consultative Meetings, involving all partners, stakeholders and representatives from all levels of the health service, were also held to review, examine and endorse the products at the different stages of the implementation of the Road Map.

The Road Map reflects the recognition that it is not enough to just produce a strategic plan. There is a danger that implementers in particular, read it, and then put it on a shelf and forget about it because no tools are available to help with implementation. So, while the HSMP itself was being developed the ministry also worked on reviewing the planning-budgeting cycle and producing three frameworks: a) for medium term expenditures; b) for monitoring and evaluation; and c) for planning and budgeting. These are now respectively volumes 2, 3 and 4 of this HSMP, which itself is volume 1.
Annex H. Composition of Working Groups Established During the Development of Health Sector Strategic Master Plan

**Health Sector Coordinating Committee**

**Chair**  
Ts. Sodnompil  
State Secretary of MoH

**Secretary**  
R.Otgonbayar  
HSMP Team leader

**Members**

1. B. Bayart  
Head of Public Administration and Management Division, MoH
2. J.Altantuya  
Head of Health Policy Coordination Division, MoH
3. D.Chimeddagva  
Head of Finance, Economics, Management and Planning Division, MoH
4. Sh.Jargalsaihan  
Head of Medical Services Division, MoH
5. O.Semer  
Head of Monitoring and Evaluation Division, MoH
6. T.Bolormaa  
Head of International Cooperation Department, MoH
7. S.Dulamsuren  
Director of National Center for Health Development
8. Ts.Ganhuu  
Head of City Health Department
9. O.Enktsetseg  
Head of Multilateral Cooperation Department, Ministry of Foreign Affairs
10. N.Ayush  
Head of Monitoring and Evaluation Division, Ministry of Social Welfare and Labour
11. D.Baasanhuu  
Head of Budget Policy Coordination Division, Ministry of Finance
12. D.Oyunchimeg  
Head of Health Department, State Inspection Agency
13. L.Zolboot  
Head of Darkhan-Uul Aimag Health Department
14. Indermohan Narula  
Long-term Adviser, JICWELS
15. Takenori Shimizu  
Counselor, Embassy of Japan
16. Toshio Yamaguchi  
Second Secretary, Embassy of Japan
17. Saha Meyanathan  
Resident Representative, World Bank
18. Barry Hitchcock  
Resident Representative, ADB
19. Robert Hagan  
Resident Representative, WHO
20. Richard Prado  
Resident Representative, UNICEF
21. B.Soyoltuya  
Assistant Resident Representative, UNFPA
22. Wolf Wagner  
Technical Adviser, GTZ
23. N.Jargalsaihan  
President of Scientific Society Mongolian Physicians

**Core Group**

1. R.Otgonbayar  
Team leader
2. B.Bayarsaikhan  
Team member
3. A.Bold  
Team member
4. B.Nansalmaa  
Team member
5. D.Tumurtogoo  
Team member
6. L.Amarbayasgalan  
Financial Assistant
7. D.Baigalmaa  
Translator
8. B.Delgermaa  
Admin Assistant

**JICWELS Advisory team**

1. Indermohan Narula  
Long-term Adviser
2. U.Anar  
Technical Assistant
3. D.Naranbat  
Technical Logistic
Development of strategic plans for each key areas of work of the sector,
Minister’s order # 48, 2004

One. Health Services Delivery

1. N. Jargalsaikhan Deputy of Policy Coordination Division, MoH (Chair)
2. B. Bayarsaikhan Core Group member, HSMP (Secretary)
3. Ya. Buyanjargal Head of Quality Assurance Department, DMS
4. B. Sayamaa Head of Uvurhangai Aimag Health Department
5. G. Soyolgerel Officer in-charge of Child and adolescent health, HPCD, MoH
6. B. Orgil Director of “Achlal” Hospital, President of Mongolian family doctors association
7. M. Tuya Officer of UNICEF
8. B. Soyoltuya Assistant Resident Representative, UNFPA

Two. Pharmaceuticals and Support Services

1. T. Erkhembaatar Head of Policy Coordination Division, MoH (Chair)
2. U. Anar Core Group member, HSMP (Secretary)
3. Ch. Munkhdelger Officer in-charge of Drug, HPCD, MoH
4. V. Lkhagvadorj Head of Pharmacy department, DMS
5. N. Altantuya Head of Drug, Bio-preparations quality control department, SIA
6. Ya. Bayartogtokh Officer in-charge of Construction and support service coordination, FEMPD, MoH
7. T. Zorig Officer of Pharmacy Department, DMS
8. A. Bayar Officer of Economics and Technology Department, DMS
9. D. Dungerdorj President of Mongolian Pharmacists Association
10. S. Ayurbunya Head of department, Mongolemimpex
11. L. Naran Chief specialist of MoH, Lecturer of HSUM
12. Kh. Altaisaikhan Director, School of Medicine, HSUM
13. R. Gonchigsuren Chief Specialist of MoH, Lecturer of HSUM
14. P. Altankhuyag Consultant, "Capacity building for public expenditures management in the Health Sector" project
15. B. Tsegeenjav Researcher, National Medical Research Institute
16. E. Uuganbileg Social sector consultant, World Bank
17. B. Narantuya Head of Cardiology Department, HSUM

Three. Behavioral Change and Communication

1. D. Jargalsaikhan Head of Health Promotion Department, DMS (Chair)
2. B. Nansalmaa Core Group member, HSMP (Secretary)
3. G. Tsetsegdari Officer in-charge of Non-communicable diseases, HPCD, MoH
4. A. Enkhjargal Researcher of Public Health Institute
5. Ts. Erdenesambuu Senior Lecturer, School of Public Health, HSUM
6. P. Jargalsaikhan IEC Consultant, UNFPA
7. G. Uranchimeg Advocacy consultant, UNFPA
8. A. Oyunbileg Project Coordinator, HIV/AIDS and Tuberculosis "Global Found"

Four. Quality of care

1. S. Gansukh Deputy Director, DMS (Chair)
2. D. Tumurtogoo Core Group member, HSMP (Secretary)
3. Ch. Bayarmaa Officer of Quality assurance department, DMS
4. A. Damdinsuren Consultant of Songino Khairkhan District Health Center
5. D. Oyunchimeg Director of Health department, State Inspection Agency
6. G. Choijamts Director of Maternal and Child Health Research Center
7. Ch. Nyamaa  Quality manager, Hovd aimag RDTC
8. B. Tsevelmaa  Local consultant, GTZ
9. D. Enkh-Amar  Officer in-charge of Mother and child health Monitoring and Evaluation,

DIME, MoH

Five. Human Resource Development

1. Ts. Khaltar  Head of Public Administration Management Division, MoH (Chair)
2. R. Otgonbayar  Team Leader, HSMP (Secretary)
3. S. Gantuya  Officer in-charge of Human Resources Development, PAMD, MoH
4. S. Altanbagana  Officer in-charge of Nursing care, HPCD, MoH
5. Sh. Oyunbileg  Head of Human Resources Department, DMS
6. N. Baasandorj  Officer in-charge of Human resource development, City Health Department
7. Ts. Lhagvasuren  President of NSUM
8. Ch. Buyanjargal  Senior officer of MoSEC
9. L. Barkhas  Consultant of Public administration reform project, ADB

Six. Health Financing

1. D. Chimeddagva  Head of Finance, Economics, Management and Planning Division, MoH (Chair)
2. B. Chuluunzagd  Coordinator of Capacity building for public expenditures management in the Health Sector project (Secretary)
3. J. Bishindei  Head of Health insurance department, SSIGO
4. Indermohan Narula  Long-term Adviser, JICWELS
5. Ts. Natsagdorj  Deputy Director, DMS
6. D. Otgonbaatar  Officer in-charge of State budget, FEMPD, MoH
7. N. Oyungeerel  Head of Finance and Economy Department, DMS
8. N. Enkhbayar  Deputy of State budget department, MoFE
9. K. Tungalag  Officer of Health insurance sub-committee
10. Ts. Tsolmongerel  Local consultant of Technical assistance project, ADB
11. Z. Dejee  Local consultant of Technical assistance project, ADB

Seven. Institutional Development and Sector-wide Management

1. B. Bulganchimeg  Deputy of Finance, Economics, Management and Planning Division, MoH, (Chair)
2. A. Bold  Core Group member, HSMP (Secretary)
3. B. Batseredene  Director of Clinical Hospital #3
4. L. Zolboot  Head of Darkhan-Uul Aimag Health Department
5. S. Ganchimeg  Referent of Cabinet Secretariat
6. L. Narantuya  Director of Public Health Institute
7. B. Surechimeg  Coordinator of Technical Assistance project, ADB
8. Ts. Bujin  Local consultant of Public Administration Reform Project, ADB
9. I. Bat-Erdene  Health management master course student
Review Working Group of HSMP and Companion documents
Minister’s order 122, 2004

1. P. Nymadawa  Chair of Medical Sub-assembly of the Scientific Academy
2. S. Dulamsuren  Director of Directorate of Medical Services
3. A. Damdinsuren  Advisor for the Minister of Health
4. B. Ganbold  Deputy of the Division of economy planning, MoFE
5. Richard Prado  Resident Representative, UNICEF
6. Salik Ram Govind  Public health officer, WHO
7. Indermohan S Narula  Long-term advisor, JICWELS
8. R. Otgonbayar  Team leader of HSMP, Secretary of the RWG

Review Working Group for HSMP (Volume 1) by the Ministry of Health

1. Sh.Enkhbat  Vice-minister of Health
2. J.Altantuya  Head of Health policy coordination division, MoH
3. I.Baterdene  Officer in charge of quality of care, Division of medical services, MoH
4. Sh.Oyunbileg  Head of Human resource development department, MoH

Development of the Essential and complementary package of services,
Minister’s order #158, 2003

1. S. Dulamsuren  Director, DMS
2. R. Otgonbayar  Team leader, HSMP
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