

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH: MONGOLIA



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1. Introduction

Mongolia is a large landmass with a low population of 2.8 million spread over 1.56 million kilometres. It is 19th largest in the world and is bordered by Russia and China. While traditionally nomadic, 69% of the population now lives in the capital city, Ulaanbaatar (UN, 2012),ⁱ and ongoing rural-to-urban migration is a recent (since 2000) demographic challenge for the country to manage. Mongolia began its transition from socialism to a parliamentary democracy in 1990 after the collapse of the USSR. Withdrawal of Soviet support and economic subsidies led to a period of severe hardship in the 1990s in Mongolia, including food shortages, high inflation, and a Total Fertility Rate (TFR) that reached a low of 1.95%.ⁱⁱ Recovery was slow but by the mid 2000s, the economy was improving and the birth rate increasing; life expectancy at birth is recorded at 69.11 years, 75.01 years for women and 65.42 years for men and the TFR reached 3.0 in 2013.ⁱⁱⁱ

The World Bank classifies Mongolia as a Lower Middle Income country, and the poverty rate averages about 1/3, with higher rates (approx. 40-45%) in rural areas and lower rates in urban areas. Although mining and other extraction industries have helped strengthen Mongolia's economy, high unemployment remains a problem, particularly among rural and less-educated people, and income inequality is increasing. The government has shown its commitment to human rights and democracy by adding a ninth national Millennium Development Goal focusing on democratic governance and human rights.

^{iv} Religion was actively suppressed during socialism, and although just over half of Mongolians are Buddhist, religion continues to

Mongolia has an adequate legal framework regarding access to sexual and reproductive health and rights (SRHR). The country has signed on to the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW) in 1980, the Convention on the Rights of the Child (CRC) in 1990, the International Covenant on Civil and Political Rights (ICCPR) in 1968, the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1968, and the International Conference on Population and Development Programme of Action (ICPD POA), and the Beijing Platform for Action. The Mongolian Constitution (1992) provides citizens the right to live in a safe and healthy environment and free access to primary health care. Article 5 states that “mothers are entitled to financial assistance when giving birth and when raising their infants.” and Article 11 states that “the state shall protect the interests of families, infants and children.” Mongolia's Law on Promotion of Gender Equality (2011), Article 13 grants equal rights to health services, stating that government shall create measures to provide health services specific to the needs of both women and men.

This country profile assesses universal access to sexual and reproductive health services (SRHS) in line with indicators described in ARROW's An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights.^{vii}

We aim to provide an overview of SRHS that will serve as a reference for all stakeholders working on the issue of sexual and reproductive health and rights in Mongolia. This country profile can be used effectively for evidence-based advocacy to improve policies and delivery of SRHS in the future.

Mongolia is 33rd of 136 countries on the Global Gender Gap Index 2013, with a score of .720.^v Gender disparities are notable in areas such as life expectancy,^{vi} higher education rates for females, and political representation.

2. The status of sexual and reproductive health in Mongolia

Contraception

The ICPD Programme of Action paragraph 7.2 urges governments to ensure that people are able to reproduce and have the freedom to decide if, when and how often to do so. It further notes the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice. In this section we look at key indicators related to contraception: the Total Fertility Rate (TFR), the Contraceptive Prevalence Rate (CPR), and the unmet need for contraception.

Sexual and reproductive health (SRH) is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the sexual and reproductive system and its functions and processes. SRH implies a safe, satisfying sex life, the capacity to reproduce and the ability to decide whether to reproduce.

SRH is a key human right, as well as a strong indicator of a country's health system and overall level of development. In addition, SRH is connected to other key development issues, such as: gender equality, human rights, poverty and inequality, health, climate change, population dynamics, disasters, food security and access to resources. Mongolia's legal framework and guarantee of free access to primary health care lays a positive foundation for sexual and reproductive health. However, as in many countries, problems with access to sexual and reproductive health services (SRHS) arise in implementation of the laws. Access to sexual and reproductive health services for women of all ages is guaranteed in law, but in practice is somewhat limited by women's location and income level. In the following sections, indicators regarding contraception, maternal and child health, adolescent and young people's sexual and reproductive health, HIV and AIDS, and availability of sexual and reproductive health services at different levels of care are discussed, thus providing an overview of sexual and reproductive health in Mongolia.

3

COUNTRY
PROFILE ON
UNIVERSAL
ACCESS TO
SEXUAL AND
REPRODUCTIVE
HEALTH:
MONGOLIA

Total Fertility Rate (TFR)

The Total Fertility Rate (TFR) is defined as the number of children a woman would have at the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to 49 years. TFR is seen as an indirect indicator of good or poor reproductive health. A high total fertility rate (>5 births) represents a high risk of reproductive ill health ^{viii} and also indicates the lack of access to contraception services for individual and couples.

Fertility decline in Mongolia began in the mid 1980s. During the 1990s, Mongolia experienced a sharp decline in fertility rates, and the TFR reached 1.9 in 2005. However, in last few years an increasing trend in fertility has been observed. ^{ix} UNFPA Mongolia attributes this increase to national policies and social welfare programmes that encourage fertility.

^x The Mongolia Social Indicators Sample Survey (SISS) 2013^{xi}, the most recent data available, shows that the TFR reached 3.1 due to large cohort of couples who have come of reproductive age.

TFR varies by urban or rural area; in urban areas the TFR is 3.0 and in rural areas it is 3.6. Rural fertility rates for teenage mothers were 3 times higher than those in the same age group in urban areas. ^{xii} In general, early fertility is more common in rural areas, while late fertility is dominant in urban areas.

At the regional level, the TFR is highest in rural Western Mongolia (3.86) and lowest in urban Ulaanbaatar (2.97), and in other regions it is about 3.1, which has been the general trend in the previous two decades. Fertility is highest for women with no or low income. For instance, the TFR was 4.0 for women with monthly per capita income of 28,264 MNT (Mongolian currency) or less compared to a TFR of 2.5 of women with a monthly per capita income of 123,786 MNT or more. Women with primary or less education tend to have higher fertility (3.61) than women with higher education (3.16).^{xiii} According to the 2008 Mongolia Reproductive Health Survey (RHS), median age at birth increased slightly from 21.6 to 22.3 over 1998-2008, which was higher for urban women (22.7) than for rural women (21.8).^{xiv}

Pro-natalist policy has a long history in sparsely-populated Mongolia. Contraception and abortion were illegal for many years during socialist times. Pro-natalism in contemporary Mongolia is not coercive but expressed through both policy and incentives such as cash payments: in an extreme example, all children born the day the population reaches three million will receive cash awards of three million togrogs.^{xv} Demographic studies indicate there is no need for the Mongolian government to promote higher birth rates, because the current rate will rise naturally as the population of women of child-bearing age increases, and this will be sufficient to match the country's economic development. In addition, data also shows that women are having the number of children that they wish to have.^{xvi}

Contraceptive Prevalence Rate (CPR)

Contraceptive prevalence rate is a sensitive indicator of both access to reproductive health services, and access to the range of contraceptive methods among women, assuming there is no coercion for acceptance of birth control through government population policy.^{xvii}

According to the RHS for each year, the contraceptive prevalence rates were 59.9, 69 and 55.2 in 1998, 2003 and 2008 respectively. The CPR declined by 54.6 in 2013, according to the SISS. The CPR was lower in urban areas (51.5%) than in rural areas (59.7%). The contraception prevalence rate is 49.6 percent for married women and 40 percent for women of reproductive age using a modern method. However, less than 4.1 percent of young married women (under age 19) use modern methods of contraception.^{xviii} And rates are declining: UNFPA notes that in 2003, 58 percent of married women and 45 percent of reproductive age women used modern contraception.^{xix}

Table 1: Percent distribution of women by specific contraceptive methods currently used, according to RHSs and SISS, Mongolia

RHSs	CPR ANY METHOD	ANY MODERN METHOD	Modern Method										TRADITIONAL METHODS	
			Pills	IUD	Injections	Norplant	Diaph./ Foam/Jelly	Male Condom	Female Condom	Female Sterilization	Male Sterilization			
SISS, 2013	54.6	48.2		8.7	23.5	3.7	0.5	0.0	8.4	0.1	3.2	0.0	6.4	
RHS, 2008	55.2	49.6	9.7	22.3	7.9	0.2	0.0	6.7	0.0	2.6	0.0		5.5	
RHS, 2003	69.0	58.4	11.0	32.8	5.8	0.3	0.0	5.4	0.1	3.0	-		10.6	
RHS, 13.1 1998	59.9	45.7		4.2	32.2	3.1	0.2	0.1	3.5		-	2.4	-	

Source: Mongolia Reproductive Health Survey 2008 National Report, National Statistical Office of Mongolia, United Nations Population Fund, Ministry of Health, 2009, Ulaanbaatar; p. 116 Mongolia Social Indicators Sample survey (SISS) 2013, Main Result, June 2014, National Statistical Office of Mongolia, UNFA, UNICEF, Ulaanbaatar p. 22

Male sterilisation and condom use reflect the extent to which men take responsibility for fertility control by using a method of contraception themselves. In contrast to the varying rates of female sterilization, the rate of male sterilization is zero each year. However, male condom use increased in these years. In Mongolia, the lack of acceptance for male sterilisation and relatively low use of condoms reflects poor male responsibility in fertility control and a continuing perception that male fertility is a positive sign of masculinity.

Unmet Need for Contraception

Unmet need for contraception serves as a proxy measure for access to reproductive health services. It reflects the gap between women's reproductive intentions and actual contraceptive behaviour.^{xx} It is also an indicator of how far governments respect women's reproductive rights.

In 2013, the unmet need for contraception was estimated at 16.0 percent,^{xxi} and unmet need in Mongolia almost doubled in recent years, from 9.9% of reproductive age women in 1998 to 22% in 2010.

^{xxii} While the most recent drop is encouraging, the RHS (2008) attributes trends of increasing rates to factors such as poverty, discrimination and violence. Unmet need is highest, or 26% in 2008 among women aged 15-24, showing that this is a particular issue for youth. It is not clear why, but urban women are also more likely to have an unmet need (17.2%) than rural women (14.1%).^{xxiii}

The fertility rate is high for women of poor families with low education levels compared with other groups. Decreased use of contraceptive methods and increased unmet needs have led to high rates of abortion and adolescent fertility,^{xxiv} implying that women lack access to their reproductive rights.

The official abortion rate as of 2010 is 16.9 per 1,000 women aged 15-49, according to United Nations figures.^{xxv} However, as abortions are performed at both government and private facilities, this figure may not be complete.

^{xxvi} Although abortion is widely practiced, there is rhetoric against it and a common perception that abortion is bad for a woman's gynaecological health. Women who miscarry are blamed for harming themselves with too many abortions, and consent forms lead women to believe that they are engaging in a high risk procedure, for which outcomes they are responsible. There is a perception that abortion is bad, so women are afraid to demand a safe abortion or ask for any precautions during the procedure; they accept what is offered.^{xxvii} Of 466 female adolescents aged 15-19 surveyed in the 2008 RHS, 56.9 percent were against abortion because they felt that it was not healthy for the mother.^{xxviii}

Maternal and Child Health

Maternal and child health statistics are one of the main indicators of primary health care quality and accessibility. Poor showings in maternal health indicators suggest a lack of investment by the concerned government in women's health and healthcare and a poorly functioning health care system.^{xxix}

In this section we review key indicators pertaining to women's health a) maternal mortality ratio (MMR), which reflects how safe child delivery is for the woman; b) perinatal mortality rate (PMR), which is a good indicator of both status of maternal health and nutrition and quality of obstetric care; c) infant mortality rate (IMR) which is a reflection of optimal maternal health, nutrition and care during delivery;

d) proportion of births attended by skilled birth attendants, which helps understand the extent to which governments have invested in developing human resources necessary for ensuring safe delivery and prevention of maternal deaths; e) availability of basic emergency obstetric care and comprehensive emergency obstetric care to ensure safe delivery and prevention of maternal deaths; f) coverage of Postpartum/Postnatal Care within 48 hours of delivery by a skilled health provider, as significant proportion of maternal and newborn deaths occur during delivery or in the one word period; and g) antenatal care coverage (ANC) which is an indicator of women's access to health care services.

Case Study: Poor Quality of Sexual and Reproductive Health Services

My name is Tserendolgor. I am 48 years old, and I live in a rural area, in Uvurkhangai province. In 1995, I gave birth to my 4th daughter at the same time as the first popular serial was broadcast on television. Everyone watched it. When my daughter was born, the people in the delivery room hit my daughter's head on the sink when they were washing her because they were hurrying to watch the serial. Because of this, my daughter had a haemorrhage. My husband and I found out about that when our daughter was 6 months, and we didn't complain to seek justice. Now our daughter is 19, one eye is blind and other eye is very bad looking due to the haemorrhage. Also, her brain is injured. Generally, there is a high level of child mortality and injury because of hospital errors in my local area. For example, this year there was one case of maternal mortality here due to bad stitches, and so a child was orphaned. Last year my friend's daughter gave birth, and the doctor injured her baby. Now the baby is not growing. Although there have been 2 or 3 maternal mortality cases in our area this year, no doctors or medical workers have been charged. There are many examples like this in our country.

Pregnant women have a lot of problems giving birth and getting birth control. To get to see a doctor takes 3 days, and all things are decided by money. Pregnant women who have no money or contacts with medical workers can't get good service. Even though there is a big regional treatment centre in our area, it is not enough for all the people who need it, especially poor, rural people and people who have no contacts in the hospital. I think when I was young the service of the hospital was better than now, and the attitudes of the doctors, nurses and workers was more polite and caring.

Interview conducted by MONFEMNET staff in April, 2014.

a) Maternal Mortality Ratio (MMR)

MMR is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period.^{xxx}

The Maternal Mortality Ratio (MMR) is 42.6 per 100,000 as of 2013; 64.6% of maternal mortality is caused by pregnancy and birth, and 39.5% by health complications,^{xxxi} which represents a significant improvement from the 1990 MMR of 199 per 100,000.^{xxxii} The government of Mongolia initiated strategies to improve maternal health outcomes, and Mongolia has become a country with moderate level of maternal mortality. The MMR target for MDG 5 was to reduce the rate by four times against the 1990 level and two times against the 2005 level, which Mongolia has achieved.^{xxxiii}

However, wide disparities remain in age and access to care between rural and urban women and between low- and middle-to-upper-income women. The MMR was 157 in 40-44 age group, which is greater by 115.2 points than the country average; unfortunately, there is no data or survey that explains this disparity.

Rural Mongolia is sparsely populated, and women may have to travel long distances over unpaved roads to reach healthcare facilities. Seventy-five percent of maternal deaths occur among nomadic herders, unregistered migrants and unemployed women, and women in the most remote province have an MMR of 206, far worse than the national rate.^{xxxiv}

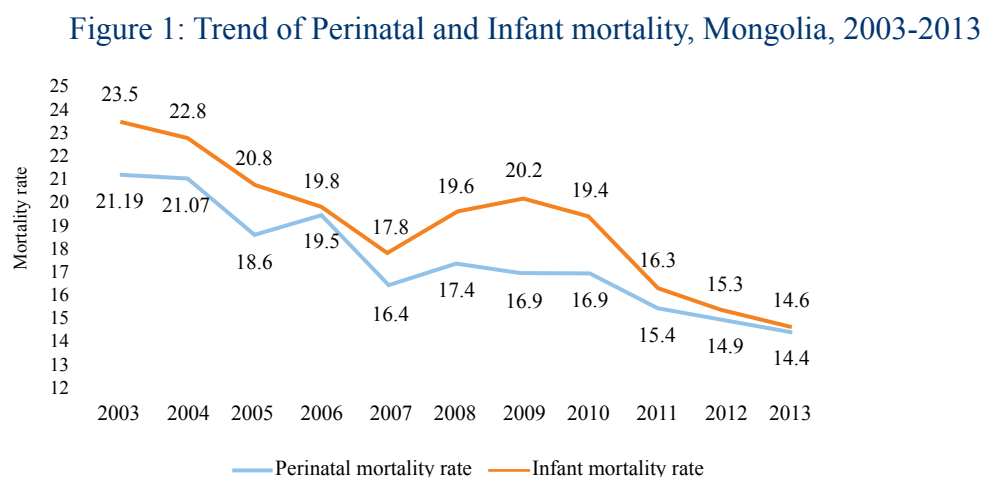
Although the rate decreased by 6 times in the past 20 years, special attention is needed for vulnerable groups such as female herders, poor and unemployed women, as well as female students. Recently, many young female students have begun to buy abortion medicines from the black market without adequate information on method of use, which puts their health at risk. Teen and young girls' pregnancy rates also tend to increase, due to poor access to SRHS and stigmatisation of sexually active young women.

The government acknowledges that poor infrastructure, lack of training for medical personnel and inadequate equipment affect the MMR, but also uses ethno-nationalist rhetoric to note that the MMR can be improved by 'implementing policies on the genetic security of Mongolia and appropriate pro-natalist policy,' among other measures.^{xxxv}

b) Perinatal Mortality Rate (PMR)

The 'perinatal period' refers to the period between 22 completed weeks (154 days) of pregnancy (the time when birth weight is normally 500 g.) to seven completed days after birth.^{xxxvi} Perinatal death thus includes both late foetal death and early neonatal death.^{xxxvii}

In Mongolia, the perinatal mortality rate went down from 21.19 to 14.4 per 1,000 births over the last 10 years (Figure 1).^{xxxviii}



Source: Health indicators, 2004, 2009 and 2012, Centre for Health Development, Ministry of Health, Ulaanbaatar

When compared to the national average, PMR of the last decade is 25.6 to 8.4 points higher in Bayan-Olgii province,^{xxxix} which is geographically isolated and includes a zone of high mountains.

According to the 2013 Social Indicators Sample Survey, the five-year average neonatal mortality rate (NMR) was 13.9 per 1,000 live births at the national level. By location, NMR was 21.6 in rural areas, 2.4 times higher than in urban areas.^{xl} Conditions originating in the prenatal period are the leading causes of deaths among infants in both in urban and rural areas.^{xli}

Stillbirths have been increasing. Stillbirths reached 6.7 per 1000 births and a total of 539 stillbirths in 2013. Rates are highest in the Western region (8.5) and lowest in the Eastern region (4.3).

The high mortality rates are caused primarily by a lack of budgetary allocations and medical facilities, and poor capabilities of doctors, midwives, nurses, and other health care providers. About half of infant mortality cases occur at the neonatal stage, and 80 percent of neonatal mortality occurs at the early neonatal stage. High rates of early neonatal mortality shows that infants are dying in cases where they are most dependent on skills of obstetricians and neonatologists, as well as indicating poor maternal nutrition and health.^{xlii}

c) Infant Mortality Rate (IMR)

Infant Mortality Rate is defined the number of infant deaths from birth to one year of age per 1000 live births. One of the major factors contributing to Infant Mortality Rate (IMR) is low-birth weight, which can directly stem from less than optimal maternal health, nutrition and care during delivery.^{xliii} Infant mortality is an indicator of both infant and maternal health.

The infant mortality rate has continued to improve, and the government of Mongolia has achieved its MDG 4 infant mortality rate target of 15.0. Neonatal deaths account for 40-60 percent of infant deaths.^{xliv} This shows that infants are dying when they are most dependent on emergency health assistance and services. Overall, 73.5% of deaths were in hospitals and 26.5% at home.^{xlv}

According to the SISS 2013, the national infant mortality rate was 21.0 per 1,000 live births, and 31.1 in rural areas, which is 2.1 times higher than that of the urban areas (14.5). Unsurprisingly, higher mortality rates are correlated to lower levels of income and education, rural locations, and the age of the mother, with mothers below age 25 at higher risk.^{xlvi} Conditions originating in the prenatal period are the leading causes of deaths among infants in both urban and rural areas. At the regional level, infant mortality is highest in the Western region (32.6 per 1,000 live births) and lowest in Ulaanbaatar (7.2 per 1,000 live births), which has been the general trend in the last two decades.^{xlvii}

In Mongolia, early neonatal mortality and respiratory diseases have been the main causes of infant mortality for the past three years. Congenital malformations are responsible for 12.4% of all infant deaths.^{xlviii}

Differentiation in the IMR depends on the household situation, especially urban vs. rural development, and access to and quality of health services. Infant mortality rate is high in isolated areas, and also areas with dense populations where facilities are overcrowded, areas of high population mobility, gold mining areas, and mountainous zones.^{xlix} In 2010, the IMR was 48 per 1000 births for rural areas, compared to 24 for urban areas.^l

d) Proportion of births attended by skilled birth attendants

A skilled birth attendant (sometimes referred to as skilled attendant) is defined as “an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns.” This definition excludes traditional birth attendants whether trained or not, from the category of skilled health workers (WHO, ICM,FIGO, 2004: p. 1).^{li}

Skilled attendants are present in Mongolia for 98.9 percent of deliveries, according to the SISS 2013, and these figures are consistent throughout the country. However, although the statistics look positive, delivery by skilled birth attendants is problematic for financially disadvantaged women and in rural, remote areas for female herders whose basic health services are inconsistent.

In Mongolia, there are 30.7 physicians per 10,000 population and 37.8 nurses and midwives, which is higher than in other developing countries. However, these numbers are higher in Ulaanbaatar (41 physicians per 10,000 population and 38.4 nurses and midwives), compared to the rural areas (21.1 and 31.9 respectively). The ratio of physicians to nurses/midwives nationally is 1:1.2; in Ulaanbaatar 1:1; and in provinces 1:1.7.^{lii}

Low quality care is a much more serious problem in areas where there are shortages of Family Group Practices, equipment, poor communications and referral systems, low skilled medical personnel and inadequate capacity to deal with complications during antenatal care. While attendants may meet a basic definition of “skilled,” the Mongolian health care system is not able to provide quality services to rural locations and there are insufficient numbers of allied healthcare staff (such as nurses) for the number of doctors. Further, all the tertiary care is in Ulaanbaatar.^{liii}

e) Availability of basic emergency obstetric care and comprehensive emergency obstetric care

The availability of basic emergency obstetric care and comprehensive emergency obstetric care services are most helpful in assessing the needs for health-system strengthening to ensure availability of Emergency Obstetric Care at the national and sub national levels. The recommended minimum acceptable coverage is four basic emergency obstetric care (BEmOC) facilities and one comprehensive emergency obstetric care (CEmOC) facility per 500,000 population.^{liv}

Access to emergency obstetric care is a significant problem for rural Mongolian women, as services may be far away. There is one BEmOC facility per 1550-6040 population, and one CEmOC facility at the provincial level per 60,000-80,000 population, which is far below the acceptable minimum coverage.^{lv} The EmOC assessment and the maternal death review (2012) found that rural women in Mongolia face great barriers to access quality emergency obstetric care closer to their homes. Reasons for poor access are low levels of community awareness and support of pregnant women’s needs, poor communication and transportation infrastructure and weak capacity and preparedness of health facilities, especially in small town hospitals, 58% of which are located in more than 120 km from the CEmOC facility.^{lvi}

According to Mongolia's 2010 Millennium Development Goals (MDG) Report, 'As of 2008 (the most recent data), 96 percent of people in cities and 34.7 percent in the countryside are able to call ambulance services by phone. In rural areas, ambulance service reaches people by car and motorcycle (38.8%), horse and carts (6.5%) and walking (19.9%).'^{lvii} Thirty-five percent of the total nomadic herders, who comprise 67 percent of the rural population, live 50-80 km from even small town health facilities.^{lviii}

f) Coverage of postpartum/postnatal care within 48 hours of delivery by a skilled health provider

Postpartum care is crucial because a significant proportion of maternal and new-born deaths occur during delivery or in the postpartum period. Recent WHO guidelines recommend that the first postpartum visit take place within the first week, preferably within the first two to three days. The purpose of this visit is early detection and treatment of complications and preventive care for both mother and baby.^{lix}

According to the data from SISS 2013, 99.4 percent of women stay in a health facility postpartum,^{lx} and 98.6 percent of newborn infants receive postnatal health checks.^{lxi} There were no differences between urban and rural areas.

However, while both the 2010 and 2013 MDG Reports note that although mothers should stay for some time in a maternity house after delivery, it is common for them to leave the maternity house within few hours after delivery because of bed shortages. Maternity houses or rooms in provincial centre facilities are overcrowded due to the policy to serve high-risk pregnant mothers, and the medical infrastructure has not expanded as the birth rate has increased.^{lxii} The fact that 70 to 80 percent of total rural births happen in provincial hospitals is overburdening; therefore, discharges from hospital happen within a day or two after birth. This, in turn, increases the chances of early-stage neonatal mortality. Additionally, in case of families newly arrived in provincial centres, mortality is caused by to lack of knowledge how to call for emergency services or if there is no one to care for them at their host households.

g) Antenatal care coverage

Measuring the antenatal care women receive is an important indicator of the woman's access to health care services. For antenatal care to achieve its potential for life-saving, four visits are considered to be necessary, during which a range of essential interventions are provided.^{lxiii}

Mongolia has a high rate of antenatal care, but there is still a high incidence of maternal mortality and morbidity across the country. According to the data from SISS 2013, the rates for antenatal care visits are as follows:^{lxiv}

Table 2: Percentage of antenatal care, Mongolia 2013

Antenatal care visits	National Average	Residence		Region				
		Urban	Rural	Western	Khangai	Central	Eastern	Ulaanbaatar
At least one visit with skilled health personnel	98.7	98.6	99.1	98.2	99.4	99.6	99.3	98.2
At least 4 visits with any provider	89.6	92.0	85.4	82.4	87.7	88.8	95.9	92.1
At least six visits by any provider	75.1	80.2	66.3	58.4	68.5	74.6	82.3	82.7

Source: Mongolia Social Indicators Sample survey (SISS) 2013, Main Result, June 2014, National Statistical Office of Mongolia, UNFA, UNICEF, Ulaanbaatar p. 19

Since 1998, when the Family Group Practice (FGP) model was introduced in Mongolia, most antenatal care has been provided by FGP doctors, mostly general physicians. In Ulaanbaatar, all FGPs function under district health centres and maternity homes, where all high-risk women are identified by FGP. MCHRC (Maternal and Child Health Research Centre) is the only referral centre in Mongolia in MCH care. There are footnotes for this section footnotes should be at bottom of page.

Internal migration and moving pregnant mothers with birth risks from rural areas to the capital city contribute to the increasing burden of antenatal care and services in the city. Mongolia's four public maternity hospitals are all in Ulaanbaatar, and facilities are consistently overcrowded, with long wait times for antenatal care and delivery services. Due to limited number of obstetricians and the fact that pregnant women have to queue at hospitals for medical check-up from 5 am, the quality of antenatal care coverage is poor although the standard is 6 antenatal visits. Higher-income women pay for private medical services.

Adolescent and young people's sexual and reproductive health

The ICPD Programme of Action urged governments to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted infection including HIV/AIDS. It also called for the reduction in adolescent pregnancies. (ICPD Para 7.44). In this section we look at indicators of a) adolescent birth rate and b) the availability of range of adolescent sexual and reproductive health services irrespective of marital status in Mongolia. These indicators reflect the status of adolescent SRHR in the country. While many women become sexually active in their teens, adolescent and young women suffer from inadequate sexuality education and a lack of privacy in school and medical facilities regarding their bodies and sexual activity.

a) Adolescent birth rate

Young motherhood affects the mother and child in many ways—it can bring down the education status and socioeconomic independence and status of the mother, as well as contributing to child and maternal morbidity and mortality. This is therefore an important indicator of adolescent reproductive health, as well as reproductive rights.^{lxv}

Mongolia's adolescent birth rate has increased since 2005, although it has levelled off from 2008. The 2008 RHS reported that the median age at first birth for all age groups was 21.3 with a fertility rate of 57 per thousand women aged 15–19 (39 in urban areas and 115 in rural areas).^{lxvi} According to the SISS 2013, the adolescent birth rate^{lxvii} reached 40.4 in 2013. The rate was 68 in rural areas and 31.2 in urban areas. In same source above, 5.3 percent of young women age 15-24 and 1.2 percent of young men age 15-24 are married or in union in 2013.^{lxviii}

In 2013, a local NGO study^{lxix} found that 2700 adolescent girls gave birth, 50 percent of whom were uneducated and 25 percent financially disadvantaged. One-third of females surveyed in the 2008 RHS had sexual intercourse at age 19 or below, and among those age 15-19, median age at first birth was 17.8.

Availability and range of adolescent sexual and reproductive health services

In this section we examine the status of adolescent sexual and reproductive health services irrespective of marital status. Adolescent SRH services include “at a minimum...gender sensitive life skills-based SRH education and a package of social protection services for adolescents and youth, including psychosocial counseling, contraception, HIV-prevention, STI prevention/treatment and maternal health services.”^{lxx}

Comprehensive sexuality education includes age-appropriate information to children and young adults throughout school years, and its content includes at least four components:

- Information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behavior; sexual diversity; sexual abuse; gender-based violence; and harmful practices;
- Values, attitudes and social norms;
- Interpersonal and relationship skills; and
- Responsibility.

To some extent, adolescents have good access to services if they are pregnant. Of 281 births to mothers under 20 years old in the 2008 RHS, 99.3 percent delivered their babies in health facilities and 0.7 at home; 47.0 percent received assistance from a gynecologist during delivery, 31.0 from a professional midwife, 21.4 from a physician and the remainder from a nurse or other practitioner.^{lxxi}

According to Ministry of Health indicators, about seven percent of abortions are among women under age 20, and this rate has been constant between 2007 and 2011.^{lxxii} In the 2008 RHS, 0.5 percent of 1,044 female adolescents aged 15–19 reported having had at least one induced abortion. Of those who had had an abortion, 40.0 percent had received pre-abortion counselling and 80.0 percent post-abortion counselling. However, post-abortion use of contraceptives was lowest among adolescent girls (40.0 percent) compared with the other age groups (>70.0 percent).^{lxxiii}

Case Study: Sexuality Education in School and Access to Contraception

Bina is a 21 year-old woman from Ulaanbaatar. She describes her experiences with sexuality education and access to contraception:

Teenagers are supposed to learn about sex through the general education lessons that should include information about sexual rights and sexual education. But we couldn't get enough information because there was not enough time for the health lessons and the content was not good. We were embarrassed in the classes on topics like condom wearing and girls' menstruation, so we were just laughing. Schools conduct medical examinations of all students, and the girls' medical examinations started from high school. Some girls were afraid, and some girls were just trying to avoid it because there was no description of what would happen or a reason for the examination. If somehow a girl was able to avoid the examination, it spread rumours that “she already had intercourse,” rather than that she had problems or may have been suffering. I also faced the same problem. I started working at a women's rights NGO from my 1st level of university, so I finally started to learn about sexual and reproductive rights from the activities of the NGO.

Contraception is available from the hospital near my home and the private hospital where my sister works. Although I knew about pregnancy and several methods of contraception, I was afraid of the risk so I didn't use them very much. When I did, it was condoms. Many people in my neighbourhood and community talk about the risks of contraception. Then I got pregnant and had a bad experience with losing the baby. After that, they still didn't give any advice or information about reproductive health.

Interview conducted by MONFEMNET staff on 6 August, 2014.

Adolescent access to sexual and reproductive health services prior to pregnancy is more limited. Among those aged 15–19 in the 2008 RHS, 92.7 percent reported knowledge of any modern method of contraception, but only 3.7 percent were current users of any modern method (male condoms, IUD and pills). Fewer, 0.4 percent, were current users of any traditional method (period abstinence and withdrawal). 33.5 percent knew that contraceptives were distributed without charge.^{lxxiv}

According to the RHS 2008, over 90 percent of adolescent girls have “heard of” STIs but only 12 percent have a “basic” understanding of modes of transmission and means of protection. In 1998, less than one percent of 15–19 year old girls reported changing their sexual behaviour as a result of improved knowledge of STIs and HIV. By 2008, this percentage had increased to 3 percent. This is an improvement but still a very small percentage. Sexuality education is incorporated in the national curriculum for secondary schools, but the teachers are not trained and may skip controversial topics. Sexual and reproductive health and rights subjects are covered only from clinical perspectives, not covering human rights or emotional aspects.

With the rising prevalence of some STIs (including HIV) and more young people having multiple sex partners, the risk of infection is increasing. According to the Second Generation HIV/STI Surveillance (SGS) report in 2009,^{lxxv} about 81 percent of youth aged 15–24 had casual sex with non-regular non-commercial partners in the past year, the rate was higher in young men; and 4.5 percent of youth reported having sex for money/gift in the past year. According to the same source, the percentage of young people who have received voluntary HIV testing and who knew the test results increased (3.2 percent in 2005, 7.7 percent in 2009). However, there was a warning sign with a considerable decrease in rate of access to HIV prevention programme reported by the youth (40.8 percent in 2005, 11.7 percent in 2009), and the rate is double in young men compared with young women.

According to the SISS 2013, 0.6 percent of young women and 4.8 percent of young men had sexual intercourse before age 15. In all, 36 percent of sexually active young women have been have been tested for HIV and know the results.^{lxxvi} Condom use rates with non-regular partners were 46.1 percent for young women and 69 percent for young men respectively, according to the SISS 2013.^{lxxvii}

Following a 2001 review of adolescent health services, the Ministry of Health and international partners developed a plan to make these services more accessible to young people through a network of adolescent-friendly clinics. Implementation steps included training for medical personnel, designated hours and clinic space for adolescents and strengthening existing structures such as school doctor cabinets and family group practice.^{lxxviii} The system has improved somewhat since implementation of the plan began, but there are still gaps in access, particularly in rural areas.

HIV and AIDS

The ICPD Programme of Action urged governments to prevent, reduce the spread of and minimise the impact of HIV infection; and ensure that HIV infected individuals have adequate medical care and are not discriminated against (ICPD Para 8.29).

In this section we look at indicators of HIV prevalence and burden as well as availability of services for HIV and AIDS in Mongolia. The prevalence of HIV among different population subgroups and the number of persons in the population living with HIV or AIDS are pointers to the status of sexual health in the population.^{lxxxix} We also review services available for people affected by HIV and AIDS.

Prevalence and burden

The prevalence of HIV among different population subgroups and the numbers of persons in the population living with HIV or AIDS are pointers to the status of sexual health in the population. A person living with HIV refers to a person whose HIV status has been tested and found to be positive.

The prevalence of HIV among Mongolian population is less than 0.1 percent, and prevalence of HIV in vulnerable groups of people is less than 5 percent, which makes Mongolia as country with low risk in population and high-risk in vulnerable groups.^{lxxx}

STIs make up 35 percent of total infectious burden in Mongolia and increase the risk of HIV transmission. Other risk factors include high rates of workforce migration, poverty and low use of condoms, as well as proximity to higher-prevalence countries, Russia and China. The rate of reported cases has risen, partly due to more testing, but transmission rates also appear to have increased. The first case occurred in 1992 and in 2013, there were 150 HIV and AIDS cases reported, of which 23 were registered in 2013. Half the cases of HIV and AIDS in Mongolia were registered in last three years.

According to the National Health Statistics in 2013, 19 people, out of 150 registered cases, have died from AIDS. By gender, 121 (80.7 percent) were males, 28 (18.7 percent) females and one of uncertain gender identity. The majority of registered cases contracted HIV infection by sexual intercourse. Cases of passing the infection through blood transfusion, medical assistance or from mother to child were not registered. HIV prevalence among men who have sex with men (MSM) was 7.5 percent in 2011^{lxxxi}, which is an increase since 2009 (1.8 percent).

It is reported that 18.3 percent of people living with HIV are women, 45.8 percent of whom are female sex workers. On the other hand, 80.9 percent of people living with HIV are men, 83percent of who are MSM.

Table 3: Estimated HIV prevalence, Mongolia, 2008 and 2013

MONGOLIA	2008	2013
Estimated HIV prevalence - adult (ages 15-49)		Approximately 1%. ^{lxxxii}
People living with HIV (all ages)	52 cases in 2008	150 cases in 2013 172 cases in mid-2014
Estimated new HIV infections (all ages)	NA	NA
Estimated new HIV infections (ages 15+)	NA	NA
Number of HIV infected female adults	11	28
Percentage of young people aged 15 to 24 who are living with HIV	<0.1	<0.1
Number of pregnant women living with HIV who received antiretrovirals for preventing mother-to-child transmission	3* As of the 2008, three children were born to three HIV-positive mothers and diagnosed virus-free.	11* As of mid-2014, twelve children were born to eleven HIV-positive mothers and diagnosed virus-free.
Reported number of adults and children on ART	11.4% in 2008, 16.9% in 2009 ^{lxxxiii}	18.54% in 2011 ^{lxxxiv}
Estimated number of adults needing antiretroviral therapy based on WHO2010 guidelines	NA	NA

Source: CHD (2014). *Health indicators, 2013*, Centre for Health Development, Ministry of Health, Ulaanbaatar, p.23 DH (2009). *Health indicators, 2008*, Health Department, Implementing Agency of the Government of Mongolia, p.9

* AIDS/STI Surveillance and Research Department, NCCD

Availability of services for HIV and AIDS

The availability of prevention and treatment for HIV for different subgroups of the population shows the availability of sexual health services in the country.^{lxxxv}

Medical services are limited for people with HIV and AIDS. Mongolia has few medical personnel trained to provide services, especially in the rural areas, and limited funds allocated to HIV and AIDS, either for prevention or treatment. The majority of training and funding comes from international organisations, and the goal is to have 2-3 trained doctors in each provincial health centre, but the government acknowledges that this goal is not met and services are insufficient.

^{lxxxvi}Laboratory services for testing and treatment are of poor quality, and people living with HIV are only involved with small-scale community based facilities.^{lxxxvii}

Few health facilities provide HIV services integrated with other health services, such as services for ART and tuberculosis, HIV counselling and testing, tuberculosis and HIV counselling, and testing with overall sexual and reproductive health. No facilities provide services that include ART and chronic non-communicable diseases, ART and general outpatient care, HIV counselling and testing and chronic non-communicable diseases, and general outpatient care and PMTCT combined with antenatal care and maternal and child health.^{lxxxviii}

Mongolia, shifting from a low-prevalence country to a centralized prevalence one, has 154 reported cases as of 2014, and 19 of them died of the virus at early stages of infection. This is due to the institutionalized stigma and discrimination towards people living with HIV and AIDS especially the health sector, failure of providing post-diagnosis, on-going and systematic counselling services as well as lack of adequate treatment and therapy. HIV-specific restrictions on entry, stay or residence in 2009 that were lifted in 2013.

According to the SISS 2013, HIV testing rates during antenatal care^{lxxxix} were 32.1 percent and 68.6 percent at the national level; 78.5 percent in urban areas and 51.3 percent in rural areas respectively. HIV counselling during antenatal care is weak. Only 32.1 percent of women reported that they received counselling on HIV during antenatal care, although testing is mandatory for all pregnant women. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth was 100. The report also states that the percentage of adults and children living with HIV known to be on treatment 12 months after initiation of ART was 50 percent in 2007, 100 percent in 2009 and decreased to 83.33 percent in 2011.

Government Expenditure on Health

Government's commitment to the betterment of its people's health is indicated by the government expenditure on health.

According to the National Statistics in 2013, total health expenditure was 3 percent of GDP and 6.9 percent of general government expenditure.^{xc} During the years of socioeconomic transition in Mongolia, total health expenditure as a share of Gross Domestic Product (GDP) increased from 3.3 percent (1995) to 4.9 percent in 2000, dropped back to 3.9 percent (2005) and then rose again to 5.4 percent by 2010. Despite these fluctuations, government health expenditure as a share of GDP has been consistently low compared to other countries in the Western Pacific Region.^{xc} Government health expenditure covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

With a legacy of hospital-based medical care, the majority of medical expenses go toward inpatient services; however, hospitals also provide so much primary care that it is difficult to gauge primary care expenditures accurately.

^{xcii} There is lack of information on how much of it is allocated for sexual and reproductive health. The funding is always dependent on WHO and UNFPA.

Out-of-pocket payments increased from 14.5 percent of total health expenditure in 1995 to 41.4 percent in 2010.^{xciii} Although this data is based on changing World Health Organisation methodology and may not be completely accurate, the level of out-of-pocket expenditures is still very high, indicating a lack of services coverage by statutory funding schemes and inconsistent distribution of health services between the government and the social health insurance system.^{xciv} The government budget covers preventive, public health services, maternal and child care, and treatment of chronic and infectious diseases, such as diabetes and HIV and AIDS. The social health insurance benefit package covers predominantly individual clinical care such as outpatient and inpatient care.^{xcv}

Availability of sexual and reproductive health services at different levels of care

In this section, we assess the broad-based availability of a comprehensive set of SRH services. A description of which services are available at which types of facilities shows geographical reach, and a review of public and private services shows what services are available to people of different income levels.^{xcvi}

Health facilities

The health facilities system of Mongolia consists of state-owned, private and public and private owned health facilities that are in charge of public health, health service, pharmaceuticals supply, health education, research and training. As of 2013, in total 16 central and specialised hospitals, 5 regional treatment and diagnostic centres, 20 province/district hospitals, 8 district public health centres, 6 rural general hospitals, 39 town hospitals, 271/19 village health centres, 228 family health centres, and 3 maternity houses deliver health service around the country. ^{xcvii}The Mongolian health system is one statutory system divided into administrative divisions by geography, the provinces and Ulaanbaatar, and administrative divisions are represented by a two-tier health system: primary care and specialized care, including secondary and tertiary care. ^{xcviii}All tertiary care is provided in Ulaanbaatar.

Primary care facilities provide contraception, antenatal care, gynaecological exams, basic diagnosis and some health education. In rural areas, primary and secondary care is provided at the same facility, so that ante- and postnatal care and simple deliveries occur in the same place. In addition, a few maternity rest homes have been established in rural areas to provide service for high-risk pregnancies, and these have increased the rates of safe deliveries for women who cannot get to Ulaanbaatar. ^{xcix}Most abortions are provided at the larger regional hospitals, but also are available at some smaller hospitals, maternity rest homes and private clinics. ^cHIV testing is available at some regional facilities, but the lack of confidentiality discourages people from using this service.

Availability of sexual and reproductive health services also varies by population. Disabled women face a perception that they are not sexually active, and there are no dedicated services for them, outside government schools or care centres. Sex workers can receive some health services through NGOs, but so far only within Ulaanbaatar.

Utilisation of public vs. private facilities

The number of private health care providers has been increasing in recent years from 683 private hospitals and clinics in 2005 to 1184 in 2011. Most of small hospitals are with 10-20 beds and outpatient clinics. There are increasing numbers of NGOs active in health promotion and awareness in HIV/AIDS, domestic violence, and drug and alcohol issues. There are limited services provided by NGOs, for example, mother and child day clinic services. ^{ci}

Use of state family health centres in cities and provincial centres has reached 71-82 percent, mainly among low-income and rural individuals. Bypassing family health centres is still common among the affluent. Social health insurance coverage was 82.6 percent in 2010, but a lack of qualified doctors in rural areas and difficulties in accessing services mean that not everyone receives the same benefits. The primary, secondary and tertiary care system that was established throughout the country has not adapted to the high levels of internal migration, so facilities in Ulaanbaatar are overcrowded. Formerly nomadic households that have settled around urban centres also experience inequities in health. Family health centres are assigned to these groups, but health service delivery is challenging due to insufficient funding. Overall, equity is influenced by geographic distance, harsh weather conditions, unregistered populations, and low-income groups. ^{cii}

17

COUNTRY
PROFILE ON
UNIVERSAL
ACCESS TO
SEXUAL AND
REPRODUCTIVE
HEALTH:

MONGOLIA

3. Recommendations

Priority issues on Sexual and Reproductive Health Services Delivery

- Maternal Mortality Rates and Infant Mortality Rates have been declining steadily but are still high, especially in rural areas.
- There is low utilization of the reproductive health services by the poor and the vulnerable groups, partly because the existing referral system is not functioning well, particularly in rural areas.
- Curative based, hospital-centred approach contributes to the over-capacity of hospital beds at the secondary and tertiary levels especially in Ulaanbaatar.
- Community participation in the planning, implementation, monitoring and evaluation of the health services is very limited.
- Hospital services are not appropriate for the corresponding level of care; costly and wasteful services predominate. Ambulatory services and day, home and palliative care are inadequate.
- Standards are inadequate for different levels of health care and services, and technological developments are not introduced into the health services in a timely manner. In rural areas, standards of diagnosis, treatment and monitoring are low, thus increasing inequities between urban and rural services, particularly in techniques and use of technology.
- A client-friendly, standardised service structure has not been established yet.
- Hospitals, health centres, health facilities lack follow-up mechanisms to assess and evaluate service provider's attitudes and communication skills.
- There is a lack of integrated management and mechanism for improvement of quality of care, and decentralisation of service, particularly reproductive health services.

Recommendations:

The government of Mongolia, together with its development partners, needs to more actively and vigorously address the growing geographic and socio-economic disparities and inequities in sexual and reproductive health. This is critical to ensure universal access to sexual and reproductive health and further reduction of maternal, prenatal and child mortality. UN agencies and other international partners, along with Mongolian civil society, must intensify their advocacy to apply a rights-based approach in all areas of sexual and reproductive health services, particularly to serve the most marginalized populations, adolescents and young people.

In addition, we call on the government of Mongolia and its development partners to address the following specific recommendations:

Contraception:

- Understand that women have full rights to determine their fertility rate and make available a full range of sexual and reproductive health services without promoting a higher fertility rate;
- Mongolia must accelerate efforts to implement context-appropriate strategy for repositioning family planning with special emphasis on human rights-based approach and addressing unmet need for contraception;
- Increase availability of improved reproductive health commodities, including condoms;

Maternal and Child Health:

- Improve access to high-quality maternal and child health services for all women, particularly rural, low-income and disabled women. Standards of care must improve at all levels.

Adolescent and young people's sexual and reproductive health:

- Implement fully comprehensive sexuality education that includes a strong focus on rights and the link between knowledge and behaviour change;
- Expand adolescent and youth friendly health services for disadvantaged people in urban and peri-urban areas and mining enclaves.

HIV and AIDS:

- With active engagement of civil society, PLWHA, the government need to strengthen political leadership and community involvement; scale up prevention among key and high risks populations and key geographic areas; respect for human rights and eliminate stigma and discrimination towards PLWHA and most at risk populations and implement more focused and human rights-based strategy for HIV testing.

Availability of sexual and reproductive health services at different levels of care:

- Increase the number of community health workers in rural and peri-urban areas trained in STI prevention and innovative behaviour change communication programs.
- Include communities, NGOs and local governments in planning, implementing, monitoring and evaluating sexual and reproductive health services.
- The central and local governments need to urgently address the funding gap to improve access to and quality of sexual and reproductive health in the context of primary health care, and strengthening emergency obstetric and newborn care.

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About MONFEMNET

National Network

MONFEMNET National Network (MONFEMNET) is a non-partisan non-governmental organisation with a mission to serve as a strong driving force for the development of a national, broad-based, democratic, sustainable and transformative movement for women's human rights, gender equality, substantive democracy and social justice. We focus on policy advocacy and participatory, rights-based training aimed at building a grassroots movement and promoting institutional reform.

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