

**WHO COUNTRY CO-OPERATION
STRATEGY**

2001 - 2005

MONGOLIA

June 2002

INTRODUCTION

WHO launched the Country Co-operation Strategy (CCS) initiative in 2000 with the aim of strengthening WHO's corporate performance at country level.

Each individual CCS will obviously reflect and respond to the specific situations of the country concerned. All, however, will reflect WHO's corporate strategic goals which are:-

- . • a more **focused** and **selective** programme of work;
- . • a more **coherent** programme of work;
- . • a more **strategic** role for WHO; and
- . • greater emphasis on **wider partnerships**.

This Strategy defines the broad framework for WHO's work with the Government of Mongolia over the next five years.

The CCS articulates a coherent vision and selective priorities for the entirety of WHO which are distinct from, but complementary to, those of the government and other development partners. It is based on a systematic assessment of Mongolia's development challenges and health needs; the Government of Mongolia's policies and expectations; and the current and planned activities of other development partners.

While a clear aim is to ensure greater responsiveness to country needs, the CCS also reflects WHO's own values, principles and corporate and regional strategies. Consequently WHO will put greater emphasis on its role as policy adviser and broker and move away from direct programme support except in emergency situations. WHO globally intends to broaden its partnerships at country level and to work with other development partners in a complementary manner.

Since 1990, Mongolia has undergone a sustained programme of liberalization and reform that has impacted on all aspects of social, political and economic life. There have been many positive changes, but the moves to a market economy, coupled with the collapse of former trading and economic support relationships, also created problems, especially in the early 1990s.

Mongolia still faces many major social problems as its people and government work together to build a new society; but there are encouraging signs that progress is again being made. This is, therefore, a timely moment for WHO to take stock and to ensure that its future contributions will yield the greatest possible benefits for Mongolia in a new, challenging and still-changing environment.

GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

A decade of change

Any discussion of development challenges in Mongolia must be viewed in the context of the dramatic changes that have taken place in the country over the past 12 – 15 years. For almost 70

years, starting in 1921, Mongolia functioned as a one-party state, with a centrally planned economy and close ties to, and support from, the former Soviet Union.

Starting in 1990, when the first democratic elections took place, Mongolia has embarked on a path of liberalization and reform that has impacted on all aspects of social, political and economic life.

Despite the obvious benefits in terms of greater personal freedom, the process of transition has been difficult for many Mongolians. In the early 1990s aid from the former USSR, which had previously contributed some 30% of GDP, was suddenly lost. Privatisation of heavily subsidized enterprises, and closure of others, led to serious unemployment. Social sector budgets had to be cut back severely.

The Government of Mongolia has sought to address the challenges of transition and, despite a number of changes in political leadership, and consequent modifications of detailed policy settings, the broad commitment to structural reform has remained firm.

Recent years have seen a partial recovery and “Mongolia has done a great deal to recover the ground lost in the early years of transition.”¹ Nevertheless, a recent survey revealed that between a quarter and a third of Mongolians considered they were worse off than they had been in the pre-1990 period². There is evidence that the gap between the incomes of the rich and poor increased in the later part of the 1990s³. Mongolia also still faces many major social problems such as unemployment, poverty, a decline in literacy and deterioration in access to education and health services.

Between 1993 and 1997 real GDP per capita increased from US\$328 to US\$467 (an average rate of 9.2% per annum) but it then dropped back to US\$426 in 1998 and to US\$374 in 1999⁴. According to the 1998 Living Standard Measurement Survey 35.6% of the Mongolian population could, at that time, be classified as ‘poor’ or ‘very poor’⁵.

Mongolia has built the foundations of a modern, liberal democracy. That has been a necessary and sometimes painful process, but it has left the country better equipped to deliver long-awaited benefits to its people.

¹ Human Development Report, Mongolia 2000, Page 25 ² Human Development Report, Mongolia 2000, Page 16 ³ Human Development Report, Mongolia 2000, Page 9 ⁴ Source Common Country Assessment for Mongolia, Annex I (all figures expressed in constant 1993 US\$) ⁵ Human Development Report, Mongolia 2000, Page 23

The people and the country⁶

Mongolia is a vast and landlocked country. The population, which stood at 2.4 million in January 2000, is spread across some 1.56 million km².

Mongolia’s population is relatively young, with 36% aged under 15 and only 3.5% aged 65 or over. The annual population growth rate between the 1989 and 2000 censuses was 1.4%; a significant reduction from the period 1956 – 1989 when the rate varied comparatively little within the range of 2.5% to 3.0%.

The 2000 Population and Housing Census identifies eight main ethnic groups in Mongolia. Roughly 80% of the population is of Khalkh ethnic origins. The next largest group (4.3%) comprises ethnic Kazakhs who have, historically, lived in the extreme west of the country. Since the early 1990s, however, many have either migrated to Kazakhstan or moved to Ulaanbaatar. Other ethnic groups are relatively small (none is larger than 70,000 people) and sometimes live in very remote areas.

Traditionally, many Mongolians lived as nomadic herders, moving their animals with the seasons, but in recent years urbanization has increased. A growing proportion (currently about one in three) of the population lives in the capital, Ulaanbaatar while about 43% live in rural areas. Rural children often attend boarding school, while many males have to travel considerable distances to tend animals. As a result lengthy periods of separation are common among rural families.

Many Mongolians, in both rural and urban areas, continue to live in traditional *gers* (tentlike, felt dwellings), which offer few modern amenities.

Population density ranges from 162 people per km² in Ulaanbaatar to just 0.5 people per km² in the southern Gobi Region of the country. Internal communications are difficult. There are just 1,600 km of paved roads in the entire country and journey times to and between near by provincial centres may be many hours or days. In addition, the infrastructure is frequently poor with many rural areas having at best intermittent electricity supplies and no private telephones.

The country endures long, severe winters, with average temperatures as low as –32°C in January (and extremes still lower). Geography and climate thus combine to present significant difficulties for those who are tasked with planning and delivering health services.

Government

Mongolia has a parliamentary system of government. The State Great *Khural* is the elected national parliament. There are two levels of local government, which have gained increasing powers under recent policies of administrative decentralization.

The country is divided into 21 *aimags* (provinces) which together with the autonomous capital region, form a second tier of government. Administrative levels below the *aimag* level are *soums* that represent rural districts.

Unless otherwise noted, data in this Section are drawn from 2000 Population and Housing Census: The Main Results. Mongolia National Statistical Office, 2001

Ulaanbaatar itself is governed by a City *Khural* (Council) and is divided into eight districts for administrative purposes.

The Government of Mongolia is committed to reducing poverty and improving the quality of life and health status of its population. The Poverty Partnership Agreement between the Government of Mongolia and the Asian Development Bank signed 24 March 2000 adopted the International Development Goals as the targets to be achieved under the agreement.⁷ These goals and their target dates are as follows:

Table 1.

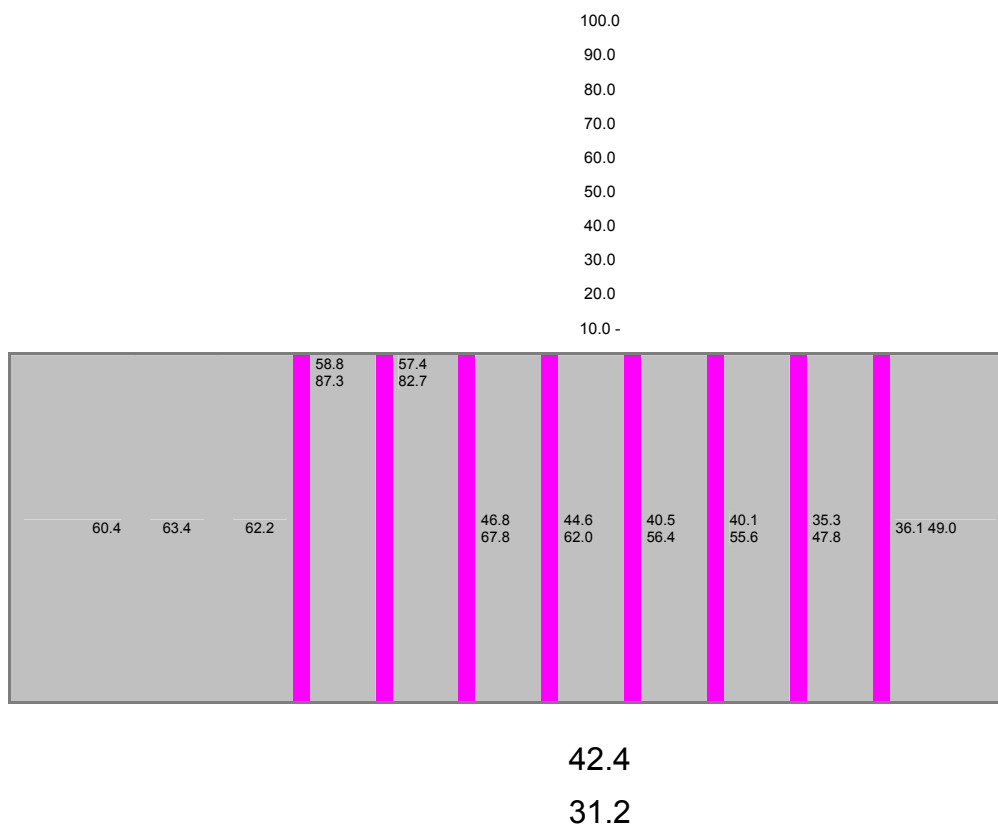
No	Indicator	Target	Period
1	Proportion of people living in extreme poverty	reduce by half	1990 – 2015
2	Primary school enrolment	100%	2015
3	Gender disparities in primary and secondary education	eliminated	2005
4	Infant and child mortality rates	reduce by 2/3	1990 – 2015
5	Maternal mortality ratios	reduce by 3/4	1990 – 2015
6	Access to reproductive health services	for all who need	2015
7	National Strategies for sustainable development	implemented	2005
8	Loss of environmental resources	reversed	2015

Source: PPA

Mongolia is committed to the Millennium Development Goals and plans to establish a formal high level committee to adapt the goals to Mongolia and to oversee efforts towards their achievement.

As detailed in the referenced report, it will require significant efforts for Mongolia to reach its IDG targets. However, as can be seen below, Mongolia is moving in the right direction:

Figure 1. Infant and under-5 mortality rates per 1,000 live births, Mongolia 1989-2000



1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000



Health profile

Official figures indicate that the infant mortality rate fell from a level of 63.4 per 1,000 live births in 1990 to 31.2 per 1,000 live births in 2000⁸. There are, however, concerns

⁷ Achievability of the IDG set out in the Mongolia Poverty Partnership Agreement, Mayling Oey-Gardiner and Isan Hitawasana Sejahtera, (RSC No. C10701: MON/ADB) 19 April 2002

Health Sector of Mongolia 80 Years (Statistical Indicators), Ministry of Health, 2001

that there may be significant under-reporting. According to the recent multiple indicator cluster survey the infant mortality rate in 2000 was 64 per 1,000 live births⁹. The low reported early neonatal and neonatal mortality are probably the result of the omission of early child deaths in the Ministry of Health statistics.¹⁰

Changes in definitions mean that the picture regarding maternal mortality trends over the same period is less clear. They appear, however, to have been more volatile. The rate initially doubled from 120 to 240 per 100,000 live births between 1990 and 1993. Thereafter, however, there was a steady annual reduction to 140 per 100,000 live births in 1997 followed by a small increase, to a rate of 160, in 2000⁸.

In 2000, life expectancy at birth in Mongolia was estimated by WHO to be 61.2 years for males and 66.9 years for females¹¹. While the former figure had remained more or less static over the preceding 10 years, the latter reflected an increase of some four years.

The main causes of death in 2000 were diseases of the circulatory system, cancer and injuries, poisoning and other external causes⁸. These figures are a reflection of the epidemiological transition that has been taking place in Mongolia during the past 30 years. There has been a reduction in deaths attributable to infectious and parasitic diseases and an increase in those due to cancers, diseases of the circulatory system, injuries, poisoning and other external causes.

Particular areas of current concern include:-

- . • tuberculosis – which has shown an increasing incidence during the 1990s;
- . • sexually transmitted infections – which are also increasing in incidence;
- . • brucellosis – which has high incidence among both humans and animals;
- . • injuries, poisoning and other external causes – which have seen a rapid increase in incidence, with alcohol believed to be implicated in many cases;
- . • hypertension, stroke and rheumatic heart disease – which feature prominently in the growing rates of cardiovascular disease; and
- . • cancers of the liver (frequently due to hepatitis B), stomach, lung, oesophagus and cervix – which together account for four out of every five deaths due to malignancies.

The last case of polio in Mongolia was reported in 1993. Neonatal tetanus and pertussis have nearly disappeared and measles morbidity has been reduced to very low levels because of successful immunization programmes.

Mongolia faces a number of environmental health risks. They include poor access to safe water and adequate sanitation (especially in rural areas) and air pollution due to coal

9

Mongolia Country Profile 2002, UNICEF

10

Evaluation of Infant, Child and Maternal Mortality Information in Mongolia, Report on a Mission to Ulaanbaatar, 5 to 12 April, 2002 by Dr. Kenneth Hill, Consultant ¹¹ Source: WHR 2001, Annex Table 1
burned in energy plants and domestic space heating as well as old, badly maintained motor vehicles.

Overall, health status in Mongolia is one of the lowest in the Western Pacific Region. The gains that have been made are precarious and there is an increasing burden of noncommunicable disease related to lifestyle factors such as smoking, high consumption of alcohol, lack of physical exercise, a fatty diet and increasing obesity. Unlike some other countries, however, there is no single condition or group of conditions that contributes disproportionately to Mongolia's burden of disease. The country's problems centre on the overall levels of poverty and ill health; and solutions must be developed accordingly.

Health sector development

The "Action Program of the Government of Mongolia" published in 2000 provides the following high-level statement of goals for the health system:-

"The quality of health service and health preventative measures shall be developed to international standards and on this basis, the objectives to improve population health and increase average life expectancy shall be achieved"

In common with many other parts of Mongolian society, the health sector has undergone significant change since the early 1990s. The main driving force has been the need to replace a Soviet style system that was dominated by hospitals with one that is more responsive and places a stronger emphasis on primary care and preventative services.

The fact that the total number of hospital beds per capita fell by more than one third between 1990 and 2000 is an indicator of progress towards that goal. In addition, a survey undertaken in 1998 suggested that about 30% of population considered that health care was "better" since the transition while fewer than 20% considered it to be "worse". In this regard, improvements in health are considered to have outstripped those in housing conditions, clothing, food and "life in general"; the other aspects considered by the survey ¹².

According to WHO estimates of national health accounts, total health spending in Mongolia accounted for 5.0% of GDP in 1997 rising to 6.2% in 1998 ¹³. Per capita total expenditure on health in 1998, expressed in international dollars (purchasing power parity), was \$88; equivalent to US\$24 at prevailing exchange rates.

After adjusting for levels of health expenditure and human capital, WHO estimated that Mongolia's health system ranked between 132nd and 144th among its 191 Member States in 1997 in terms of its performance with respect to health adjusted life expectancy ¹⁴.

The *State Public Health Policy* was produced in 2001 with the objective of “defining the long-term perspective for the development of public health for the next 10 to 15 years.” It states a number of principles that should underlie the development of health services and programmes, but these are largely aspirational and provide relatively little by way of clear developmental goals and policies. Consequently, further work will need to be

¹² Human Development Report, Mongolia 2000, Page 16 ¹³ Source: WHR 2001, Annex Table 5 ¹⁴ Source: WHR 2000, Annex Table10

undertaken to establish a formally recognised and widely promulgated statement of national health policy that can be used to direct a longer-term programme of health system development.

The health system is underpinned by numerous legislative instruments that have been developed and implemented in the post-reform era. In May 1998 a comprehensive package of revised health legislation passed into law ¹⁵.

The current structure of the sector seeks to separate responsibility for health policy, funding and delivery of health services. In summary, government’s role is shared among:-

- . • The central Ministry of Health – which is responsible for overall planning, policy formulation, regulation and monitoring of health status and service delivery. It also directly manages tertiary and specialist hospitals in Ulaanbaatar.
- . • A separate Health Insurance Fund (part of the State Social Insurance General Office under the Ministry of Social Welfare and Labour) – which collects income-related contributions from employers, wage earners and the self-employed. The Fund also receives subsidies from the Ministry of Finance in respect of vulnerable groups such as children and pensioners. It then makes prospective payments to hospitals in line with their anticipated levels of activity. Amendments to the health insurance law were adopted by the Government in April, 2002 that utilized the expert assistance provided by several WHO consultants.
- . • *Aimag* and *soum* governments, and the Ulaanbaatar City *Khural* – which manage public hospital services at the local level. They receive an allocation of funds from central government, some of which is allocated to health services. *Aimag* and *soum* hospitals, and those that are managed by the Ulaanbaatar City *Khural* also receive direct payments for inpatient treatment from the Health Insurance Fund (90%) and patient fees (10%).

Capitation-funded Family Group Practices have recently been established in many areas to provide primary care services. In areas where they do not yet exist, such services continue to be delivered either by doctors working in hospital-based public health departments or by locally-based *feldshers* (physician’s assistants) in more remote, rural areas.

There are a number of small private specialist hospitals, most of which are situated in Ulaanbaatar.

Since 1989 traditional medicine has become increasingly popular. Most hospitals now offer traditional medicine services; about 10% of doctors have been trained in aspects of traditional practice; and the Health Insurance Fund pays for inpatient treatment using traditional methods. The Government of Mongolia is committed to the continued development of traditional medicine.

¹⁵ Available in English translation as Health Legislation, Ulaanbaatar, 1999

The resulting institutional arrangements are relatively sophisticated in their design and place heavy demands on the limited technical, managerial and information resources that are available in Mongolia.

The main health system challenges currently facing Mongolia include:-

- Hospital domination – It is still widely acknowledged that the Mongolian health system is unduly dominated by hospital services and specialist clinicians. Access to secondary and tertiary services is possible without referral; and the national health insurance scheme provides cover for most inpatient services but for very few ambulatory services. There remains a need to redirect financial and human resources towards the provision of better and more accessible primary care and prevention services.
- Lack of role clarity – Despite the attempt to assign distinct roles to different actors in the health system, there is still confusion over how, precisely the system does (or should) function. The roles of the various organizations involved in the sector and the relationships between them are not always clear. For example, despite efforts to decentralize, *aimag* and *soum* governments have few opportunities to rationalize the use of resources; hospital governance arrangements are unclear; and resource allocation mechanisms and responsibilities are poorly defined.
- Human resources – The large-scale changes that have taken place in both clinical and managerial arrangements over the past ten years have created many new challenges for staff throughout the Mongolian health system. There is an over-supply of medical staff but the skill-mix of the medical workforce is not appropriate to today's needs. There is also scope to make better use of nursing skills. Many clinicians have struggled to adapt to new approaches to treatment and meet demands for higher quality services. Managerial and administrative staff have faced significant restructuring coupled with a need to move away from a highly centralized 'command and control' approach and adapt to working in a more flexible environment. Established approaches to capacity building have failed fully to address these issues. Improvements are often transitory and fail to make a significant and lasting impact on established ways of working. There is a clear need to find more innovative solutions to the human resource challenges that confront the system.
- Financial resources – Mongolia is not a wealthy country. The resources available for health are inevitably constrained and yet the country's climate and geography impose additional demands in terms of high energy costs and the need to maintain underutilised assets in remote areas. Against a backdrop of constrained resources, the need to ensure that financial allocations are fair and efficient, and that spending is properly prioritized in light of population health needs, create special challenges. Development of accurate and comprehensive national health accounts will be an important step. Further efforts will also be needed to rationalize outdated hospital facilities, to foster a greater sense of cost-effectiveness, to clarify and enforce accountability for resource use, and to develop evidence-based approaches to clinical practice.
- Weak implementation capabilities – In recent years, numerous changes to the structure and functioning of Mongolia's health system have been proposed. Few of

those proposals have, however, resulted in significant and lasting changes in the day-to-day operation of the system. There often appears to be a gap between planning at the centre and action at the level of service delivery. This may be a reflection of the problems with human and financial resources highlighted above; or it may indicate that the current institutional arrangements are a constraint on effective implementation of plans. Alternatively, the fault might lie with over-ambitious or unrealistic plans (often prepared

by external experts who are unfamiliar with the country and its health system), weaknesses in management or poor communication within the system. Or it may be a legacy of a former, more bureaucratic style of working.

Emergencies

Mongolia is exposed to risk in a number of areas. Most recently, in the winters and springs of 1999 – 2000 and 2000 – 2001, the country was affected by a *dzud*, or a period of particularly severe weather. Such events are usually thought to occur roughly once every ten years and can lead to widespread loss of livestock, with consequent setbacks both to economic growth and to improvements in standards of living. More immediately, transport problems can be exacerbated and large-scale movements of populations in search of new pastures and other essentials can jeopardize established patterns of access to health services.

Occasional outbreaks of infectious diseases such as plague and measles arise, but they are generally contained. In addition, forest fires, storms and floods can occur and may place additional demands on the health system from time to time.

DEVELOPMENT ASSISTANCE: AID FLOWS, INSTRUMENTS AND CO-ORDINATION

Overall trends in aid

Between 1994 and 1999 Mongolia received almost US\$1 billion in external assistance. Of that sum, 80% took the form of loans and credit, with the balance being accounted for by various forms of technical assistance¹⁶. The balance between multilateral and bilateral assistance during that period was 2:1.

The main sources of multilateral assistance were the Asian Development Bank (US\$358 million – of which 91% was in the form of loans/credits) and the IBRD (US\$160 million loans/credits). Major bilateral development partners included Japan (US\$165 million – 97% loans/credits), the USA (US\$83 million technical assistance) and Germany (US\$64 million – 71% loans/credits).¹⁶

In 1998 and 1999, external assistance accounted for between 20% and 25% of total GDP making Mongolia the world's fifth most aid-dependent country¹⁷.

Support for health¹⁸

Prior to the period of reform that started in 1990 Mongolia's health system was financed almost exclusively from central government budgets. Government funding was supplemented by limited individual and community contributions. In addition, a variety of partnerships with, and subsidies from, the Soviet Union and other former socialist countries provided support for infrastructure and operating costs.

During the 1990s patterns of health financing in Mongolia became more diverse. Central government funding fell to roughly two-thirds of the total, with the balance coming from a

changing mix of health insurance, out-of-pocket payments and donor support.

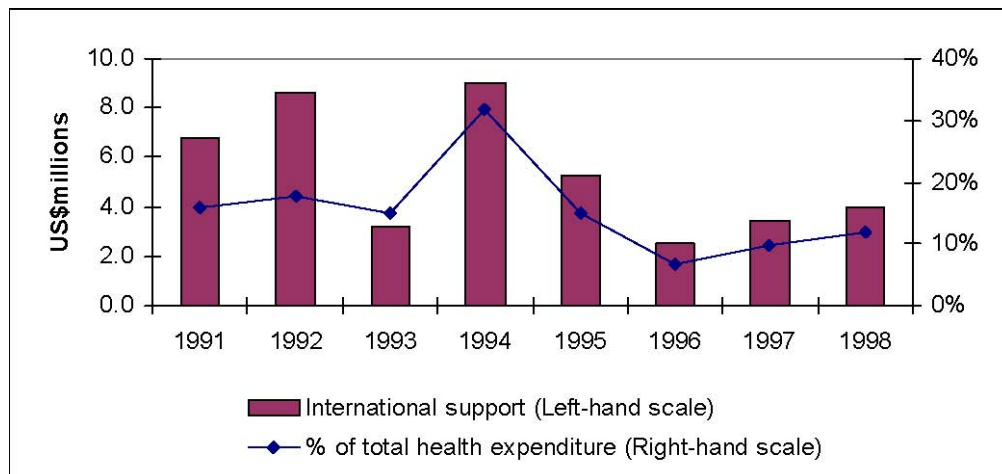
Figure 2 below shows that levels of international support for health in Mongolia (excluding loans) varied significantly during the 1990s. They peaked at almost one-third of total health spending in 1994 and fell to less than 10% in both 1996 and 1997. Between 1996 and 1998 international support grew steadily, both in absolute terms and as a proportion of total health spending.

In addition to the sums shown in Figure 2, Mongolia has also received loans for health sector development from the Asian Development Bank which between 1998 and 2002, has provided US\$16 million in loan support to the health sector.

Most development assistance in the health sector appears to be directed towards specific projects rather than disbursed via the Ministry of Health. Thus, the resources provided are not channelled through the Government budgeting and priority-setting system.

¹⁶ Data from ADB Country Assistance Plan (2001 – 2003), Appendix 3 ¹⁷ A strategy for poverty reduction in Mongolia, K Griffin et al, UNDP Mongolia, 2001 ¹⁸ Data in this section are from Mongolia Health Sector Review, Government of Mongolia/WHO, June 1999

Figure 2: International support for health in Mongolia



The support above has been complemented by numerous broader development assistance initiatives in areas such as public management and legislative reform which have also impacted on the Mongolian health sector.

Multilateral assistance for health

Currently, the Asian Development Bank is the main source of multilateral aid to health in Mongolia. The Bank's *Health Sector Development Programme and Project* were launched in 1998. Through a combination of loans and technical assistance, worth in total more than US\$16 million, these initiatives have provided support to the Government's health sector reform efforts.

They have sought to re-focus health services in Mongolia away from the former Soviet model by emphasising service quality and supporting a shift towards primary care. Key elements have included the establishment of Family Group Practices, improvements to referral systems, provision of training in primary care models, hospital renovation and clinic construction.

When the ADB's Health Sector Development Programme and Project come to an end in 2002 it is anticipated that the Family Group Practice model will have been implemented in all *aimag* centres and throughout Ulaanbaatar.

The ADB is currently developing plans for a Second Health Sector Development Program that will run for four years starting in 2003.

United Nations development partners have been active in Mongolia for many years and maintain a generally high level of involvement in health.

Between 1997 and 2001 UNFPA provided US\$7.3 million for reproductive health and population activities in the country. Between 2002 and 2006 UNFPA plans to provide a further US\$9 million in support to Mongolia of which some 80% is destined for reproductive health programmes.

UNICEF has undertaken significant work in connection with immunization, essential drugs, with collaborative programs with WHO including baby-friendly hospitals, integrated management of childhood illnesses and child nutrition. During 2001 UNICEF spent some US\$468 000 on health and nutrition related projects in Mongolia.

UNDP has contributed in the area of HIV/AIDS and plans future support for efforts to counter alcoholism. In collaboration with WHO, UNDP spent some \$2 million to improve the water supply for rural populations under its WASH21 project. Although this project assisted 70 *soums*, some 170 *soums* still have difficult water supply, of which 40 *soums* are in a critical situation.¹⁹

The European Union's TACIS programme provided €1 million between 1999 and 2001 to improve financial management in the health system.

Bilateral assistance for health

In terms of bilateral support for health, Mongolia's main development partners in recent years have been Japan and Germany.

Japan, through JICA, has provided substantial support to maternal and child health in areas such as immunization and efforts to combat iodine deficiency disorders. Considerable assistance has also been provided in the form of equipment donations, mainly to secondary and tertiary level hospitals.

The joint Mongolian-German project *Improving Reproductive Health in Mongolia* was launched in May 1998. Over 10 years, it seeks to improve the quality of reproductive health services, support improvements in management and human resources, overcome deficiencies in supplies and equipment, expand community participation and develop information, education and communication activities. During its first three years (up to November 2001) the project has

focused on work in three *aimags* and Ulaanbaatar (areas selected to be complementary to those covered by UNFPA activities). The geographic scope of project activities is now set to expand.

In addition to the major development partners identified above, a great many local and international NGOs are also active in the health sector in Mongolia. Details of their activities are, however, not routinely reported to either the Ministry of Health or WHO and so the scale, scope and, ultimately, the effectiveness of NGO support cannot be determined.

Donor co-ordination

In the main, development partners appear to consider that the Government of Mongolia is receptive to their involvement. In some cases, however, problems have reportedly arisen because of weaknesses in local implementation capabilities and a lack of productive engagement between donor agencies and Government officials.

From time to time members of the UN system have established 'Theme groups' to "promote information sharing, dissemination, and programme collaboration among UN agencies and development partners". At the end of 2001 five such Groups were in operation focusing on gender, statistics and Millennium Development Goals, young

¹⁹ Mr. D. Basandorj, Permanent Secretary of National Water Committee, Tripartite Review Report, 29 January 2002 people, human rights and good governance, and STI/HIV/AIDS (the last chaired by WHO).²⁰

A CCA for Mongolia was completed in May 2001. The UNDAF for the country was then published in June 2001 and establishes a basis for closer collaboration among UN agencies. WHO was involved in the preparation of both documents but their broad scope has meant that they were of only limited assistance to the formulation of the WHO's Plan of Action for 2002 – 03 in Mongolia.

The UNDAF notes that "The UN system in Mongolia has had many positive and successful experiences in interagency co-operation" but it also contends that "there is room for improvement" citing dialogue between the UN system and the Government of Mongolia on macroeconomic issues and assistance to the government to develop strategies and policies and to obtain grants rather than loans, principally in the social sectors, as examples of areas where more could be achieved.

An Interim Poverty Reduction Strategy Paper (I-PRSP) was also prepared in 2001 although it has been criticized, from some quarters, for lacking detailed proposals for inter-agency action to address the links between health and poverty. The Government is committed to approve the final PRSP in 2002.

Within the Ministry of Health, the Department of International Co-ordination (in the Division of Strategic Planning) has formal responsibility for co-ordination of international support for health. Current arrangements are perceived as both somewhat *ad hoc* and that there is scope for better co-ordination among donor agencies. The result, it is believed, would be to ensure that contributions are maximized, initiatives yield the greatest possible benefits, potential synergies among programmes are realized and duplication is minimized.

With the goal of improved co-ordination in mind, informal meetings for UN agencies, donor embassy representatives and NGOs with an interest in health have taken place on a fortnightly basis for some time. At the end of 2001 the arrangement became more formalized with WHO providing limited financial support for more structured, monthly meetings. In addition, more than US\$45,000 has been allocated in the regular country budget to support donor co-ordination activities during the 2002 – 03 biennium.

²⁰ Details are from <http://www.un-mongolia.mn/rescor/untheme-index.htm>, <http://www.un-mongolia.mn/who/anrep-july.html#PROJECT> and Resident Co-ordinator's Report 2001

CURRENT WHO COUNTRY PROGRAMME

WHO and Mongolia

Mongolia joined as a member country of WHO in April 1962. The Basic Agreement on cooperation between the Government of Mongolia and World Health Organization was concluded on 21 June 1963 after which a medical officer was recruited to coordinate WHO projects.

WHO established its Representative Office in 1971. Initially there were only three fields of cooperation, namely control of communicable diseases, laboratory services, and maternal and child health. Subsequently WHO has collaborated in 30 projects covering practically all areas of public health and health services.

Key areas of work

Key areas where WHO provides support include:-

- *Health sector reform* – The Ministry of Health is focusing on primary health services, rural health care, private health services and expanded health insurance coverage. The government has put strong emphasis on health policy, programme and standard development. WHO has provided technical advice, for example, to amend the Health Act, Health Insurance Act and the Act on Drugs, and to develop a national drug policy. WHO also supports fellowships and study tours to learn experiences from other countries, and provides supplies and equipment.

- *Environmental health and health promotion* – WHO has supported:-
 - the development of healthy workplaces, healthy markets, and health promoting schools and hospitals – although integration of these programs is under way, their impact in terms of improved health behaviours is not yet clear;
 - assessment of environmental health risks (including food safety) and planning of corrective actions – through provision of technical advice;
 - the development of public health policy – which was approved in 2001;
 - planning of health education and promotion activities; and
 - water supply support with the UNDP project WASH21 and water safety testing and monitoring
- *Human resources development* – With the purpose of improving local capacity, WHO supports some fellowships to the WPRO Learning Centre and at universities for Master's level qualifications. In 2000 – 01 the number of study tours was reduced but they remain the Ministry's preferred approach to human resource development. WHO and the Ministry must work more to ensure that future study tours are really necessary to implement planned activities and that the needed knowledge and skills are not already available locally. The Plan of Action for 2002 – 03 includes a shift from short fellowships to long-term studies abroad. Distance learning approaches are also starting to be used. WHO also supports local training courses and provides training materials and equipment to selected training centres.

WHO supported the preparation of a draft national health workforce plan for 2002 – 2012 and new training curricula for nurses. Health workforce planning has proved difficult in the absence of a formal medium or long-term plan for the sector, and coordination between the Ministries of Health and Education is sometimes inadequate.

- *Child health and nutrition* – Training and programming for the integrated management of childhood illnesses (IMCI) in Mongolia has reached an optimal level in many of the project sites. However, additional support from the Government, WHO and UNICEF continues to be required to ensure the availability of needed drugs and equipment at those sites and to extend IMCI to the rest of the country.

WHO has supported the Ministry of Health and the Ministry of Food and Agriculture to finalize a National Plan of Action for Food Security, Safety and Nutrition, which was approved by the Government in 2001.

- *Reproductive health* – WHO has supported training programmes and the preparation of materials to reduce excessive maternal mortality. WHO support was essential for the development of the National Strategy for Maternal Mortality Reduction, which was approved in 2001. However, much more needs to be done to improve access to good quality antenatal and delivery services, particularly outside the main centres of population.
- *Combating communicable diseases* – WHO has supported the Expanded Program on Immunization, programs on tuberculosis and STI/HIV/AIDS, as well as disease surveillance and laboratory network. WHO support has mainly focused on increasing and maintaining high immunization coverage, implementation of DOTS for treatment of TB, improvement of

prevention and treatment of STI including HIV/AIDS and enhancement of epidemiological response and laboratory capacity for communicable diseases.

Financial resources

During 2000 – 01 WHO allocated some US\$3.3 million to Mongolia (comprising US\$2.7 million regular budget plus US\$0.6 million country office operating costs).

Figures 3 and 4 illustrate how the regular budget was allocated to programmes and types of expenditure in 2000 – 01. More than 40% of the regular budget was allocated to health sector reform, with human resources development (12%) and environmental health and health promotion (11%) being the next largest elements.

In terms of types of expenditure, just over one-fourth of the total regular budget was allocated to fellowships and study tours. Other major expenditure types were supplies, equipment and vehicles (21%), and local costs including APWs (19%).

Figure 3: Allocation of Mongolia regular budget to programmes (2000 – 01)

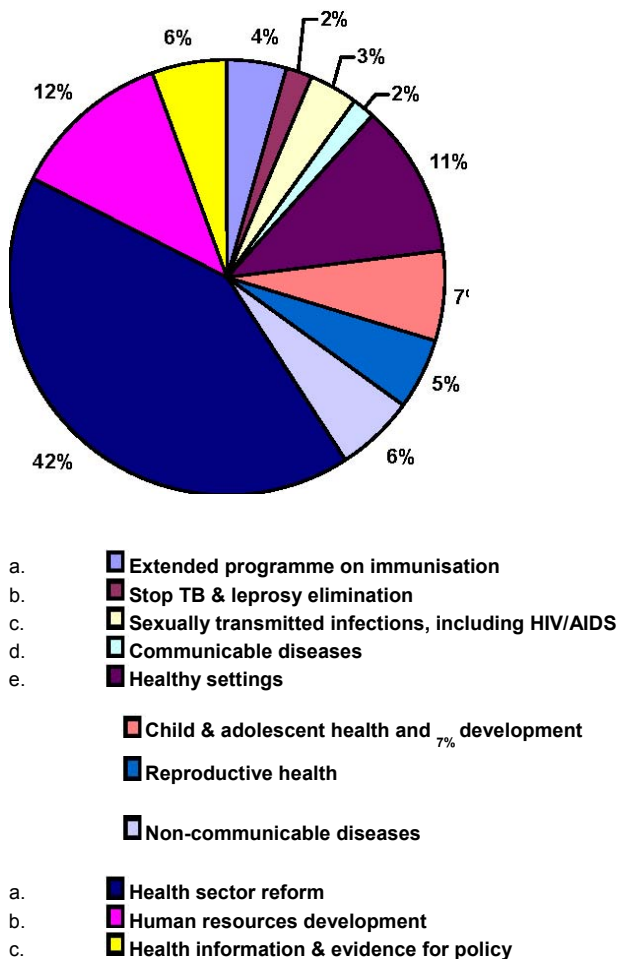
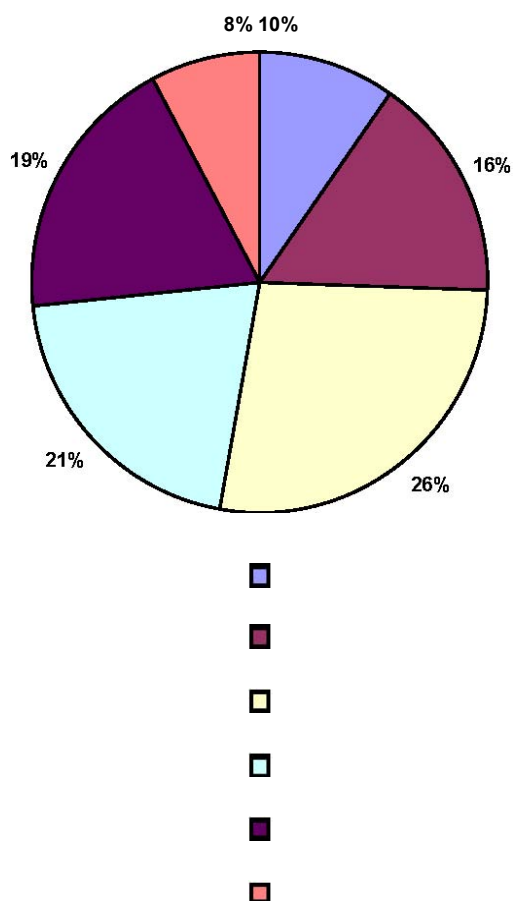


Figure 4: Allocation of Mongolia regular budget to types of expenditure (2000 – 01)



Project staff Short-term consultants Fellowships and study tours Supplies, equipment and

vehicles Local costs and APWs Other

WHO's total allocation to Mongolia is reduced to about US\$3.0 million for 2002 – 03. The regular budget component available for consultancies, fellowships, study tours, supplies and equipment will be about US\$1.8 million. More resources will be used to fund international professional staff positions in the country office: a new medical officer post was established in 1998, and a new epidemiologist post has been agreed for 2002. In 2002 – 03, about 40% of total funding will thus be assigned to international professional staff and country office operating costs. This shift is expected to provide more continuity and long-term support to the MOH, as it has been noticed that the impact of one-time short consultancies is often low.

During the 2000 – 01 biennium the following major items of extra-budgetary funding were received:-

- US\$173,000 for an adolescent health and development project from the United

Nations Foundation for International Partnerships (UNFIP);

- . • US\$54,000 from the Royal Netherlands Government for enhancing access to essential drugs;
- . • US\$25,000 for food safety work from the Korean Health Industry Development Institute;
- . • inter-country program funding from WPRO, used principally for EPI, child health and environmental health activities;
- . • funding and consultancies from WHO headquarters for projects in areas such as brucellosis, plague, health insurance, diabetes and human reproduction research; and
- . • Regional Office (US\$30,000) and local donor provided funds (US\$35,000) for assistance as a result of the winter disaster-*Dzud*

Human resources

The WHO country office is staffed by the WHO Representative, a Medical Officer, an Administrative Assistant, two secretaries and two drivers. In addition, three locally recruited professional staff support projects in adolescent health and immunization.

The Ministry of Health and WHO agreed to establish a new post in 2002 for an Epidemiologist, to support the Ministry and other government agencies in communicable diseases, environmental health and food safety. In addition, the Ministry has asked WHO to seek funding from extra-budgetary sources for a further professional staff member to work in the field of hospital management, starting from 2002. Additionally, the Ministry has agreed to jointly identify a UNV who can work with WHO in support of Ministry of Health programs.

During the year 2001, more than 70 WHO staff members or consultants/temporary advisors visited Mongolia. Almost half of those visits concerned child health and nutrition, and health reform. Most visits took place between May and September. This is a well-established pattern. Although the weather may provide some justification, the disproportionate number of activities and consultant visits during the short summer months places a strain on both the limited absorptive capacity of the Ministry of Health and the operational capacity of the WHO office.

Current partnerships

WHO is co-operating with UNICEF, UNFPA and UNDP on an adolescent health program and on STI/HIV control, and with UNICEF on integrated management of childhood illnesses. WHO was a partner with UNDP in the WASH21 programme to improve the availability of safe water and sanitation facilities. New collaborative arrangements with UNDP include traditional medicine studies and publications.

WHO has active collaboration with many governmental and non-governmental agencies including JICA, Soros Foundation, GTZ, Save the Children Fund (UK) and national NGOs.

At the beginning of 2001 WHO, UNICEF and UNFPA prepared the health, water and sanitation portion of the *dzud* disaster appeal that detailed full co-operation and coordination of their responses. WHO's contributions included IMCI training and supplies, a mental health survey and counselling in disaster affected provinces and donation of a vehicle to a remote mental health hospital. A GIS software package was given to the Ministry for its use in mapping the health effects of the *dzud* and for routine health systems monitoring. In addition WHO assisted UNDP

to procure ambulances and equipment for disaster areas.

Other collaborative efforts have included:-

- . • preparations for a health and nutrition assessment survey with a CDC team – (WHO and UNICEF);
- . • a survey of sexually transmitted infections (WHO, UNFPA and GTZ);
- . • propagation of the integrated management of childhood illness approach to five more provinces in 2001 (WHO and UNICEF);
- . • support for finalization of the National Plan of Action for Food Security, Safety and Nutrition (WHO and UNICEF); and
- . • safe motherhood activities (WHO, UNICEF, UNFPA and GTZ).

Assessment

Many of WHO's achievements in Mongolia are reflected in the achievements of the Ministry of Health in the country's health sector. Notable features are high immunization levels, TB control using DOTS, implementation of essential drugs policies and increased attention to the prevention and control of non-communicable diseases including tobacco control.

In terms of WHO itself, the Organization's ability to deliver a comprehensive and flexible programme of support throughout a period of significant change has undoubtedly been a sign of success. WHO has maintained close and effective working relationships with the Ministry of Health through a number of major re-structurings, and has firmly established itself as the principal source of credible, trusted and independent advice on health matters. The Ministry's recent support for the establishment of a new post in the WHO country office is a clear sign of the quality of the relationship.

WHO's ability to build and maintain productive partnerships with other development partners is another key strength that has undoubtedly supported progress towards the achievement of national health goals. Furthermore, there is wide recognition within both the government and the development community that WHO's role in responding to the recent *dzud* disaster provided a clear demonstration of the Organization's strengths.

There are, however, some issues that need to be addressed:-

- . • fellowships and study tours continue to play a major role in the Plan of Action. However, they create a disproportionately heavy administrative workload for both WHO and the Ministry of Health and may not always be the most cost-effective means to build capacity in areas of greatest need. When used, they should form part of a coherent development programme;
- . • the Ministry of Health's requests for supplies and equipment purchases are sometimes not directly linked to the workplan. There is an additional need to ensure all items that are purchased can be used, maintained and repaired by local personnel, and that they contribute to the goals of greater health equity and improved service quality;
- . • the heavy workloads connected with fellowships, study tours and purchase of supplies and equipment have restricted the country office's ability to secure additional extra-budgetary funding – the planned appointment of additional professional staff, coupled with a more strategic orientation of the work programme should help to address this concern;
- . • the Country Office sometimes has insufficient say in both the nature and timing

of Headquarters' and Regional Office's initiatives and associated visits to Mongolia – with the result that the Office's capacity to offer adequate and effective local support may occasionally be prejudiced;

- . • the cap on local costs (15% of regular budget) can inhibit effective use of in-country resources – provided that there are adequate safeguards, the office will make more effective use of existing flexible arrangements for locally-based training and development initiatives, translation of training materials and technical manuals into Mongolian and English language training; and
- . • joint planning for the use of the country allocation could be improved to ensure that WHO's responsibility and accountability for these funds is protected

In its efforts to improve the equitable distribution of resources and training opportunities for improved health in the distant *aimags* and *soums* of Mongolia, the Ministry is hosting larger numbers of training exercises and workshops in these distant locations. Given our current staffing levels and the required long travel times, it is not possible for WHO to participate in or verify the quality of many of these exercises. WHO will explore the possibility of establishing a sub-office in the Western *aimags* to be intermittently staffed on a rotating basis.

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO corporate policy framework

A WHO Country Co-operation Strategy must reflect the Organization's corporate policy framework and regional strategies, as well as the health needs of the country and the activities of other development partners.

WHO's mission, as set out in its constitution, remains the attainment, for all people, of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill-health; the greater complexity of health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the values and principles articulated in the global Health for All policy, which was re-affirmed by the World Health Assembly in 1998 with new emphases on:-

- . • adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- . • playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- . • triggering more effective action to improve health and to decrease inequalities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- . • creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

WHO's goals and priorities

WHO's goals are to build healthy populations and communities and to combat ill-health.

To attain these goals, the following four interrelated strategic directions have been set for WHO's areas of work:-

- . • reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- . • promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
- . • developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair;
- . • developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

These four strategic directions are inter-related and mutually supportive. They all call for the Organization to build new and broader partnerships.

In addition to these strategic directions, WHO has also defined limited specific priorities.

These are based on criteria which include the potential for a significant reduction in the burden of diseases using existing cost-effective technologies (particularly where the health of the poor will demonstrably benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of diseases. The specific priorities are malaria, HIV/AIDS and TB; maternal health; mental health; tobacco; noncommunicable diseases; food safety; safe blood; health systems; and investing in change in WHO.

Regional Emphasis

Within the WHO corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes:-

- . • combating communicable diseases;
- . • building healthy communities and populations;
- . • developing a strong health sector; and
- . • reaching out (which encompasses information technology, external relations and communication).

Poverty is one of the most important determinants of health status. Large numbers of people living in poverty, the transition to market economies and globalisation can all have significant impacts on health. At the same time, rapid population growth and ageing of the population have huge implications for the health sector. Environmental factors associated with urbanization and industrialization contribute to much of the disease burden and, although communicable diseases still impose a heavy burden, disease patterns are changing. The epidemiological transition is resulting in non-communicable diseases becoming increasingly important throughout the Region.

In recent years, emerging and re-emerging diseases have been a major public health issue in

several countries of the Region and tuberculosis is a particularly serious problem.

Health systems in many countries of the Western Pacific Region are underdeveloped and several are still struggling to deliver a minimum level of health services to all areas. Consequently, upgrading the Region's health systems is a major challenge.

STRATEGIC AGENDA FOR MONGOLIA: THE NEXT FIVE YEARS

Overall goals

The overall goal of WHO in Mongolia is to support the Government of Mongolia in its efforts to build a modern and effective health system that can contribute to substantial improvements in population health.

In this context, it is important to appreciate that the boundaries of such a health system need to be drawn widely. It encompasses not just the delivery of conventional curative services, but also a wide range of preventive services and traditional medicine (where it can be shown to be safe and effective). It is concerned both with those services that the government delivers and funds and with those that are delivered or funded privately. It also must include the various agencies, at national and local level, that are tasked with developing and implementing policies, regulating the sector, paying for services and managing aspects of service delivery. All these components must work well and work together if real health gains are to be achieved.

Setting priorities

Given the broad scope of the above goal, it will clearly be important for WHO to target its efforts. Otherwise there is a risk that the limited resources that are available will be spread too thinly and, consequently, no significant progress will be made.

WHO's priorities must reflect the needs of the country, and must also take into account its recent history. Mongolia is not a country that is locked in a cycle of deprivation and decline but rather it is a young democracy that has shown itself to be committed to rapid and significant change. It is thus important that the health sector and the institutions within it are able to change too, and to grow and mature in line with rest of society.

One of the key guiding principles in setting priorities for WHO's support is thus the need to build local capabilities. Mongolia needs a health sector that is robust and responsive, that can identify and capitalize on opportunities when they present themselves, and that can exert influence across government and society in support of health enhancing policies.

Other principles to be taken into account are:-

- . • the need to be able more clearly to distinguish the work and performance of WHO from that of government, while maintaining a close relationship as partners;
- . • the need explicitly to take account of the contributions of other development partners who are active in health, to achieve synergies and to avoid duplication or overlaps;
- . • the need to maintain the visibility and credibility of WHO, to focus on what the organization does best and to acknowledge its strengths and weaknesses;
- . • the need to be receptive to requests as they arise, and to have the capacity to

respond where appropriate, but also to make clear the boundaries within which responses can be expected;

- the need to remain alert to, and capable of addressing, health-related emergencies as and when they occur.

The strategic agenda

At present, WHO's role in Mongolia is dominated by the provision of technical service support to the Ministry of Health. Relatively little support is provided in key areas of policy formulation and planning; and there is limited formal collaboration between WHO and the other Mongolian organizations (both public and private) that play increasingly important roles in the sector.

It would be feasible to maintain a broadly similar pattern of support over the next five years (the period covered by this strategy). WHO could continue to offer technical support across a wide range of programmes, and there can be no doubt that benefits would continue to be realized. Little would be achieved, however, in terms of lasting development. To adopt a clinical analogy, WHO's actions would focus on the symptoms of a struggling health system, rather than seeing to identify and address the underlying causes.

In considering alternative strategies for WHO, it is important to acknowledge that Mongolia faces many significant health problems. There have been some notable improvements but also some disturbing areas of deterioration over the past 12 years. Overall, however, the levels and patterns of ill health do not present insurmountable problems. What makes tackling those problems difficult, however, is the context in which they arise.

Some of the major threats to health in Mongolia come not from disease itself, but from other factors such as:-

- the climate and geography of the country – which affect both the cost and practicality of delivering services to many who would benefit from them;
- the challenges of making sophisticated and unfamiliar organizational structures work effectively – and the demands that they place on those who work within them;
- the legacy of Soviet style medicine – which has left the country with an over-investment in buildings, no history of effective ambulatory care and many inappropriately skilled staff (whose retraining is made difficult by weaknesses in the system of continuing medical education);
- the social effects of reform – including the breakdown of long-established community support networks, reductions in social sector spending, wider exposure to economic realities and growing urbanization; and
- life style associated growth in the burden of non-communicable diseases; and
- The degraded water supply system and health care infrastructure, especially at the *soum* level.

An alternative strategy for WHO, therefore, is to seek to complement its established pattern of technical support with additional efforts that aim to help equip the Ministry of Health and other key agencies in the sector to be able better to address the broader contextual issues that make their task so challenging.

Within a tight budgetary constraint, such a change of emphasis could only be achieved by

carefully targeting technical support activities. This would mean focusing on those areas of greatest potential benefit where WHO has particular expertise and where other partners are unable or unwilling to take on the role. It would certainly require withdrawal from, or a major reduction in, some current areas of activity.

A number of development partners and NGOs are providing support to Mongolia's health system, and plan to continue to do so. In particular, the Asian Development Bank expects to maintain its extensive investments in health system development, the joint Mongolian-German project *Improving Reproductive Health in Mongolia* is scheduled to continue until at least 2007, and several agencies have indicated that they intend to continue work in the field of STI/HIV/AIDS. It may therefore be appropriate for WHO to re-focus its efforts towards a more strategic role that adds leverage to the work of other agencies and helps to realize potential synergies in these important areas.

On balance, an approach that sees WHO shifting its technical support in favour of greater efforts to build stronger institutions in health appears more likely to yield long term, sustainable benefits for the people of Mongolia. It is in step with the reform agenda, and has the potential more rapidly to build capacity in important areas of need. It is not without risks, and may prove uncomfortable or be perceived as threatening in some quarters. The benefits of success will be significant, however.

WHO activities and Country Office staff

In light of the above, WHO will re-configure its international and national staffing patterns to permit support to the Government of Mongolia to be focused on the following six principal components:-

1. 1. Health sector: policy analysis and institutional strengthening
2. 2. Facilitating donor co-ordination
3. 3. Controlling communicable and non-communicable diseases
4. 4. Environment and healthy lifestyles
5. 5. Health information and evidence for policy
6. 6. Emergency preparedness and response

A re-configuration of WHO's international staff presence in Mongolia is likely to include long term support in health systems development and epidemiological surveillance with the possible addition of UNV support for a sub-office in the more remote Western provinces of Mongolia.

WHO's core set of activities are discussed below..

Component 1: Health sector: policy analysis and institutional strengthening

This Component will grow to become the major area of focus for WHO in Mongolia. It will involve WHO working with institutions throughout the health sector to improve their ability to plan, manage and monitor the development and improve delivery of programmes and services.

It has been suggested that "lack of strong public sector management and control has led to poor access and quality of basic services, such as education and health"²¹. and also that "Democratic Mongolia must shed the old tradition of a handful of high level technocrats establishing policies

and expecting people to understand, then to follow.”²² Work in this area will endeavour to identify and address such problems in the health sector.

In particular, WHO will seek to:-

- . • extend its working relationships within the health sector to encompass relevant Ministries (such as Education, Finance, Social Welfare and Labour), Aimag Health Departments and the Health Insurance Fund; and offer support to those agencies as required in order to ensure better alignment of policies and capabilities across the sector;
- . • work with the Ministry of Health to better understand and assess the processes by which government policies are developed, analysed and implemented; and the organizational context within which such work is carried out;
- . • review the methods by which policy decisions are communicated within both the sector and wider society; and assess the regime of sanctions and incentives that are employed to ensure compliance; and
- offer support to ensure that staff employed in health sector agencies have both the specialist technical knowledge and the more generic public management skills needed to function effectively in the current environment.

Successful performance of the above tasks will require the continued use of expert consultants to conduct reviews, develop recommendations and support the management of change. There may, however, be a shift towards those with more general skills in public policy, management and governance rather than ‘pure’ health sector expertise.

In order to ensure relevance and to facilitate effective implementation of changes at the local level, greater reliance will also be placed on in-country training and development (often using visiting experts) as a means to build capacity rather than fellowships and study tours. More people can then benefit, and there will be greater scope for shared

²¹ Source: Government of Mongolia, Interim Poverty Reduction Strategy Paper. June 2001 ²² Human Development Report, Mongolia 2000, page 49

understanding of new concepts as they are introduced. A further consequence of extending WHO’s work in this area will be that more agencies will enjoy the opportunity to work alongside WHO and benefit from WHO funding. A clearer distinction will thus need to be drawn between WHO resources and those of the Ministry of Health; with consultative decisions on the use of the former resting with the WHO Representative and Regional Office.

This Component is a logical extension of WHO’s previous work on health systems and health sector reform in Mongolia. It offers the prospect of addressing many of the weaknesses identified in earlier sections of this Strategy. It also responds to the need to support the government in developing strategies and policies that were identified by the UNDAF. By strengthening implementation capabilities within the sector it will also help to ensure successful outcomes from work carried out under the other Components described below.

Component 2: Facilitating donor co-ordination

There is a clear need for donor inputs to health in Mongolia to be better co-ordinated. At present the Ministry of Health does not have a comprehensive overview of the nature and extent

of donor inputs. In addition, there are no formal mechanisms for deciding priorities for donor support, assessing its effectiveness, avoiding duplication and identifying areas of potential synergy.

The Ministry of Health should continue to be responsible for co-ordinating donor inputs throughout the sector (including any support that flows directly to *aimags* or *soums*). WHO's role, therefore, will be to offer support for the establishment and operation of systems and processes for donor co-ordination within the Ministry. In addition to establishing more comprehensive databases of donor inputs, this should also include more formal approaches to ensure that there is clear monitoring of, and accountability for, the impacts of donor support (purchasing of equipment, implementation of consultants' recommendations etc).

WHO can support the Ministry's efforts in this area by providing specialist technical input to assist in the assessment of proposals and the evaluation of outcomes as well as helping the Ministry to ensure that recommendations are followed through. As a result development assistance will better support appropriate policies and be in line with the government's overall goals.

As part of its work within this Component WHO will also seek to act as a broker and source of expert advice for the Ministry of Health as well as offering similar support to other development partners.

Component 3: Controlling communicable and non-communicable diseases

Much of WHO's current work in Mongolia is aimed at disease control, with a shifting emphasis from communicable to non-communicable diseases. A number of other development partners are also involved in similar work.

As the Mongolian health system improves, it should be possible for many areas that presently require significant technical support to become better integrated into routine patterns of service. If that is to become a reality, however, the Ministry of Health will need to become better able to identify and respond to priority needs. At present, WHO is able to offer the Ministry technical support in many aspects of disease control. Consequently, the Ministry does not have to decide which are the areas of greatest need. With WHO's help a wide range of problems can be addressed. WHO believes, however, that an essential strategic goal should be for the Ministry to develop its capabilities in resource allocation and prioritization. WHO's support under Components 1 & 6 will contribute in that area.

Where there are needs that clearly cannot be met from local resources, NGOs and other development partners may provide an alternative source of finance and expertise. Better donor co-ordination (see Component 2 above) will help to target other partners' support into areas of greatest need.

Of course, WHO will continue to provide technical support in any areas of special need; and to respond rapidly to epidemics and other health emergencies. Overall, however, such instances will be the exception rather than the rule and the level of resources that is routinely allocated to disease control will reduce in parallel with the planned increased focus on support for policy analysis and institutional strengthening across the sector (Component 1).

Component 4: Environment and healthy lifestyles

Mongolia is undergoing an epidemiological transition from communicable to noncommunicable diseases. In addition, there is clear evidence that the recent economic reforms have caused considerable social stress; and that excessive consumption of alcohol, smoking, poor diet, injuries and environmental health risks pose a threat to population health.

WHO has supported work in the field of 'healthy settings' in Mongolia for several years and proposes to continue to do so. The Organization's close working relationship with the Ministry of Health, and the proposal to develop closer ties to other Ministries and to agencies working at other levels of the health system (see Component 1) mean that it is well-placed to influence and support both policy development and service delivery in this important area of activity.

Component 5: Health information and evidence for policy

Mongolia's health system is decentralized. In order to function effectively, it must rely on effective relationships between a variety of agencies. Timely, relevant and accurate information is essential to the proper working of such a complex system. Information is needed throughout the system: to communicate plans; to define roles and responsibilities; to allocate resources; to monitor achievements; and to detect emerging problems early.

WHO plans significantly to increase the support it provides to the Ministry of Health and other health sector agencies under this component. Rather than adding to existing data sources, however, the focus will be on making better use of existing data and integrating data collection/analysis with routine planning, management and monitoring activities. Some areas that could be addressed are:-

- . • use of epidemiological and demographic data to support resource allocation;
- . • risk monitoring and disease surveillance;
- . • development of routine performance monitoring reports;
- . • analysis of service quality; and
- . • clinical and non-clinical workforce planning.

Clearly, improvements in information systems will both aid better policy analysis and be assisted by institutional strengthening (Component 1).

Component 6: Emergency preparedness and response

WHO, together with other development partners, offered significant support to the Government of Mongolia's efforts to alleviate the impact of the two recent *dzud* disasters.

WHO will maintain the capacity to respond quickly to any other disasters that might occur in the future. The organization will also seek to work closely with other UN agencies to further improve the effectiveness of their collaboration in addressing needs arising from emergencies.

Key functions

WHO has identified five main functional areas where it works at country level. These provide another basis for classifying future activities. They are:-

- Function 1 – supporting limited essential routine implementation
- Function 2 – catalysing adoption of technical strategies and innovation; – country-specific adaptation of guidelines; – seeding large-scale implementation;
- Function 3 – supporting research and development; – policy experimentation and case studies; – development of standards and guidelines; – stimulating monitoring of health and health sector performance; – trends assessment and anticipation
- Function 4 – providing information and sharing knowledge (global, interregional, inter-country);
 - advocacy;
 - generic policy options and positions
- Function 5 – providing specific high-level policy and technical advice;
 - serving as a broker and arbiter;
 - exercising influence on policy, action and spending of governments and development partners

Table 2 (below) indicates the extent to which each of these functions will contribute to the six Components of the WHO strategic agenda outlined above.

Table 2 : Relative importance of WHO functions to the strategic agenda

Components	Function 1 Routine implementation	Function 2 Catalysing adaptation of technical strategies	Function 3 R&D, monitoring	Function 4 Knowledge sharing and advocacy	Function 5 Policy advice
Health sector: policy analysis and institutional strengthening	1	12	122	1222	1222
Facilitating donor coordination	1	1	12	12	1222
Controlling disease	1	12	1	12	1
Environment and healthy lifestyles	12	12	1	12	1
Health information and evidence for policy	1	1	1222	12	12

Emergency preparedness and response	ㄱ	ㄴ	ㄴㄴ	ㄴ	ㄷ
--	---	---	----	---	---

- Key:
- ㄷ Function does not contribute to strategic component
 - ㄴ Minor contribution
 - ㄴㄴ Medium contribution
 - ㄴㄴㄴ Major contribution

Based on the crude analysis presented in Table 2 WHO in Mongolia will, in the future, pay most attention to Function 4 (Knowledge sharing and advocacy), Function 3 (R&D and monitoring) and Function 5 (Policy advice). Routine implementation activities will play a less important role.

Conclusion

Mongolia has changed substantially over the past 10 – 12 years. The transition has created new opportunities for the people of Mongolia, but it has also resulted in many new challenges. WHO must ensure that the support it provides to the Government of Mongolia evolves to help meet those challenges.

The strategy outlined in this report establishes the foundations for a new relationship between WHO and Mongolian health sector. It will be a relationship that reflects the growing sophistication of the sector, while still acknowledging the major health problems that the country faces. It will be a more inclusive relationship, that encompasses a wider variety of partners at national and local levels, all of whom can help in achieving the overriding goal of building a modern and effective health system; and thus contributing to substantial improvements in the population health and poverty reduction.

In line with its global and regional strategies, WHO sees its role in the future as focusing more on developing the institutional framework of the Mongolian health sector rather than on delivering technical support services. Therefore, WHO will have to start providing new types of assistance, in new ways and, quite possibly, to new organizations and individuals. There will be a clearer focus on six essential components of activity, and consequently, the mix of functions undertaken by the WHO Country Office will change.

The country co-operation strategy will not be implemented overnight. Careful management will be required to ensure that changes take place in a planned and coordinated manner. The process will place demands both on WHO and on its Mongolian partners, but the potential benefits for the people of Mongolia are substantial.

SUPPORTING AND IMPLEMENTING THE STRATEGY

Implications for WHO

While responsibility for implementing the country co-operation strategy must ultimately rest with the WHO Country Office, there are some areas where support and assistance from other levels of the organization will be required. This section considers the implications of the strategy for all levels of the organization.

Clearly, the WHO Country Office will need to devote considerable time and energy to extending its network of contacts within the Mongolian health sector. It will also need to ensure that the level and skill mix of international staff is appropriate to the new roles proposed by this strategy. Given the small size of the office it is inevitable that all staff work in a flexible manner, and do not consider themselves as being constrained to provide support in specific areas. Such flexibility will be invaluable in the future. The current strengths in health systems and health policy will also be highly relevant to the new strategic agenda.

It is essential that the Regional Office and Headquarters recognize and support the direction set by this country co-operation strategy. They can assist by ensuring that any initiatives they seek to undertake in Mongolia are consistent with the broad direction of the strategy; and that the scale and timing of missions to the country do not impose undue burdens on the Country Office.

Support will also be needed to identify and establish relationships with international experts in areas such as public policy, management and governance. Such skills will be essential to support the process of institutional strengthening that lies at the heart of this strategy.

This strategy has also identified some internal administrative changes that would greatly assist the Country Office. They will be discussed independently of the CCS process.