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**ICPD/15**

International Conference on  
Population and Development



# 15 **MONGOLIA**

years after the International  
Conference on Population and  
Development





# MONGOLIA

15 years after the International  
Conference on Population and Development

## COUNTRY REVIEW

Ulaanbaatar  
2009

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# LIST OF ACRONYMS

<b>ADB</b>	Asian Development Bank
<b>ANC</b>	Antenatal Care
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>GDI</b>	Gender Development Index
<b>GDP</b>	Gross Domestic Product
<b>GEM</b>	Gender Empowerment Measurement
<b>GIA-DOH</b>	Government Implementing Agency-Department of Health
<b>GTZ</b>	German Agency for Technical Cooperation
<b>HDI</b>	Human Development Index
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICPD</b>	International Conference on Population and Development
<b>MDGs</b>	Millennium Development Goals
<b>MMDGs</b>	Millennium Development Goals of Mongolia
<b>MOH</b>	Ministry of Health
<b>MOSWL</b>	Ministry of Social Welfare and Labour
<b>MPs</b>	Members of Parliament
<b>NCAV</b>	National Center Against Violence
<b>NCGE</b>	National Committee on Gender Equality
<b>NCHD</b>	National Center for Health Development
<b>NGO</b>	Non-governmental organization
<b>NSC</b>	National Statistics Committee
<b>NUM</b>	National University of Mongolia
<b>PGA</b>	Police General Authority
<b>PHC</b>	Population and housing census
<b>POA</b>	Plan of Action
<b>PTRC</b>	Population Training and Research Center
<b>RH</b>	Reproductive Health
<b>RTI</b>	Reproductive Tract Infection
<b>SOE</b>	School of Economics
<b>STIs</b>	Sexually transmitted infections
<b>UN</b>	United Nations
<b>UNDP</b>	United Nation's Development Programme
<b>UNFPA</b>	United Nation's Population Fund
<b>UNICEF</b>	United Nation's Children's Fund

# MONGOLIA

## 15 years after the International Conference on Population and Development

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### INTRODUCTION

In 1994, delegates from 179 countries, including Mongolia, attended the International Conference on Population and Development (ICPD) held in Cairo. Different countries, with varying histories, cultures, religions, traditions, populations, territories and stages of development reached consensus on the main principles of population and development, endorsing a Plan of Action (POA) to implement for the next 20 years.

At the ICPD, the participating countries agreed that population and development issues are closely linked and that empowering women and meeting people's needs for education and health, particularly reproductive health (RH), are necessary for individual advancement and balanced development. Emphasizing RH and reproductive rights as core elements of human rights and development was a major shift compared with the previous conferences held in 1974 in Bucharest and in 1984 in Mexico. In addition, it has also been agreed that the fundamental goals of population and development are to ensure gender equality, to enable women to decide when and how many children they will have, and to combat violence against women. Specific objectives from the ICPD POA include providing equal education to everyone, decreasing maternal and child mortality, and providing

universal access to RH services, including family planning and prevention of sexually transmitted infections (STIs), human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS).

In 1999, the first POA implementation review was conducted and the findings discussed at the United Nations (UN) General Assembly Special Session, which ultimately included adopting Key Actions for the Further Implementation of the Programme of Action. The Special Session evaluated POA implementation as very good, as many countries had affirmed reproductive rights at the policy level and incorporated population issues into their development strategies. The Special Session also determined further interventions for the future, based on current circumstances, as it had also been noted that countries needed to pay more attention to reducing high maternal morbidity and mortality, improving sexual and reproductive health (SRH) of young people, and preventing HIV/AIDS<sup>1</sup>.

In 2000, the Millennium High-level Meeting adopted the Millennium Declaration, which includes the global Millennium

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<sup>1</sup> UN, Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, adopted by the 21<sup>st</sup> special session of the General Assembly, New York, 30 June – 2 July 1999

Development Goals (MDGs) that identify the most important issues needing the attention of all people. Many issues on the ICPD POA agenda were included; therefore, achievements and progress made to this point served as a baseline for MDGs' implementation. Moreover, MDGs that were closely connected to the goals and objectives of the POA of the ICPD gave additional stimulus and support for implementation of latter.

In 2004, 10 years after the Cairo conference, the progress made toward implementation of the POA was again evaluated. UNFPA conducted a survey covering 151 countries, and findings showed that many countries had made progress and had achievements in developing legislations and policies on protecting women's and girl's rights, provisioning of RH services and ensuring reproductive rights, and providing information to and increasing accessibility of SRH services for adolescents. According to the survey

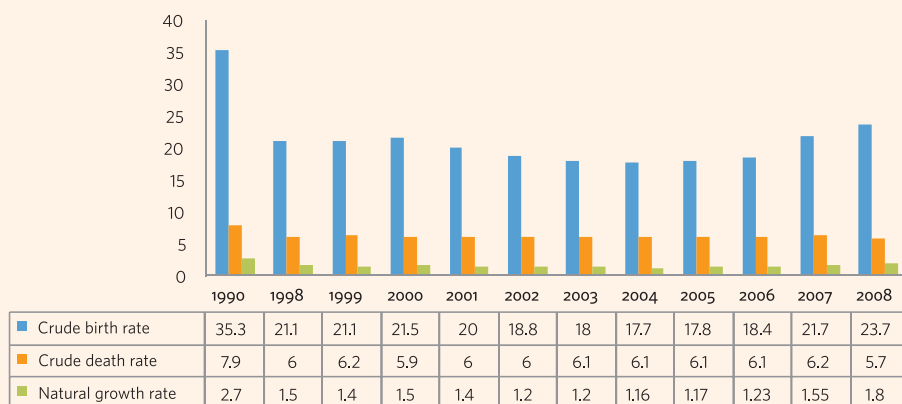
Mongolia was among countries that had taken many actions to improve quality and accessibility of RH services.<sup>2</sup>

2009 marks 15 years after the ICPD, and thus it is an opportunity to review achievements and progress made toward implementation of the POA, as well to identify challenges in fulfilling goals and objectives within the remaining five year period. In this brief report Mongolia presents the progress, major achievements, and challenges in implementation of the POA according to three key areas outlined in the ICPD Further Actions<sup>1</sup>, approved in 1999.

## POPULATION AND DEVELOPMENT

As of 2008, the population of Mongolia has reached 2,683,500.<sup>3</sup> Birth rates and population growth, which had been decreasing since 1990s, have been on the rise again since 2007.

**Figure 1** SOME DEMOGRAPHIC INDICATORS, BY YEAR



Resource: 1) Reproductive Health Indicators, 1998-2007, (NCHD, UNFPA) 2) Health Indicators 2008 (GIA-DOH)

<sup>2</sup> UNFPA, In 10 years after the International Conference on Population and Development, Mongolia, Report  
<sup>3</sup> NSC, Statistical Yearbook 2008

In terms of gender structure, 49.6 per cent of the total population is male and 50.4 percent is female. Regarding age structure, a high proportion of young and working-age people relative to the entire population demonstrates the potential boost to economic development though an emerging «demographic window»<sup>4</sup>. However, the percentage of people above 65, a proxy indicator of an ageing population, is also projected to rise in the future. In recent years there has been an increase in internal migration from rural to urban areas as well as an increase in external migration with citizens seeking employment abroad for remittances.

From 1995 to 2007, population density in rural areas increased to 0.93 people per square kilometer from 0.91 people per square kilometer. For areas where internal migrants most often are moving, namely, the capital, Ulaanbaatar and Orkhon aimag (a province), this indicator increased by 1.6 and 1.3 times to 223.9 and 102.3 people per square kilometer, respectively, in twelve years, from 136.6 and 81.5 people per square kilometer, respectively, contributing to urban population growth.<sup>5</sup>

As of 2008, 61.8 per cent of the total population lives in cities and urban areas and 38.2 per cent live in rural areas. There are 1,071,700 residents in the capital city, Ulaanbaatar, accounting for about 40 per cent of the total population.

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4 Period with the highest proportion of working age people  
5 MOSWL, NUM/SOE/PTRC, UNFPA, Trends and Impact of Internal Migration In Mongolia, Survey Report, Ulaanbaatar, 2009

## Progress and achievements

Population and development issues have been at the centre of attention in Mongolia and appropriately reflected in relevant policy documents. Following the ICPD, key policy and implementation mechanisms were defined in the State Policy on Population and Development, endorsed in 1996 by the State Great Khural (Parliament) of Mongolia, and then revised according to the latest development trends in 2004<sup>6</sup>.

Mongolia has a pro-natalist policy since it has a small population and a large territory. Stronger linkage of this policy with human rights and socio-economic stimuli was a major shift made in 2004. Incentives for newborn children and pregnant and breast-feeding mothers, as well as monthly incentives for all children under 18 years old, introduced in recent years (see table 2), have had an impact on the income of families and the growth of the population.

It is stated that the goal of the state policy on population and development is to ensure consistent growth of the population and to create an enabling environment for people to live longer, healthier, more creatively, and to develop themselves. Within the broader goal, the following main principles have been outlined consistent with the principles adopted by the ICPD, including: 1) to put the issue of human development at the center of country's development, 2) to assure human rights based development perspectives, 3) to ensure social

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6 Resolution of the State Great Khural, No 21, April 23, 2004, Endorsement of the State Policy on Population and Development

consensus and participation in population and development issues, and; 4) to ensure gender equality.

The Millennium Development Goals of Mongolia (MMDGs) adopted by the State Great Khural (Parliament) in 2005 include reducing poverty and hunger, providing primary education for all, supporting gender equity, increasing women’s participation at the decision-making level, improving maternal and child health, and combating STIs/HIV/AIDS.<sup>7</sup>

As mentioned previously, the overlap of MMDGs with the ICPD POA strengthens the push for RH-related goals. When adopting national MDGs, Mongolia aimed to link global goals with national policies and strategies as well as an additional goal on democratic governance.

The progress towards MMDGs has been quite good and the implementation status of 22 national objectives is currently at 60 per cent complete<sup>8</sup>.

**Table 1** Comparison of ICPD POA and MMDG target concerning population and development

ICPD POA	MMDGs				
	Indicator	1990	2008	2015 target	
...“Governments, international agencies, non-governmental organizations and other concerned parties should undertake timely and periodic reviews of their development strategies with the aim of assessing progress towards integrating population into development and environment programmes that take into account patterns of production and consumption and seek to bring about population trends consistent with the achievement of sustainable development and improvement of the quality of life”... Chapter III, 3.6	Target 1: Halve, between 1990 and 2015, the proportion of people whose income is below national poverty	Poverty headcount ratio (percent age)	36.3*	35.2	18.0
		Poverty gap ratio (percent age)	10.9*	10.1	6.0
		Share of poorest quintile in national consumption	-	7.2	11.0
		Per capita GDP (thousand of tugriks)	-	2,305	6,800
	Target 2: Reduce by six times, between 1990 and 2015 the proportion of people who suffer from malnutrition line	Prevalence of children under age 5, malnourished	12.0++	6.3**	2.0
		Proportion of children under age 5, stunted	-	21.0**	13.0
		Proportion of children under age 5, underweight	-	2.2**	1.0
	Target 3: Increase employment rate of population, reduce unemployment rate of young people newly entering to the labour market	Labour force participation rate (percentage)	-	63.5	70.0
		Unemployment rate of 15-24 year olds (percentage)	-	3.0	2.5
	Objective 4: Reduce negative consequences of urbanization, and migration and to increase coverage of social basic services for migrants	Proportion of population living in urban areas without official registration	-	-	-

7 Resolution of State Great Khural, No 25, April 21, 2005, Endorsement of the Millennium Development Goals of Mongolia (Amendments and changes were made in January 31, 2008, Resolution No 13)

8 Human Development Report of Mongolia, 2007

ICPD POA	Comparison of ICPD POA and MMDG target concerning population and development				
... "All countries should further strive to ensure the complete access to primary school or and equivalent level of education by both girls and boys as quickly as possible, and in any case before the year 2015" ... Chapter XI, 11.6	Target 5: Provide primary education to all children by 2015	MMDGs			
		Net enrollment ratio in primary education	97.5*	91.5	100.0
		Proportion of pupils starting grade 1 who reach grade 5	91.0	92.8	100.0
		Literacy rate of 15-24 year olds	99.0+	-	100.0
Sources: NSC, Statistical Yearbook 2008 +=1989, ++=1992, *=1995, **=2005					

Regular monitoring and evaluation of MMDGs<sup>9</sup> provides an opportunity for evaluating the progress made toward implementation of the ICPD POA as well.

At the initiative of the President of Mongolia, the State Great Khural endorsed the MDGs-based Comprehensive National Development Strategy, which defines long-term development goals and objectives until 2021.

**Table 2** STATE BUDGET TRENDS, 1990-2006, (IN 1990 MILLIONS OF TUGRIKS)

	1990	1995	2000	2006
Revenue	5,328.7	3,009.6	3,415.4	9,938.8
Expenditure	6,481.5	3,072.7	4,179.7	8,128.0
Health sector spending	578.9	426.3	447.0	653.1
Education sector spending	1,202.7	502.5	798.8	1,271.0
Note: Revenue and expenditure indicators were corrected using Consumer price index Source: Human Development Report Mongolia, 2007				

**Table 3** STATE BUDGET TRENDS, 1990-2006, (AS PERCENTAGE OF GDP IN 1990 TUGRIKS)

	1990	1995	2000	2006
Revenue	50.9	25.6	34.5	42.9
Expenditures	61.9	26.1	34.5	39.0
Health sector spending	5.5	3.6	4.5	3.1
Education sector spending	11.5	4.3	8.1	6.1
Note: Revenue and expenditure indicators were corrected using the Consumer price index Source: Human Development Report Mongolia, 2007				

9 1) Millennium Development Goals: National Report on the Status of Implementation in Mongolia, Ulaanbaatar, 2004; 2) Implementation of MDGs, Second National Report, Summary, Ulaanbaatar, 2007

In the 1990s Mongolia faced economic difficulties during the transition period. However, prior to the 2008 global financial and economic crisis, Mongolia's economy was doing well with an average annual growth rate of 8.7 per cent during the last four to five years. Government spending had increased by over 30 per cent with a significant proportion of the spending focusing on carrying out social programmes targeted at human development. For instance, in 2006 9.2 per cent of GDP, or a quarter of the government budget was spent in the health and education sectors. Government spending for these two sectors in 2006, adjusted for inflation, was much higher compared to the 1990 level (see Table 2 and Table 3). Even though spending was less than

that during socialist times, it can be considered a big achievement during the difficult transition period.<sup>10</sup>

With the growth of the economy a lot of attention was paid to and budget increased for social welfare interventions, which is evidence of the government's attempts to increase the population and its well being while reducing poverty.

At the end of the socialist era (late 1980s) there were no surveys conducted to define the poverty level. During the early 1990s, the economic crisis deepened and poverty drastically increased. In 1995, it was estimated in the Living Standards Measurement Survey that 36.3 per cent of the population (828,000 people) was poor and that many were living close to the poverty line.

**Table 4** Social welfare services, income and expenditures, with selected indicators, 2005-2008 in million tugrik

	2005	2006	2007	2008
Income, total	43,294.1	74,907.2	117,812.2	221,579.0
Expenditure, total	42,025.9	75,401.2	115,290.8	218,666.5
Pensions	7,699.7	12,024.2	15,742.4	22,520.2
Allowances and incentives, total	28,325.6	57,506.1	93,767.4	184,608.7
Allowances, newborn children	-	4,111.0	5,769.3	6,381.5
Allowances, pregnant and breastfeeding mothers	-	-	-	15,753.6
Social welfare services	724.7	1,120.7	793.3	974.3
Pensions for the elderly	3,017.2	2,666.5	2,690.2	6,214.8
Pensions for the disabled	1,419.1	1,430.7	1,396.6	3,364.6
Allowances granted for children under 18 from the Mongolia Development Fund	-	-	-	89,958.1

Source: NSC, Statistical yearbook, 2008, Chapter 20

<sup>10</sup> NSC, Statistical Yearbook, 2008, Chapter 27

During the late 1990s, the economic situation had somewhat stabilized, and the survey conducted in 1998 found that the poverty incident remained almost at the same rate; however the number of poor people had increased to 850,000. The Living Standards Measurement Survey conducted after the dzud (natural disaster) in 2002-2003 showed that 36.1 percent of the population was poor, with poor people mainly living in countryside. As of 2007-2008, the poverty has not reduced much; 35.2 per cent of the population (930,000 people) is poor<sup>11</sup>.

Mongolia has attached great importance to the reduction of poverty, which has been a challenging issue since the early 1990s. Within the framework of the National Poverty Reduction Programme (1994-2000) and the Economic Growth and Poverty Reduction Strategy, 13,000 large- and small-scale projects have been implemented with support from the UN, World Bank, Asian Development Bank (ADB), donor countries and other international organizations.<sup>2</sup>

The Sustainable Livelihood Project of the Government of Mongolia and the World Bank is one examples of a larger and more comprehensive effort, with a time frame of over 12 years and three phases. Currently the project is in its second phase (2008-2012), and it aims to improve accessibility and quality of health care, education, infrastructure and social services in the capital city and all aimags, to improve preparedness capacity of herdsmen for natural disasters and climate changes, and to support liveli-

hood of people by introducing nationwide system to provide small loans to local citizens based on their needs and with their participation.

The government has also reflected in its Plan of Action (2008-2012) plans to implement programmes to support family initiatives and development, with the objective to increase well-being of at least 50,000 families.

The new Constitution of Mongolia, approved in 1992, assures the citizens' rights to choose a place to live, resulting in an increasing migration from rural to urban areas. The existence of the fourth objective of the MMDGs, which defined as «to reduce negative consequences of urbanization and migration and to increase coverage of basic social services for migrants» shows that the issue is already on the local policy agenda.

Since 1999 the Ministry of Social Welfare and Labour (MOSWL) has conducted a series of surveys to collect needed data, particularly on the current status, causes, consequences and future trends of internal migration and effectiveness of the implemented interventions in order to plan and formulate appropriate actions. In 2005, the State Great Khural, MOSWL and UNFPA jointly organized a High-Level National Summit on Migration where issues of internal and external migration were discussed and important policy decisions and recommendations made.

The government has since been developing activities to improve civil registration of internal migrants, to improve infrastructure, and to bring social services closer to migrants, especially in peri-

<sup>11</sup> NSC, World Bank, Findings of the Household Social and Economic Survey, 2007-2008, Features of Poverty in Mongolia, Ulaanbaatar, 2009

urban areas. Additionally, UNFPA and the Japanese Human Security Trust Fund have piloted an innovative approach aimed at provision of mobile basic social services to migrants; the results have been promising.<sup>12</sup>

Before the 1990s, great weight was given to importance of the population's education, and all levels of education were provided free of charge. Accordingly, a high literacy rate can be regarded as an achievement of socialist times. Despite economic difficulties faced during the transition after the 1990s, the literacy rate of people over 15 has been maintained in recent years at a remarkable 98 per cent.

Beginning in 1969, Mongolia has conducted a population and housing census (PHC) every ten years. In 2000, for the first time, the PHC was conducted in accordance with international standards with assistance from UNFPA.<sup>2</sup> Moreover, a database to facilitate planning and decision-making at the national as well as local levels was set up. Another importance feature of the 2000 PHC was the capacity-building of national specialists who are now able to carry out large-scale surveys according to the international standards. The inclusion of the PHC and other major population surveys with routine data collection schedules into the National Statistical Committee's (NSC, formerly the National Statistical Office) Master Plan to Develop Formal Statistics is another important step for ensuring improved quality of core statistics used for planning and evaluation.

<sup>12</sup> Government of Mongolia, UNFPA, Report of the Mid-Term Review of UNFPA's 4<sup>th</sup> Country Programme of Assistance for Mongolia (2007-2011), 2009

## Challenges

Poverty levels have stagnated at around 35 per cent for the decade since 1995 while many other social and economic indicators have been improved over the same time period. It proves that poverty is still one of the most challenging issues of human development in Mongolia. In 1995 the Gini coefficient<sup>13</sup> was 0.31<sup>8</sup>, indicating that the gap in income was small even though there were many poor people. The trend of increase of this coefficient in recent years (0.36 as of 2008<sup>11</sup>) indicates that a limited number of people are benefiting from the economic growth and that the gap between rich and poor is widening. Even if the economy is rapidly growing, poor and vulnerable people are less likely to move out of the poverty without a good health status and education. Therefore, policies to reduce poverty through increasing employment opportunities should also be supported by investments in health and capacity-building of the poor. These investments should specifically target the poor and aim to reduce poverty, engage them in the labour force, and contribute to their economic growth.<sup>8</sup> Related to this, many social welfare measures cover everyone equally; these should be instead focused on poor and vulnerable people, who are disproportionately disadvantaged.

It was noted earlier that there is some progress in eliminating negative consequences related to migration and in expanding coverage of basic social services for migrants. However, migrants still face difficulties in getting civil registration at their new places of residency and in

<sup>13</sup> Gini coefficient is commonly used as measure of inequality of income or wealth. Ranges from 0 to 1, with 0 corresponding to perfect equality and 1 to inequality

getting permission for land acquisitions as well as a lack of professional skills for finding a job. General environmental and sanitation conditions are inadequate in ger (traditional felt tent) districts, which are the main residential areas for most migrants. For example, 35.6 per cent of families migrating to Ulaanbaatar live without a standard toilet, 12.1 per cent with no toilet whatsoever, 30 per cent dump their waste into open-air location, and 34.2 per cent dump waste water into the soil without any treatment. The supply of clean water is also a problem. The average distance from families' homes to a hand-carried water source is 600 meters, and there are no facilities for bathing.<sup>5</sup> Thus, efforts to bring basic social services closer to migrants, to provide workplaces, and to improve infrastructure in their residential areas need to be continued.

Subsidizing free of charge school dormitories for students coming from remote areas and school lunches for primary school students by the government in two last years have had a positive influ-

ence on decreasing school drop-outs, which was rapidly rising in the 1990s. However, the drop-out rate is still unacceptable; more than twice as many boys as girls drop out of school, which is another issue for concern.

The findings of the survey on the transition from educational institutions to workplaces for youth aged 15-24, conducted by NSC in 2006, showed that 3.3 per cent of youth (6.4 per cent in the countryside) did not complete primary education, which reinforces the above. The majority of school drop-outs mentioned the need to work or an interest in becoming a herder as reasons to leave school, which may indicate that they did not have an opportunity for an ordinary childhood.

To reach the goal of all girls and boys obtaining primary education by 2015, set by the ICPD POA and the MMDGs, there is a need for policies and actions to decrease school drop-outs along with non-formal education targeting those who have already dropped out.

At the present, population ageing is not widely considered as a challenging issue for Mongolia. In 1950 the proportion of elderly people (above age 60<sup>14</sup>) was 5.4 per cent; over the past 50 years it has increased slightly, to 6 per cent. However, according to the projections made by experts, the proportion of elderly people out of the total population could reach 11 per cent by 2025, and 25 per cent by 2050<sup>15</sup>, indicating that ageing could become a challenging issue for Mongolia very soon.

14 Definition of the World Assembly on Ageing in Vienna, 1982, approved by the World Assembly on Ageing in Madrid, 2002

15 Ghazy Mujahid, B.Oyun, How Mongolian Elderly View Social Pensions: Result of a Participatory Study, Draft July 2009, UNFPA Mongolia

**Table 5** School enrollment rates and drop-outs, 2005-2007

	2005-2006	2006-2007
School enrollment, percentage		
Preschool	92.3	93.7
Primary school	93.3	93.5
Secondary school	91.2	93.8
Number of 7 to 15 year-old school drop-outs, thousands		
Total	9.0	12.3
Female	3.6	4.8
Sex ratio of school drop-outs, male to female	1.6	2.2

Source: Human Development Report of Mongolia 2007

Table 6 Comparison of ICPD POA and MMDG targets concerning gender and women's empowerment						
ICPD POA			1990	2008	2015 target	
... "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development –related programmes"...  (Principle 4)	Target 6: Achieve appropriate sex ratio in primary and secondary education by 2009, and at all levels by 2015	Indicator				
		Ratio of girls to boys in primary education	1.03*	0.97	1.0	
		Ratio of girls to boys in secondary education	1.33	1.08	1.0	
			Ration of girls to boys in higher education	1.56	1.54	1.0
	Target 7: Promote gender equality among wage employed population	Proportion of women engaged in wage employment in non-agriculture sectors	51.1	53.0	50.0	
	Target 8: Increase women's participation in politics and at decision making level	Percentage of women elected to parliament	24.9	3.9	30.0	
		Percentage of women candidates in parliamentary elections	-	18.5	30.0	
	Source: National Statistical Committee, * 1995					

## GENDER EQUALITY, PROMOTING EQUAL RIGHTS AND EMPOWERING WOMEN

### Progress and achievements

Following the ICPD, the Government approved National Programme on Improving Women's Condition (1996-2002), and the National Programme to Promote Gender Equality (2002)<sup>16</sup>. This shows that Mongolia's commitment to gender issues at the policy level.

Moreover, issues of promoting gender equality and empowering women have been reflected in the MMDGs, which link tightly with implementation of the national programme developed for the ICPD POA.

<sup>16</sup> Resolution of the Government of Mongolia, # 274, 30 December 2002, Approving National Programme on Promoting Gender Equality

The Gender development index<sup>17</sup> (GDI) and gender empowerment measure<sup>18</sup> (GEM) are used to assess gender equality. In terms of GDI, even though Mongolia is ranked at 87 out of 136 countries, it is an improvement compared to previous years.

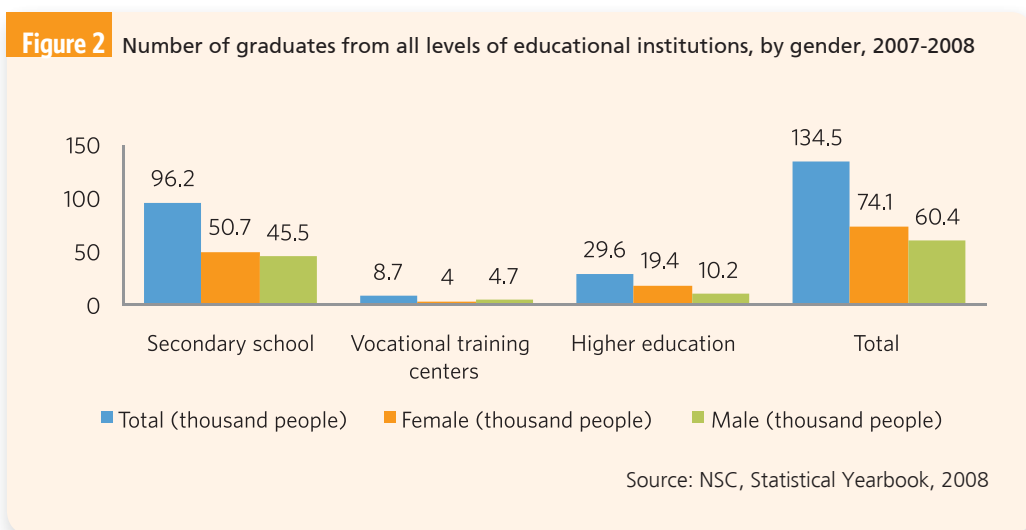
In some specific indicators used to calculate GDI, women are doing much better.

Regarding GEM, Mongolia is ranked 65 out of 76 countries with no trend showing improvement and with a note of insufficient implementation of policies to provide equal opportunities for women in politics and at the decision-making level.

**Table 7** Human development indicators, Mongolia, 2000-2006

	2000	2001	2002	2003	2004	2005	2006
<b>HDI</b>	0.667	0.667	0.667	0.680	0.692	0.707	0.718
<b>GDI</b>	0.667	0.666	0.667	0.679	0.693	0.707	0.719
<b>GEC</b>	0.449	0.468	0.468	0.468	0.415	0.414	0.422

Source: Human development report Mongolia, 2007



17 GDI calculated using same with the Human Development Index indicators such as life expectancy, literacy rate, and per capita GDP. The difference is that GDI gives possibility for comparing status of men and women.

18 GEM is measure of inequalities between men's and women's opportunities in a country. It combines inequalities in three main areas: political participation and decision making, economic participation and decision making, and power over economic resources

The ICPD POA and the MDGs emphasize the importance of primary education for girls and boys. Mongolia has promoted equal rights for girls and boys in obtaining education. Nonetheless, while boys' school enrollment has been steadily increasing after a decline during the first

half of the 1990s, their completion of different levels of education, apart from vocational training, is still lower than that of girls.

In terms of employment, Mongolia also promotes equal opportunity and partici-

**Table 8** Proportion of women employed in various by economic activity sectors, 2002-2003, 2006

Economic activity sector	Labour Force Survey, 2002-2003	Population and Employment survey, 2006
Agriculture, hunting, forestry	46.3	47.1
Mining, exploration industry	26.6	36.0
Processing	54.6	54.5
Electricity, heating generation, water supply	28.8	45.6
Construction	26.0	44.3
Whole and small sale, repair of household goods	56.1	59.8
Hotel, restaurants	66.4	66.8
Transportation, storage	26.0	37.4
Financial transaction	52.5	59.7
Real estate, renting, business endeavor	41.0	50.1
Public administration, defense, mandatory insurance	33.3	44.2
Education	68.0	67.2
Health, social welfare	77.3	68.5
Provision of other services for individuals and society	50.1	48.5
Household business which hire people	46.0	52.0
International organizations	34.5	53.6
Total	48.0	51.3

Source: NSC, ADB, Main Report of the Labour Force Survey, 2002-2003, table 41, NSC, Population and Employment Survey, 2006

pation, enabling women to contribute to the economic development of the country. Even though there are differences by sector, the overall proportion of employed women to men is roughly equal, with women dominating the education, health and financial sectors (table 8).

For instance, according to the population and employment survey, conducted in

2006, over 51 per cent of the employed population is women, particularly in education, health, finance, trade and service sectors, women are overwhelmingly employed.

There are improvements in combating domestic violence as well. In 2004, State Great Khural ratified the Law to Combat Domestic Violence that outlines

the role of the state in cases of domestic violence. Non-governmental organizations (NGOs) actively participated in the development of the draft law and carried out effective advocacy campaigns targeted at members of the parliament (MPs) and other decision-makers. Due to the law, there have been perceptions shifting to the idea that violence within the family is no longer a private or a family issue; it is a social issue. Starting from 2007, the government has initiated the National Programme Against Domestic Violence to facilitate enforcement of the law. Early detection of violence, rapid response, prevention of repeat abuse, protection of victims, provision of rehabilitation services, and facilitation of behavior change in perpetrators have been comprehensively included in the national programme.

National RH Survey conducted by NSC in 2008, devoted a chapter to domestic violence and collected related baseline data. This survey is conducted on a regular basis every five years and is crucial for providing comparative data for planning of preventive and educational interventions. Another example of the progress made to increase the evidence base for domestic violence initiatives is collection of information on gender-based violence via routine police statistics by the Police General Authority (PGA) starting in 2008.<sup>12</sup>

From an intervention standpoint, since 2002 the government has contributed funds for the operation of domestic abuse shelters run by the National Center Against Violence (NCAV), as well as

cooperating with them to combat violence, protect and rehabilitate victims.

The National Committee for Gender Equality (NCGE) was established with the secretariat to create a national system for addressing gender issues and facilitating implementation of the national programme. The NCGE organized a series of discussions and advocacy activities for decision makers to build support for the development of the Law on Gender Equality. It should be noted that NCGE responds not only to issues related to women, but also to issues related to men. For instance, the NCGE jointly with the Mongolian Men's Association in 2008 organized a national conference called the "Current Situation and Problems of Mongolian Men". Over 150 delegates representing government institutions, NGOs and international organizations discussed and developed recommendations concerning men's role in the family and in society. The conference has played an important role in attracting public attention to men related issues.<sup>12</sup>

The scope of work related to promotion of gender equality and combating domestic violence has been expanding with the active participation of women's, population and development and RH NGOs, which have formed a coordinating network. NGOs have led initiatives actions against human trafficking and sexual exploitation of women and sexual harassment at the workplace in educational environment. As a result of advocacy targeting MPs changes were made to relevant laws, including those against human trafficking, which were in-

tegrated into Section 113 of the Criminal code, and against using work status and economic power for sexual harassment, which were integrated into the Section 126.2.5 of the Criminal code.

## Challenges

The low GEM (0.397 as of 2008) demonstrates that there is a lack of women's participation in politics and at the decision-making level. As of 2000, 11.8 per cent of MPs, 4.5 per cent of committee chairs, 12.9 per cent of members of aimag and capital city citizen's representatives khurals (provincial- and city-level parliaments), 13 per cent of soum (sub-province) and district governors, and 25 per cent of members of soum and district citizen's representatives khurals (sub-provincial- and district-level parliaments) were women, which shows insufficient representation of women.<sup>16</sup> Consequently, in 2005, amendment to the Law on Political Elections specified

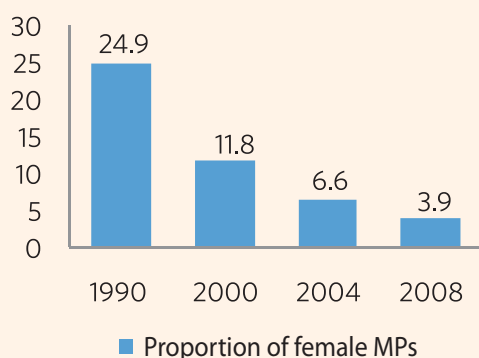
that the percentage of women candidates in parliamentary elections should be not less than 30 per cent. Unfortunately, prior to the actual implementation of the law, in December 2007, the State Great Khural abolished the provision; at present women's representation in the national parliament has deteriorated significantly.

Additionally, there is a lack of women leadership at the middle management level, which is easily demonstrated by the situation in the education sector. In 2006, 68 per cent of employees in the education sector were women.

Specifically 94 per cent of primary school teachers, 71 per cent of secondary school teachers, 68 per cent of high school teachers were women, while school principals were mostly men.<sup>8</sup>

Women comprised 48 per cent of participants of the employment survey conducted by NSC in 2000-2002, but only 35 per cent of the female participants were working at the managerial level.

**Figure 3** Proportion of women in the State Great Khural, by election year



Source: 1) Annex of Resolution of State Great Khural No 12, 2008, NSC, Statistical Yearbook 2008, Chapter 27

In terms of some economic indicators women are in lower positions as well. Per capita national revenue for women is USD 2.611, while for men is USD 3.045.<sup>8</sup> The Living Standards Measurement Survey 2002-2003 concluded that women headed households were generally poorer. Specifically, 43.8 per cent of female headed households were poor and 34.8 per cent of male headed households were poor. There has been no difference observed in the 2007-2008 survey, but still 34.7 per cent of poor households were headed by women.

Even though there is progress being made in creating a supportive legal environment and collecting baseline data, domestic violence remains a challenging issue. According to the National RH Survey conducted in 2008, 74 per cent of female participants responded that they know families where the husband or wife is jealous or verbally abuse the other, 69 percent responded that know families where sex is forced without consent of the spouse.

This indicates that domestic violence is common, and there is a need to intensify efforts to implement the law and national programmes to combat it.

In recent years trafficking of children and women for sexual exploitation has been on the rise in East Asia and Pacific. There is the possibility that the issue could become a challenging one in Mongolia as well. According to the statistics of the PGA, 78 children were victims of sexual exploitation, 68 children were trafficked, 30 children and women were forced to cross the border with fake documents, and only 16 of

them were returned home in 2006. In 2005, the Government approved the National Programme to Prevent Trafficking of Children and Women for Sexual Exploitation which will be implemented until 2014. There is a need to intensify implementation of activities indicated in the national programme, such as creating legal environment to prevent and combat human trafficking, conducting information campaigns, and rehabilitating victims.<sup>19</sup>

It should be noticed that health status of men is an issue for specific concern. As of 2008 the life expectancy of men is 64 years old compared to 71 years for women. There are many issues influencing men's health, including more exposure to alcohol<sup>20</sup> and tobacco<sup>21</sup> than women, according to the latest surveys. Death rates from cancer are also higher among men than women (13.11 versus 9.58 per 1,000 population<sup>22</sup>).

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19 UNICEF, Mongolia's Children First, Newsletter, January – March 2006

20 MOH, WHO, CMHN, Epidemiological Study on Prevalence of Alcohol Consumption, Alcohol Drinking and Alcohol Related Harms in Mongolia, Ulaanbaatar, 2006

21 MOH, PHI, WHO, Mongolian STEPS Survey on the Prevalence of Non Communicable Diseases Risk Factors, Ulaanbaatar, 2006

22 GIA-DOH, Health Indicators 2008

## REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

“...Reproductive health is 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 reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying health and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit on this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant...”

POA of the ICPD, Chapter VII, 7.2

### Progress and achievements

Mongolia is a country with a small population and a vast territory. Prior to 1990, various pro-natalist interventions to encourage births were devised and implemented, including awarding mothers who had many children with a Mother's Honour medal, provisioning of maternity leave with cash payments before and after delivery for pregnant and breastfeeding mothers, and levying extra taxes for people without children. The only contraceptive available was intrauterine devices, and it was given based on the decision of a specially formed medical committee based on the women's medical indicators. During the early 1990s, about 10 per cent of reproductive age women used contraceptives<sup>23</sup>, and only 10 per cent of population had knowledge about family planning methods<sup>24</sup>. It was

difficult for women and couples to select appropriate family planning methods based on their needs and interests. In 1989 women's rights to decide whether to become a mother or not, and accordingly right to use contraceptives were legally declared by the Health Protection Law.

Starting in 1992, the implementation of the Maternal and Child Health, and Family Planning Project, with assistance from UNFPA, significantly contributed to promotion of reproductive rights and family planning. As follow up to the ICPD, various interventions were conducted intensively to increase knowledge about RH and reproductive rights, and to seek support of policy- and decision-makers. As a result, the First (1997-2001) and Second (2002-2006) National RH Programmes were successfully<sup>25</sup> imple-

23 Zahidul Hogue, G. Purevsuren, I. Davaadorj, Maternal Health and Family Planning Situation in Mongolia, 1993  
24 P.Nyamadavaa, Let's Grow Population Without Harm for Health, Public Health Concerns, 2004, page 199

25 MOH, Reports of the Monitoring and Evaluation of the National RH Programmes, 2001, 2007

mented, with the Third National RH programme (2007-2011) currently in progress. The Ministry of Health (MOH) is leading and coordinating implementation of the National RH Programme through local health authorities and organizations with the participation and support of training and research institutions. A comprehensive approach towards RH issues, along with cooperation with UNFPA, other international organizations and NGOs, has made the national

programmes a success.

Reducing child mortality, improving maternal health, and combating HIV/AIDS have already come to the center of the world's attention since they are part of the MDGs approved by the Millennium High Level Meeting in 2000. Mongolia has also included these into the MMDGs, linking them with the implementation of the National RH Programme and tightly connected to the ICPD POA.

**Table 9**

Comparison of ICPD POA and MMDG targets concerning reproductive health and rights

ICPD POA		Indicator	1990	2008	2015 target
<p>"...By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further..." (Chapter VIII. 8.16)</p>	<p>Target 9: Reduce under 5 mortality by 4 times in 2015 compared to 1990</p>	Under five mortality rate (per 1,000 live births)	88.8	23.4	21.0
		Infant mortality rate (per 1,000 live births)	64.4	19.6	15.0
		Proportion of children immunized against measles	82.3*	98.4	99.0
<p>"... Countries should strive to effect significant reductions in maternal mortality ... by one half of the 1990 levels by the year 2000 and a further one half by 2015..." (Chapter VIII. 8.21)</p>	<p>Target 10: Provide essential RH services to everyone and reduce the maternal mortality ratio by 4 times in 2015 compared to 1990</p>	Maternal mortality ratio (per 100,000 live births)	200.0*	49.0	50.0
		Proportion of delivery attended by skilled health personnel	100.0	99.7	99.8
<p>"Governments, with assistance from UNAIDS and donors, should, by 2015, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally..." (ICPD + 5, Key Actions)</p>	<p>Target 11: Halt and prevent the spread of HIV/AIDS by 2015</p>	HIV prevalence among pregnant women (percentage)	-	-	< 0.1
		HIV prevalence among youth aged 15-24 (percentage)	-	0.0005	< 0.1

Source: Health indicators, DoH, MoH 2008, \*=1991, \*\*=1992 \*mbsdfkj \*8

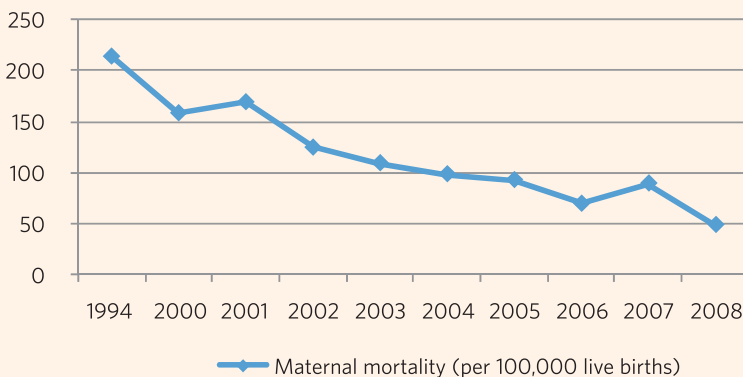
“To support sustainable population growth and achieve MDGs by the means of improving reproductive health and social services, based on reproductive rights and free choice, in an equitable, accessible, high quality and reliable manner”.

Goal of the National RH Programme (2007-2011)

In 1994, the maternal mortality ratio per 100,000 live births was 214, the highest in the last fifteen years. This peak of maternal mortality was a big challenge for the country. Despite declining numbers of births, it was difficult to reduce maternal mortality because of the financial difficulties faced during the transition, which affected living standards and accessibility and quality of health care. The Government has paid a lot of attention to reducing maternal mortality. Primary health care and medical services related to pregnancy and delivery are

tality Reduction Strategy (2000-2004) was implemented in close connection with the national RH programme. The strategy has been revised (2005-2010)<sup>27</sup> and is in the implementation stage now. Within the strategy, important activities have been implemented, including improving registration and follow up of maternal deaths, restoring maternity rest homes, improving client-friendly health service for mothers, and improving referral systems. Due to this integrated approach, maternal mortality has been steadily declining since 2001 and in 2008

**Figure 4** Maternal mortality ration, (per 100,000 live birth)



Sources:  
NCHD, UNFPA,  
RH Indicators,  
1998-2007;  
GIA-DH, Health  
Indicators, 2008

subsidized by the state and provided free of charge.<sup>26</sup> Also the Maternal Mor-

the rate was 49.0 per 100,000 live births, achieving one of the MMDG targets.

<sup>26</sup> Health Law of Mongolia, Chapter 4, 28.1; 35.2

<sup>27</sup> MOH, Maternal Mortality Reduction Strategy, 2005-2010

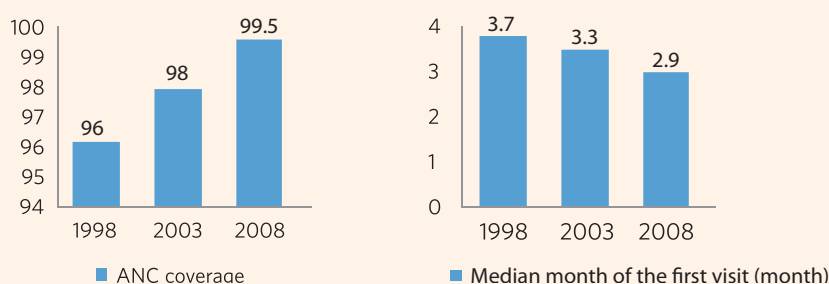
This achievement could be regarded as a major success of Mongolia.

Within the framework of the national RH programme, antenatal care (ANC), delivery, and postpartum care have been improved with assistance from UNFPA, GTZ (German Agency for Technical

the percentage of early ANC visits has increased as ANC coverage has increased (see Figure 5).

The Regulation on Providing Health Care to Pregnant Mothers<sup>28</sup>, approved in 2001, and the Regulation on HIV/AIDS Testing for Pregnant Mothers<sup>29</sup>, ap-

**Figure 5** ANC coverage, median month of the first ANC visit occurs



Source: NSC, UNFPA, MOH, RH Survey, 2008, Ulaanbaatar, 2009

Cooperation), ADB and other international organizations. Breast-feeding has been promoted, immunization coverage has been consistently high at 98 percent, and integrated management of childhood illnesses has been effectively implemented due to support by UNICEF. As result, infant and under 5 child mortality has been decreasing steadily. As of 2008, infant mortality was 19.6 per 1000 live births, and under 5 child mortality was 23.4<sup>22</sup> per 1000 live births; Mongolia is on track to achieve these mortality-related MMDG targets by 2015.

As mentioned above, an improvement in health care, including mother-friendly antenatal, delivery and postpartum care, has made an impact on the decline in maternal and child mortality rates. In particular, the RH survey found out that

proved in 2004 by the orders of the Minister of Health, contributed significantly in improving quality of ANC. Moreover, efforts to improve laboratory diagnostics at the soum (sub-province) level have formed the basis for improving ANC quality. For instance, increased coverage of laboratory tests aimed at early detection of anaemia, gestosis, kidney diseases, fetal abnormalities, reproductive tract infections (RTIs), STIs/HIV/AIDS and its complications may be one indicator of improved ANC quality. As of 2008, 80 per cent of pregnant women had blood and urine general tests, 75 per cent ultrasound and pap smears, 68 per cent had HIV tests, and 66 per cent had

28 Order of the Minister for Health, #39, 2001, Approving the regulation on providing health care to pregnant mothers  
29 Order of the Minister for Health, #197, 2004, Annex 4, Regulation on HIV/AIDS testing for pregnant mothers

syphilis detection tests.<sup>30</sup>

Delivery care has also improved, with the percentage of non-health service facility deliveries dropping from 6 per cent in 1998 to 2.8 per cent in 2003 and 1.7 per cent in 2008. The proportion of deliveries with attendance by medical personnel has also increased from 94 per cent in 1998 to 97 and 98.3 per cent in 2003 and 2008 respectively.<sup>30</sup>

Prior to 1990, each soum hospital had a maternity rest home with two to five. Maternity rest homes are designed for mothers from who are in remote herder families who, in order to have an attended birth, stay before and after delivery with their babies under the observation of doctors. It is a unique and suitable service for a country like Mongolia, which has a population density less than 2 people per square kilometer. During the 1990s, the number of maternity rest homes decreased to 52 because of economic conditions. They have since been restored during the last few years with 343 currently active.<sup>22</sup> In 2008 62.5<sup>22</sup> per cent of women used maternity rest homes.

Since 1992, knowledge and use of modern contraceptives among the population has been increasing as family planning methods have been introduced nationwide. This has influenced couples to plan birth spacing and has had a positive influence on maternal and child health. Furthermore, it could be a sign that in-

formation, education and communication interventions in family planning targeted at the general population to change their behavior as well as inclusion of RH into secondary school health education programmes since 1998 have had an impact. The 2008 RH survey found that all women, in particular married women and their spouses knew about contraceptive methods. Married women named 7.9 methods, and on average all women named 7.6 methods. Contraceptive use among women reached 45 per cent in 2008 compared to 10 per cent in 1992. Among married women, 55 per cent used a contraceptive method, meaning that there may be a change in behavior apart from increased knowledge.<sup>30</sup> However, the survey also revealed that unmet need for family planning is 14.4 per cent of the currently married women of reproductive age. Availability of at least three different choices of modern contraceptives at the primary health service delivery points has a positive impact on consumption.<sup>12</sup>

Satisfying needs for RH drugs and commodities of men and women is the basis for efforts around the world to save their lives by protecting reproductive health".

Thoraya Ahmed Obaid, Executive Director, UNFPA

Since 1992, supply of RH commodities, especially contraceptives, for public health services has been significantly dependent on external assistance. In 2008, the Government approved the National Strategy on RH Commodity Security, allocating for the first time funds for RH

30 NSC, UNFPA. MOH, National Reproductive Health Survey, 2008, Ulaanbaatar, 2009

commodities of 85 million tugriks (equal to USD 50, thousand) in the 2009 state budget. The amount of government funding is planned to increase gradually until commodities are fully covered by the state; this is a strategic step in ensuring a sustainable independent supply of RH commodities.<sup>12</sup>

Government efforts in combating STIs/HIV/AIDS are significant. The Law on Prevention of HIV/AIDS was ratified in 1993 and amended in 2004 to protect the rights of affected individuals in accordance with international conventions and standards. In addition, the National Strategy against HIV/AIDS (2006-2011)<sup>31</sup> was approved in 2003, and National Committee on HIV/AIDS was established in 2006, and expanded in 2008. The committee is chaired by the Deputy Prime Minister of Mongolia, and the Minister for Health acts as the deputy chair. The formation and activities of the National Committee on HIV/

AIDS has made a significant contribution to effectively coordinating the national response against HIV/AIDS involving the government, NGOs and international organizations<sup>32</sup>.

Mongolia, with its low HIV/AIDS prevalence status, is not a priority country for donor funding. However, increased funding from the UN, the Global Fund to Fight AIDS, Tuberculosis and Malaria, GTZ, ADB and other organizations has played a significant role in strengthening the national response against STIs/HIV/AIDS over the last few years.<sup>32</sup>

In addition, more attention has been paid in the past five years to high risk population groups such as sex workers, man having sex with man, injectable drug users and their partners, illegal gold miners, and mobile populations. It is worth it to note that the role of NGOs has increased concerning outreach to at-risk and vulnerable groups who often have limited access to social services.

**Table 10** Funding for activities to fight STIs/HIV/AIDS, in USD, by major contributors

	2006	2007
Budget funding (Government)	196,516	442,849
UN (WHO, UNICEF, UNFPA, UNDP)	520,000	892,000
Global Fund against AIDS, Tb and Malaria (Round 2)	613,554	1,151,335
Global Fund against AIDS, Tb and Malaria (Round 5)	761,000	1,574,327
ADB, GTZ and other donors	547,516	1,995,474
Total international	2,442,070	5,573,136
Total spent on STIs/HIV/AIDS	2,638,586	6,015,985

Source: National Committee on HIV/AIDS, UN, GTZ, Comprehensive Review of the National Response to HIV/STIs in Mongolia, October 2008

31 Government of Mongolia, Resolution No 240, October 2006, To Endorse National Strategy against HIV/AIDS

32 National Committee on HIV/AIDS, UN, GTZ, Comprehensive Review of the National Response to HIV/STIs In Mongolia, October 2008

One of the objectives of the Healthy Mongolian National Programme, implemented in 2007-2008, was to estimate prevalence of, increase early detection of, and treat common communicable diseases, especially STIs/HIV/AIDS among people above the age of 15. A total of 1,020,705 people (83.8 per cent of the target population) were covered by the primary screening and 811,820 cases were estimated with 64.8 per cent of them referred to specialists. There were 7,166 confirmed cases of STIs out of which 97.9 per cent were cured and 81.0 per cent were covered by the follow-up monitoring. The programme has contributed to diagnosis and treatment of STIs. Additionally, STIs/HIV/AIDS diagnostic and treatment capacities at all levels of health care were strengthened, an electronic database on prevalence of disease is now available at the national level, and a wide range of information dissemination activities on STIs/HIV/AIDS prevention have been undertaken with the general public.

Starting from the 1998-1999 academic year, Health Education was included as one of compulsory secondary school programme topics. UNFPA has provided comprehensive support for developing content and methodology, printing of training materials, and teacher pre- and in-services trainings for the RH com-

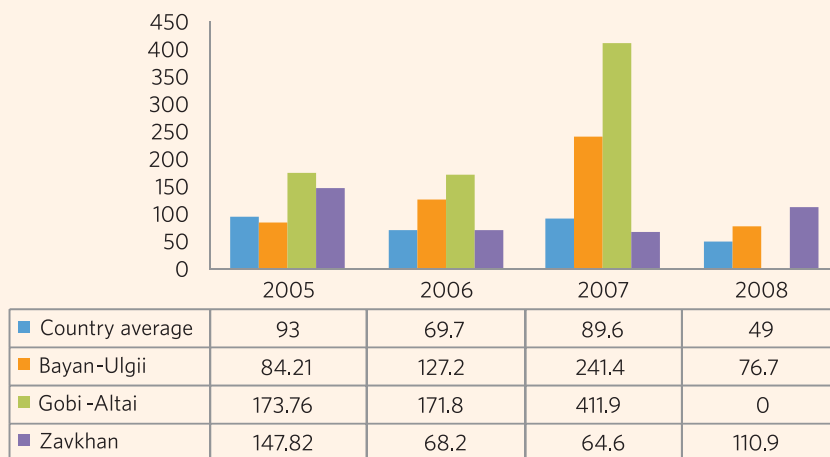
ponent of the school Health Education Programme. Furthermore, teachers training is now being institutionalized at the University of Education and teachers' colleges. The RH component of the school health education has become a model for teaching of other health topics, and the experience has been recognized internationally as a best practice.<sup>33</sup>

Additionally, a network of centers providing comprehensive adolescent-friendly health services has been established with UNFPA assistance. It was a major investment in adolescent and youth health in general and in RH in particular. Initial eight centers, established in 2003 in three districts of Ulaanbaatar and two aimags centers, expanded into a network of fourteen centers.<sup>12</sup> The integration of RTI/STI prevention services attracted more and more young clients to these centers, which operate with the active participation of adolescents, including Teen Boards that support each center. With adolescent' contribution the *UerkhelLove* newspaper, which combines appealing layout, alternative forms of outreach to young people, and sound expert advice, is printed and distributed at no cost nationally with a quarterly circulation of 100,000, the largest of any newspapers in Mongolia. UNFPA funds its production through a national NGO.

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33 Population Council, Quality/Calidad/Qualite, Universal Sexuality Education in Mongolia: Educating Today to Protect Tomorrow, Number 12, 2002

**Figure 6** Maternal mortality ratio (per 100,000 live births), nationally and by selected aimags, 2005-2008



Source: GIA-DOH, Health Indicators 2008

## Challenges

Even maternal mortality is steadily declining at the national level, some remote regions and aimags still have higher and/or fluctuating maternal mortality rates that are above the national average. In particular complications related to pregnancy, delivery and postpartum have been observed among poor and/or vulnerable women and mothers from herder families.

Therefore it is important to reach them through such initiatives as mobile RH services and telemedicine support for maternal and child health care, which were piloted recently and have already showed their effectiveness.<sup>12</sup>

It is worthwhile to point out that improving maternal health is an issue

that cannot be solved quickly. On the contrary, it requires continuous efforts and investments. For example, maternal mortality ratio in the first seven months of 2009 is doubled that compared to the same period last year. Despite the global financial and economic crisis, which started in 2008 and most likely to continue through the near future, it would be a wise to maintain investments in improving maternal health. Over the last two years the number of births has increased which brings heavier workload for aimag hospitals as well as maternity hospitals in the capital city.

With an increasing number of deliveries and workload, there may be an increased chance for more complications and less staff time for each mother. There is a

need to increase investment in order to maintain an adequate level of health care in terms of human resource, equipment, drugs and transportation<sup>34</sup>.

In Mongolia the abortion rate remains high and is a challenging RH issue. Before 1990 abortion was allowed only due to medical conditions. During that time, 11,000 to 13,000 women had miscarriages annually, and experts interpreted this as a result of illegal abortions performed by non-professionals.<sup>23</sup> There were many cases of women losing their lives because of illegal abortions. In 1989, abortion became legal due to the Health Protection Law, which specified that “woman shall decide whether to become mother or not”. Spontaneous miscarriages rates declined by 3 to 4 times after enforcement of the new law. However, abortion rates have been rising according to the routine statistics collected since the 1990s<sup>22</sup>. A variety of activities have been undertaken to decrease legal abortion and to make abortion safer, including ensuring a supply of contraceptives and introduction of post-abortion counseling and safer methods of abortion. As result, even though abortion rate is still high, it has decreased from 248 in 2001 to 169 per 1,000 live births in 2008<sup>35</sup>. In addition, very few women responded that they had an abortion due to lack of knowledge about contraceptives. This means that there is a need for comprehensive interventions addressing other causes that lead to abortion apart from provision of family planning services. It is alarming that prevalence of STI/HIV/AIDS is still high, and that for

34 Order of the Minister for Health, No 149, 2009, Interventions to reduce maternal mortality

some infections prevalence is increasing despite efforts at the policy as well as at the implementation levels. STIs comprise 65 percent (including viral hepatitis) of all registered communicable diseases, and the incidence of syphilis and gonorrhoea is likely to increase. STI infections, particularly those that produce lesions are known to increase the risk of HIV infection. Until 2005, the increase in number of HIV cases was slow; however, number of HIV cases was slow; however, the number of HIV-infected people has risen sharply from 15 in 2005 to 57<sup>35</sup> as of August 2009. While prevention and detection may be improving, the situation is alarming; controlling the spread of STIs/HIV/AIDS is a problem which requires consistent attention.

At the same time, there is a need to increase government funding for the national response against STI/HIV/AIDS since currently the majority of financing comes from external sources (see Table 10). It is important to develop a cost-effective strategic plan within the existing legal framework on combating HIV/AIDS, to improve leadership for the effective implementation of the strategic plan, and to build efficient multi-sectoral partnership mechanism. It is also important to strengthen capacity of the National Committee on HIV/AIDS and role of the committee in leading and coordinating the activities of governmental and non-governmental organizations and international community.<sup>32</sup>

Within the coordination framework, it would be useful to roll out initiatives to

35 National Communicable Diseases Center under MOH, August 2009

integrate STIs/HIV/AIDS prevention with RH services, to provide mobile services for remote and vulnerable people, and to expand the establishment of centers for voluntary counseling and testing if outcomes are further documented.<sup>12</sup>

Adolescent fertility (20.4 per 1,000 adolescent girls aged 15 to 19)<sup>37</sup>, abortion (7.1 percent of all abortion)<sup>22</sup> and STI incidences have not been decreasing despite interventions that had initially positive outputs. The findings of recent studies suggest that there is a need to improve quality of health education programmes at secondary schools and increase training of teachers; this requires the attention of education institutions at all levels. It could be also helpful to expand the network of adolescent health centers established with UNFPA assistance into other districts and aimags.<sup>12</sup>

## Conclusions

During the last 15 years since the Cairo conference, Mongolia has made substantial progress in the implementation of the ICPD POA. The principles of the ICPD have been integrated into the national and sectoral laws and development strategies related to poverty reduction, population and development, gender, and health such as the National population development policy (2004-2015) the Health sector master plan (2005-2015), the National reproductive health programmes (1997-2011), the National gender equality programme, (2003-2015)

the law on Combating against domestic violence (2005) and others. Many issues on the agenda of the POA have been linked to the national MDGs endorsed by the parliament of Mongolia in 2005, which facilitated the achievement of the national target on the reduction of the maternal mortality by 2015.

During the transition in 1990s, Mongolia faced socio-economic difficulties that negatively affected the well-being of the population as well as financing of education and health sectors. Despite this difficult period, Mongolia provided free primary and secondary education, maintained high level of literacy, and protected equal access to education for girls and boys.

Ensuring women's reproductive rights and providing quality and accessible reproductive health services for the population, among others, have been positively contributing to the considerable reduction of maternal and child mortality in the recent years. Also progress is being made in provision of reproductive health education and services for adolescents as well.

Financial resources for social protection and services including health and education have been constantly increasing when the country's economy was growing at faster rate during 2006-2008. In the light of the current economic slowdown, the government recognizes the need for maintaining the progress made already and has indicated its commitment to maintain investment in health and education sectors.

The government has expanded its partnerships with NGOs, other civil society organizations, media, UN and international development agencies in implementing the national policies and programmes related to population and development, gender equality and reproductive health.

Despite the progress made, there are persistent challenges that the country faces and needs to be tackled. Greater efforts and investments are needed for reducing high level of poverty; addressing issues related to migration; creating more effective mechanisms for provision of basic social services for disadvantaged groups such as migrants and illegal miners; promoting women's participation in

political arena and decision making; preventing effectively gender based violence; improving quality of reproductive health services in remote rural areas; decreasing abortion; and preventing STI/HIV/AIDS transmission. Further, population ageing, trafficking of women and children; intensifying urbanization, concerns related to men's health are the issues that need more attention.

In the five years that remain for the achievement of both the ICPD goals and the national MDGs, Mongolia is reaffirming its commitment to fulfilling the goals through better investment in people, improvement of national systems and institutions, effective partnerships with local and international communities.

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