МОНГОЛ УЛСЫН ЗАСГИЙН ГАЗАР
ЭРҮҮЛ МЭНДИЙН ЯАМ

UNFPA

unicef
for every child

FINAL REPORT ON:

NEEDS ASSESSMENT AND GAP ANALYSIS OF EXISTING PRIMARY HEALTHCARE SERVICES FOR INTEGRATION OF EARLY CHILDHOOD DEVELOPMENT AND ADOLESCENT–YOUTH–FRIENDLY HEALTH SERVICES IN MONGOLIA

31 January 2024

Steering Group for the Joint Assessment at the Ministry of Health (MOH)

1. Chair: A.Unurjargal, Director of Medical Services Department, MOH
2. Secretary: O.Bayarzaya, Officer in charge of primary health care, MOH

Members:

3. U.Enkhmaa, Officer for child and adolescent health care, MOH
4. Ts.Tungalagtamir, officer for quality and safety of medical care, MOH
5. B.Orolzodmaa, Officer for RH, youth and men health issues, MOH
6. S.Enkhjin, Officer of Monitoring and Evaluation Department, MOH
7. Kh.Battuya, Youth Programme Analyst, UNFPA Mongolia
8. Ch.Bataa, Child Health Programme Analyst, UNICEF Mongolia

Assessment Team

1. Kh.Enkhjargal PhD (Medicine) MD, Team leader
2. Ya.Buyanjargal Master of Medicine, MD, Team member/consultant
3. M. Nandinchimeg MPH, MD, Team member/consultant

Abbreviations

ANC	Antenatal care
AYFHS	Adolescent-youth-friendly health services
CHW	Community health worker
ECD	Early childhood development
EHSP	Essential health services package
FHC	Family health center
GBV	Gender-based violence
HIF	Health insurance fund
HIV	Human immunodeficiency virus
ICD	International classification of diseases
IEC	Information, education and communication
HIGO	Health insurance general office
MICS	Multi Indicator Cluster Survey
MOH	Ministry of Health
MOLSP	Ministry of Labour and Social Protection
NGO	Non-governmental organization
NCD	Non-communicable diseases
PHC	Primary health care
RDTC	Regional Diagnostic and Treatment Center
RMNCHC	Reproductive, maternal, newborn and child health care
SDG	Sustainable Development Goals
SISS	Social Indicator Sample Survey
SHC	Soum health centre
SOP	Standard operations procedure
STI	Sexually transmitted infections
UHC	Universal health coverage
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Terms specific to Mongolia

aimag	administrative division, equivalent to province (outside Ulaanbaatar)
bag	administrative division, equivalent to sub-district (outside Ulaanbaatar)
ger	Traditional Mongolian tent dwelling
khoroo	administrative division, equivalent to municipal sub-district (in Ulaanbaatar)
khural	Citizens' representative body
soum	administrative division, equivalent to district (outside Ulaanbaatar)
State Great Khural	National Parliament of Mongolia

CONTENTS

TABLES

FIGURES

1. INTRODUCTION

Commissioned by the United Nations Population Fund Mongolia Country Office (UNFPA CO), and in line with the original Terms of Reference developed for the Needs assessment and gap analysis of existing primary health-care services for integration of early childhood development and adolescent-youth-friendly services, this **Report** sets out background and rational, and the assessment methodology and key findings emerged from the assessment with conclusions and proposed recommendations.

1.1 BACKGROUND

Primary health care (PHC) is a cornerstone of sustainable health systems for the achievement of universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs)[1]. It is at the core of providing accessible, person-centered, appropriate and equitable care from a population-based perspective[2].

Over the past 3 decades, with the support of the Asian Development Bank and other development partners, Mongolia has achieved significant results in reforming and improving PHC such as restructuring the old system and introducing new management models based on public–private partnerships, increasing the range of services provided, introducing more effective financing methods, building human resources, and creating better infrastructure[3].

PHC plays a pivotal role in improving early childhood development (ECD), given the contacts between health services and pregnant women and families with young children. Furthermore, adolescent-youth-friendly health services (AYFHS) are integral part of primary care and essential public health functions. According to the World Health Organization (WHO), AYFHS should, as far as possible, be integrated into existing health services at all levels of health care rather than offered only as a stand-alone service.

By adopting the SDGs, Government of Mongolia has committed to ensure that everyone has access to affordable and quality health care. The past two to three decades have seen great improvements in child health and survival, and the country achieved the Millennium Development Goal of 75 per cent reduction of child mortality by 2015. The coverage of health-care services and effective interventions delivered to mothers and children within the PHC such as early antenatal care (ANC), institutional delivery, postnatal care (PNC), immunization and prevention and treatment of childhood illnesses, have sustainable improvements towards the achievement of UHC. However, the integration of child health and development remains in adequate.

1 *World Health Organization and United Nations Children's Fund. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018*

2 *European Commission, Tools and Methodologies for assessing the performance of primary care, Report of the Expert Panel on effective ways of investing in Health, European Union, 2018*

3 *Altantuya Jigjidsuren, Bayar Oyun, and Najibullah Habib, Supporting primary health care in Mongolia, ADB East Asia Working paper series No.35, 2021*

The adolescent and youth health is one of global health priorities. At the global level, over 1.5 million adolescents and young adults aged 10–24 years died in 2021, about 4500 every day. Injuries (including road traffic injuries and drowning), interpersonal violence, self-harm and maternal conditions are the leading causes of death among adolescents and young adults. Half of all mental health disorders in adulthood start by age 14, but most cases are undetected and untreated.

In Mongolia, although the majority of adolescents and youth are healthy, there is still a significant amount of premature death, disease, injuries and mental disorders among teenagers. Top five causes of death among adolescents in 2019 were self-harm, unintentional road injury, tuberculosis, drowning and interpersonal violence. Suicide mortality rate per 100,000 is 19 in 2019 (deaths due to self-harm). To give further examples, there were 27 births per 1000 in girls aged 15–19 years in 2020; the percentage of those aged 13–15 years who used any tobacco in the past month was 13% in males and 3% in females in 2019. Since 2010, the prevalence of overweight among children and adolescents in Mongolia has dramatically increased[4]. It is beginning at a younger age: in 2018, one in six children under 5 and one in every 8 adolescents were overweight.

These evidences suggest that the country needs to pay much more attention to improve ECD as well as to increase the accessibility and quality of AYFHS. The international practices showed that a holistic and integrated approach to these services within PHC can lead to improved health, development and well-being of children, adolescents, and youth.

1.2 RATIONAL

The science evidences highlighted the critical importance of the early years ("1000 golden days") being the time when the brain develops rapidly; it is also the period when the fetus and child are most sensitive to health, nutrition, security and safety, responsive caregiving and opportunities for early learning[5].

Globally, given the critical importance of enabling children to make the best start in life, the WHO, United Nations Children's Fund (UNICEF), and the World Bank Group launched the Nurturing Care Framework for improving ECD at the World Health Assembly in 2018 to provide a Roadmap for action for all relevant sectors[6]. This framework focuses on the period from pregnancy to age 3 within a life-course approach.

In Mongolia, despite sustainable improvements in the child health indicators has been observed over the years, important gaps persist in improving ECD. According to the Social Indicator Sample Survey (SISS), the ECD index (SDG indicator 4.2.1) is not adequate (national 75.7) in Mongolia. Moreover, early stimulation and responsive caregiving by any adults, mother and father is low at 58, 38 and 16 per cent respectively; one in every ten children under five years old is stunted

4 *Understanding integrated adolescent development in Mongolia, Situational analysis: UNICEF CO Mongolia, 2019*
5 *The Lancet Series, Advancing Early Childhood Development: from Science to Scale, 2016*
6 *UNICEF, WHO, the World Bank group, The Nurturing Care Framework, 2018*

(9.5%) and one in every ten children of this age group is overweight (10.5%). More than half of all children 6-23 months of age (61%) don't have minimum diet diversity[7].

Therefore, by supporting the 'nurturing care' concept and recognizing the importance of improving ECD, the Government of Mongolia recently released new multi-sectoral Action plan on improving ECD for 2023-2026. The plan includes comprehensive interventions to be implemented by health, education and social sectors.

AYFHS should be designed to cater to the unique needs of young people, taking into account their physical, emotional, and social well-being. The health-care providers must ensure key quality standards of the AYFHS such as acceptability, accessibility, equity, privacy and confidentiality, and non-judgmental attitude and appropriateness for adolescents[8].

In Mongolia, AYFHS have been established since 1995. During the period 2013-2018, UNFPA, UNICEF and the WHO supported the Ministry of Health (MOH), the establishment of and customized support to all Adolescent and Youth-Friendly Centers (AYFHC) in 21 provinces, and 8 districts and institutionalized by applicable government standards[9]. However, because of the limited capacity of existing AYFHCs, currently the accessibility of AYFHS is still limited, particularly in rural areas and for marginalized adolescents and youth. Therefore, the Ministry of Health is exploring potential opportunities to integrate AYFHS in existing PHC services to increase the reach to adolescents and youth with healthcare services that are appropriate to meet their specific health needs.

Thus, this collaborative assessment which represents a joint effort involving UNICEF, UNFPA, and the Ministry of Health, aims to identify areas of improvement and to uncover opportunities for enhancing the integration of services to better meet the diverse healthcare needs of the population, especially young children, their parents and caregivers, adolescents, and youth.

The primary users of the needs assessment findings will be decision-makers in the United Nations (UN) and their counterparts in the Government of Mongolia. The results of the assessment will also be used by implementing partners who are directly involved in realizing the recommendations of this assessment, as well as potential donors who are interested in investing to strengthen the PHC in Mongolia and improve ECD and AYFHS.

7 *Social Indicator Sample Survey, Mongolia, 2018, NSO, UNICEF, UNFPA*

8 *Handbook for conducting an adolescent health services barriers assessment (AHSBA) with a focus on disadvantaged adolescents. Geneva: World Health Organization; 2019. License: CC BY-NC-SA 3.0 IGO.*

9 *UNFPA Mongolia CP4 evaluation report, 2022*

1.3 DEFINITIONS OF KEY TERMS

Adolescence is the phase of life stretching between childhood and adulthood. In other words, the second decade of life is a period in which an individual undergoes major physical and psychological changes. Alongside this, there are enormous changes in social interactions and relationships. It is a phase in an individual's life rather than a fixed period; a phase in which an individual is no longer a child but is not yet an adult.[10]

Adolescents: The WHO and UN define 'Adolescents' as individuals in the 10-19 years age group and 'Youth' as the 15-24 year age group, while 'Young People' covers the age range 10-24 years.[11]

Adolescent–Friendly Health Services: Adolescent-friendly health services are services that are comprehensive, accessible, acceptable, and appropriate for adolescents.[12]

Early and Late Adolescence: Adolescence can be broken into two stages: Early adolescence: 10—14 years; Late adolescence: 15—19 years.

Early Childhood Development refers to the process of cognitive, physical, language, temperament, socioemotional, and motor development of children that starts at the time of conception until 8 years of age.[13]

Early learning refers to any opportunity for the baby, toddler, or child to interact with a person, place, or object in their environment, recognizing that every interaction (positive or negative, or absence of interaction) is contributing to the child's brain development and laying the foundation for later learning.[14]

Nurturing care: Characterized by a caregiving environment that is sensitive to children's health and nutritional needs, responsive, emotionally supportive, and developmentally stimulating and appropriate, with opportunities for play and exploration and protection from adversities[15].

Nurturing Care Framework for early childhood development (WHO, UNICEF & World Bank Group, 2018) was launched at the World Health Assembly in 2018 to provide a roadmap for action. The Framework focuses on the period from pregnancy to age 3 with a life-course approach and addresses all relevant sectors but with a spotlight on the health sector.

Responsive caregiving: Incorporates anticipatory guidance for safety, education, development, and the establishment of a caring and understanding relationship with one's child. Parenting is not limited to biological parents, but extends to guardians or caregivers providing consistent care for the child[16].

10 *The health of young people: A challenge and a promise. Geneva, World Health Organization, 1993*
11 *A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents, page 7*
12 *Handbook for conducting an adolescent health services barriers assessment (AHSBA) with a focus on disadvantaged adolescents. Geneva: World Health Organization; 2019. License: CC BY-NC-SA 3.0 IGO.*
13 *Improving Early Childhood Development: WHO Guideline [Internet]. WHO 2020*
14 *Improving Early Childhood Development: WHO Guideline [Internet]. WHO 2020*
15 *UNICEF, WHO, The World Bank Group, Nurturing Care Framework, 2018*
16 *Improving Early Childhood Development: WHO Guideline [Internet]. WHO 2020*

1.4 OBJECTIVES OF THE ASSESSMENT

The overall objective of this assessment is to conduct a thorough needs assessment and gap analysis of existing primary healthcare services to identify areas of improvement and integration opportunities, with a focus on ECD and AYFHS.

Specific Objectives:

1: Assess the Current Status of Primary HealthCare Services: Evaluate the existing policies, strictures, and practices and determine the range and quality of services offered.

2: Examine Services Pertaining to Early Childhood Development: Identify the accessibility and quality of early childhood development services within primary health care. Evaluate the effectiveness of interventions in place for early childhood developmental needs.

3: Analyze Adolescent–Youth–Friendly Health Services: Measure the reach and effectiveness of health services targeted towards adolescents and youth and identify barriers, if any, faced by adolescents and youth in accessing healthcare services.

4: Identify Gaps and Overlaps: Pinpoint areas in the primary healthcare system where services are redundant or overlapping and determine gaps where essential services are lacking or under-provided.

5: Assess Resource Allocation: Review the current distribution of human, financial, and infrastructural resources, determine if resources are being optimally utilized, and identify areas of potential inefficiency.

6: Recommend Integration Opportunities: Propose strategies to amalgamate services where possible to improve efficiency and user experience. Suggest ways to strengthen collaboration between early childhood development services and adolescent-youth-friendly health services within the primary healthcare system.

1.5 ASSESSMENT PROCESS

The assessment process began in 2023, with consultation between the UNFPA and UNICEF, Mongolia management and follows up visits to several health settings in rural and urban areas to initiate this joint needs assessment and developed the Terms of Reference. Briefing meetings were then held with the Minister for Health by the Head of Office, UNFPA Mongolia and the UNICEF Representative. The assessment was agreed upon, and the Joint steering group established in the ministry with the Terms of Reference approved by the Vice minister.

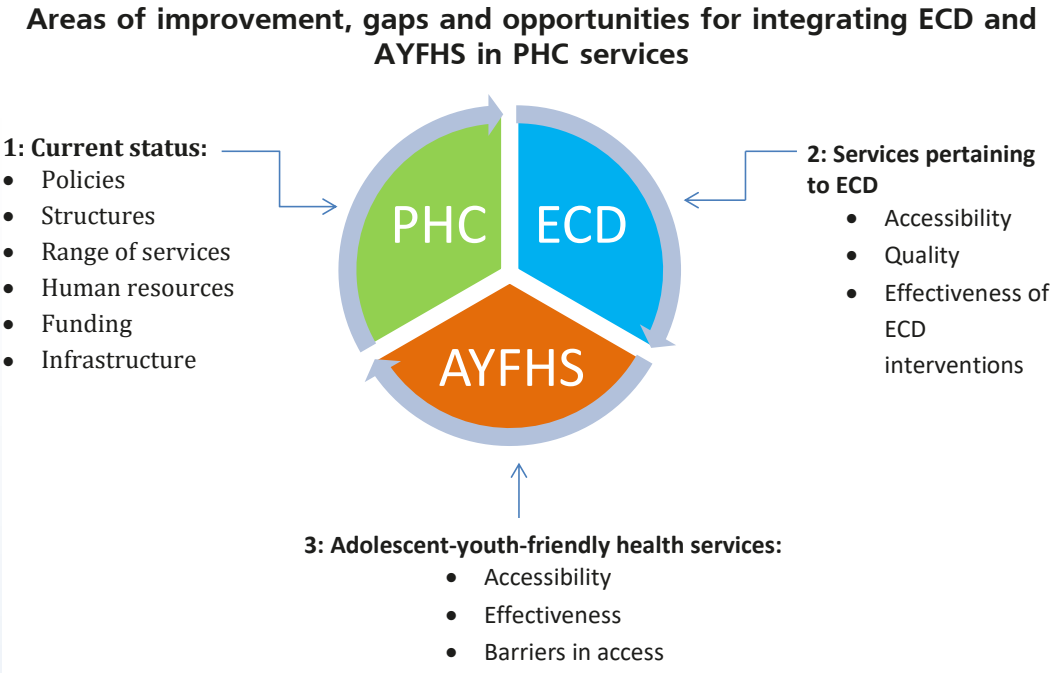
In October 2022, the UNFPA CO in Mongolia hired the Assessment team and developed the assessment methodology. Following the approval of the assessment methodology by the Joint steering group, field data was collected in November 2023. The preliminary findings were presented at a validation workshop in December, and comments obtained from key stakeholders were incorporated to the assessment report. The assessment results were presented at the dissemination

meeting held on 26 January 2024.

1.6 ASSESSMENT FRAMEWORK

Primary health care, early childhood development and adolescent-youth-friendly health services are broad healthcare areas. These health services have synergy and common characteristics, with each of them having specific features and determinants that impact on the accessibility and quality of health-care and services. Therefore, in order to define scope of the needs assessment and gap analysis, based on the specific objectives, the Assessment team (the team) designed the following framework, which includes three main themes, each incorporating several sub-themes to be assessed within this assessment (Figure 1).

Figure 1: Framework of the Needs Assessment and Gap Analysis



Based on the identified themes and sub-themes to be assessed, the team designed the Assessment matrix that provides overall guidance for conducting the needs assessment and gap analysis. The matrix includes the assessment questions; data collection methods; data sources; tools for data collection and analysis for each theme under the specific objectives of the assessment (For details please refer to the Assessment matrix in Annex 1).

2.2 SAMPLING AND SAMPLE SIZE

2.2.1 Selection of assessment sites

In consultation with UNFPA and UNICEF, Mongolia Country Offices and the Steering group in the Ministry of Health, it was agreed to use purposive sampling approach for selection of assessment sites based on following criteria.

BOX 1: Criteria for selection of the assessment sites (provinces and UB districts)

- Geographic and regional representation;
- Number and composition of population;
- Urbanized nature and remoteness from the capital city Ulaanbaatar;
- Cross border mobility factor;
- Proportion or concentration of adolescent-youth population;
- In-equities in key child and adolescent health indicators
- Level of soums with regards to their population size and range of PHC services.

With consideration of above criteria, Bulgan, Dornod and Khovd aimags (provinces), and Bayanzurkh and the Sukhbaatar districts of the capital city Ulaanbaatar were purposively selected as the assessment sites.

Bulgan aimag is in the central and northern khangai region of Mongolia, with an area of 48,800 square kilometers. As of January, 2023, total population of the province is 61,717. The province has 20 PHC facilities. In terms of population and number of soums and PHC facilities, this aimag can represent a typical province.

Dornod aimag is a center of the eastern region of Mongolia. The provincial center Choibalsan city is located 636 km from Ulaanbaatar. As of January 2023, total population is 84,650. The province has 16 PHC facilities. This aimag is one of more urbanized large provinces of Mongolia; and borders with Russia and China, thus, the province has high cross-border mobility. One of 5 Regional Diagnostic and Treatment Centers (RDTC) exists in Dornod.

Khovd aimag is located in the western part of the country, and center of the western region. As of January 2023, the province has a total population of 90,671 with diverse ethnic minority population groups such as zahchin, khalkh, uriankhai, lold, torgud. This aimag is one of remote provinces of Mongolia. The provincial center Khovd city is 1,580 km from Ulaanbaatar. The province has 22 PHC facilities and one of 5 RDTCs operates in Khovd city. This province is also regional educational hub and many adolescents and young people from other provinces in the region study in Khovd University.

Bayanzurkh district is one of the largest districts of Ulaanbaatar, with population of 408,797 persons as of January 2023. The district has 26 family health centers (FHC). This district has seen rapid expansion of new residential areas both

apartment khoroos (administrative unit) and underserved ger khoroos.

Sukhbaatar district is in central Ulaanbaatar and mostly composes apartment khoroos with a population of 142,444. The district has 20 FHCs. The majority of universities, colleges and student dormitories are located in this district.

2.2.2 Sampling of PHC facilities and recruitment of respondents

As this assessment is facility-based assessment, the data collection target units were randomly selected family health canters (FHC) and soum health centers (SHC) delivering PHC in the assessment sites. Total number of sampling unit was 19 PHC facilities (13 FHC and 6 SHC).

Table 1: Number of sampled PHC facilities by location

PHC facility type	Bulgan aimag		Dornod aimag		Khovd aimag		Bayanzur-kh district		Sukhbaatar district		TOTAL	
	All	*Sam-ple*	*All*	*Sam-ple*	*All*	*Sam-ple*	*All*	*Sam-ple*	*All*	*Sam-ple*	*All*	*Sam-ple*
Family Health Cen-ter	2	2	3	2	6	2	26	4	20	3	**57**	**13**
Soum Health Cen-ter	16	2	13	2	16	2	2	0	0	0	**47**	**6**
TOTAL	**18**	**4**	**16**	**4**	**22**	**4**	**28**	**4**	**20**	**3**	**104**	**19**

The respondents for interviews and focus groups were recruited randomly while visiting the selected FHCs and SHCs, depending on their availability. The recruitment of key informants, such as PHC policy makers in MOH, head or manager of aimag and city health departments and leaders of the PHC associations were recruited purposively. For parent focus groups, caregivers who visit health centers with young children were invited for focus group discussions. Participants of adolescent focus groups were randomly recruited from school and university students in assessment areas. All respondents were recruited with their permission and obtained informed consent prior to the start of interviews and discussions.

2.3 DATA COLLECTION

2.3.1 Methods

The assessment used mixed methods such as desk review, facility survey and qualitative research methods (interviews and focus group discussions).

Desk review: A literature review directly aimed to address specific objective 1 of the assessment and is also relates to other objectives. The document review is focused on following issues concerning 3 main themes of the assessment:

- Global perspectives on strengthening PHC and improving ECD and increasing

accessibility and quality of AYFHS including internationally recognized strategies, standards, practices and guidelines.

- The national laws, policies, plans, standards, guidelines and procedures related to PHC services, ECD and AYFHS.
- Health indicators and thematic population-based survey reports to examine current status and recent trends and existing gaps in relation to accessibility, quality and effectiveness of PHC services, ECD interventions and AYFHS offered at primary level of health care.

The major sources were the available WHO, UNICEF, and UNFPA publications, international and national websites, including legalinfo.mn and website of the Ministry of Health, and available printed reports and the annual national health indicators bulletins. Combinations of keywords including "*primary health care" "early childhood development"* and *"adolescent-youth-friendly health services*" were used for the literature search. Also, the policymakers and managers who were interviewed and contacted were important sources to access relevant data and documents.

Facility survey: For the direct observation and facility document review, the quantitative checklists were used to collect data from 19 PHC facilities to understand the extent of PHC services being offered; readiness of facilities for the integration in terms of human and infrastructural resources; and quality of selected ECD interventions and AYFHS.

Interviews: The key informant interviews (KII) and in-depth interviews (IDI) with relevant health policy makers, managers and service providers primarily aimed to achieve specific objectives 1, 2 and 3 of the assessment, and are also relate to other objectives. All interviews were conducted individually face-to-face with their permission.

The KIIs focused on policymakers' views on ongoing reforms for improving PHC, ECD and AYFHS policies and strategies and the resources allocated for the provision of these services in the PHC settings, and their views and support for the integration of ECD and AYFHS in existing PHC services.

The IDIs with PHC facility managers and service providers aimed to examine their perspectives concerning broad range of issues such as current status of PHC services offered in their facilities; existing gaps and potential opportunities for integrating ECD and AYFHS in their daily functions and services offered. Reaching the children and adolescents with disabilities, young children with developmental delays, and meeting their special needs, was an important consideration.

Focus group discussions (FGD):
ECD with parents and caregivers: ECD is primarily interactions between parents/caregivers and young children. Parents and other primary caregivers need to be supported through policies and services in order to have good knowledge, skills, time, and material resources for appropriate childcare[17]. Thus, the team conducted series FGDs with parents of young children under the age of three to examine

17 *WHO guideline for improving early childhood development, Geneva, 2020*

the effectiveness of ECD interventions delivered to parents by PHC providers and gain information about caregivers' engagement and practice in stimulating and caring young children.

The FGDs with adolescents aimed to understand their perspectives in terms of accessibility, acceptability and quality of the PHC services, including privacy, confidentiality, safety, and non-judgmental attitude of PHC providers and barriers if they face in access to PHC services.

2.3.2 Development of data collection tools

The team developed comprehensive set of data collection instruments which consist of 8 specific questionnaires and check lists and informed consent form:

KII guides: Two KII guides are developed and used to collect responses from the PHC policy makers and managers at national (Guide A) and sub-national levels (Guide B).

IDI questionnaires: Three semi-structured IDI questionnaires with mixed open and closed questions were developed and used to collect qualitative data from the PHC facility managers (Questionnaire A); the PHC service providers on ECD (Questionnaire B) and adolescent services (Questionnaire C) offered in their facilities.

FGD guides: Two FGD guides were developed and used to collect input from parents and other primary caregivers (Guide A) and adolescent boys and girls (Guide B). Copy of the tools and the informed consent form is provided in Annex 2-9 of the report.

Pre–testing of data collection tools

The assessment team pre-tested the data collection instruments in Dornod aimag on 7-8 November 2023 with involvement of child and youth programme analysts from UNFPA and UNICEF, Mongolia Country offices. Based on the pre-testing findings, draft tools were modified accordingly and used for data collection in other sites.

2.3.3 Field data collection

The field data collection was carried out by the assessment team consisted of team leader and two national consultants during the 1.5 months period between November and December 2023. In total, the team conducted 16 face-to face KIIs; and 95 individual IDIs with 22 head and managers of PHC facilities and 73 PHC service providers. 42 parents and 70 adolescents participated in FGDs. Total number of respondents is 223. Details of primary data sources are presented in Table 2 below.

Table 2: Summary of primary data sources by assessment sites and categories

	Bulgan aimag	Dornod aimag	Khovd aimag	Bayanzur-kh district	Sukh-baatar district	Ulaan-baatar/ national	#Total
IDI interview: Facility manager	**4**	**4**	**5**	**5**	**4**		**22**
Head of FHC/SHC	2	4	4	4	3		**17**
Managers	2		1	1	1		**5**
IDI interview: PHC provider	**9**	**19**	**19**	**15**	**11**		**73**
General practitioner	2	6	6	5	4		23
Midwife		3	1				4
Nurse	3	3	5	6	5		22
Bag feldsher	2	3	3				8
Public health officer	2	4	4	4	2		16
Participants of FGD	33	30	30	8	11		**112**
Parents/caregivers	6	13	7	8	8		42
Adolescents	27	17	23		3		70
Key informant interview	**5**	**1**	**3**		**1**	**6**	**16**
Policymaker at MOH						1	1
PHC officer at MOH						1	1
Child health officer						1	1
Representative NHI						1	1
Head of aimag HDs	1	1	1				3
Managers in HDs	2		1				3
AYFHC doctor	1		1				2
School doctor	1				1		2
PHC Associations						2	2
Facility survey	**4**	**4**	**4**	**4**	**3**	**0**	**19**
Total number of respondents of KIIs, IDIs and FGDs:							**223**

2.4 DATA ANALYSIS

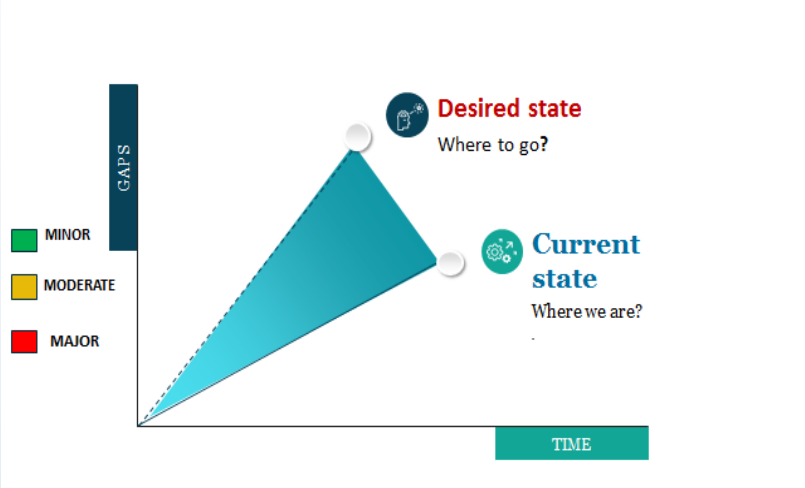
Descriptive analysis: This method is primarily used for secondary data analysis. The quantitative and qualitative data collected through national and facility document reviews were used to assess current status of PHC including governance and polices, structures, practices, resources allocation and utilization, coverage of services pertaining to ECD and AYFHS.

Thematic analysis: This method is used for analysis of qualitative data emerged from KIIs, IDIs and FGDs. The qualitative data were organized into major categories in line with the identified three main themes and sub-themes, and then used short abbreviations as descriptive codes to label data. After data compilation, names and any identifying information associated with the interviewer's personal details were removed. Any additional comments or impressions were typed up from the voice recorder. Each interview and FGD represented one unit of analysis.

The assessment team had limitations on time and human resources to translate all interview notes into English to enter to the qualitative data analysis software. Therefore, we used Excel platform for the thematic analysis of qualitative data. Coded and entered data by the national consultants were double-checked by the team leader.

Gap analysis: The team also conducted gap analysis to identify existing gaps between the current state and the desired state of PHC, services pertaining to ECD and AYFHS. In order to identify the desired state for three main themes, we developed the 'operational definitions' based on international and national standards of PHC, services pertaining to ECD and AYFHS. Gaps were identified in three ranges as **MINOR, MODERATE, MAJOR.**

Figure 2: Gap analysis of current and desired states



In addition, for assessing the extent of potential gaps and prioritizing areas of improvement for integrating ECD and AYFHS in the PHC services, the standard methods of needs assessment, such as scoring, ranking and SWOP analysis, were

used when appropriate.

2.5 QUALITY ASSURANCE

Quality data assured through the following mechanisms, which was deployed during the design stage, data collection, and after fieldwork.

- **Joint steering group:** The group had the meeting prior to starting field data collection and reviewed the assessment methodology and provided guidance on the next steps of the assessment.
- **Assessment matrix:** Assessment goal was broken down to key themes/ sub-themes, questions and summarized in an assessment matrix to give an overview of the assessment objective, questions, issues, method, relevant target group, and type of data collection tool.
- **Inception report with a set of assessment tools** were developed through a rigorous process in which items in the questionnaires were thoroughly reviewed by UNFPA and UNICEF CO experts, refined and finalized. Questions were framed to be as simple and understandable as possible.
- **Field testing:** Prior to the fieldwork, data collection tools were field tested at two FHCs and two SHCs in Dornod aimag and were modified accordingly. The final versions of the assessment matrix and tools were cleared by the Task Force.
- **Oversight and supportive supervision:** The team leader conducted oversight and supervision throughout data collection and provided support to team members to ensure that they adhered to the tools, guides, and procedures, and asked probing questions where appropriate. During the fieldwork, the data collection team had daily wrap-up meetings and online access for advice via the assessment telegraph group. The accuracy of the transcripts and answers was cross-checked against the audio recordings by the team leader and consultants.

2.6 ETHICAL CONSIDERATIONS

The work of the assessment team is guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). The assessment team members adhered to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG.

The ethical issues around safeguarding respondents' rights and concerns were considered and individual written informed consent (Annex 9. Informed Consent Form) was obtained from all interviewees and participants of focus groups. Interviews were recorded where consent was given on tape.

The confidentiality of records, tapes and transcripts are assured through numerical coding. Each participant was assured that the information gathered would only be used for policy development and programming to strengthen the PHC and improve integration of ECD and AYFHS. Anonymity was maintained in all interviews to ensure that individual participants could not be identified.

2.7 LIMITATION OF THE ASSESSMENT

A few assessment limitations should be noted:

- The present findings may not be fully generalizable to other PHC facilities in Mongolia. Our assessment did not aim to cover statistically sound number of PHC facilities in Mongolia and used purposive sampling approach. Therefore, we used some nationwide secondary data in addition to primary data that emerged from the assessment for presenting assessment findings.
- The assessment had a limitation to evaluate all dimensions of PHC and services pertaining to ECD and AYFHS such as the effectiveness and the efficiency due to limitation in availability of data and limitation of time.
- The accuracy of primary data derived from respondents may be affected by the respondents' bias and level of understanding and involvement in child and adolescent healthcare services. Some responses may not reflect the actual practices and attitudes of the provider.

3. KEY FINDINGS

3.1 THE CURRENT STATUS OF PRIMARY HEALTH CARE IN MONGOLIA

This section reviews the current status of Mongolia's PHC with emphasis on integrating ECD in existing PHC services. The key areas analysed in the section are organized into 8 thematic pillars round PHC: national policies; structures; range of services; human resource; physical infrastructure, funding; information management and monitoring and evaluation.

Vision of PHC: *Primary health care as outlined in a Vision for primary health care in the of 21st century, is a whole-of-government and whole-of-society approach to health that combines three core components: multiesectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services" (WHO, UNICEF, 2020 [43].*

This whole-of-government and whole-of-society approach to health emphasizes that the true aim of PHC is not only to provide 'primary care', but also to maximize 'multi-sector policy and action', also 'participation of communities'. Based on the key findings of the current situation of PHC, the team made attempt to identify the areas of improvement and gaps towards achieving the vision of primary health care in Mongolia.

3.1.1 Mongolia's PHC policies

Overall, Mongolia's PHC policies are integrated within broader national health policies and regulations outlined in the Health law and other related laws and policy documents. Overarching goal of national health policies including the PHC policies is to ensure equitable access to quality health care for all people of Mongolia [4, 17, 19, and 20].

Key findings include the following:

- Achieving better health and well-being of all people of the nation is included as one national top priorities in the Constitution of Mongolia [4] and the "Vision-2050"- Mongolia's long term development strategy [42].
- At the strategic level, political commitment and leadership for strengthening PHC has been improved and recognize the broad contribution of PHC towards the achievements of UHC and the health-related SDGs.
- Under the Health law PHC is free [17]. This promotes the equity in access to primary care and protects individuals from financial hardship.
- The Health sector action plan for 2023-2026 prioritizes PHC and includes important strategic actions to strengthen the PHC [12].
- The PHC policies aim to meet people's health needs through broad range of integrated primary care and essential public health functions including promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life-course [36].
- The PHC functions strategically prioritize key health care services aimed at individuals and families (people-centered PHC) through health assessment, supervision, and early detection of non-communicable diseases and risk behaviors [36].
- The new Law on Public health recently endorsed by the Parliament defines the roles and responsibilities of all sectors to address the broader determinants of health.
- The PHC policies are well translated into action or operationalized in the Standard of Mongolia on structures and operations of FHC [40] and SHC [41]; broad range of standard operation procedures (SOP) and technical guidelines.
- The PHC managers and service providers interviewed generally provided positive feedback on existing PHC polices and regulations; most of them reported that existing policies and regulations are supportive for the provision of PHC services. Few managers mentioned about frequent change of regulations approved by the ministerial orders.
- Review of availability of the policy documents and technical guidelines in PHC facilities showed that the standards of FHC and SHC and the SOPs related to financing of PHC services were available in all 19 facilities assessed.
- However, the majority of service providers interviewed were not able to show printed or soft copy of technical guidelines or SOPs related to the provision of specific primary care and services. For example, the Action plan and programme for improving ECD approved in 2023 were available in only 2 FHCs out of 19 PHC facilities assessed.

Based on the findings of PHC policy review and analysis, the team identified following areas of improvement and moderate gap in promoting and implementing broad vision of PHC.

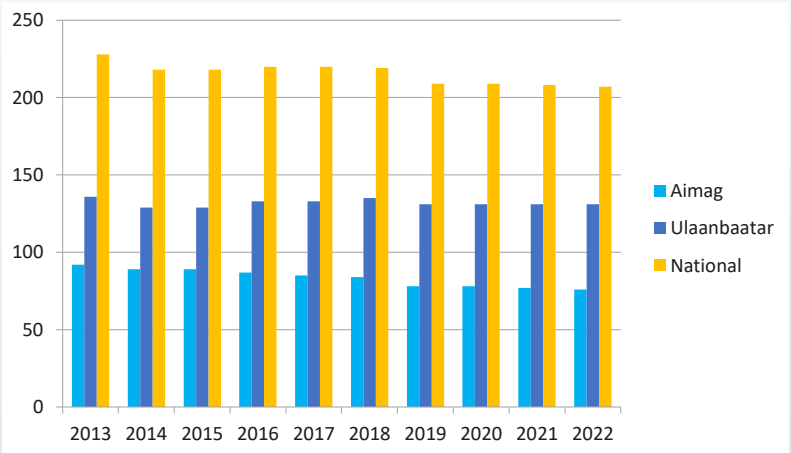
Areas of improvement	Gap rating	Desired state
• Overall, Mongolia's PHC policies promote integrated primary care and essential public health services but more "primary care" focused. • Existing policies and regulations are not yet effectively promoted broad "*whole-of-government*" and "*whole-of-society*" approach" in PHC.	MODERATE	PHC is a whole-of-government and whole-of-society approach to health that combines three core components: multi*e*sectoral policy and action; empowered people and communities and integrated services

3.1.2 Structures of PHC in Mongolia

Overview: The national health-care system of Mongolia has basically two tiers: primary health care and referral health care. The PHC is delivered through community-based health care organizations as FHC and SHC. The FHC is a where healthcare workers are organized into 'partnerships' and provide PHC services urban areas (Ulaanbaatar and aimag centers) based on contractual arrangements. The soum and village health center (SHC) is a public health organization providing inpatient and outpatient primary care and essential public health functions for rural population.

PHC organizations: As January of 2023, total 544 PHC organizations operate in Mongolia including 207 FHCs and 337 SHCs. In the last decade, the number of SHCs is not substantially changed while the number of FHCs has slightly decreased from 228 in 2013 to 207 in 2022 mainly due to structural changes (Figure 3).

Figure 3: Family Health Centers, Mongolia, 2013-2022



Source: Health indicators, 2022, Health development centre, Ministry of Health

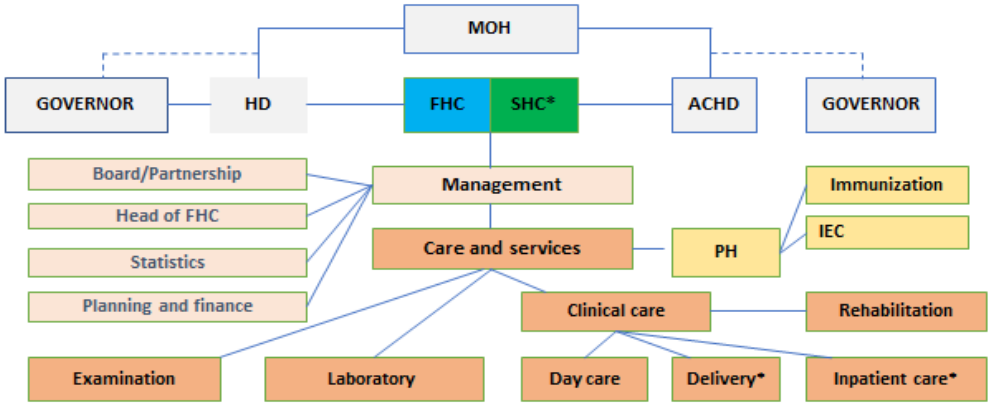
- Cathment population of PHC providers served: 3,368,632 or 97% of total population of the country (2022). Population density ranges from 0.8 facilities per 10,000 populations in Ulaanbaatar to 2.3 per 10,000 in provinces.
- Average number of households: 3,175 for FHC and 920 for SHC; the average number of population served: 11,825 for FHCs in Ulaanbaatar
- The PHC facilities are community-based and available in all primary administrative units called soum and khoroo of the country.
- The average distance between SHC and remote households is approximately 100 kilometers.. These distances make it difficult to deliver health care to rural populations in remote areas.

Key findings include the following:

The structural arrangements of PHC are defined by the Health law, the standards of FHC and SHC and other related SOPs. According to existing regulations:

- The Ministry of Health defines PHC policies and regulations and manages public health budget. In the ministry, the Department for medical services is primarily responsible for PHC policy making and coordination of policy implementation and has a designated full-time officer in-charge PHC issues.
- The Ministry of Finance allocates the state annual budget approved by the Parliament for PHC to the Health insurance general office (HIGO) in line with the implementation of 'single purchasing' mechanism (since 2021). The PHC facilities develop agreement with the HIGO.
- The provincial and city Governor's offices and Health departments provide oversight of PHC performance based on the tri-partite agreement.
- All Health departments visited had designated PHC officer who manages day to day activities related to PHC policy implementation, monitoring and bi-annually provides progress report to the Governor's office on performance of the tri-partite agreement.
- According to the PHC managers interviewed (n=22) the Health departments pay attention to improve PHC, usually support and work closely with them and organize training.
- It was also observed that the Governors provide some additional funding support for organizing specific primary care services and events. For example, the Governor of Dornod aimag allocates 1.5-2 million tugriks for each FHCs and SHCs for every year to organize 10-14 days targeted interventions for young children with developmental delays in rehabilitation homes during the summer time.

Figure 4. ***Organizational structure of PHC facilities***



- Organizational structure of the PHC facilities is adapted to the country context. For example, SHCs have inpatient and delivery sections.
- Basically, current structure of PHC facilities more primary clinical care oriented. For public health services, only immunization is included, one public health worker works on IEC.
- The majority of PHC managers and providers interviewed (n=95) had positive feeling about existing structure of PHC facilities and said that it is appropriate for the provision of PHC services in their context.
- Despite PHC centers have similar structure in line with their standards; it depends on the availability of space in the facility.

"According to the standard, a family health centre should have 15 rooms but our centre has only 7 rooms because of limited rooms and space" (Respondent of IDI, Head of FHC in aimag)

If the country will move towards the public health oriented PHC model in the future, existing public health part of the structure should be strengthened. This will enable more effective integration of ECD and AYFHS within the PHC services.

3.1.3 The range of PHC services

The team reviewed a range and quality of existing PHC services with emphasis on integrating ECD and AYFHS. Overall, under the Health law, Mongolia's PHC represents as entry point or gate keeper of referral health care and have link with district and provincial health centers and hospitals. The referral mechanisms are defined by relevant SOPs.

Key findings include the following:

- In 2023 the Ministry of Health released new SOP that defined comprehensive integrated primary care and essential public health service package to be of-

fered by PHC providers [36]

- According to this SOP, Mongolia aims to deliver integrated, people-centered, accessible and high-quality primary care and essential public health services, and promotes life-course approach.
- The package of integrated primary care and essential public health services consists of broad range of preventive, protective, promotive, curative, rehabilitative and palliative primary care and basic public health services.
- As showed in the Table 3, maternal, newborn, infant and child health services pertaining to ECD and basic clinical and public health services targeted to adolescents and youth are substantial part of integrated PHC package.
- Despite new package includes comprehensive list of integrated services, in practice, it was observed that existing PHC services are more 'clinical care oriented'. According to the review of 2022 service data of FHCs and SHCs assessed, and responses of providers interviewed, substantial proportion of PHC services provided were outpatient and inpatient medical examinations including 'preventive examination' and early screening.

Table 3: Integrated PHC services to be offered in PHC centers

Preventive and curative care	Sexual and reproductive health care and services	Child and adolescent care and services	Public health functions
Early screening of arterial hypertension, diabetes, heart diseases, cancers such as cervical and breast cancers	Antenatal care, identification and management of pregnancy complications, referral	Postnatal home visits and newborn care, breastfeeding promotion, and counseling, identification of newborn illnesses and referral	Prevention and control of communicable diseases
Emergency care ambulance care	Delivery care and early postnatal maternal and newborn care and home visits, referral	Active supervision of infants under 1 year and home visits	IEC and health education and health promotion for disease prevention
Laboratory services an diagnosis	Family planning and contraceptive services	Immunization according to the national schedule	Environmental health WASH education, public awareness activities
Outpatient, inpatient care (SHC), management of acute and chronic diseases, referral	Counseling for adolescent on puberty and SRH issues, referral	Child development assessment at 9, 18 and 36 months	Food security and healthy food education activities
Palliative care, home care for elderly and seriously ill patients	Identification and management of puberty and sexuality problems and referral	Nutritional counseling support, vitamins, micronutrients	Waste and disposal management issues, awareness raising

Rehabilitation and day care	STI diagnosis and treatment, counseling and referral	Prevention and management of childhood illnesses and referral	NCD screening and prevention, IEC
Traditional medicine and pharmaceutical services	Mental health care and basic psychological counseling and referral	Early screening of children under five years old and follow up	Injury, violence and suicide prevention IEC, awareness

- By range of services, it was found that antenatal and postnatal maternal, newborn and child care, immunization and essential curative care were regularly offered services in PHC facilities and these services are well in place.
- Sexual health services including STI diagnosis and treatment, contraceptive services, adolescent mental health and sexual health counseling were under-provided services across all PHC facilities assessed. The number of people who received these services in 2022 was very limited in some facilities or no accurate service data on provision of these services in others.
- The service providers reported that rehabilitation, day care and home care seems to be increased due to inclusion of these services to health insurance funding.
- The PHC facilities assessed had limited data on health promotion and other community outreach services. The managers and providers interviewed reported that they usually organize some information, communication and education (IEC) activities on thematic health days such as breast feeding week but not regularly.
- Most of the respondents interviewed from SHCs mentioned challenges of reaching remote rural households. Usually, they organize mobile health care and services for rural populations once or twice a year with involvement of specialists from general hospital.
- The regular quality assurance functions and supportive supervision mechanisms are not yet in place in PHC facilities. Some evidences on quality of PHC services will present in next two sections of the report.

Based on the findings of the assessment on range of PHC services, the team identified following areas of improvement and moderate gaps between the current state and desired state of model care described in the WHO operational framework of PHC [50].

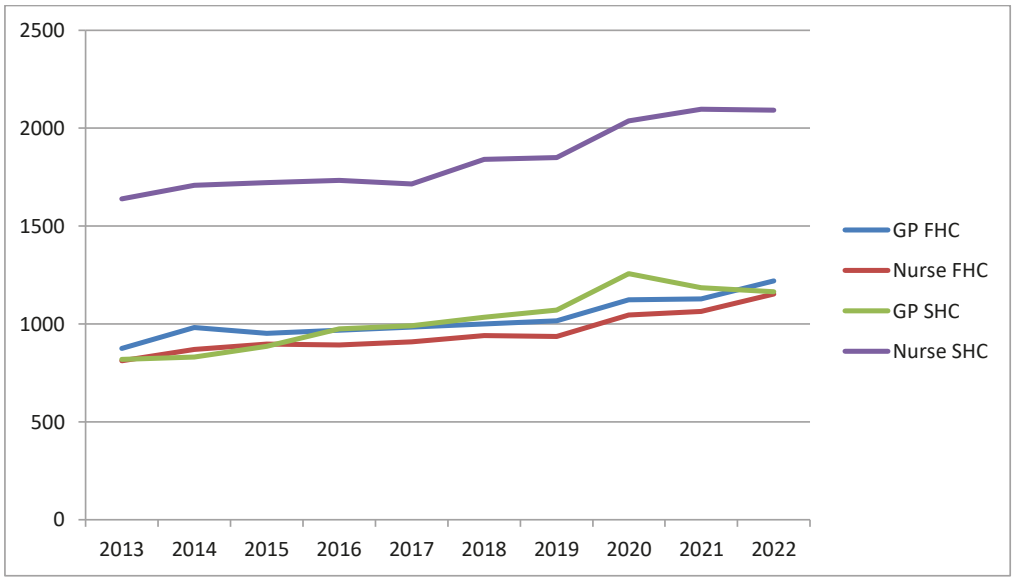
Areas of improvement	Gap rating	Desired state
• Despite new PHC package includes broad range of integrated PHC services, existing services are more 'clinical care' oriented. • Existing PHC services becoming more people-centered but the quality needs a lot of improvement.	MODERATE	Models of care that promote high-quality and people-centered primary care, and essential public health functions as the core of integrated health services throughout the course of life.

3.1.4 PHC workforce in Mongolia

Overview: As of 2022, the FHCs and SHCs employ 11,843 healthcare staff, which comprises 18.7% of the total health-care workers of the country. In the last decade, the number of doctors and nurses of FHC has increased about 40% (doctors from 875 in 2013 to 1220 in 2022; nurses from 812 in 2013 to 1193 in 2022). The number of nurses of SHCs also increased by 27% compared to 2013 (1639 in 2013 and 2092 in 2022). However, since 2020, the number of soum doctors has been decreased from 1257 to 1165 in 2022 (Figure 5)

The density of PHC physicians is 7.0 per 10,000 populations and for nurses 9.7 per 10,000. The physician to nurse ratio is low (national 1:1; in Ulaanbaatar 1:1) compared to the international benchmark which is 1 to 4. Overall, more doctors fewer nurses work in PHC facilities especially in the capital city .

Figure 5: Number of physicians and nurses of FHC and SHC, 2013-2022



Source: Health Indicators 2022, Health Development Center, MOH

Key findings include the following:

- According to the standard, adequate number of general practitioner should be one per 1800-2000 populations in FHC; one per 1200 populations for soums of category I and 1000 populations for soums of category II-III.
- PHC shall be provided by a professional, skilled team with relevant competencies and medical doctor specialized in family medicine.
- Adequate and sustainable employment of health care professionals in PHC and in rural areas are promoted through appropriate compensation measures such as bonus 6 months' salary for every 3 years for PHC (5 years general) compensation prior to retirement (10 years for PHC, 25 years overall); state-

paid advanced training for every 5 years of employment in SHC.

- Mongolia's PHC providers working in team include general practitioners/family physicians, nurses, midwives, public health worker, bag feldshers and pharmacists in SHC, and management and support staff.
- Despite there is policy to recruit medical doctors specialized in family medicine to provide PHC centers care facilities, in reality, about half of our respondents were young doctors who are not specialized in family medicine or traditional medicine specialists.
- The majority of nurses interviewed have not received certified competence building training to provide integrated primary care and essential public health functions except the immunization nurses.
- Midwives usually provide ANC, family planning and delivery care in SHCs, according to the respondents, their involvement in ECD and AYFHS is currently limited.
- Bagh feldshers should provide community outreach services for rural households, however, but they usually base in soum center, could not regularly reach to rural community due to transport problem; they did not receive any refresher training in basic primary care and essential public health services.
- There is no official system to recruit, promote and support community health workers (CHW) as part of PHC team. Only in Bayanzurkh district, some CHWs were trained with support from UNICEF, and they have not yet started actual work.
- PHC managers interviewed frequently raised concern about shortfall of doctors in SHCs and shortfall of nurses in FHCs of Ulaanbaatar, because salary of PHC providers and working environment are not attractive for doctors and nurses.
- Most of the respondents mentioned that they perform double tasks, and the workload is high. This may be because their job description includes statutory tasks, and the organization does not officially apply a "task-shifting" policy. Generally it was observed that job satisfaction is quite low.

"*Shortfall of soum doctors became a real issue now. There are SHCs with only one doctor who is the head of the center and even there o doctors. I am really concerned that SHCs may fail, because the financing system is also not supportive for SHC and the supply of workforce is getting worse".* ***Key informant, Soum doctors' association.***

"I have been working as a bag feldsher for almost 40 years. When I was young I used to ride horses to reach herder households. Now I live in the soum center, with my motorbike broken and I cannot reach remote areas. In our soum, families in remote areas live in a 100-160 km radius distance, and during the summer and winter time when we have a lot of rain or snow, there is no way to reach them". ***IDI respondent: Bag feldsher of SHC***

Based on the findings, the team identified following areas of improvement and major gaps to adhere basic requirements of PHC workforce outlined in the WHO Operational framework

Areas of improvement	Gap rating	Desired state
• The PHC workforce policies support basic principles of PHC workforce • However, the quantity is not adequate: shortage of doctors in soums, and nurses in Ulaanbaatar. • Multidisciplinary PHC workforce is not yet in place. • Competency level is not adequate to deliver integrated services defined in new package. • The productivity, efficiency, management and supportive supervision need improvement.	MAJOR	Adequate quantity, competency levels, and distribution of a committed multidisciplinary PHC workforce that includes facility- outreach- and community-based health workers supported through effective management supervision and appropriate compensation

3.1.5 Physical infrastructure of PHC facilities

Overall, physical infrastructure of FHCs and SHCs in Mongolia has been improved in the past three decades. However, according to the FHC professional association, half of all FHCs do not have adequate designated premises or work in old buildings which need maintenance. One third of PHC facilities don't have reliable transport system.

Family Health Center

Soum Health Center

Key findings include the following:

- There is no unified national standard of FHC' building. Thus, some FHCs in Ulaanbaatar were working in community centres together with khoroo Governor's office and police; some in apartments and few had new offices.
- In FHCs in Ulaanbaatar, usually 2-3 family doctors and nurses were sharing their examination room. In such environment, it is difficult to provide private and confidential examination and counselling for clients.
- Most of the FHCs in aimags were working in old buildings which need maintenance.
- The team assessed some basic requirements of PHC infrastructure such as reliable power supply, telecommunication connectivity, reliable water and sanitation system in 19 PHC facilities.

- According to the assessment all 19 PHC facilities assessed had internet connectivity and reliable power supplies. The SHCs visited (n=6) and some FHCs (n=2) in aimags did not have reliable water and sanitation system although they have some clean water in the building, still were using outside latrines (Table 5).
- Two out of 6 SHCs visited did not have reliable transport. The bagh feldshers interviewed also mentioned about reliable transport and fuel problems.
- Some managers interviewed mentioned the supply of basic medical equipment and laboratory supplies have been improved in recent years, however, the quality of some equipment is not adequate.

Table 4: Presence of key elements of PHC infrastructure

Key elements of physical infrastructure	FHCs (n=13)		SHCs (n=6)		Total: (n=19)	
	Yes	No	Yes	No	Yes	No
Facility's office building complies with minimum requirements	11	2	6	0	17	2
Facility has a reliable WASH system	11	2	0	6	11	8
Facility has a reliable power supply	13	0	6	0	19	0
Facility has internet connectivity	13	0	6	0	19	0
Ramp slope	13	0	6	0	19	0

"Our building does not meet the standard requirements. Rooms were very cold in winter time because of no reliable heating system. We have a shortage of doctors because young people don't have an interest to work in such conditions. Last year we made maintenance and established heating system with internal resources, now it is much better and at least became warmer". ***Respondent of IDI, Head of FHC in aimag***

Based on the findings, the team identified following areas of improvement and moderate gaps in PHC infrastructure to meet basic requirements outlined in the WHO Operational framework of PHC (50).

Areas of improvement	Gap rating	Desired state
Moderate gaps remain to ensure all PHC facilities, especially all SHCs have reliable transport and designated standard offices with reliable water and sanitation system to secure accessible and effective services.	MODERATE	Secure accessible health facilities to provide effective services with reliable water, sanitation and waste disposal/ recycling, telecommunications connectivity, and a power supply, as well as transport systems that can connect patients to other care providers

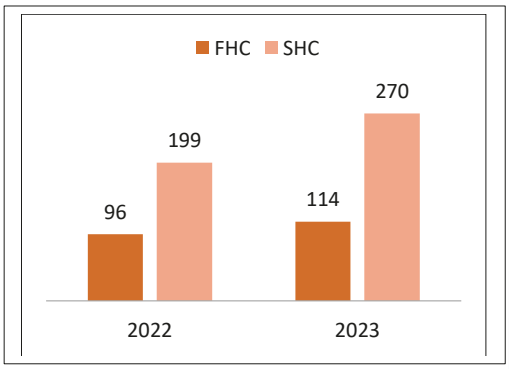
3.1.6 Finding and allocation of resources for PHC

Overview: In Mongolia, under the Health law, PHC financing is the state's responsibility and primary care is provided free of charge for all people of the

country. This promotes equity in access to primary care and protects people from financial hardship. Currently, FHCs and SHCs are financed from domestic revenue based on capitation fees (19) In addition, according to the

Health insurance law, 4 types of primary care including day care, home care, and rehabilitation and laboratory services provided in PHC facilities are eligible for health insurance funding through performance-based financing scheme [18]. Public health functions are financed by the state budget allocated to the Ministry of Health in economic terms.

Figure 6: PHC expenditure, Mongolia, 2022-2023



- Share of total health expenditure in GDP increased to 3.6% in 2022 which was between 2.2-3.2% in 2005-2019.
- The total funding allocated for PHC increased by 18%-35% in 2023 compared to 2022 (Figure 6)
- In 2023 spent 114,436,620,200.00 MNT. for FHC 270,019,941,900.00 MNT for SHC approximately 32US$ per capita
- PHC workers' salary also increased in 2022

Source: Ministry of Health, 2023

Key findings include the following:

- In the Health sector action plan for 2020–2026, it was planned to increase the share of total health expenditure to 15.7% of the total government budget, and to 4.8% in GDP, by 2026 WHO recommends the expenditure to be not less than 5 per cent.
- The capitation fee has been increased over the years. However, according to the PHC managers and providers, it is not adequate to cover actual cost of multiple integrated primary care and essential public health services to be provided by PHC facilities.
- One critical issue frequently raised by the managers and providers interviewed (n=95) was the discrepancy between the number of residential population (funding is based on residential population) and the actual number of population which was not included to the calculation of capitation fee due to high number of unregistered residents especially in Ulaanbaatar.
- The providers also mentioned that capitation fee for children under 5 is not adequate to cover actual cost of age-specific services such as 4 postnatal newborn home visits, active supervision of infants and child developmental assessment etc.
- According to the managers interviewed, the HIGO directly disburses 80% of allocated funds to PHC facilities and remained 20% based on an evaluation of 7 performance indicators. They usually could not receive the full amount

of remained 20% due to unmet indicators, documentation errors, technical constraints (sometimes programme does not work properly), and sometimes not certain on reasons for dedications.

- According to the facility managers, they do not have designated budget for public health activities. Usually spent a small amount (approximately 1-4 million MNT per year) from their funding received under the capitation payment, sometimes receive a small amount (approximately 1.5 million MNT) from the Health department when they occasionally organize IEC and health promotion activities.
- Lack of efficient use of available scarce resources allocated to PHC was documented in some reviews and assessments. During our assessment, it was observed that PHC services provided by SHCs in remote rural areas are widely accepted and used, while SHCs located close to the provincial center are often ignored by the residents of soum centers as they can easily and directly access a broader range of services available in the provincial general hospital. For instance, one of the SHCs assessed which is located near to aimag center did not conduct any deliveries in 2022.

"Usually we receive about 10 per cent of remained 20%" - ***Respondent of IDI, Head of SHC***

"*Usually we could not receive the remained funding (20%)* - ***Respondent of IDI Head of SHC***

"Every year, about 300 unregistered children stay in our catchment area. They receive primary care from our center, which we have to provide. However, the capitation payment of these 300 children is not included in our funding which is based on the registered population" – ***Respondent of IDI, Head of FHC in the provincial center***

"Calculation of capitation fee does not include age-specific services. For example, we conduct 4 home visits in the postnatal period, but it calculates as 1 capita and the fee is the same with other children" – ***Respondent of IDI, GP of FHC Ulaanbaatar***

"*Anyway, we have to pay attention to increasing the scope of these services that have more financial benefit as financing mechanism promotes such prioritization."* ***Respondent of IDI, Head of FHC in aimag***

Based on the key findings, the team identified following areas of improvement and moderate gaps in funding and resource allocation to PHC to meet requirements outlines in the WHO Operational framework of PHC [50].

Areas of improvement	Gap rating	Desired state
• No designated budget for essential public health service provision and health promotion activities • Lack of evidence-based estimation of capitation fee and in adequate funding to provide a platform and incentive environment to enable high-quality care and services	MODERATE	Adequate funding for PHC that is mobilized and allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship.

We also identified some areas of improvement and gaps in PHC data management, use of technologies, engagement of communities and monitoring and evaluation based on the levers the WHO' Operational Framework of PHC [50].

Table 5: Areas of improvement and gaps in other areas PHC

Areas of PHC	Desired status	Gap rating	Areas of improve–ment
Engagement of Communities and other stakeholders in PHC	Engagement of communities and other stakeholders from all sectors through policy dialogue	**MAJOR**	Lack of engagement of communities and other stakeholders
Use of digital technologies for PHC	Use of digital technologies for health in ways that facilitate access to care, improve effectiveness and efficiency, and promote accountability	**MINOR**	A lot of issues associated with overlaps of software; inefficiency in use; limited use of digital technology in service delivery
Systems for improving the quality of PHC	Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services	**MODERATE**	Despite the accreditation system in place mechanism to continuously assess and support the quality of care remain in adequite
Data management; Monitoring and Evaluation of PHC	Monitoring and evaluation through well-functioning HIMS that generate reliable data and support the data use for planning	**MODERATE**	Overlaps in registration forms; Data quality is not adequate.

3.2 INTEGRATING EARLY CHILDHOOD DEVELOPMENT IN PHC SERVICES

This section summarizes the key results from the assessment on current status of primary care services pertaining to ECD including the accessibility and quality of services and the effectiveness of ECD-specific interventions. Based on the findings it defines the areas of improvement and gaps as well as opportunities for integrating ECD aspects within PHC services.

3.2.1 Enabling policy environment for integrating ECD in PHC services

According to the WHO, Early childhood development refers "the process of cognitive, physical, language, temperament, socioemotional and motor development of children that starts at the time of conception until 8 years of age". Implementing early interventions in the first '1000 golden days' which is the time when the brain develops rapidly is critically important for childhood development.

Nurturing care framework

Overview: The policy review showed that the national health, education, child rights and child protection policies fully support comprehensive childhood development as well as the importance of the "nurturing care" concept as a basic right of every child. In recent years, the country made great progress towards the development of ECD-specific policies and actions. In 2023, the Ministries of Health, Education and Social Protection jointly approved multi-sectoral comprehensive Action plan for improving ECD and the ECD intervention guide. Also the Ministry of Health updated the Child health book (pink book) to support PHC providers and parents for home-based monitoring of child development milestones.

Action plan to support ECD, 2023-2026 [1]

ECD intervention guide, 2023 [30]

Health book of children under 5 years old [3]

Key findings include the following:

- The key informants interviewed (n=16) including PHC, child and adolescent

health policy makers from the Ministry of Health and the managers from the provincial and city Health departments visited, all were very supportive for integration of ECD interventions in existing PHC services. Most of them emphasized the role of health sector, particularly the role of PHC providers for improving ECD. The policy makers interviewed highlighted the urgent need for competence building training of relevant PHC service providers and early detection of young children with developmental delays and follow up provision of early interventions.

- The ECD-specific interventions recommended by WHO and UNICEF and outlined in above Action plan and intervention guide have not yet explicitly incorporated into the new package of integrated primary care and essential public health services to be offered in PHC facilities (36)
- The ECD action plan and the intervention guide (ECD programme) and updated child health book were not available in most of the PHC facilities assessed (17/19).
- The PHC managers and providers interviewed (n=52) were not aware of the ECD Action plan and the intervention guide (ECD programme. It may be because these documents are recently endorsed by the ministries and have not yet distributed.

"*Doctors, nurses and other PHC service providers of FHCs and SHCs have day to day contact with families and parents of children under 3 years old, so they are most suitable people to support parents with information and knowledge about the importance of ECD and early interventions. To do this, they should be trained and have good knowledge and skills in ECD aspects. The PHC facilities can implement ECD interventions within existing PHC services according to the national technical and operational guidelines*" ***The key informant from Ministry of Health***

3.2.2 The availability and range of services pertaining to ECD within PHC

Key findings include the following:

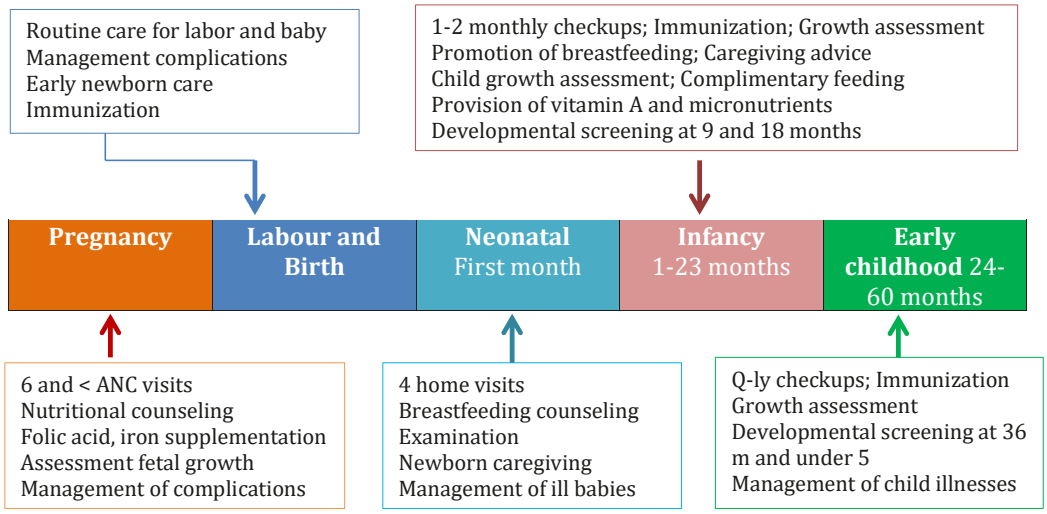
It was found that broad ranges of services pertaining to ECD already exist within PHC. As illustrated in the service mapping in Figure 5, the provision of these services usually begins from the period of pregnancy and continues throughout birth and the early neonatal and postnatal period, infancy and early childhood up to 3 years old. According to the respondents (n=52), these services usually offered regularly in their facility.

In addition to above frequently named services pertaining to ECD, postnatal emotional support for mothers; occasional parental short term group training and IEC for parents; targeted rehabilitation interventions for children with developmental delay, providing access to or linking with existing social services were mentioned by few PHC managers and providers.

"There are many services that are suitable for integration of ECD interventions.

*For example, while we visit family, we can provide family members with knowledge and skills on caregiving. However, because of high workload and time limitation we could not provide such integrated services***". *Respondent of IDI, family doctor of FHC in Ulaanbaatar***

Figure 7: Mapping of existing services pertaining to ECD within PHC



The team also obtained input from the PHC service providers interviewed (n=35) on the extent of feasibility of services in relation to integration of ECD-specific interventions in future. The respondents rated most of services with 4-5 scores (strong or high extent); some services such as adolescent-youth-friendly health services; preventive checkup and screening of NCDs; and patient examination and curative care were rated with 3 score (medium extent for the integration); and GBV services, injure care, elderly care, basic mental health counseling and palliative care were rated with lowest extent with 1-2 scores.

These findings indicate great opportunities for the integration of ECD interventions in terms of availability and range of services offered in PHC settings. Only identified area of improvement was currently, the tasks related to integration ECD interventions in existing relevant PHC services were not included to job description of PHC service providers including family physician, midwife, nurse and public health worker.

Table 6: Perceived feasibility to integrate ECD interventions in PHC services

A range of existing services in the PHC settings	Extent of feasibility to integrate ECD according to responses of PHC providers interviewed (n=35)
1. Antenatal care (ANC)	
2. Post-natal maternal and newborn care / home visit	
3. Child immunization	
4. Nutritional counseling, provision of macro/micro supplements	
5. Community outreach services and home visits	
6. Adolescent youth-friendly health services	
7. Preventive check-up / screening of NCDs	
8. Injure prevention and basic medical care	
9. Basic mental health care and psychological counseling	
10. Essential RH/FP services, provision of contraceptives	
11. RTI/STI and HIV prevention and management	
12. GBV prevention, identification, first line support, referrals	
13. Health education and promotion (IEC/BCC)	
14. Infectious disease control and management	
15. Curative care for children and adult	
16. Rehabilitation services	
17. Elderly care	
18. Palliative care	
19. Outreach activities in schools, kindergartens, community	

3.2.3 Accessibility and quality of PHC services pertaining to ECD

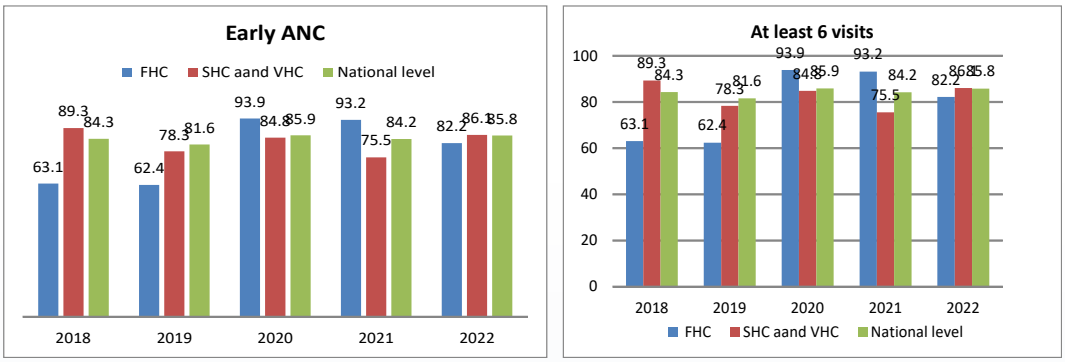
Essential reproductive, maternal, newborn and child health (RMNCH) care and services benefit not only child survival and health, but also support childhood development. Therefore the team assessed following PHC services pertaining to ECD offered within PHC with emphasis on accessibility of these services and current status of integration of ECD interventions:

1) Antenatal care
2) Postnatal newborn and child care
3) National immunization programme
4) Child developmental assessment at 9, 18 and 36 months
5) Early screening of children under 5 years old

3.2.3.1 Assessment of ANC offered in PHC centers

Overview: The coverage of early enrolment of pregnant women in ANC and having at least 6 ANC checkups during the pregnancy period has been constantly high in Mongolia, over 80 per cent in urban as well as in rural areas. Both FHCs and SHCs have the same level of these ANC coverage indicators. According to 2022 data showed more increase of coverage of ANC services with 91.6 per cent of pregnant women enrolled in ANC within the first 3 months of pregnancy and 85.8 per cent of them had at least 6 ANC visits (Figure 7). Coverage of 6 and more ANC visits is one of 7 indicators of performance-based financing; therefore, PHC providers pay more attention to meet the target of this indicator

Figure 8 Coverage of ANC services (%), Mongolia, 2018-2022



Source: Health Development Center, Ministry of Health, 2023

Key findings include the following:

- The facility's document review and responses of providers confirmed high ANC coverage indicators from 85 to 90 per cent in all PHC facilities assessed (n=19).
- The PHC providers interviewed (n=35) reported that they provide ANC services according to the national ANC guideline updated in 2020 by the Ministry of Health [2]. The half of them (17/35) were able to show copy of the guideline to the interviewer. Generally, all managers and providers interviewed were well informed about the Guideline.
- The team examined randomly selected ANC records of the PHC facilities. The review result showed that the early enrollment and 6 and more ANC visits were well documented.
- Majority of the mothers, who attended in parent focus groups (35/39) also reported that they enrolled in ANC within the first 3 months of pregnancy; regularly attended in doctor' examination on scheduled due dates.
- According to the PHC providers, they integrate following types of interventions pertaining to ECD in ANC: nutritional counseling; ultrasound fetus growth monitoring; folic acid supplementation and some IEC or group sessions for pregnant women.
- Direct observation and review of medical records (n=90) showed that ANC

visits and counseling were documented in all cases (90/90); ultrasound check-up were documented in most cases (86/90); folic acid supplementation was recorded in half of reviewed records (50/90). The FHCs in Ulaanbaatar were providing folic acid tablets and prenatal vitamins to pregnant mothers, but all FHCs in provinces and SHCs visited usually offer or prescribe folic acid to take.

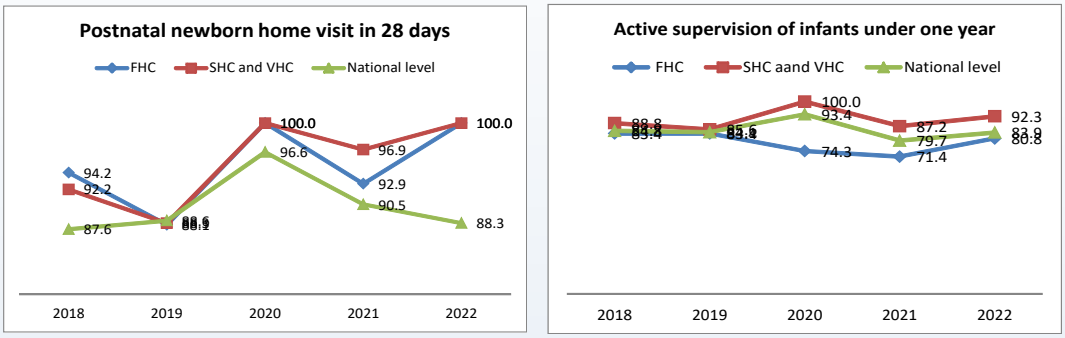
- The majority of mothers attended in FGDs reported that they purchased folic acid tablets from pharmacy by themselves and used.

"I purchased folic acid from pharmacy and used it. Price was 400 Tugriks per tablet. It may be good to include it to insurance discount, because some pregnant women may not be able to buy themselves" ***Participants of parent FGD***

3.2.3.2 Assessment of postnatal newborn and child care in PHC

Overview: In 2019, the Ministry of Health updated the Guideline on Home visit for newborn babies and active supervision of children up to 2 years old (9). According to the guideline, family physicians and nurses of PHC centers should undertake weekly home visits for newborns; two weekly home visits for infants from 28 days up to 2 months; monthly visit or check up for infants with 3-6 months and quarterly active supervision for children from 7 months up to 2 years old. Also specific tasks for each home visits are specified in the guideline. As of 2022 national data, 88.3 per cent of newborn babies received 4 postnatal home visits within 28 days; and 83.9 per cent infants under one year received active supervision (Figure 8).

Figure 9: Coverage of child active supervision (%), Mongolia, 2018-2022



Source: Health Development Center, Ministry of Health, Mongolia

Key findings include the following:

- All PHC facilities assessed (n=19) reported nearly universal coverage of newborn home visits in 28 days. According to the review of child health books (n=90), 3-4 home visits with medical examination were recorded in all cases (90/90).
- The PHC providers reported that they usually conduct home visit and active supervision of young children according to the national Guideline.

- According to the PHC providers interviewed (n=35) young children up to 1.5-2 years usually receive regular supervision and routine checkup because they regularly visit the health center for vaccination.
- Following ECD interventions are partially integrated to postnatal newborn home visits and active supervision of young children: breastfeeding and nutritional counseling; child growth assessment and information on caregiving for parents.
- According to review of child health book (n=90) only breastfeeding counseling was recorded in all reviewed books (90/90); growth assessment (weight and height, Z score, use of growth chart) and caregiving counseling were documented in less than half of reviewed books (38/90).
- Most of the parents attended in focus groups (36/39) said that soum and family doctors and nurses visited their home 2-4 times within the first month after discharge from maternity hospital and received counseling on breastfeeding, good sleep and general newborn care. Few mothers said that doctors and nurses did not visit, maybe because of we did not inform health center.
- Majority of the parents (36/39) responded that they don't have any challenge to access services offered by PHC providers and they regularly receive medical examination, advice and vaccination offered by health center. Only few participants reported about their challenge associated with distance and transport cost and critisized frequent change of FHC doctors; their low knowledge and skills; lack of counseling; and negative and judmental attitudes of providers. Also the parents were suggesting to "train young doctors with good knowledge and skills".

"Actually physically healthy children up to 1.5-2 years are enrolled in active supervision regularly; when they come to the scheduled vaccination, we examine them and check weight and height and provide counseling. When child reaches 2 years, mothers enter to their job, children go to kindergarten or to their grandparents, and thus, physically healthy children usually don't come to the center and regular supervision is interrupted". ***Respondent of IDI, physician of FHC***

"My baby born before due date; therefore, we stayed in hospital longer. After coming home, doctor did not come, therefore, we made call. Doctor said that we did not receive information about baby discharged from hospital, you should inform us" ***Participant of parent FGD***

3.2.3.3 National immunization programme

Overview: The child immunization programme is one of successful health programmes in place within PHC of Mongolia. It is also one of major public health functions performed by PHC providers. It also supports ECD. The country has specific law on immunization effective from 2009 [22]. In 2024, updated National vaccination schedule was endorsed by the Government [26]. (Table 8) Mongolia have had universal immunization coverage for children under one year and under two years. Due to COVID-19 influence, the vaccination coverage has slightly decreased since 2020 at national as well as sub-national levels (Table 9).

Table 7: Immunization coverage in Mongolia, 2018-2022

	Immunization coverage for children under one year					Immunization coverage for children under two years				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Aimag average	99%	98%	98%	96%	94%	98%	98%	98%	95%	93%
Capital city average	99%	98%	96%	94.2%	95%	98%	99%	93%	92.0%	93%
National level	99%	98%	97%	95.2%	95%	98%	98%	95%	93.0%	93%

Source: Immunisation department of National center for communicable diseases control, 2022

Table 3: National vaccination schedule, Mongolia

	within 24 hours	2 months	3 months	4 months	5 months	9 months	14 months	2 years	7 years	11 years	15 years
BCG	0 dose										
Hep B	0 dose										
OPV		I dose	II dose	III dose							
IPV					IV dose						
DTwP-Hib-Hep B		I dose	II dose	III dose							
PCV13		I dose		II dose		III dose					
MMR						I dose		II dose			
Hep A							I dose	II dose			
Td									I dose		II dose
HPV										I dose	

Key findings include the following:

- The PHC providers interviewed (n=55) reported that they implement the immunization programme according to the Immunization law and the National vaccination schedule.
- The immunization coverage has been high round 95-100 per cent over the years in all PHC facilities assessed.
- All facilities had full-time vaccination nurse who demonstrated good knowledge and confidence during the interviews. Some of them said that through the on-line peer group they share knowledge and experience and learn from each other. They usually apply different approaches such as sending invitation, contacting with families by phone prior to the scheduled due date of

vaccine etc.

- All PHC facilities assessed (n=19) also had designated vaccination room equipped with cold chain equipment and supplies.
- From the review of child health books (n=90), it was found that vaccines were recorded in reviewed books (90/90). In addition to vaccine, usually child weight and height were also recorded on same page.
- Immunization programme does not have much integration with ECD interventions except to measure child weight and height and document in child health book.

3.2.3.4 Child development assessment

Overview: Development assessment of young children at 9, 18, 36-months has initiated in 2018 in Mongolia. In order to implement this intervention nationwide the Ministry of Health developed two screening forms (questionnaires) for 18-months- and 36-months-olds and approved. These screening forms were include comprehensive questions for assessing emotional, cognitive, motor, language and socioemotional development of young children and full body medical examination form. This ongoing routine child development assessment is very important intervention to support and integrate ECD within PHC.

Key findings include:

- The development assessment of children at 9, 18 and 36 month-olds is included to the integrated services to be offered by PHC providers. It also included to outputs to be delivered under tri-partite agreement of FHCs.
- All PHC facilities assessed (n=19) have been implemented child development assessment since 2018 by using above-mentioned two questionnaires. The providers mentioned that there is no assessment questionnaire for development assessment of children with 9 months, therefore they use the questions in the health book (pink book).
- Some PHC officers working in provincial Health department informed that the department organized orientation training for PHC providers prior to the start of child development assessment in 2018. But the PHC service providers who joined after 2018 did not receive appropriate training on child development assessment because refresher trainings have not been organized.
- The PHC providers make plan/schedule in January based on birthday of children. We found that the number of children to be involved in 9, 18, 36 month development assessment is manageable: 7-10 per month in SHC and about 20 in FHC per month.
- Despite this important intervention has been implemented in all PHC facilities, the coverage and quality is not adequate. The PHC facilities assessed were not able to report accurate data on result of child development assessment. The child book review results (n=64) showed that documentation of routine child development assessment decreases by age of children. The 9 months assessesment was much more documented while 18 months assessment less and 36 months assessment was documented rare.

"In 2019-2020 PHC centers overloaded with COVID-19 responses, therefore the coverage of 9, 18 and 36 months screening has been low. After that from 2022, mass early screening has started. Again it influenced on low coverage of routine child development assessment. The questionnaires and forms overlap with each other; for example, for assessment of children there are 6 forms. it takes lot of time to fill. Indeed, we focus more to increase the coverage of early screening examination of population, because it is one of key indicators to receive full 20 per cent of the state funding". ***Manager of PHC center interviewed***

"We collect data from all PHC facilities on number of children enrolled in 9, 18 and 36 months developmental screening and report to the Governor. If coverage of developmental screening is included to the evaluation criteria of Governor's contract with the Minister, it could support increase of the coverage like antenatal care". ***Key informant PHC officer of Health department***

Table 9: Documention of child development assessment at 9, 18, 36-months

Interverventions	9 months (n=34)	18 months (n=15)	36 months (n=15)
Growth assessment (weight, height, BMI, Z)	28 (80%)	6 (40%)	5 (30%)
Child growth chart	23 (68%)	6 (40%)	5 (30%)
Nutritional assessment	30 (88%)	13 (86%)	5 (30%
Medical examination	34 (100%)	15 (100%)	15 (100%)
Development assessment by MORBAS score	12 (35%)	4 (26%)	0 (0%)
Counseling for caregiving	32 (94%)	9 (60%)	0 (0%)
Advice on development of children	30 (88%)	9 (60%)	0 (0%)

3.2.3.5. Early screening of children under five years old

Key findings include the following:

- All PHC facilities assessed (n=19) reported that they conduct early screening of children under five according to the Guideline approved by the Ministry of Health in 2022. For this screening, the ministry approved 6 pages long questionnaire ("Health Screening Form-1) with many questions about family, pregnancy and birth history; physical and cognitive development and full body comprehensive medical examination, basically overlapped with the questionnaires designed for routine developmental assessment of children at 9.18 and 36 months.
- According to the PHC providers interviewed, the screening examination of children is mostly organized in preschool settings. In some cases, kindergarten teachers and parents were filled the screening questionnaire even questions in medical checkup section. No any additional funding support is provided to the PHC facilities from the HIGO (Indeed, the referral facilities

received funding from the HIGO for the screening of adults).

- The coverage of early screening of children under 5 years old was low around 20-43 per cent in the PHC facilities visited. According to the national data obtained from the National center for maternal and child, during this screening of children under 5 years old, only 24.5%, 20.9% and 11.7% children aged 9, 18 and 36 months old were enrolled respectively in 2021-2023.
- From the review of the filled questionnaires and interviews many gaps and overlaps and inefficiencies were found. Review of 41 completed early screening questionnaires showed high percent of uncompleted development assessment questions such as BMI and Z score and the conclusion and follow up actions were completed in less than half of cases.
- The PHC facilities assessed were not able to present accurate data on identified children under five with developmental delays and interventions undertaken for them and the effectiveness. Overall, the reach, quality and effectiveness of ongoing early screening were not adequate so far.

Table 10: Results of review of completed early screening questionnaires (n=41)

Interventions to be undertaken	**Number and % of actions completed**	
	Number	Percent
Comprehensive medical examination	28	70%
Assessment of weight	37	90%
Assessment of height	35	85%
BMI	6	**15%**
Calculation of Z score	14	**35%**
Assessment of nutritional status	33	80%
Development assessment questions	22	55%
Advice to support development	16	**39%**
Follow up action plan	18	**45%**

3.2.4 Areas of improvement for integrating ECD in PHC services

The team identified following areas of improvement to ensure effective integration of ECD aspects in existing PHC services:

a) Training and competence of PHC providers on integrating ECD in PHC services
b) Engagement and empowerment of parents and caregivers in improving ECD
c) Availability of high quality materials on ECD in PHC facilities

3.2.4.1 Training and competence of PHC providers on integrating ECD in PHC services

All PHC providers interviewed (n=73) were not trained on WHO recommended ECD interventions in 4 areas such as responsive caregiving; promoting early

learning opportunities; optimal nutrition of children and support maternal mental health. According to the providers, they mostly attended in clinical trainings including newborn screening; immunization; management of childhood illnesses and early screening among children under 5 years old (on-line) in the last 3 years. These trainings were not incorporated ECD subjects.

"Actually we invite professors from the medical university and pay them to conduct child health care training for PHC providers. They usually give training on clinical management of child diseases and never talk about childhood development issues. Thus, I think that PHC workers' knowledge and skills to provide counseling for parents on child development related issues are not adequite". ***Key informant, representative of family doctors' association***

As the providers have not received yet training, they do not have **accurate understanding** about "*What exactly mean ECD?*". Their responses include just one or two elements of ECD or named the child care services. The key words and phrases frequently stated by the providers to define "ECD" and the key words which included to the WHO' definition of ECD, but none of the respondents mentioned are summarized below.

Frequently cited key words and phrases to define ECD	*What was not mentioned?*
"physical growth of children"; "good spiritual ability"; "good nutrition"; "provision of vitamins", "caregiving for child", "routine immunization", "home visit and counseling", "child growth monitoring", and "prevention of injure and accidence and violence".	*"socioemotional, language and motor development"; and "the time of conception until 8 years of age"*

As PHC providers are not trained, the **content and quility of counseling** is not adequite and they were not able to coach and support parents with adequite knowledge and skills to effectively interact with their children and use responsive caregiving and stimulate early learning opportunities.

According the parents focus group participants family doctors and nurses usually give them advice on breastfeeding, preparation of complimentary food for infants, baby care and hygiene. Some participants said that they did not receive any counseling and information from health care providers, usually receive information through social media.

Response of providers: What they advise?	*What they did not mentioned?*
"breastfeeding; general baby care; washing; preparation of complimentary food; good sleep (mother and baby); newborn jaundice; being more in fresh air; protect children from home injures; prevent from infectious and diseases"	*"stimulation of child; responding to child cues; reading book; singing; storytelling and talking; playing; psychological interventions for maternal stress and anxiety; management of behavioral difficulties; prevention of child neglect and maltreatment and violence"*

3.2.4.2 Engagement and empowerment of parents and caregivers in improving ECD

Early childhood development is basically effective interaction between caregivers and children. To be able to do this, parents and primary caregivers should be supported with adequate policy, knowledge, skills, time and materials. However,

all PHC facilities assessed (n=19) did not have good quality regular parenting programme, which is critical to support parent capacity building for improving ECD. They don't organize regular "**healthy-child day**". Only few FHCs and SHCs reported that they occasionally conduct parent group sessions, which usually talk about general child health issues but not about responsive caregiving; stimulation and supporting early learning opportunities.

From the parent FGDs we learned that parents generally know they need to support childhood development, but they don't know **how to support what exactly to do**. Actually, the Child Health Book (pink book) is very good tool to improve parent knowledge about physical, motor and emotional development of young children since newborn period and practice home-based child development assessment continuously. Unfortunately, review results of 90 child health books showed that the questions to be used and filled by parents mostly were not completed. The parents said that "*don't know how to complete*" or "*just ignore*" or "*looked it but did not complete*".

Review results: *45% of questions of children between 0-8 months; 33% of questions of children between 9-18 months were partially completed. None of questions were completed of children between 19-36 months.*

3.2.4.3 Availability of high quality materials on ECD in PHC facilities

The facility survey results showed that different leaflets and posters on breast-feeding or nutrition were available in all PHC facilities assessed (n=19) in limited copies. Few PHC facilities had video on general child care and prevention of childhood illnesses. In general PHC facilities did not have wide range of good quality IEC materials in sufficient copies for distribution to clients. ECD-specific IEC and training materials were not available in all PHC facilities assessed.

Table 4: Availability of IEC materials in PHC facilities

Topic of available IEC materials	Number of PHC facilities that had IEC material			
	FHC (n=13	SHC (n=6)	Urban (n=7	Rural (n=12)
Breastfeeding and nutrition	13	6	7	12
General child care	3	0	3	0
General mental health issues	4	0	4	0
Social support services	3	0	3	0
Child safety and protection	10	4	6	8

3.2.5 Gaps in integrating ECD aspects in existing PHC services

Based on the key results of the assessment on current status of services pertaining to ECD offered within PHC, the team identified following gaps between the current state and desired state based on the "operational definitions" developed in line with the WHO Guideline for improving early childhood development (2020).

*Table 12: **Gaps in integrating ECD in PHC services***

Areas and services	Current status	Gap rating	Desired status or operational definition
Policy support for integrating ECD in PHC services	ECD-specific action plan in place. But ECD-specific interventions are not yet operationalized.	**MINOR**	Parent supported by policies, services, knowledge, skills and time to have adequate capacity in improving ECD.
Availability and range of services pertaining to ECD offered in PHC centers	Broad range of primary care and essential PH services already exist in PHC facilities	**NO GAP**	Broad range of essential maternal, newborn and child care services are in place in PHC to support ECD.
Prenatal care and integration of ECD	Coverage of prenatal care indicators are nearly universal and support ECD	**NO GAP**	Accessible and good quality pre-natal care and services in place in PHC to support ECD from the time of conception.
National immunization programme and integration of ECD	Vaccination programme is well in-place in PHC with universal coverage and support ECD	**NO GAP**	Accessible and good quality national immunization programme in place in PHC to support ECD.
Child development assessment and integration of ECD	Coverage of ongoing child development assessment is low; the quality is not adequate; ECD-interventions are not yet integrated.	**MODERATE**	Accessible and high quality child development assessment is in place in PHC and integrated ECD-specific interventions.
Training and competence of PHC providers in integrating ECD in PHC services	PHC providers are not trained and don't have specific competence to support parents with knowledge and skills in improving ECD	**MAJOR**	All PHC providers are trained in ECD aspects and have full competence to provide quality counselling and coach parents in improving ECD.

Engagement and empowerment of parent and caregivers in improving ECD	Parents and caregivers don't have specific knowledge and skills to support ECD and lack of their engagement in improving ECD	**MAJOR**	All parents and caregivers received competence building training, and have adequate knowledge, skills and competence in improving ECD
Availability of ECD-specific material in PHC settings	Most of PHC facilities don't have good quality IEC and training materials on ECD aspects and interventions	**MAJOR**	All PHC facilities have good quality IEC and training materials in 4 WHO recommended areas of ECD and effective parent programme is in place within PHC
Supportive supervision and continues quality assurance system	The provision of existing services pertaining to ECD is not well supported by regular supervision and quality check.	**MODERATE**	Effective supportive supervision and quality assurance system in place to ensure effectiveness of PHC services.

3.3 INTEGRATING ADOLESCENT, YOUTH FRIENDLY HEALTH SERVICES IN PHC

This section summarizes the key results from the assessment on current status of PHC services targeted adolescents and youth including the availability, a range, accessibility, acceptability of existing services, and the readiness of service providers to integrate adolescent and youth-friendly health services (AYFHS) into PHC services. Based on the findings, it defines the needs or areas of improvement and the gaps between the current state and desired state in integrating AYFHS within PHC services.

3.3.1 Enabling policy environment for the provision of AYFHS

According to the WHO recommendations, adolescent-friendly health services should be integrated at all levels of health care. These services are designed to cater to the unique needs of adolescents and young people, taking into account their physical, emotional, and social well-being. Adolescent-friendly health services are characterized by a range of features, such as convenience, confidentiality, non-judgmental attitude, privacy, and accessibility. Adolescent and youth-friendly health services are those that are comprehensive, accessible, acceptable, and appropriate for adolescents [49].

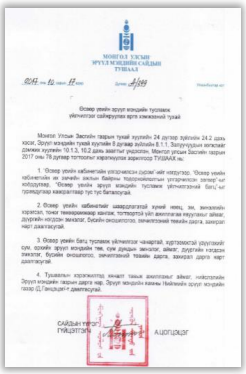
Mongolia's policies and procedures for providing AYFHS are founded on the international norms and principles outlined in the global standards of AYFHS [48].

The results from the policy review showed that the national policies on health, education, child rights and protection fully support AYFHS provision. Over the years, the Ministry of Health developed and approved a number of important clinical guidelines and SOPs on the provision of AYFHS including the medical and psycho-psychological counseling to children and adolescents affected by domestic violence [34]; supply of adequate medical equipment for adolescent clinics [5]; and the provision of health care to adolescents who have attempted suicide [11]; and surveillance of adolescent health [37].

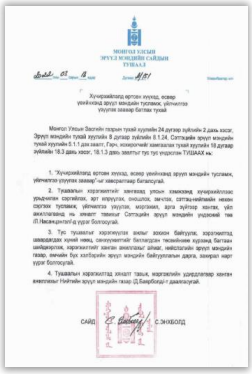
The Ministry of Health is now planning to revise the SOP approved by Ministerial Order No. A/399, 2017 on the provision of AYFHS. The forthcoming order to be issued by the health minister will play a crucial role in integrating AYFHS into PHC services.

The facility survey and interviews with PHC managers and service providers revealed that the availability of policy documents and guidelines on AYFHS provision was low across the assessed PHC centers (n=19). Only some policy documents and guidelines were available in one of third (6/19) of PHC centers visited.

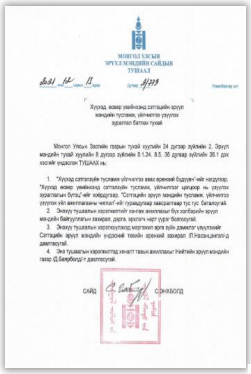
"Our health center does not provide us with the up-to-date clinical guidelines and protocols. The distribution of them to soum center may have been delayed by the aimag (province) Health department office. For that reason, we are lacking with any guidelines." ***Respondent of IDI, SHC***



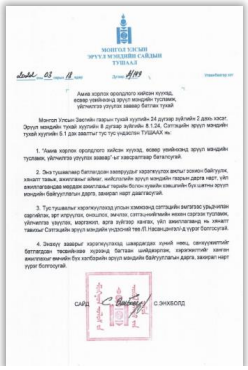
Measures to improve adolescent health care



Guidelines for providing health care and services to children and adolescents affected by violence



Plan for providing mental health care and services to children and adolescents



Guidelines for the provision of health care to adolescents for children who have attempted suicide

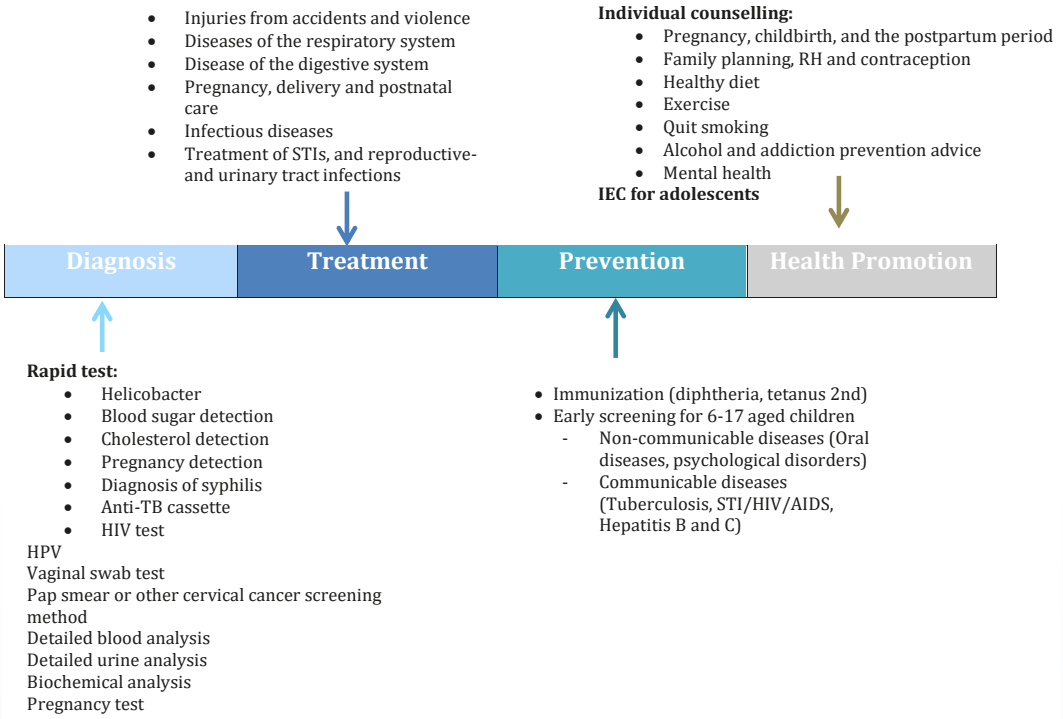
During the field assessment it was observed that the implementation of AYFHS policies and guidelines and monitoring at the *aimag* (provincial), soum and primary level of health care are inadequate. According to the PHC managers' and service providers' responses, the implementation of policies that prioritize and emphasize the provision of AYFHS has been challenged due to the following reasons:

- There is lack of clarity in policy documents and technical guidelines related to AYFHS about specific details of who, when, for whom and what to do and how they can do, for example, in context of SHC who will provide AYFHS.
- The timely distribution of newly approved policies and guidelines to SHCs and FHCs usually challenged.

3.3.2 Availability and a range of services targeted to adolescents and youth in PHC

According to the PHC managers and providers interviewed (n=60), multi-dimensional healthcare services are available in PHC facilities and are offered for all age groups, including adolescents and youth. However, not all adolescent health services (for instance, abortion and management of unwanted pregnancies) are integrated into existing services at PHC centers. According to the SOP endorsed by the order No. A/283, the Minister of Health, the FHCs and SHCs shall offer wide range of integrated health care and essential public health services to address the health needs of communities including adolescents and youth [26]. A range of services should be offered at the PHC settings and more relevant to addressing adolescent and youth health needs are illustrated on mapping in Figure 10.

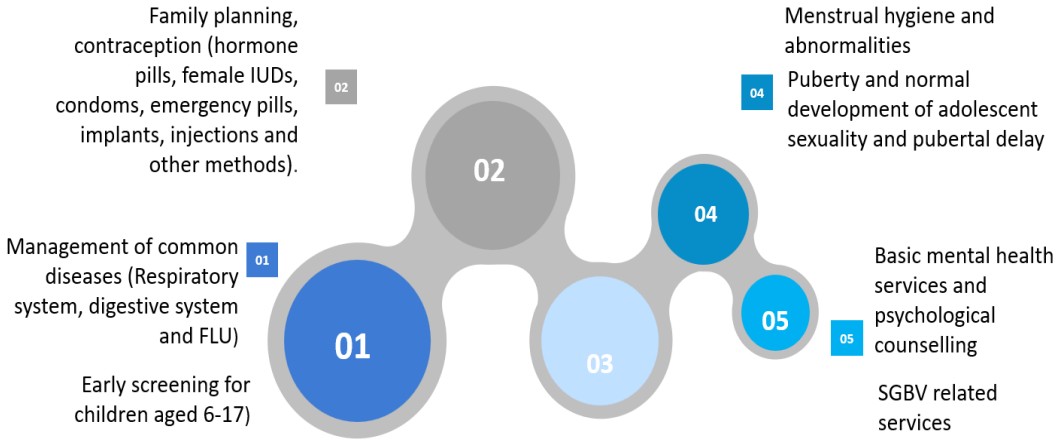
Figure 10. Mapping of services pertaining to adolescent needs to be offered in PHC facilities



The PHC service providers interviewed (n=38) were asked what range of services actually they deliver to adolescents and young people at their facilities. Most of the health service providers named general and sexual reproductive health preventive and curative care and services such as "management of common diseases; early screening for children aged 6-17; contraceptive counseling, provision of condoms, oral contraception, injectable; and pregnancy testing as usually provided services at PHC centers for adolescents and youth. Most of the facilities had adequate stock of pregnancy test, contraceptives including condoms, oral pills and injectable and oral pills. The services mentioned by the least number of service providers were basic mental health services and psychological counseling on adolescent-health specific issues such as adolescent sexuality issues, puberty and pubertal development delays.

The Assessment team also reviewed and analyzed the service statistics of the facilities visited to get the details on which service categories adolescents mostly use and which service categories they use less. According to the review, the adolescent age group mostly received curative health care and enrolled in the early screening. The services related to adolescent sexuality and sexual health issues; mental health, prevention of drug and alcohol use and GBV were the least used categories (Figure11.

Figure 11. Ranking of PHC services provided to adolescents



Early screening among children and adolescents

On a national level, the early screening among children and adolescents aged 6-19 has been conducted in 2022-2023 according to the Guideline approved by the Ministry of Health. The adolescents who enrolled in the early screening had comprehensive medical examination and assessment of their physical and psychological development; mental health and behavioral disorders and risks and screening of tuberculosis and NCDs. Unfortunately, the screening failed to tackle a crucial aspect of adolescent health, namely the identification of puberty growth and disorders. The age category 6-19 is too wide and not appropriate to assess adolescent-specific sexual and reproductive health issues.

According to the national data, the screening was given to 3,465 children and adolescent in 2021 and 3,496 in 2022. 60% were from rural areas (38). The results of early screening showed high prevalence of dental and oral health disorders among children and adolescents and high likelihood of developing urinary tract disorders and respiratory diseases among teenagers.

3.3.3 Accessibility of PHC services for adolescents and youth

3.3.3.1 Convenience of PHC services to adolescents and youth

Convenience of PHC services being assessed by convenience of the locations; operating hours of the PHC centers; the time taken by the adolescent to reach the PHCs; and the waiting times and service fee in receiving services at PHC settings based on direct observation, interview with service providers and feedback received from adolescents during the FGDs.

The adolescents were asked to share their concerns and actual experiences round these issues. In general, the most of adolescents discussed (n=70) in FGDs had positive feelings and experiences of short time to approach to family and soum health centers in their areas; welcoming environments; short waiting time; and convenient operating hours.

Operating hours of PHC centers:

Service days and hours for all assessed PHC centers were from Monday to Friday and from 8:00 am to 6.00 pm local time. During the flu season, family and soum doctors and nurses usually work by extended hours, up to 8 p.m.

In general, majority of the participants of FGDs (n=70) had a positive view of the PHC centers' operating hours and perceived that the operating hours generally work for them as an example. However, some of the participants attended in FGDs cited about long waiting time in health facilities to get services. Also the participants frequently mentioned about discomfort with having to wait alongside adults and small children; some of them said that it is shame since adult health services are also there. Similarly, the observation and results of interviews with the PHC managers and service providers (n=58) revealed that the waiting time for clients at FHCs is usually more than 30 minutes, especially during the winter time and outbreak of respiratory infections.

"This summer, when visiting a soum hospital, I found how simple it is to get treatment there without waiting in line. I was diagnosed with appendicitis, and referred to the provincial hospital, there I had to wait about 3 hours for examination, and it was tough to go up and down the stairs several times while I was hardly walking.

An adolescent participant of FGD, Dornod aimag.

***Location of PHC centers*:**

Most of the assessed PHC centers were community-based and easily accessible by walking or by public transport. Also, the adolescents in FGDs were asked how long it took them to reach the PHC facilities. Majority of adolescents interviewed (n=70) said it took them between 5 and 30 minutes. However, accessing health centers is challenging for out of school adolescents living in remote rural areas.

Services fee:

The counselling and examination and laboratory tests are offered free of charge to all adolescent clients visiting PHCs. The participants did not mention any experience or concern related with service fee.

3.3.3.2 Reaching adolescents with information, education and communication activities

***Outreach activities*:**

The PHC service providers interviewed (n=38) were asked whether they offer an outreach programme for adolescents and young people within PHC services. 84 per cent (32/38) of them reported that they do. However, a significant number of affirmative respondents indicated that outreach health education activities and trainings usually take place only in the schools and student dormitories with assistance from school doctors and social workers.

"Because our family physicians and nurses are often busy with their daily services, we normally offer training and outreach activities at the target school 1-2 times a year in collaboration with the school doctor and social worker. However, it is generally organized as a lecture for many students. Actually talking with boys and girls individually or in small groups would be more beneficial, unfortunately we do not have enough time. I believe that school doctors and social workers should be well-trained in adolescent health issues".

Public health office of FHC, Khovd aimag

One school doctor said: *"The Ministry of Education and the Ministry of Health do not pay school doctors enough attention what services they provide, what challenges they face. Last year, I only participated in one training session organized by UNICEF. In addition, there is a shortage of standardized methodologies and guidelines for school health services, along with an inadequate budget. My annual budget is only 300,000 MNT, so I bought only pain reliever and some wound bandages with this budget."*

Few public health workers of PHC centers (n=3) cited during the interviews that they do not implement outreach activities for adolescents and youth as this is not 'priority issue', because we are fully occupied with other 'priority issues' such as maternal and child care for children aged under three and screening of tuberculosis and NCDs.

Peer education

Peer education programs/activities were implemented in only four out of 19 assessed PHC centers. In addition, 3 PHC centers (FHC=2, SHC=1) had memorandum for partnerships with local schools in their target areas. Six out of the 70 adolescents who participated in the FGDs had received peer educator' training and were also members of their school health clubs. Peer educators (n=2) interviewed attributed the limited scope of their outreach activities to two factors: insufficient, outdated educational materials and limited support from adults.

3.3.3.3 Availability and use of IEC materials on adolescent health issues

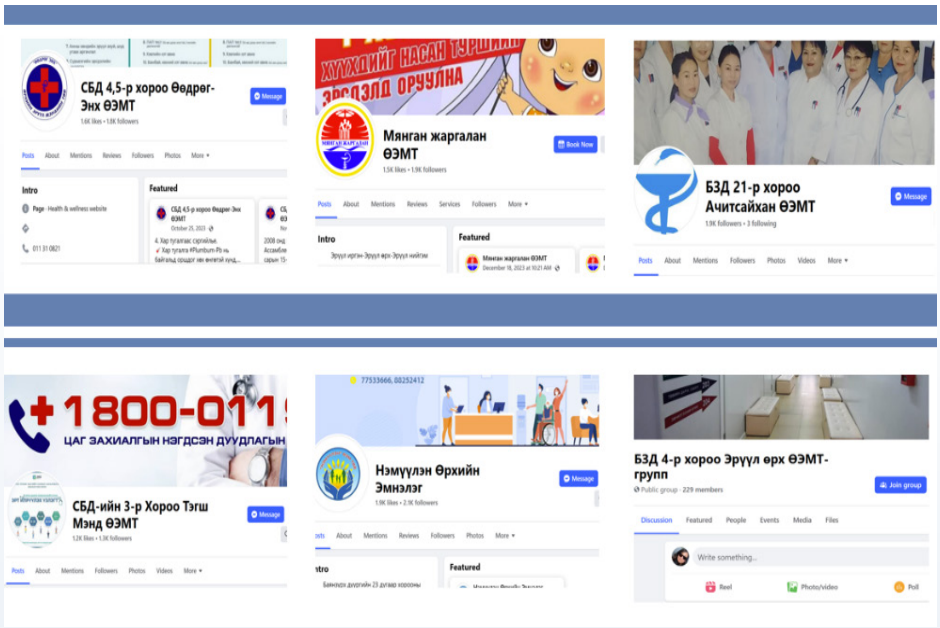
Availability and theme of IEC materials: HIV/AIDS, STIs, contraception and pregnancy were the most popular topics of printed IEC materials available across the assessed PHCs for general public, followed by harm of alcohol and tobacco use, safer sex and condom use. Few PHC facilities visited had IEC materials on pubertal development (5/19), mental health issues (7/19) specifically targeted for adolescents and

youth. Some PHC centers had information board and displayed information posters or leaflets and brochures.

The PHC centers borrow the photocopier from hospital to print leaflets and brochures in limited copies. The service providers use the printed IEC materials only for training and community events, but not widely distribute. Due to limited funding for public health activities the FHCs and SHCs could not print the IEC materials in sufficient copies. In general, it was observed that the content, design and color scheme of available printed IEC materials were substandard.

Other channels to disseminate information to adolescent and youth:

All adolescents participated in FGDs (n=70), were agreeing that the 'school' is the most common source of health information after 'friend'. Interestingly, posters and leaflets are seen as the least common source of information on adolescent health issues. An adolescent in FGD stated that *"The television in the health center and hospital waiting area is mostly turned off, and there is limited educational or informative material on the walls to enable us to read and educate ourselves"* .



A half of PHC centers involved in the assessment have created social media profiles (Facebook pages) to disseminate information and announcements to the general public, which is an interesting channel for information dissemination. The content uploaded on social networks varied in terms of frequency and extent, but the majority were uploaded news about the center' operations, health alerts, and announcements along with some health advice for general public.

Most of the adolescents of focus groups mentioned about spending a lot of time on their phone or social network sites, thus, this channel for information dissemination could be explored as an option for providing not only health information but also using digital technology in reaching to adolescents with AYFHS outside

the health facilities (e.g., with information posters that encourage viewers to scan a QR code and get more information or be directed to a site that gives more and make individual appointment for private counseling).

The UNFPA, Mongolia Country office and the Public health institute have developed more than twenty videos/contents on adolescent health topics and uploaded to social networks (Youtube, Facebook) in the last five years. On average, approximately 1000-5,000 visitors accessed to each contents.

This strategy to use social media was also highlighted in FGDs with adolescents as well as during the interviews with service providers.

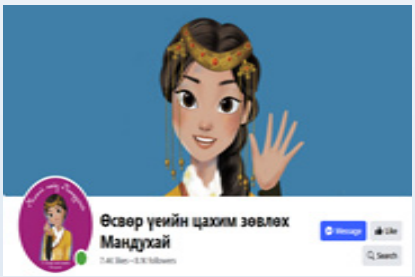
"Using the social media platform (FB page) has been good and the results have been positive. For instance: I found that after an outreach activity for young students at Khovd University, somebody commented on social media...well, I went there and I got this training and it was very interesting and helpful." The public health officer of FHC in Khovd province

The participants in the FGDs were asked whether they would recommend PHC centers to their peers and other adolescents to get health services. The intention to do so was expressed by roughly half of the respondents, with mostly males being the majority. Thus, it can be hypothesized that these teenagers trust the services and are motivated to use them again. Conversely, the young individuals who had not used the services said during the FGDs that they were either unaware that the services were intended for them or had doubts about the service's ability to provide them privacy, confidentiality, respect, or high-quality assistance.

The teenagers questioned during the FGDs highlighted the importance of outreach programs that target adolescents and young individuals inform about the services/programmes targeted for them or that they can access. By doing this, they will be aware of the programs' availability and confident they are specifically meant for their benefit.

Launching and operating an artificial Intelligence based Chatbot:

In 2021, the UNFPA Mongolia Country office, the National Centre for Maternal and Child Health, and the unitel Group collaborated to develop a new "Manduhai" chatbot for adolescents. The chatbot was powered by artificial intelligence. The Manduhai chatbot allows adolescents to access accurate and scientifically proven data on the challenges they face, particularly unintended pregnancies and sexually transmitted diseases.



In addition, the chatbot has created a mobile-friendly e-consultant that is available 24/7, thereby expanding healthcare services and safeguarding young individuals from any potential risks. As a result, there will be a decrease in the number of teen pregnancy cases.

Furthermore, their privacy is thoroughly protected, and they can access pleasant or neces-

sary services. More than 8,000 individuals have visited (as followers) the website in the past two years.

3.3.4 Acceptability of adolescent health services offered in PHC

3.3.4.1 Adolescent and youth privacy in PHC

The Assessment teams observed waiting areas, basic amenities (functional and clean toilets, hygiene facilities, etc.), and audio and visual privacy in PHC settings visited. The PHC service providers were asked which client rights were being implemented in the PHC facilities and how, while adolescents were asked about privacy, welcoming environment, basic amenities at the health facility, as well as interaction with PHC providers.

The results of IDI with the PHC managers and providers (n=60) and facility survey quantitative questionnaires/checklists data revealed that the policies and procedures on privacy and confidentiality of adolescents and young people were present in 11 facilities out of 19 (73%) PHC facilities visited. The client records were stored securely in all PHC centers visited.

Although basic amenities appear to be met at the majority of the PHC centers, the privacy and confidentiality concerns regarding physical infrastructure are not adequately addressed. This includes the absence of private rooms or space for counseling and examinations of adolescents and youth. Out of the 19 PHC centers visited, 7 were using examination rooms shared by physicians and nurses, which compromises the confidentiality and privacy of the clients. Despite the presence of a wall between the areas designated for physicians and nurses at a particular FHC, it is not fully effective in preventing the transfer of sound. Only midwifes of SHCs, immunization nurses, public health workers and bagh fieldsher had individual room.

Most of the FHCs visited have insufficient space in comparison to SHCs. Even though this does not appear to affect the level of satisfaction expressed by young clients, it remains a barrier for those adolescents and young people not accessing the PHC services.

"Due to limitation of space at our FHC, I share the same room with our nurse and sit together. I know that the client may find it challenging to have an additional person present during the examination. If I require private time with my client, I request the nurse leave room. However, these situations are uncommon". ***Family physician of FHC in khovd aimag***

Figure 2. The rating for privacy in PHC centers

PHC facilities required allocating resources and implementing established standards for fundamental characteristics, both of which are crucial.

"To me, the primary factor contributing to the limited entry of adolescent clients into the SHC is their unwillingness to visit the SHC. Their reluctance stems from their lack of trust in the physicians and nurses working within the local communities, privacy issues, and their uncertainty about the services provided". ***Family physician of FHC in Dornod aimag***

As mentioned earlier, the majority of adolescents were able to get to the PHC centers within 5- 30 minutes. However, adolescents have said, access to PHC services is challenge due to privacy concerns, therefore prefer not to use the PHC services even near to them. This indicates that to facilitate adolescents' and young people' access to PHC services, it appears that privacy, confidentiality, and support are more vital than the physical access to services.

"A year ago, I experienced a sudden swelling in my head, which led me to visit a doctor at Soum Health Center. The doctor's daughter and I are classmates, and the next day, she learned about my visit to the doctor and my health issues. I believed that if I had a severe illness, all of my classmates would be aware of it. Since then, I have lost faith in the doctors' ability to keep people's secrets private". ***Adolescent girl participant of FGD, Dornod aimag***

3.3.4.2 Non–judgmental and considerate communication

The PHC service providers interviewed (n=38) were asked whether any services could not be provided to adolescents and young people. (probed due to age, need for parental consent, and other reasons) A family physician in IDI said, *"There are certain services that adolescents cannot receive at the family clinic. However, this is not due to their age, gender, or status in society; rather, it is primarily due to lack of properly trained service providers and lack of expertise, skills, and experience."*

Within this theme, adolescent were asked about their feelings about communication of staff at the PHC centers, including biases or discriminatory or judgmental attitudes. Half of all FGD participants have experienced contact with doctors, nurses and support staff (cleaning staff, security staff, etc.), Majority of the adolescents said that they felt the staff were friendly and treated them with respect. A few adolescents (about 10 out of 70) had feeling that the doctors and other staff were not friendly or did not treat them with respect.

I experienced severe pain during my period last month. Then, when I went to visit a doctor at the local health centre, the doctor criticized me, stating that this is what happened because you girls wear thin clothing that makes you look slim. I was constantly dressed warmly since it was chilly outdoors, but I couldn't tell. I felt so horrible that I vowed never to go back to that doctor.

Adolescent girl attended FGD. Bulgan aimag

Most PHC service providers interviewed (n=38) admitted during the interviews to having limited knowledge about clients' rights, non-discrimination, and non-judgmental behaviour. In other words, only few of health service providers interviewed (6/38) had been trained on issues round privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.

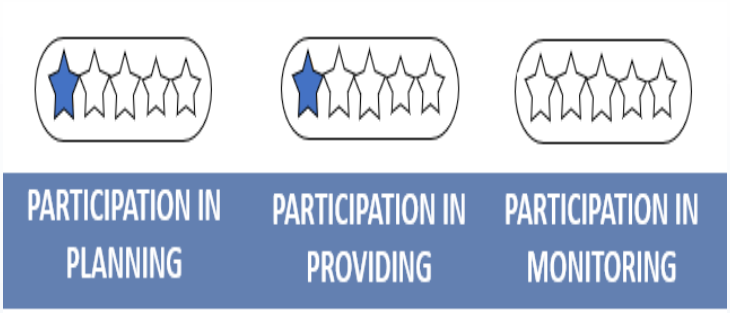
According to an FGD participant, adolescents are afraid of adult service providers and may avoid sharing sexual and reproductive matters with them because they fear their health conditions will be discussed in the community.

3.3.5 Participation of adolescents and youth in AYFHS offered in PHC.

The qualitative data obtained from the FGDs indicated that a small number of PHC service providers and public health workers (5/38) recognize and include adolescents and youth in the design and execution of activities targeted to them. For example, in Dornod province, a public health officer from an FHC stated that she closely collaborates with adolescent and youth peer educators and often hold meetings with them to plan and work together on activities designed to reach adolescents and young people.

While we discussed with adolescents their engagement in the planning and provision of health care appeared very low especially, they never involved in the monitoring of the adolescent health services offered in PHC settings.

Figure 13. ***The rating for adolescent's participation***



Regarding the receiving feedback from adolescents, only one FHC in Ulaanbaatar had initiated a comment box exclusively for adolescents. Unfortunately, the comment box was not visible in the waiting area.

An adolescent interviewed in Bulgan province stated that youth are not involved in planning or decision-making; they are told what to do. The planning and implementation of youth activities are not being fully engaged by young people, as a public health officer from FHC in Khovd province stated.

Frankly, I would say, we (health worker) and youth are not key players in AYFHS provision. Parents and members of the community failed to acknowledge the significance of AYFHS and do not entirely encourage the implementation of healthcare packages for this age group.

Public Health Officer. Dornod aimag

3.3.6 The readiness of PHC providers to integrate AYFHS in PHC services

The PHC service providers' readiness to integrate AYFHS in PHC services were assessed by inclusion of tasks related to AYFHS in their job descriptions; review of training records; and availability of continuous professional development plan in PHC facilities; trainings attended in the last 3 years and training needs for integrating AYFHS in PHC services.

Figure 14. The results of self assessment of providers on their readiness to deliver AYFHS.

The PHC service providers (n=38) asked to assess their knowledge and competence or readiness to deliver AYFHS. A total of 30 percent of the interviewees reported that they possess the requisite skills and expertise to deliver PHC for adolescents and youth. The majority (70%) responded that they need additional training to deliver AYFHS.

As mentioned by a public health officer of SHC in Bulgan aimag, *"There is no continuous or comprehensive training program for PHC providers on AYFHS. It is very hard to say that we have adequate knowledge and skills that enable us to provide services efficiently. Some may take the training a long time ago."*

Figure 15 below shows the training topics that the PHC service providers interviewed (n=38) had been trained on. The topics that PHC providers had trained most include "provider-initiated HIV testing for adolescents, pre-and post-HIV test counseling" (50%), followed by "counselling and provision of first line support for teenagers subject to domestic and gender-based violence" (40%). The topics least covered were related to "social-psychological problems, mental health" (20%), "the importance of respecting the rights of adolescents on access to information, health care and services, and non-judgemental attitude and non-discrimination" (2%).

Figure 15, Training topics related to AYFHS received by PHC providers

A total of 47% (18/38) of the PHC service providers who were interviewed indicated that they were informed about the Ministerial orders on AYFHS. The nurses and *bagh* feldshers were not informed with the guidelines and standards on PHC

services including AYFHS. For instance, one IDI participant expressed, *"Our understanding of the PHC policies and guidelines is limited as such information has not yet been provided to us."*

Most PHC providers lack national guidelines and training manuals on AYFHS and have not received comprehensive AYFHS-specific training. Consequently, health service providers may be confronted with challenges in providing high-quality services to adolescents and young individuals.

> *" I have recently started work at an adolescent clinic in my province after having completed one year of adolescent health postgraduate training. It is common for pediatricians and neonatologists to receive extensive training and there are plenty of training materials, guidelines, and learning documents on neonatal care. The training program for adolescent physicians is not sufficient. At the moment, adolescent psychology holds my interest and I am dedicated to developing my counseling skills. Despite this, no institution currently offers a suitable training program in this particular field.*
>
> ***Adolescent Doctor, Adolescent Clinic, Khovd aimag***

After the interview, several health service providers were inquired about the requirements for completing specific certified training for getting credits to provide AYFHS.

Table 13. ***The need or areas of improvement and gap matrix***

AREAS	DESIRED STATUS	GAP RATING:	NEED OR AREAS OF IMPROVEMENT	CURRENT STATUS
Availability and accessibility of AYFHS in PHC				
AYFHS policies and procedures	Adequate policies for the provision of AYFHS in PHC in place and operationalized.	**MINOR**	In adequate distribution of AYFHS policy documents and technical guidelines to the field	Several SOPs round AYFHS are issued but they were not available in PHC facilities and providers.
Convenience of PHC services to adolescents and youth	The location, operating hours, waiting time and service fee of AYFHS are convenient for adolescents and youth.	**NO GAP**	No areas of improvement	Most adolescents consider that the location, operating hours, waiting time and free AYFHS work for them.

Availability and quality of information, education and communication (IEC) on adolescent health	High quality printed and digital materials on adolescent health issues are widely available and used by adolescents.	MODERATE	-Lack of funding for public health; -Limited quantity and in adequate quality of IEC materials	Some printed and digital IEC materials are available on adolescent health issues in limited copies but most of PHC centers have limited funding; and the quality of materials is not good enough.
Acceptability of PHC services targeted adolescents and youth in PHC				
Adolescents' privacy in PHCs	Private and confidential counseling and examination are in place in PHC settings.	MODERATE	Lack of adequate physical environment to ensure privacy in service provision	Majority of FHCs have limited space to provide private and confidential counseling and examination for adolescents and youth
Non-judgmental and considerate communication	All PHC service providers have non-judgmental attitude towards adolescents in service provision.	MODERATE	Limited knowledge and competence of providers on effective, non-judgmental communication with adolescents	PHC service providers have limited knowledge about clients' rights, non-discrimination, and non-judgmental behavior
Adolescent and youth participation in AYFHS.	Adolescents are allowed to engage in the planning, provision and monitoring of AYFHS.	MAJOR	No approach/ tools or mechanism to involve adolescents in AYFHS	Adolescents have very limited involvement in the planning and provision of AYHS in PHC and no involvement in monitoring.
The readiness of service providers in integrating AYFHS in PHC				
The use of evidence-based protocols and standards by PHC service providers	All PHC providers are fully informed and use the technical guidelines for provision of AYFHS	MODERATE	Lack of knowledge of PHC providers about existing SOPs on AYFHS	Series SOPs issued by the MOH, but the PHC service providers mostly do not know these SOPs
Training and competence of PHC providers on AYFHS	All PHC service providers trained on AYFHS and have adequate competence to provide high quality services for adolescents and youth in PHC.	MAJOR	No in-service training program on AYFHS	Only 30% of interviewed service providers were confident to provide AYFHS in PHC Limited number of trained service providers in PHC settings for the provision of good quality AYFHS

4. CONCLUSIONS AND RECOMMENDATIONS

Drawing upon the key findings of the Assessment and analysis in the report, this chapter identifies the several priority needs and areas of improvement as well as potential opportunities in the effort to effectively integrate the ECD aspects and AYFHS into the PHC in Mongolia. The chapter also proposes several action points to address the identified needs and gaps in integrating ECD and AYFHS into existing PHC services.

An overriding conclusion of the Assessment is the country has adequate policies and technical guidelines to provide people-centered, accessible and high quality integrated primary care and essential public health services that promote basic principles of PHC outlined in the vision of PHC and the global strategies.

Despite the policy implementation faces with several challenges, the achievements towards UHC are also evident. Some ECD-specific interventions and some aspects of adolescent-friendly service standards are already exist or incorporated into the PHC services, but not all and not in adequate quality. Many issues examined under the Assessment revolve around the limitations in the integration and the challenges in improving the accessibility, quality and effectiveness of services pertaining to ECD and AYFHS.

The priority needs and areas of improvement and potential opportunities are grouped according to the three thematic areas of the Assessment framework presented in chapter 1 and depicted in Figure 1.

Thematic area 1: Current status of PHC services in Mongolia: the policies, structures, a range of services offered, human, financial and infrastructural resources allocated for the provision of quality PHC services.

The needs and areas of improvement to facilitate good integration of ECD and AYFHS

- Despite Mongolia's PHC policies generally support basic principles of PHC, there are still minor gaps and needs to increase the impact of national PHC policies and strategies to implement "*whole-of-government*" and "*whole-of-society*" approach in PHC.
- Engagement of empowered people and communities and other stakeholders from all sectors for health needs improvement trough policy dialogue and partnerships.
- Existing structure of PHC facilities is adapted more to the provision of clinical care and there is need to match the structure with the provision of all integrated primary care and essential public health services specified in new SOP approved in 2023 by the order No. 283 of the Health Minister.
- The competency level, the productivity, efficiency, effective management of available scarce human resources of PHC facilities need a lot of improvement; in addition, the shortfall of doctors in SHCs and nurses in FHCs of Ulaanbaatar should be addressed.
- FHCs need standardized facility with reliable physical infrastructures and enough space for provision of high quality confidential services.

- The shortage of reliable transport adapted to specific needs of delivering PHC services in urban and rural areas needs to be prioritized and strategically addressed.
- The funding and resource allocation should be matched with the provision of integrated primary care and essential public health services specified in new SOP mentioned above.
- Rational use of digital technologies in distance learning, service delivery and data management within PHC should be enhanced; and existing operational gaps related to overlaps and use of various digital health records need to be reviewed and improved.
- Supportive supervision and continues quality assurance mechanisms need to be in place within PHC.

Action points:

- Strengthen political commitment and leadership and cultivate champions in advocating the importance of PHC towards the achievements of UHC and health-related SDGs, and implementation of '*whole-of-government*' and '*whole-of-society*' approach in PHC
- Establish formal multisectoral coordination mechanisms at national and sub-national levels to ensure broad engagement of all influential sectors of society in implementation PHC policies and new Public health law recently approved by the Parliament.
- Foster community awareness raising that promotes the empowerment and mutual accountability of people and communities for health.
- Establish effective community-based joint multisectoral team (similar to the Multisectoral Joint Team in responding to GBV) to ensure broad engagement of relevant sectors in the implementation of PHC policies and new public health law at primary level.
- Conduct costing of new integrated primary care and essential public health service package to be offered in PHC facilities in line with the new SOP mentioned above.
- Allocate evidence-based adequate funding for PHC mobilizing various funding sources to create incentive environment to ensure the provision of high quality integrated primary care and essential public services.
- Develop the standard of FHC facility and provide upgraded physical infrastructure for these FHCs and SHCs that currently providing PHC services in substandard facilities.
- Develop the standard of reliable transport system for SHC and FHC adapted to the unique needs of providing services in urban and rural areas.
- Develop service-specific checklists or other tools for supportive supervision of the provision of quality ECD and AYFHS integrated in PHC services.

Potential opportunities for integrating ECD and AYFHS in PHC services

- The PHC policies are in place, well operationalized and support integrated

approach in PHC to increase the efficiency of scarce resources and the effectiveness of service provision.

- The share of total health expenditure in GDP, and the total PHC expenditure have increased over the years.
- Free provision of PHC promotes equity in access to PHC services including AYFHS and ECD interventions within PHC.
- Existing governance and structures of PHC are supportive for integrating ECD and AYFHS in PHC and there is no need for re-organization or structural change.
- Core professional team of general practitioners, nurses, midwives and social workers exist across all PHC facilities.

Thematic area 2: Early childhood development: the accessibility and quality of services pertaining to ECD and the effectiveness of interventions in place for ECD needs

The needs and areas of improvement for integrating ECD into PHC services

- There is need to incorporate the ECD-specific interventions outlined in the Action plan for improving ECD into existing operational regulations including the standards of FHC and SHC and the integrated service package to be offered in PHC facilities etc.
- The coverage and quality of routine child development assessment and early screening of children under 5 years old and integration of ECD interventions in these services need a lot of improvement.
- Despite broad range of services pertaining to ECD are already exist in PHC, the integration of ECD interventions on responsive caregiving, promoting early learning opportunities and supporting maternal mental health into these services is currently limited and should be improved.
- All PHC providers need competence building training on integrating ECD in PHC services and improving quality of counselling and coaching parents to practice ECD interventions.
- There is no effective parenting programme and no 'well child day' in PHC facilities.
- Parents and primary caregivers of young children need to have adequate knowledge, skills and materials to effectively interact with their children and stimulate their cognitive and socioemotional development.
- All PHC facilities need to have good quality IEC and training materials in WHO recommended four areas of ECD such as responsive caregiving, promoting early learning opportunities, optimal nutrition and supporting maternal mental health of mothers

Action points:

- Ensure the explicit integration of "***early childhood development***" into relevant health policy documents, standards of PHC facilities and other relevant guidelines and SOPs in the future.

- Develop ***training module*** on ECD-specific interventions in line with the WHO recommendations for promoting responsive caregiving; optimal nutrition; early learning opportunities and supporting maternal mental health. This module could be integrated into existing training modules on management of childhood illnesses.
- Provide ***ECD training*** for all PHC providers (family physicians, nurses, midwifes, public health workers and bagh feldshers) to ensure they integrate ECD interventions in the relevant PHC services.
- Develop pocket book with ***Job-aids*** to be used by PHC providers to integrate ECD messaging into all relevant services pertaining to ECD including ANC visits; postnatal newborn home visits; active supervision of infants; conducting assessment of child development; immunization and other.
- Develop SOP or Guideline to have the "***Healthy Child Day***" in PHC facilities to conduct quality child development assessment of children aged 9, 18 and 36 months and coach parents on how to assess child development on monthly basis by themselves.
- Establish "parent groups" on voluntary basis, develop and implement on-line "***parenting programme***" for mothers of young children moderated by public health worker or one of family nurses trained on ECD interventions.
- Develop high quality ***video content*** on the importance of the first 1000 days for brain development and upload to the social platforms to motivate parents to take early action
- Promote ***community-based ECD activities*** initiated by NGOs and CHWs and educators within health promotion activities financed by the health promotion fund
- Support inclusion ECD related topics into the medical, nursing and midwifery school' relevant ***curriculums***
- Train ***CHWs*** and formalize their roles in the provision of PHC services.
- Include the specific roles and responsibilities of providers around integration of ECD in services pertaining to ECD to ***their job descriptions*** and performance evaluation by formalizing "task shifting" and "task delegating" mechanisms.

Potential opportunities for integrating ECD in PHC services:

- The ECD-specific Action plan, technical guidance for assessing development of young children is in place; the child health book is updated.
- Parent counselling and developmental assessment of children aged 9, 18 and 36 months are explicitly included to new service package (2023) to be offered in PHC facilities.
- The country is close to achieving UHC in several services pertaining to ECD offered in PHC such as ANC coverage, postnatal newborn home visits, and immunization.
- The PHC policy makers, managers and services providers recognize the importance of ECD interventions and support the integration them within PHC services.

- PHC providers usually have much training on newborn care and management of child illnesses that is opportunity for integrating ECD training module in these trainings.

Thematic area 3: Adolescent–youth–friendly health services: the accessibility and quality of adolescent and youth health services within PHC and the effectiveness of interventions in place for AYFHS needs.

The needs and areas of improvement for integrating AYFHS into PHC services

- The accessibility and quality of essential sexual and reproductive health services, basic mental health and behavioral counseling for addressing specific health concerns among adolescent, the first line support for adolescents and youth effected sexual and physical violence need a lot of improvement and expansion. Currently adolescents mostly receive curative care from health PHC facilities.
- Community outreach and adolescent health promotion activities are lacking and need to increase the reach through effective partnerships with school health workers and adolescent peer education clubs in schools.
- Allocation of more funding public health activities to educate and empower adolescents and youth and increase their participation in PHC needs to be prioritized.
- All PHC providers need to have evidence-based protocols and standards for the provision of AYFHS within PHC and use them to effectively integrate AYFHS in PHC. Currently, there is a gap in availability and use of AYFHS policy and technical documents in PHC facilities and providers' knowledge of about existing SOPs on AYFHS in adequate.
- PHC service providers need competence training to have adequate knowledge about clients' rights, and principles of non-discrimination, and non-judgmental behavior in service provision because they have not trained on these important standards of AYFHS.
- The high quality printed and digital materials on adolescent health specific issues are not widely available in PHC facilities, and there is need to provide adequate funding for development of good quality printed and digital materials and disseminate through various channels.
- The enabling physical environment for private and confidential counseling and examination for adolescents and youth is not secured in FHCs and they need upgraded facility to comply basic standards of AYFHS.
- PHC providers need to allow active engagement of adolescents in the planning, provision and monitoring of AYFHS; currently adolescents have very limited involvement in the planning and provision of AYFHS in PHC and no involvement in monitoring.

Action points:

- In collaboration with relevant UN agencies, develop and implement effective ***advocacy strategy*** to promote a holistic approach to AYFHS.
- Formulate ***national plan*** for improving AYFHS that promote the cross-sec-

toral collaboration.

- Assemble all existing ***policies and guidelines*** related AYFHS and deliver to PHC facilities to initiate the integration of relevant types of services targeted adolescents and youth in PHC services.
- Conduct assessment on current situation of ***school–based primary care*** and services to identify the needs and gaps as well as opportunities of further improvement and implement follow up actions.
- Enhance ***partnership*** of PHC facilities with schools and universities in their area and support effective community-based joint initiatives for addressing specific health needs of adolescents and youth
- Implement pilot initiative in selected FHCs of Ulaanbaatar and few SHCs to develop ***innovative effective approaches*** and ***models*** of integrating AYFHS within PHC and evaluate the effectiveness of the initiative

The potential opportunities for improving AYFHS within PHC are:

- Several SOPs round AYFHS have been issued and these are complying with basic international norms and principles of adolescent-friendly service standards.
- The order of the Minister of Health issued in 2017 includes important actions for improving health care and services for adolescents and youth. Now the ministry is working to update.
- Adolescents perceive that the locations, operating hours, waiting time and free AYFHS are convenient for them.
- Many FHCs have shown positive results in disseminating information to the public through their Facebook pages which is good opportunity to reach adolescents with information about available services and establish feedback mechanism.
- Most of the PHC facilities have had adequate stock of pregnancy test strip, essential medicines, contraceptives including condoms and emergency contraceptive pills for provision of sexual and reproductive health services for adolescents and youth.

5. References

1. Action plan for improving early childhood development, 2023-2026, Joint order A/236, A/637, A/218 of 2022 of minister of education, minister of health and minister of labor and social protection
2. Antenatal and postnatal care guideline, Order A/318 of 2020 of minister of health
3. Child Health Book, Order A/347 of 2023 of minister of health
4. Constitution of Mongolia, 1992
5. Distribution of medical equipment to youth-friendly clinics, Order A/99 of 2016 of minister of health
6. Essential health care package, Order A/216 of 2020 of minister of health
7. Guideline for improving the quality and safety of health care and services for 2022-2025, Order 136 of 2022 of minister of health
8. Guideline on health sector's official statistics and information management, Order A/611 of 2019 of minister of health
9. Guideline for home visits for children under one year by FHC and CHC, Order A/546 of 2019 of health minister
10. Guideline for improving the quality and safety of health care and services for 2022-2025, Order A/136 of 2022 of health minister
11. Guidelines for the provision of health care to adolescents for children who have attempted suicide Order A/149 of 2022 of health minister
12. Health sector action plan to implement the state policy on health in 2020-2026., Order A/103 of 2020 of health minister
13. Health Indicators 2022, 2023 Health development center
14. Job description of midwife, Order A/216 of 2017 of health minister
15. Job description of nurse, Order A/183 of 2012 of health minister
16. Job description of physician, Order A/182 of 2012 of health minister
17. Law of Mongolia on Health, 2011 (amended)., Legalinfo.mn
18. Law of Mongolia on Health insurance, 2015 (revised)., Legalinfo.mn
19. Law of Mongolia on Medical care and services, 2016., Legalinfo.mn
20. Law of Mongolia on Child protection, 2016., Legalinfo.mn
21. Law of Mongolia on Protection of personnel information, 2021 (revised)., Legalinfo.mn
22. Law of Mongolia on Immunization, 2000
23. Law of Mongolia on Nutrition of infant and young children, 2017
24. Measures to improve youth health care, Order A/399 of 2017 of health minister
25. Multi-Indicator Cluster Survey report, National Statistical Office, 2017
26. National immunization schedule, Government Resolution No 472 of 2023

27. Nutrition status of the Population of Mongolia, UNICEF, Public health institute , 2017
28. Primary health care registration forms and records of FHC and SHC, Order A/611 of 2022 of health minister
29. Primary health care financing of FHC and SHC, Resolution No23 in 2023 of National council of health insurance
30. Programme for improving early childhood development, Joint order: A/236, A/189, A/80 of 2023 education, health and labor and social protection ministers
31. Procedure for providing health care and services for children and adolescents exposed to violence, Order A/151 of 2022 of health minister
32. Procedures for providing medical, psychological and counseling services to children subjected domestic violence, Order No. A/394 of 2017 of health minister
33. Procedure for data collection of on child information and confidentiality, Order A480 of 2018 of health minister
34. Procedure for the provision of psychological services to victims and provision of medical and psycho-psychological assistance to children affected by domestic violence, Order A/394 of 2017 of health minister
35. Procedure for the financing for packages for prevention, screening and diagnosis for insurers, rate of payment, Resolution No 06 2022 of National council of health insurance
36. Revision of the procedure, list, and performance evaluation criteria for care and services provided to families, soums, and village health center, Order A/283 of 2023 of health minister
37. Regulations for health surveillance of adolescents, Order A/97 of 2021 of health minister
38. Report on health surveillance of adolescents., National center for maternal and child health, 2023
39. Socio-economic situation of Mongolia, statistical bulletin, April (2020) National statistical office of Mongolia, UNICEF
40. Standard of Mongolia on Structure and operations of Family health center, MNS 5292:2017.
41. Standard of Mongolia on Structure and operations of Soum health center, MNS 5081:2013.
42. VISION-2050, Long-term development policy of Mongolia, Resolution No. 52 of 2020, State Great Khural of Mongolia,

References of international literatures

43. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF);

2018
44. Accelerated action for the health of adolescents (aa-ha!) a manual to facilitate the process of developing national adolescent health strategies and plans, guidance to support country implementation, 2017, accessed at global accelerated action for the health of adolescents (aa-ha!).pdf
45. Developing National Quality Standards for adolescent-friendly health services, World Health Organization, 2012, accessed at 9789241503594_eng.pdf (who.int)
46. Global standards for Quality Healthcare Services for adolescents, World Health Organization, UNAIDS: a guide to implement a standards-driven approach to improve the quality of health-care services for adolescents, 2015
47. Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development: UNDESA United Nations Department of Economic and Social Affairs, 2017
48. Global standards for quality health-care services for adolescents: a guide to implementing a standards-driven approach to improve the quality of health care services for adolescents. Volume 1: Standards and criteria. Geneva: World Health Organization, 2015.
49. Handbook for conducting an adolescent health services barrier assessment (AHSBA) focusing on disadvantaged adolescents. Geneva: World Health Organization; 2019.
50. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020.
51. Quality assessment guidebook: a guide to assessing health services for adolescent clients, World Health Organization, 2009
52. Standards for improving the quality of care for children and young adolescents in health facilities: WHO, 2018
53. WHO Guideline for improving early childhood development, 2020
54. WHO, UNICEF, the World bank group, Nurturing care framework,

ANNEXES

Annex 1:
Assessment matrix

Annex 2:
Guiding questions for key informant interview

Annex 3:
Questionnaire for in-depth interviews with primary healthcare managers

Annex 4:
Questionnaire for in-depth interviews with primary healthcare service providers (ECD)

Annex 5: Questionnaire for in-depth interviews with PHC service providers (AYFHS)

Annex 6:
Guiding questions for focus group discussion with parents and caregivers

Annex 7:
Guiding questions for focus group discussion with adolescent boys and girls

Annex 8:
Facility observation checklist

Annex 9: Informed consent form